



July 1, 2011

Director Julie Hamos
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0002

Dear Director Hamos:

The Illinois Primary Health Care Association is pleased to respond to the request for comments regarding the **Department of Healthcare and Family Services' (HFS) Coordinated Care Program**. IPHCA is the membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the state, and is a 501(c)(3) organization.

Background

IPHCA is limiting its comments primarily to issues that are of particular importance to health centers in their efforts to play a critical and supportive role in the implementation of HFS' Coordinated Care Program as described in P.A. 96-150, effective January 25, 2011. To best explain and support our focus on certain aspects of the program, we believe the following background review is appropriate.

In Illinois, there are 43 FQHCs with more than 400 sites serving over 1.2 million patients statewide. Most of these FQHCs receive federal grants to help cover the cost of serving the uninsured under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS. To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and *the health center must offer services to all persons in its area, regardless of one's ability to pay*. Approximately 50 percent of Illinois health center patients are Medicaid recipients and approximately 30 percent are uninsured. Ninety-five percent (95%) of Illinois health center patients have family incomes at or below 200% of the poverty level.

Recognizing the importance of health center services to Medicaid beneficiaries, Congress in the Omnibus Budget Reconciliation Act of 1989 made the services of an FQHC *a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program*. Throughout its 45-year period, the health center program has been recognized by Congress, by Presidential Administrations (both Democrat and Republican), and in various academic studies as providing critical cost-effective and high quality primary and preventive health care and enabling services to a relatively high-risk vulnerable population and that they offer a health care home model that should be a central and necessary component in any legislative or public policy effort seeking to expand or modify coverage to the underserved in this country.

Cost Savings & Quality Outcomes

Although health centers provide services not typically furnished in other care settings, their costs are still lower. Their costs run at least a dollar less per patient per day compared to all physician settings (\$1.67 vs.

\$2.64), and far below the cost of a hospital stay.¹ Despite their lower costs of care, health centers generate significant returns on investment. Their proficient provision of preventive and primary care services reduces unnecessary, avoidable, and wasteful use of health resources. Research also shows that they reduce the rate of preventable hospitalizations, inpatient days, and Emergency Department (ED) use. They also meet or exceed national practice standards for chronic condition treatment. In fact, the Institute of Medicine (IOM) and the U.S. Government Accountability Office (GAO) have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV.²

These cost-effective outcomes are achieved through health centers' ability to successfully:

- Coordinate care;
- Rapidly incorporate and disseminate evidence-based practices;
- Motivate patients to become more actively involved in changing health behaviors and receiving necessary care; and³
- Utilize multiple health professionals with varied skills.

FQHC team-based settings involve physicians, nurse practitioners, physician assistants, nurses, social workers, case managers, behavioral health specialists, dental providers, health educators, outreach workers, and others. Research shows that team-based care improves patient outcomes⁴ and reduces health disparities.⁵ "The health center movement could be considered an early adopter of many elements of the medical homes model, and health centers should serve as a model and beacon as the health care delivery system is redesigned to enhance quality and value."⁶ (*Attachment - George Washington University policy paper*)

Responses to Key Policy Issues

1. How comprehensive must coordinated care be?

Questions for Comment

- a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?
- While not precluded, coordinated care should not be limited to Managed Care Organizations that arrange care for the entire range of services.
 - Should look at programs in other states, e.g. North Carolina Community Care program – importance of community based coordination.
- b) Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?
- Illinois geography is such that regional approaches may be appropriate for different levels of

¹ Agency for Healthcare Research and Quality. Medical Expenditure Survey Summary Tables, 2008. Available at <http://meps.ahrq.gov>. 5: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data. System

² U.S. General Accounting Office. (2003). *Health care: Approaches to address racial and ethnic disparities*. Publication No. GAO-03-862R. Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Washington, DC: National Academy of Sciences Press; 2003.

³ Chin MH, et al. "Improving and Sustaining Diabetes Care in Community Health Centers with the Health Disparities Collaboratives." 2007 *Medical Care* 45:1135–1143.

⁴ Hing, Hooker, and Ashman, Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. *J Comm Health* Nov 2010.

⁵ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

⁶ Shin Peter, et al. "Financing Community Health Centers as Patient-And-Community-Centered Medical Homes: A Primer," George Washington University, May 2009.

“comprehensiveness.” May be appropriate to phase in elements gradually based on the services currently available in a given area.

- c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?
- Agree that Medical Homes should be the hubs of coordinated care. In fact, FQHCs were the first providers to participate in the Illinois Health Connect.
 - Agree that at some point PCPs should achieve PCMH recognition/certification through a nationally endorsed program with the understanding that practice transformation is costly and takes time to accomplish.
- d) How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?
- Agree that integrators, patient navigators and care coordinators have been successful in achieving clinical and financial outcomes, but adequate funding is required or the model will not be feasible. The care coordinator model would be very effective in FQHCs given their experience in managing patients with complex chronic conditions.
- f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?
- Incentives for FQHCs – care management fees, pay for performance bonuses, reimbursement for costs associated with PCMH recognition/certification. For a medical home model to be effective, we also encourage incentives for specialists.

2. What should be appropriate measures for health care outcomes and evidence-based practices?

Questions for Comment

- a) What are the most important quality measures that should be considered?
- Quality indicators should be chosen from nationally accepted measures, including HEDIS, Meaningful Use, HRSA’s Bureau of Primary Health Care UDS Reports (*attached*). In choosing quality measures, HFS must consider that some quality indicators cannot adequately be measured through claims data alone. Until EHR systems are fully integrated with HFS, the Department must accept other forms of data collection, including disease registries.
- b) Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?
- Different measures are appropriate for different groups.
- c) How should the Department think about client risk adjustment in order to level the playing field as providers deal with patients across a wide range of situations?
- Quality based payments should be adjusted based on factors such as diagnosis, age, and

homelessness.

- d) What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?
- The number of measures by type of service or client should not be too great as healthcare systems need time to develop their EHR capabilities.
- f) How can the Department most effectively work with other payors to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?
- IPHCA supports the idea of working with other payors to adopt a coordinated set of quality measures as not to overburden providers – this will be especially important as HFS works with the Department of Insurance and other stakeholders on the development of the State Health Insurance Exchange.

3. To what extent should electronic information capabilities be required?

Questions for Comment

- c) If additional incentives were going to be added for being electronically enabled, that would inevitably mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to induce electronic connectivity? What trade-offs would be appropriate to support such incentives? (For instance, should the amount of money available for outcome incentives be reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)
- Additional state funds for incentives should not be directed toward EHR adoption/MU, given that scarce resources would mean less reimbursement elsewhere.
- d) On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?
- IPHCA supports the adoption and meaningful use of Electronic Health Records as a means achieving better health outcomes and cost effectiveness. However, given that most providers are in the early stages of adoption and the fact that Illinois does not expect to make the first year of Medicaid incentive payments available until 2012, we agree with HFS' assertion that it is unrealistic to require these capabilities initially.
 - Individual providers should not be penalized if not all providers in their coordinated care network are not operating at the same level, which will impact the flow of information between providers. This will become increasingly difficult as more providers come into the networks, ex. nursing homes, optometrists, podiatrists.

4. What are the risk-based payment arrangements that should be included in care coordination?

Questions for Comment

- a) How much risk should be necessary to qualify as risk-based?
- Health centers have different levels of comfort when it comes to risk. Some have a great deal

of experience with Medicaid HMOs, while others have no experience. Given their patient mix of mostly Medicaid and uninsured, FQHCs already operate very close to the margin and are financially vulnerable.

- b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?
- Support models with only upside risk. Losing an opportunity for shared savings is having "skin in the game."
 - FQHCs with a lack of experience in taking risk may especially need an arrangement without down-side risk given Congress' mandate that FQHCs, as America's healthcare safety-net, be paid adequately for serving Medicaid patients so as not to use their Public Health Service Act grant funds (intended to cover costs associated with the uninsured) to subsidize low Medicaid payments.
- c) If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?
- Some arrangements may never be able to accept down-side risk.

5. What structural characteristics should be required for new models of coordinated care?

Questions for Comment

- a) Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?
- HFS should be open to new providers and models.
- b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different for one and two-sided risk arrangements? Should Department of Insurance certification be required?
- The financial base for FQHCs is their current Prospective Payment System (PPS) rates to maintain their financial viability and federally mandated requirements. Additionally, providers responsible for patient management must be compensated for the additional services/administrative costs. These additional incentives will produce cost savings through improved clinical outcomes and reduction in unnecessary services.
- c) Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?
- Any reimbursement methodology based on capitation will require a minimum number of enrollees in order to fund additional staff associated with care coordination.
- d) What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?
- In instances where a coordinated care arrangement is provided through a Managed Care Entity (MCE), the network should include all FQHCs in the geographic area. Mandatory

- e) Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?
- Yes.

6. What should be the requirements for client assignment?

Questions for Comment

- a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?
- May not be practical in instances where the patient's PCP does not participate in the entity that specializes in his/her medical condition.
- b) How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?
- HFS should be mindful of the continuity of care for persons moving between neighborhoods or different areas of the state.
- c) Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?
- Yes.
- d) On what basis should assignment of clients who have not self-assigned be made in the first year?
- Follow the standard algorithms – current provider based on claims data and then geography.
- g) Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?
- Client Lock-ins should be based on current Illinois Health Connect standards.
- h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?
- One way might be to enroll but not lock in clients currently being served by the care coordination entity, so as to comply with federal regulations.

7. How should consumer rights and continuity of care be protected?

Questions for Comment

- c) Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?
- Not all coordinated care models will meet the definition of “qualified health plan” as defined in the ACA. For those that do meet the definition, they should be required to participate in both programs not only for seamlessness for the patients, but also for the providers.

8. What is your organization’s preliminary anticipation of how it might participate in coordinated care?

Questions for comment:

- a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?
- As the statewide organization representing all of Illinois’ FQHCs, we expect our members to propose and participate in a variety of coordinated care models.
- c) Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?
- The ACO model defined in the Medicare Shared Savings program does not allow FQHCs to fully participate due to limitations in the Medicare claims data. Therefore, any reforms based on the Medicare ACO model are not likely to garner much support from FQHCs. We are also concerned that there are no Illinois regulations for Accountable Care Organizations.

Conclusion

IPHCA appreciates the opportunity to provide initial comments regarding HFS’ Coordinated Care Program. As a member of the Medicaid Advisory Committee’s Subcommittee on Coordinated Care, we will continue meeting with our health center members on this issue over the next several months in effort to provide HFS with the most up to date information on health center initiatives related to coordinated care. IPHCA is available to provide whatever assistance or support the Department might request as it endeavors to implement new models of care. Should you have questions or wish to follow-up with further communication on these comments, please contact me at 217-541-7413 or by email at kcarter@iphca.org.

Respectfully Submitted,



Kelly Carter
Chief Operating Officer

**FINANCING COMMUNITY HEALTH CENTERS
AS PATIENT- AND COMMUNITY-CENTERED MEDICAL HOMES:
A PRIMER**

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Executive Summary

Federally-qualified health centers have historically furnished comprehensive primary health care for low-income and medically vulnerable patients and the communities they serve. The role of health centers has generated increasing interest in recent years because of a general concern about the adequacy and durability of the primary care infrastructure, particularly in the case of medically underserved communities. Growing interest in the “patient-centered medical home” (PCMH) concept, which seeks to improve the quality and efficiency of primary care through better management of chronic conditions, also shines a spotlight on health centers.

A review of health center data indicates that most health centers have attributes that correspond with the types of PCMH criteria developed by the National Center for Quality Assurance (NCQA). Furthermore, health centers’ core attributes make them not only “patient-centered,” but “community-centered” as well, thereby strengthening their PCMH potential. Indeed, from their inception, health centers have sought to deliver “community-oriented primary care,” which emphasizes not only individual patient needs but also those of the community. A substantial body of evidence has shown health centers’ positive impact, not only on the health of patients, but on community-wide health measures such as infant mortality and racial and ethnic disparities in health and access to health care.

Health centers’ ability to realize their full potential as patient- and community-centered medical homes is affected by numerous factors, including the financial, clinical, and system access challenges associated with serving their patients, virtually all of whom are low income and nearly two-fifths of whom are uninsured. In addition, the multi-payer financial environment leads to added complexities; each funder and payer applies different payment rules and incentives that, paradoxically, may contravene one another and dilute quality improvement efforts. Health centers depend on many types of funding, including federal grants, Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, private health insurance, private grants and contracts, and state and local funding.

This project, supported by The Commonwealth Fund, has been undertaken to consider strategies for advancing health centers as patient-centered medical homes. This initial report describes the PCMH concept in a community health center context, outlines how health centers are now financed, and considers recent legislative reforms that can be expected to expand and strengthen health centers. A subsequent report will consider options for strengthening health center financing in ways that can advance health centers not only as “patient-centered” medical homes but as “community-centered medical homes,” with augmented primary care duties that reach beyond standard PCMH attributes in order to customize the model to the needs of underserved populations and communities.

In the current health reform context, three important lessons are already beginning to emerge:

- First, health centers struggle to balance their resources between offering basic primary health care to all community residents, including both uninsured and seriously underinsured patients, and investments aimed at improving health care quality and efficiency. Community health centers that serve a high volume of uninsured patients are expected to encounter resource-based barriers to health care quality improvement. As the recent experience of health centers in Massachusetts highlights, even as the statewide number of uninsured dropped sharply, health centers became even more important as safety net providers for the remaining uninsured.
- Second, like other health care providers, health centers respond to payment incentives. Thus, when formulating payment reform, it is important to focus on changes to the Medicare and Medicaid FQHC payment systems that would help align payment and quality by augmenting basic reimbursement with quality improvement incentives. For instance, the special incentives for HIT adoption offered under Medicaid under the recent American Recovery and Reinvestment Act (ARRA) encourage health centers to invest in new technology. As the population continues to age, renewed efforts to reshape FQHC Medicare payments becomes similarly important in order to support the types of primary health care investments that can reduce disparities in health and health care in an aging population. Furthermore, even as health insurance coverage expands, it is critical to consider ways that the existing federal health center grant program might be altered to incentivize quality improvement, especially for those who are uninsured or underinsured, for example by encouraging quality-related service investments such as translation or transportation services that insurers (other than Medicaid) do not customarily reimburse.
- Third, it will be important to assure that recent investments like those under ARRA are sustainable over the long term. Using payment reforms to maintain and enhance recent quality improvement investments will be critical. ARRA provides a substantial amount of new funding from 2009 through 2011 in order to strengthen and upgrade health centers, especially to develop infrastructure and health information technology.

I. Introduction

This policy brief is part of a Commonwealth Fund-supported project that examines community health centers in the context of the patient-centered medical home (PCMH) movement. Community health centers—non-profit primary care facilities that provide care to patients regardless of their ability to pay—are widely lauded as critical components of the health care safety net, providing comprehensive primary care for low-income, high-risk populations in both urban and rural areas. Since their inception, health centers have directed their activities at improving patient care—through comprehensive primary health care, coordination with specialty care, and the provision of enabling services—as well as improving population-level health status and access to care.¹ Health centers are models for the organization and delivery of health care based on the principles of *community-oriented primary care*, which focuses on the health of both patients and communities.

National discussions of health reform often consider the potential for the patient-centered medical home model to strengthen primary care, prevent or alleviate the long-term consequences of chronic health conditions and disease, and bring greater efficiency to the health care system.² A 2008 report released by Senate Finance Committee Chairman Max Baucus describes an emphasis on primary care as “a common element of high-performing health systems” and recommends further testing and implementation of the PCMH model. The report notes that community health centers represent a critical component of the health care safety net, and have already implemented many elements of the PCMH model.³ An April 2009 bipartisan policy options report released by the Senate Finance Committee also cites patient-centered medical homes as a possible way to improve care for chronic health conditions.⁴

This brief provides a summary of the “patient-centered medical home” concept, followed by an overview of health centers and an in-depth look at health center financing. Because further evolution toward a PCMH model depends on the realignment of health center payment incentives, it is critical to understand how financing arrangements currently operate, what types of conduct and practices may be incentivized or deterred, and the types of challenges that lie ahead as health care payment policies are reformulated over time. Some of these challenges are faced by all providers as they attempt to reconcile multiple—and potentially competing or inconsistent—incentives created by insurers. Other challenges are associated with the unique mission of health centers and their ability to align quality improvement efforts with their fundamental duty to serve all community residents, regardless of their uninsured or underinsured status.

¹ Geiger, H.J. (2005). The first community health centers: A model of enduring value. *J Ambul Care Mgmt*, 28(4): 312-319.

² James, A. (2009). Patient Centered Medical Home likely to form basis of federal health care reform. *American Academy of Family Physicians News Special Report*.

³ Baucus, Hon. M. (2008, November). Call to action: Health reform 2009. *Senate Finance Committee*.

⁴ Senate Finance Committee (2009, April). Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.

II. A Brief Overview of the “Patient-Centered Medical Home” Concept

The term “medical home” has been used since the 1920s in pediatric circles, but the concept of “patient centeredness” is of relatively recent vintage. The idea of the “patient-centered medical home” (PCMH) gained momentum in 2007, after being endorsed by the four main primary care medical societies as a key way to enhance the quality and cost-effectiveness of primary care.⁵

The PCMH concept encompasses several global principles: a personal physician, physician-directed medical practice, coordinated and integrated care, quality and safety assurance, enhanced access, a “whole person” orientation (moving beyond the narrow focus on the acute problem at hand to consider the effect of other parts of the patient’s body and mind), and a payment structure that recognizes and rewards these elements. Some suggest that culturally appropriate service is another element of a medical home.⁶

In addition, the concept of a medical home has been enhanced to incorporate a number of elements related to improving the quality of care and health outcomes for patients, particularly those with chronic diseases. Many of these new elements are rooted in a special Chronic Care Model developed by Dr. Edward Wagner⁷ and loosely based on criteria from the Institute of Medicine’s 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century* and the 2005 follow-up report.⁸ Some of the newer elements found in the PCMH model are using ongoing care management systems, supporting patient self-management, having data systems that support clinical decision-making, and detailing performance information to providers to close the feedback loop.

Proponents of the medical home model argue that strengthening primary care through a greater emphasis on prevention, coupled with improved management of chronic diseases, will reduce the need for more costly specialty care and reduce the risk of expensive emergency room care and inpatient hospitalization. The benefits of the medical home model, along with a general systemic orientation towards primary care, are documented in a multinational meta-analysis that concludes that access to a medical home is associated with better health outcomes, decreased overall costs of care, and a reduction in disparities.⁹ Evaluations of projects in North Carolina—a system that is anchored by

⁵ American Academy of Family Physicians, et al. (2007). Joint Principles of the Patient-Centered Medical Home.

⁶ Mulvihill, B. et al. (2007). Does access to a medical home differ according to child and family characteristics, including special-health-care-needs status, among children in Alabama? *Pediatrics* 119: S107-S113.

⁷ Wagner, E.H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*, 1(1): 2-4.

⁸ Committee on the Quality of Health Care in America, Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*; Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs, Institute of Medicine. (2005). *Performance measurement: Accelerating improvement*.

⁹ Starfield, B., & Shi, L. (2004). The medical home, access to care, and insurance: A review of evidence. *Pediatrics* 113(5): 1493-1498.

community health centers—and Iowa have demonstrated that a medical home approach to primary care can reduce overall medical expenditures.¹⁰ The Commonwealth Fund recently estimated that revamping the payment structure to reward primary care providers for adhering to a medical home model could save up to \$175 billion over a 10-year time period.¹¹

Because of the multifaceted and evolving nature of the medical home concept, definitions abound; different pilot programs and research and evaluation efforts utilize varied criteria to evaluate whether a provider qualifies as a PCMH. According to the National Committee for Quality Assurance (NCQA), whose health care system certification standards are respected by insurers and payers, a patient-centered medical home is characterized by four basic criteria:¹²

- **First contact care**, which examines the manner in which patients make initial contact with the medical care system for emerging health problems;
- **Longitudinality**, which captures the ability to maintain a relationship with a patient over time, thereby heightening the value of that relationship;
- **Comprehensiveness**, which relates to the ability of the provider, through a patient care team, to provide, arrange for, or refer to, the full range of needs, not only those that can be appropriately carried out within the “four walls” of a primary care practice;
- **Coordination**, which encompasses the ability of the primary care provider to integrate its activities with those across different health care settings and providers, and across all of the patient’s conditions.

Several assessment tools for medical homes exist. The most popular is the three-tiered NCQA Physician Practice Connections Patient-Centered Medical Home (PPC-PCMH) certification, which was introduced in January 2008.¹³ The PPC-PCMH tool contains nine functional areas: (1) access and communication, (2) patient tracking and registry, (3) care management, (4) patient self-management support, (5) electronic prescribing, (6) test tracking, (7) referral tracking, (8) performance reporting and improvement, and (9) advanced electronic communications.

¹⁰ Abrams, M. (2008, March). Why patient-centered medical homes are important: Impact on quality and cost. Presented at the National Academy for State Health Policy seminar.

¹¹ Guterman, S., Davis, K., & Stremikis, K., (2009, March). Reforming provider payment: Essential building block for health reform. *The Commonwealth Fund*.

¹² Takach, M., Kaye, N., & Beesla, R., (2008, May). Strategies states can use to support the infrastructure of a medical home. Presented at the National Academy for State Health Policy Seminar, Washington DC.

¹³ The level of recognition depends on the number of points that a provider scores on their survey; a Level 1 provider scored 25-49 points and at least 5 of the 10 must-pass elements, a Level 2 provider scored 50-74 points and 10 of 10 must-pass elements, and a Level 3 provider scored 75-100 points and 10 of 10 must-pass elements. National Committee for Quality Assurance. (2008, October). Standards and guidelines for physician practice connections Patient-Centered Medical Home.

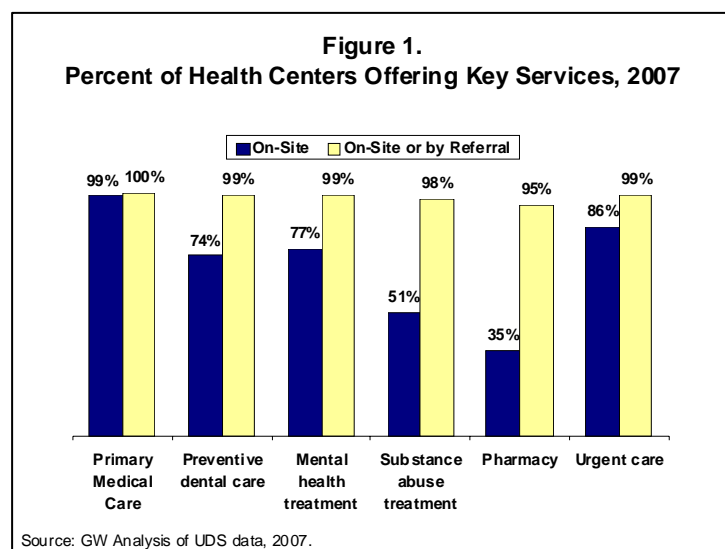
Other public and private insurers and payers use other functional definitions of a medical home. For example, Colorado elaborated on Medicaid Early Periodic Diagnosis, Screening and Treatment (EPSDT) service standards for children and adolescents and developed an 11-standard framework to classify providers as medical homes.¹⁴ Other popular tools are the Primary Care Assessment Tool developed by Starfield and Cassidy¹⁵ and the Medical Home Index by Cooley.¹⁶

III. An Overview of Community Health Centers

A. Location, Services, Patients, and Quality

Community health centers are a critical component of the health care safety net for rural and urban populations at risk for medical underservice and poor health outcomes. This report focuses on community health centers that receive federal §330 funding from the Health Resources and Services Administration, which are referred to as federally-qualified health centers (FQHCs). FQHCs embody several features that set them apart from other primary health care providers.

First, by statutory mission, health centers are required to furnish comprehensive and affordable primary medical care to the community residents they serve, regardless of any attribute other than the need for care.¹⁷ As shown in Figure 1, many health centers also provide behavioral, dental, urgent care, and pharmacy services, either on-site or through formal referral arrangements. Availability and willingness of providers in the



¹⁴ Robinson, G. & Forlenza, E. (2008, July). Medical homes for children. Presented at the National Academy for State Health Policy Medical Home Summit, Washington DC.

¹⁵ O'Malley, A. (2008, July). How do we know a practice is a PC-MH? Presented at National Academy for State Health Policy Medical Home Summit, Washington, DC.

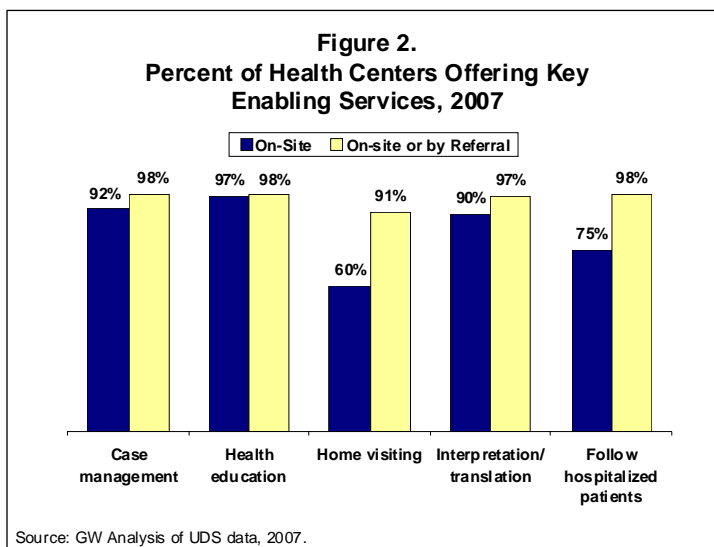
¹⁶ O'Malley, A., Torda, P., Robinson, G. & Forlenza, E., (2008, July). How do we recognize a medical home? Presented at National Academy for State Health Policy Medical Home Summit, Washington, DC. The Joint Commission. The Bureau of Primary Health Care. The Bureau of Primary Health Care (BPHC) has an initiative with the Joint Commission's ambulatory care accreditation program that combines the Joint Commission survey with BPHC's own statutory requirements for health centers to eliminate duplication; BPHC pays the fee for health centers to gain Joint Commission accreditation and then deems that accredited centers satisfy its statutory requirements. This has not been used to date to measure medical home orientation.

<http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/BPHC/bphc.htm> (accessed May 7, 2009).

¹⁷ 42 U.S.C. §§ 1396a(bb).

community to serve health center patients, ability to recruit and retain clinical staff, and results of health center assessment of community need dictate generally the provision of on- and off-site services.¹⁸

Health centers also often provide case management, health education, interpretation services, and other supportive enabling services to meet the complex needs of their patients (Figure 2). Although the literature shows that enabling services are critical to effectuating medical care, most of these services are not generally covered by third party payers; and, thus, other primary care providers are unlikely to offer such uncovered services.¹⁹ They



are largely covered by federal grant funding, and to a much lesser extent, Medicaid and state and local financing sources, which are more vulnerable than grant funding to budgetary pressures and changes in financing policy.

Second, health centers must be located in (or serve) communities or populations that are considered medically underserved, or are experiencing a shortage of primary health care outlets. The concept of medical underservice is more expansive and fluid than the arithmetically straightforward question of primary care provider shortages; by law, the concept of medical underservice is intended to capture populations whose socioeconomic profiles or health and health care outcomes indicate the lack of access to primary health care..²⁰ Maldistribution of the supply of physicians who are willing to treat low-income, uninsured, and underinsured patients is a critical issue that inhibits access to care among the underserved.

¹⁸ National Association of Community Health Centers. (2009). Primary Care Access: An Essential Building Block of Health Reform. <http://www.nachc.com/client/documents/pressreleases/PrimaryCareAccessRPT.pdf> (Accessed April 23, 2009); Cook, N.L. et al. (September/October 2007). Landon Access to Specialty Care and Medical Services in Community Health Centers *Health Affairs*; 26(5): 1459-1468.

¹⁹ Park H. (2006). Enabling Services at Health Centers: Eliminating Disparities and Improving Quality, Challenges and Opportunities for Health Centers in collecting Data on enabling Services, New York Academy of Medicine.

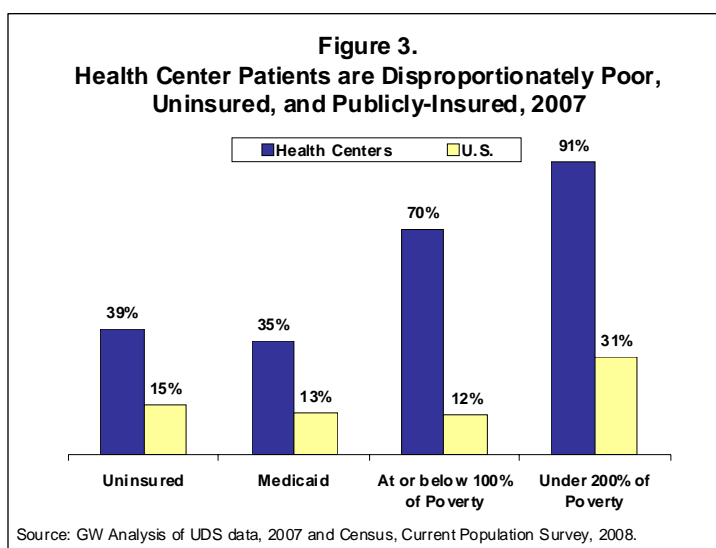
http://www.aapcho.org/altruessite/files/aapcho/Publications_FactSheets/ES%20Metlife%20Report.pdf (Accessed April 23, 2009); General Accounting Office. (1995). Community Health Centers: Challenges in Transitioning to Prepaid Managed Care. T-HEHS-95-138. <http://archive.gao.gov/t2pbat1/154166.pdf>.

²⁰ Shin, P. et al. (April 2008, Revised May 2008). Analysis of the Proposed Rule on Designation of Medically Underserved Populations and Health Professional Shortage Areas. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Research Brief #2.

Third, in order to assure that services are accessible to the entire community, health centers must treat all patients without regard to their ability to pay for services. Health centers prospectively adopt sliding scale fees based on patients' financial circumstances. This obligation means discounting the cost of care for uninsured patients who pay out-of-pocket, in addition to discounting charges to underinsured patients with high deductibles and copayments.

Finally, FQHCs must be non-profit and governed by a patient-majority board; both of these requirements are designed to ensure that both patient *and* broader community needs are met. For example, in order to improve access to health care among adolescents, community boards may vote to expand health center services into schools through local partnerships. As an extension of their nonprofit status and their community governance and accessibility requirements, health centers must fully participate in patients' health insurance programs (no matter how limited a particular insurer's payments may be) and adhere to federal reporting and performance requirements.²¹

As illustrated in Figure 3, in 2007, FQHCs served more than 16.1 million patients (18 million when including look-alike health centers), the majority of whom lived in families with incomes at or below 100 percent of the federal poverty level (\$18,310 for a family of 3 in 2009)²²; 91 percent had family incomes below twice the federal poverty level.²³ Health centers also serve a disproportionate share of uninsured and publicly insured patients. Compared to an uninsured rate of 17.9 percent among the under-65 population that year, 39 percent of health center patients were uninsured in 2007.²⁴



As shown in Figure 4, health centers serve a higher mix of medically vulnerable patients compared with physicians who practice in private primary care practices. Uninsured and Medicaid patients account for 74 percent of health center patients, while they account for just 21 percent of patients in private physician's offices. In 2007, Medicaid and CHIP-insured patients accounted for 35 percent of all health center patients, nearly three times the national average. By contrast, private insurance accounts for a much smaller

²¹ Shin, P. et al. (February 2008). Health Centers: An Overview and Analysis of Their Experience with Private Health Insurance. Kaiser Family Foundation.

²² Assistant Secretary of Planning and Development, Department of Health and Human Services. (2009). The 2009 HHS Poverty Guidelines. <http://aspe.hhs.gov/poverty/09poverty.shtml> (accessed May 7, 2009).

²³ 2007 Uniform Data System, HRSA.

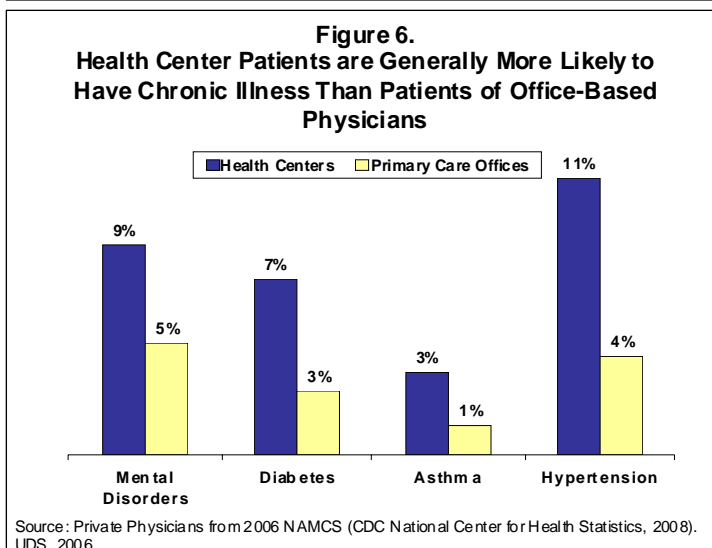
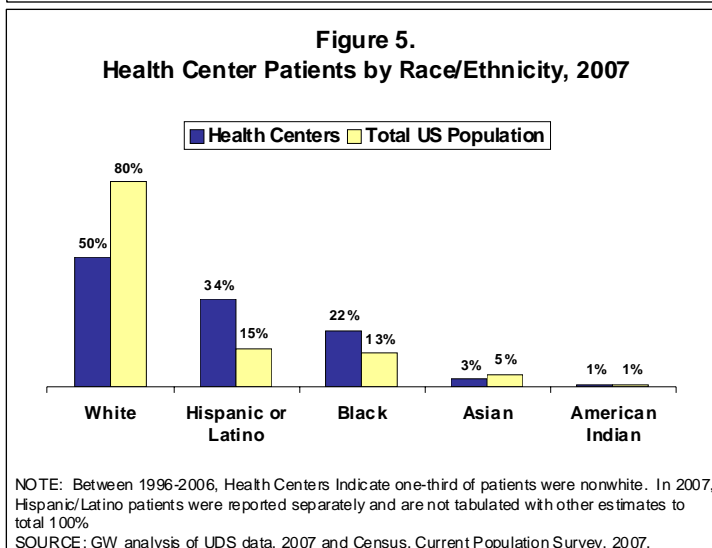
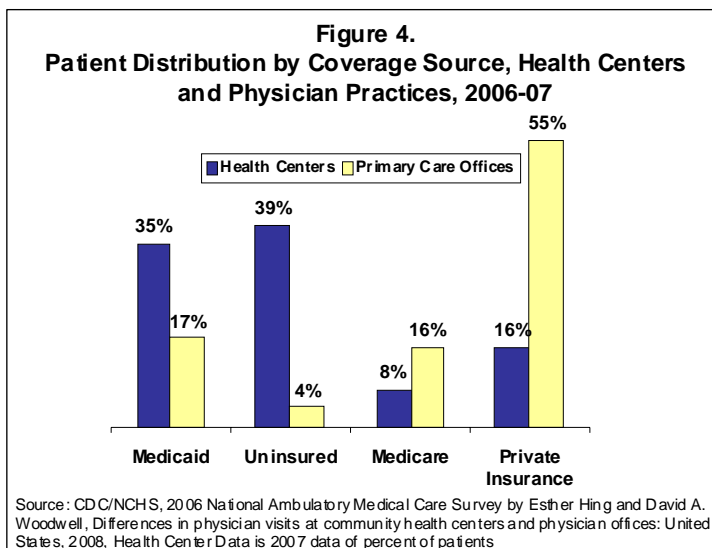
²⁴ Holahan, J. and A. Cook. (2008, October). The Decline in the Uninsured in 2007: Why Did it Happen and Can it Last? Kaiser Commission on Medicaid and the Uninsured.

percentage in health centers. In addition, the literature suggests 24 percent of low-income patients tend to be underinsured.²⁵

Figure 5 shows that in 2007, about half of health center patients were members of racial and ethnic minority groups. The two largest groups served by health centers are Hispanic (34 percent) and African American (22 percent),

for a combined 56 percent of health center patients served (these two groups comprise only 28 percent of the general population). Over one quarter (27 percent) of all health center patients experienced a linguistic barrier when seeking care. Health centers also serve especially vulnerable and hard-to-reach subpopulations: about five percent of health center patients in 2007 were migrant or seasonal workers and about five percent were homeless.

Not unsurprisingly, given their low family incomes and the social and residential isolation that so often accompanies poverty, health center patients disproportionately experience serious and chronic diseases such as diabetes, hypertension, asthma and mental health problems, compared with patients at private physician's offices (Figure 6). Given the prevalence of these chronic



²⁵ Schoen C, et al. (July/August 2008). How many are underinsured? Trends among U.S. adults, 2003 and 2007" *Health Affairs* 27(4): w298-w309.

diseases, most health centers have altered their practice patterns to improve chronic disease management, emphasizing the Chronic Care Model elements of empowered patient self-management, team-based health care, decision support and clinical information systems. More than 800 health centers participated in HRSA's Health Disparities Collaborative (HDC) initiative, an effort to create networks to encourage dissemination of best practices and quality improvement initiatives. Evaluations have demonstrated that involvement with the HDC improved the quality of care for patients with diabetes and asthma.²⁶ Health center participation has continued despite a decision by the last Administration to defund the Collaborative, but the lack of funding, the elimination of federal leadership, technical support, and disparities reduction goals have inevitably hampered the functioning of the Collaborative.²⁷

Despite the challenges, these long-term quality improvement efforts have translated directly into cost-savings. One study found that the cost of treating patients with diabetes in health center settings was approximately \$400 less than that experienced by other primary care settings.²⁸ Other estimates indicate health centers save \$400 to \$2,200 per patient and help reduce emergency care usage by 32-36 percent.²⁹

As with other quality improvement efforts, studies also indicate that health centers incur significant costs in implementing quality improvement initiatives. Studies indicate that implementing the changes needed to improve care in turn created other management challenges, such as the exacerbation of already existing clinical staff shortages.³⁰ Studies also suggest that the implementation burden is the most onerous for centers with a larger share of uninsured patients.³¹ One study estimated that while the diabetes quality improvement efforts were cost effective, it involved a small increase in annual administrative costs by between \$6 and \$22 per patient and did not lead to the type of revenue increases that might, from a business case perspective, cover the cost of the investment.³² Although the social mission of health centers means that the "business case" need not be strict criteria of the worthiness of a quality improvement initiative,

²⁶ Landon, B., et al. (2007). Improving the management of chronic disease at community health centers. *NEJM* 356(9): 921-34.; Chin, M.H., et al. (2004). Improving diabetes care in Midwest community health centers with the health disparities collaborative. *Diabetes Care* 27(1): 2-8.; Huang, E., et al. (2007). The cost-effectiveness of improving diabetes care in U.S. federally qualified health centers. *Health Serv Res*, 42(6 Pt 1): 174-93.

²⁷ Cheung, K., et al. (2008). The perceived financial impact of quality improvement efforts in community health centers. *J Ambul Care Management* 31(2): 111-119.

²⁸ Proser M, Deserving the Spotlight: Health Centers Provide High-Quality and Cost Effective Care. *J Ambul Care Management*, 2005; 28(4): 321-330.

²⁹ The Robert Graham Center, Capital Link, and the National Association of Community Health Centers, *Primary Care Payoff*, 2007. http://www.nachc.com/client/documents/issuesadvocacy/policy-library/research-data/research-reports/Access_Granted_FULL_REPORT.pdf

³⁰ Cheung, K. et al. (2008). The perceived financial impact of quality improvement efforts in community health centers. *J. Ambul. Care Manage.* 31(2):111-19.; Graber J, et al. (2008). Predicting change in staff morale and burnout at community health centers participating in the Health Disparities Collaborative. *Health Serv Res.* 43(4):1403-1423.

³¹ Cheung, K. et al. (2008). *op cit*.

³² Huang, E.S., et al. (2008). The cost consequences of improving diabetes care: The community health center experience. *The Joint Commission Journal on Quality and Patient Safety*, 34(3), 138-146.

health centers, like any provider, need revenues to operate. Thus, the return on investment matters, at least in the sense of expansion and sustainability.

Health centers and their patients also experience another type of hurdle that is not surprising, given their mission and the environment in which they operate: difficulties in securing necessary referrals and specialty care for their patients.³³ The issue is not well understood and is attributable to many factors including the geographic location of health centers and their patients, the inability to guarantee competitive reimbursement for the specialist, and the broader economic, social and cultural aspects of the general relationship between primary and specialty medical care providers in some communities (specialists may be more willing to accept a limited number of referrals from their colleagues in private practice, knowing that such referrals will be relatively modest in number because of the controlled nature of patient access to privately operated primary care practices). It is also worth noting that the difference in specialist utilization may also be attributable to the fact that some health center clinicians may judge referrals to be necessary less frequently, even for patients with advanced conditions, because such patients can, in fact, be appropriately managed in primary care. It also may be the case that health center clinicians make greater use of alternative forms of specialist consultation (e.g., telephone or email consultation) rather than a standard referral, given the modest economic environment in which they practice.

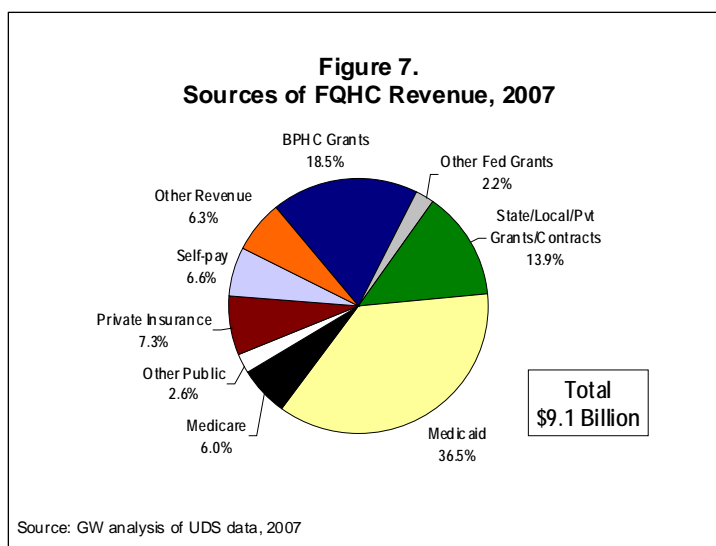
B. Financing Health Center Growth and Operations

Like all health care systems, FQHCs depend on multiple revenue sources, but health centers are unique in the degree to which they depend on grant funding. Health centers also receive state and local funding in order to serve the uninsured and carry out special activities such as health and nutrition programs, the provision of care to uninsured adults with serious mental and behavioral health conditions, and the provision of care in schools, women's shelters, homeless shelters, mobile vans, and other non-traditional locations. Also, the third party payer mix is significantly different than other provider types, tipping heavily toward Medicaid and away from private health insurance.

Although this diversified funding landscape helps avoid overreliance on any single source of payment, the fragmented nature of the funding inevitably increases the cost and complexity of health center administration, as is the case with private clinical practices that participate in multiple insurance and employee health benefit plans. Unfortunately, this fragmentation can blunt the effects of quality improvement efforts by any single payer acting unilaterally, as health centers attempt to reconcile priorities, preferences, and rules from different payers. Even the potential leverage of Medicaid, the largest payer for FQHCs, is somewhat diluted since the program is often administered by multiple managed care organizations with different payment systems and incentives.

³³ Gusmano, M.K., Fairbrother, G., and Park H. Exploring The Limits Of The Safety Net: Community Health Centers And Care For The Uninsured. *Health Affairs*, November/December 2002; 21(6): 188-194.

FQHCs receive two primary forms of revenue: *grant revenue*, from federal, state, local or private grants; and *patient-related revenue*, from insurance or patient out-of-pocket payments. Figure 7 reveals the diversity of health center revenue sources in 2007, although the relative importance of various revenue sources varies considerably between health centers. For example, health centers that serve predominantly migrant and seasonal farm worker populations receive significantly less Medicaid revenue, but more grant revenue than other types of centers.



Patient revenue, primarily insurance payments, is the largest income source for health centers nationally, comprising almost 60 percent of receipts, while grant funding accounts for about a third of revenue. Compared with private physician's offices, this is very low patient revenue; only four percent of patients are uninsured in private physician's offices, compared with 39 percent of patients without insurance at health centers. Revenue from other sources, comprising 6.3 percent of total revenues, is primarily made up of indigent care program revenue (disbursed through grants or paid per patient, accounting for 3.7 percent of total revenue) and other income sources, such as interest or revenue from other business interests. Studies indicate that health centers operate very close to the margin and are financially vulnerable to state and federal budget pressures and changes in coverage benefit and provider payment terms.³⁴

Federal, State and Local Grant Revenue

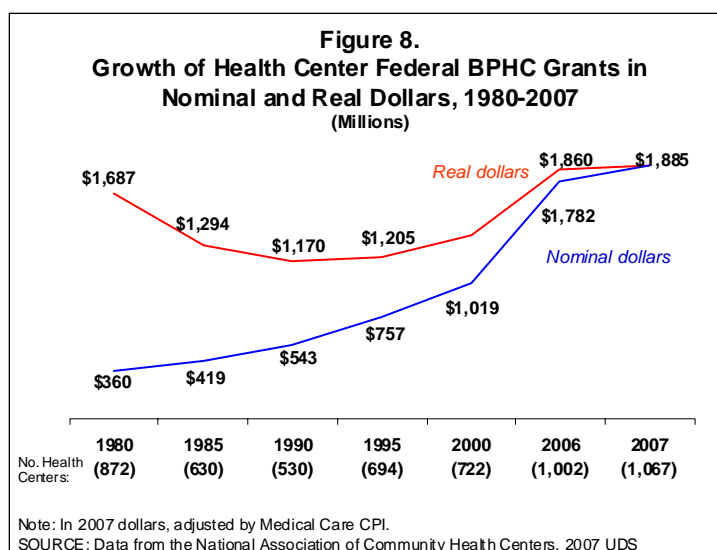
Grant funding accounts for about 35 percent of community health center revenues. Grants support four general purposes: (1) meeting or improving basic infrastructure and organizational needs, such as administration, rent, equipment, or operational improvements; (2) providing broad community services, such as community education or needs assessments, for which there are no specific 'patients' to bill; (3) special purposes elicited by specific grants or contracts (e.g., grants that expand dental or HIV services); or (4) subsidizing care for uninsured and underinsured patients. This fourth function sometimes means covering virtually all of the cost of a patient encounter, financing the uncovered deductibles and copays, or financing certain services and supports not covered by the patient's insurance (e.g., nutrition education, an interpretation services, eyeglasses,

³⁴ McAlearney JS. The Financial Performance of Community Health Centers, 1996–1999 *Health Affairs*, March/April 2002; 21(2): 219-225; Rosenthal MB, Fernandopulle R, Song HR, Landon B. Paying for quality: Providers' incentives for quality improvement. *Health Affairs*. 2004;23(2):127–141.

longer office visits, or multiple visits in a single day to allow patients to meet with different clinical professionals without having to make multiple appointments).

Federal grants, authorized under §330 of the Public Health Service Act (often referred to as “section 330 grants”) constitute the core grant funding source for FQHCs. The federal Health Resources and Services Administration’s (HRSA’s) Bureau of Primary Health Care (BPHC), offers four basic types of grants: (1) *new access point* grants which support new service delivery sites; (2) *expanded medical capacity* grants to expand service capacity for existing grantees; (3) *service expansion* grants which expand mental health/substance abuse or dental services via current grantees; and (4) *service area competition* grants to support new grantees or services among centers whose grants are about to expire. Total funding allocated to health centers by BPHC comprises only 18.5 percent of total FQHC revenue. In 2007, 1,067 health centers received §330 grants.³⁵ Eighty percent of total §330 funding allocated to the direct support of health center operations and growth is awarded to community health centers; the remaining 20 percent is divided among health centers serving migrant populations (about 8.7 percent of total §330 allocations), homeless (another 8.7 percent of allocations), and public housing health centers (1-2 percent).³⁶ Among health centers, about 40 percent of the grant funding is awarded to urban centers and 60 percent to rural grantees.

Figure 8 shows the growth in BPHC grant funds from 1980 through 2007. Although federal funding increased nearly five-fold in nominal dollars, the actual value of those funds (after adjusting for inflation) decreased, returning to 1980 levels only in 2007; over this time period, the number of uninsured rose nearly three-fold. While the section 330 grants are relatively modest, their receipt triggers eligibility to enhanced payment through Medicaid and Medicare, malpractice liability protection through the Federal Tort Claims Act and reduced pharmaceutical prices through HRSA’s 340B Drug Pricing Program.



The American Recovery and Reinvestment Act (ARRA) provides \$2 billion in direct funding for 2009 and 2010, essentially as a special payment to health centers, outside the

³⁵ In 2007, approximately 100 ‘look-alikes’ did not receive §330 funding, but did qualify for cost-based reimbursement from public payors. GW analysis of 2007 UDS data.

³⁶ Health centers are eligible for additional funding if they provide services to special populations, such as migrant farm workers or homeless patients. Taylor, J. (2004, August). The Fundamentals of Community Health Centers. *National Health Policy Forum Background Paper*.

normal §330 appropriations process. The ARRA funding is allotted to support two fundamental purposes. The legislation provides \$1.5 billion to improve their infrastructure with an eye toward longer term reform. Improvements made possible with this funding include capital equipment, health information technology (HIT), and site expansion, renovation, and construction. The additional funding for HIT is particularly useful for health centers that seek to develop electronic medical records and information systems to improve their status as medical homes.

The ARRA allots the remaining \$500 million to support ongoing health center operations, in recognition of the surging need for care for large numbers of uninsured patients in communities across the country. On March 2, 2009, \$155 million was awarded to 126 health centers to expand services under new access point grants.³⁷ On March 27, an additional \$338 million was released as grants to further respond to the increased demand for services, with allocations based on formulae that take into account additional patients and uninsured health center patients.³⁸ HRSA was one of the first federal agencies to disburse federal funds appropriated under ARRA, which is testimony to the ability of program administrators and grantees alike to rapidly and efficiently respond to new health care opportunities.

Grants are capped and do not automatically rise to meet an increasing demand for services. When a health center has more uninsured and underinsured patients, it will need to draw more heavily on grant funding to finance necessary care and may have fewer resources available for other purposes, including operational and infrastructure improvements. Because federal grant funding is based on appropriations and may be subject to uncertainties, such as continuing resolutions or the recent availability of stimulus funds from the ARRA, grant announcements and funding decisions may be made at various times during the year.

Health centers also rely on other smaller federal funding streams programs, including Ryan White HIV, Title X family planning, Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), Title V Maternal and Child Health funds, and Women, Infants and Children (WIC) nutrition services). State and local funding also help provide primary care funding to supplement §330 funding; and much of the funding comes from general revenue, dedicated taxes, federal grants to states and tobacco settlement monies.³⁹ States such as Colorado and Florida that have indigent or uncompensated care pools allow health centers to draw down primary care funds to improve capacity and subsidize care for low-income and uninsured residents.

³⁷ Office of the White House Press Secretary. (2009, March). President Obama Will Nominate Governor Kathleen Sebelius Secretary of HHS, Announces Release of \$155 Million of ARRA Funds for Health Clinics Across America.

³⁸ U.S. Department of Health and Human Services news release. (2009, March). HHS Releases \$338 Million to Expand Community Health Centers, Serve More Patients.

³⁹ Wilensky, S., Rosenbaum, S., Hawkins, D., Mizeur, H. State-Funded Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations: 1995 vs 2000. *Am J Public Health* 2005 95: 254-259.

Patient-Related Revenue: Medicaid, Medicare and Private Insurance

Three-fifths (59 percent) of total health center revenue comes from patient-related revenue sources. Medicaid (including Medicaid administered CHIP) dwarfs other payers, providing more than one-third (36.5 percent) of total health center revenue. Other insurers account for much smaller portions: Medicare (6.0 percent), private insurance (7.3 percent), and other public (2.6 percent), which includes separate CHIP programs and other state public insurance programs such as high risk pools. Patient self-payments (sliding scale payments from uninsured patients and copayments or coinsurance from insured patients) contribute 6.6 percent of total revenue. Unlike grant funds, patient-related revenues generally rise or fall (excluding managed care) with the utilization of services; when there are more insured patients, insurance revenues rise. However, a critical deficiency of insurance-based payments is that they usually only flow for insured patients, and do not help meet the service costs of uninsured or underinsured health center patients, or uninsured services such as dental care for a patient with private health insurance that excludes dental coverage. A few states provide uncompensated or indigent care payments to health centers for serving uninsured patients, usually based on volume of service to the uninsured, but these funds are typically not intended to help finance care for underinsured patients.

However, it is critical to consider whether insurance payment rates—especially private insurance rates—are adequate to meet the costs of serving health center patients and whether payment levels change to meet varying service needs. Since health centers provide comprehensive care that is not available in other ambulatory settings (and thus not reflected in most reimbursement rates), most insurance payments do not cover the cost of the care provided at health centers. Medicaid is required to reimburse health centers on a cost related basis, and thus is the only payer where revenue closely mirrors patient costs. In the case of private insurance, for example, payments as a proportion of total payments (7.3 percent) stand at half the level of privately insured patients as a proportion of total health center patients (15 percent).

In addition, health centers receive out-of-pocket payments directly from patients. But since health centers adjust charges in relation to the patient's ability to pay, the total amount of revenue recovered through direct patient payments, 6.6 percent in 2007, is far smaller than the amount received by private physicians. Patient nonpayment of even modest charges is an issue, although the level of revenues received from patients served by health centers is small enough to make the problem of non-recovery less problematic than it is for some private practices. Non-payment and slow payment by private insurers or managed care organizations in which health centers participate is a larger problem; outstanding receivables can be high at health centers, just as they are in private practice, forcing centers to borrow against lines of short term credit, sometimes at high interest rates.⁴⁰

⁴⁰ Hayashi, S.A., Finnegan, B, Shin, P, Jones, E & S Rosenbaum. (April 2009). Examining the Experiences of Puerto Rico's Community Health Centers Under the Government Health Insurance Plan. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 8.

Medicaid

Medicaid is the largest single revenue source for FQHCs. During the 1970s and 80s, health centers struggled financially because Medicaid payments were often too low to cover the cost of serving Medicaid-enrolled patients. This serious underpayment in relation to the cost of care led health centers to divert a portion of their federal (or state and local) grant funds to subsidize Medicaid losses, making it harder for health centers to serve uninsured patients. This situation resulted in the enactment of a special cost-based “FQHC” payment policy under both Medicaid and Medicare.

In creating the FQHC payment system in 1989 (which has been subsequently amended as described below), Congress established a central tenet of health center reimbursement: given the special mission of health centers to serve the uninsured and to support medically underserved communities and populations, public payers—even when their payment is made via sponsorship of a managed care or insurance arrangement under Medicare, Medicaid, or CHIP—should assure that health center payments are reasonably related to the cost (as determined by federal principles of cost accounting)⁴¹ of furnishing covered services to patients who are sponsored by public insurance programs. The payment rate was to be computed on an all-inclusive per visit basis known as an encounter; FQHCs were paid a set amount per visit for “FQHC services” which are defined to include a specific bundle of services (Exhibit 1), sometimes referred to as “core” FQHC services.⁴² “FQHC services” include services provided by the following:

- Physicians
- Physician Assistants and Nurse Practitioners
- Clinical Social Workers
- Clinical Psychologists
- Nurses providing home health services (only in areas with a shortage of home health agencies)

The FQHC payment for these core services is provided regardless of the actual services delivered during that visit. Under the original FQHC provisions, and in some states today, adjustments are made retroactively if the estimated payments do not correspond with reasonable costs. Health centers receiving Section 330 grants are required by the Public Health Service Act to provide additional services, known as ‘core’ services (Exhibit 1). Medicaid is not required to cover these services unless they are mandated Medicaid services, part of a state’s ambulatory care service, part of the EPSDT program, or a core FQHC service.

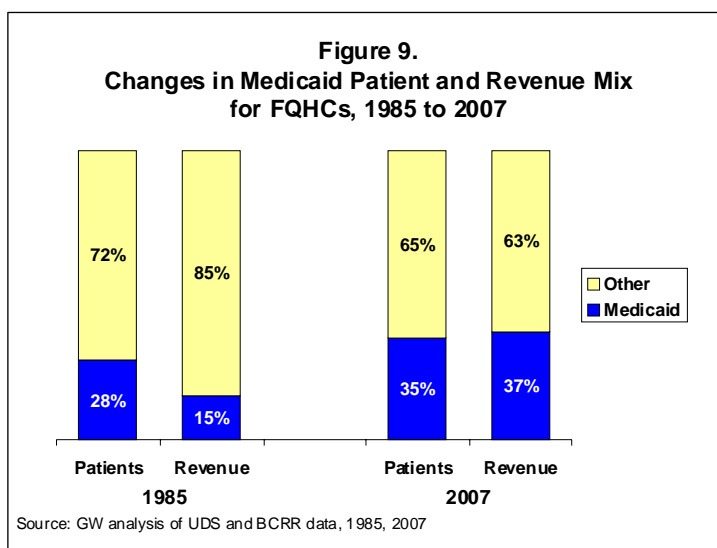
⁴¹ Rosenbaum, S., Shin, P., et al. (2000). Health Centers’ Role as Safety Net Providers for Medicaid Patients and the Uninsured. Kaiser Commission on Medicaid and the Uninsured.

⁴² In addition, states pay health centers for other covered services furnished to health center patients and may or may not use the cost-based payment formula for these services.

Exhibit 1. Core Services required by Section 330 of the Public Health Service Act	
<ul style="list-style-type: none"> • Primary care • Preventive services, including prenatal and perinatal • Well child services, including eye, ear, and dental screening • Diagnostic laboratory and radiologic services • Cancer screening • Screening for communicable disease, high cholesterol, and elevated blood lead levels 	<ul style="list-style-type: none"> • Immunizations • Preventive dental services • Voluntary family planning services • Case management • Referral to appropriate specialty services • Enabling services such as outreach, transportation, and translation services <p>Patient and community education on the availability and proper use of health services</p>
<p>Note: Core services also include other ambulatory services identified in each State Planning Amendment. Source: 42 USCS § 254b (Section 330 of the Public Health Service Act). http://bphc.hrsa.gov/about/legislation/section330.htm</p>	

The FQHC payment system means that in the case of Medicaid, FQHCs may be paid more than private physicians (who in many states are seriously underpaid under Medicaid, at least in relation to Medicare). This higher payment policy reflects the broader array of services furnished by FQHCs, the heavier burden of illness experienced by health center patients, and health centers' low participation in private insurance and their resulting inability to shift cost to private health insurers.⁴³

The impact of this change is illustrated by comparing financial and patient data from before and after the FQHC Act was passed. In 1985, 28 percent of health center patients were covered by Medicaid, but Medicaid only accounted for 15 percent of revenues (Figure 9). By 2007, Medicaid revenue and patient loads were more closely aligned, with Medicaid comprising 35 percent of patients and 37 percent of revenues.



Federal policies have been modified since the FQHC methodology was developed. The Balanced Budget Act of 1997 called for phasing out cost-based reimbursement by 2003, but the deadline was later extended to 2005.⁴⁴ Congress subsequently modified this approach, instead developing a prospective payment system (PPS) in 2000 for Medicaid

⁴³ Zuckerman, S, D. Miller and E. Pape. (2009, February). Missouri's 2005 Medicaid cuts: How did they affect enrollees and providers? *Health Affairs* 28(2): w334-345.

⁴⁴ *Ibid.*

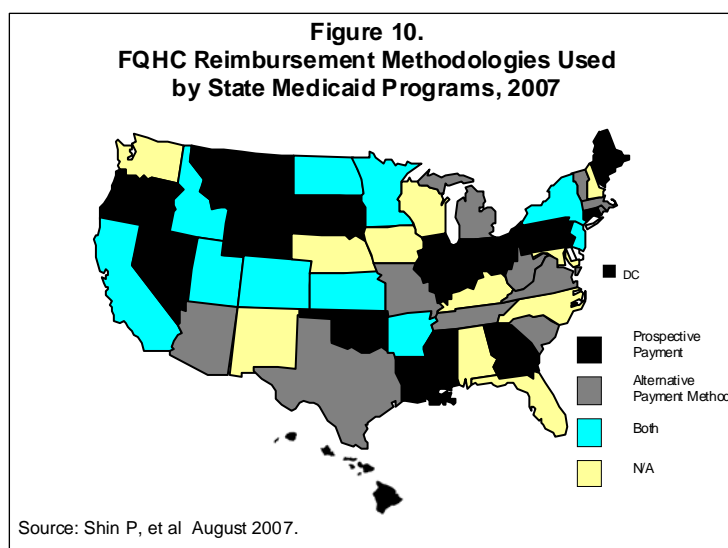
payments for FQHC services as part of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA).⁴⁵

Under PPS, the FQHC Medicaid per visit payment is based on the average allowable costs from earlier years, updated annually for inflation using the Medicare Economic Index (MEI).⁴⁶ Thus, if a health center's actual costs per visit rise faster than the inflation index, its PPS payment rate will lag behind actual costs, leading to losses over time, but if actual costs at a health center rise more slowly than the inflation index, the payment rate will be above actual costs and the health center's efficiency will be rewarded. BIPA also allows states to implement alternative payment methodologies (APMs), including the use of other inflation indices and regular rebasing with more recent cost data, as long as they do not pay less than what FQHCs would have received under PPS and as long as each FQHC agrees to the change in payment terms.⁴⁷

Payments must also be adjusted for changes in health center scope of service. Request for changes in PPS rates due to the addition of wholly new services, such as dental and on-site pharmacy, are generally approved by state. States are much more reluctant to approve rate adjustments that involve discrete changes; for example, participation in the Health Disparities Collaboratives, adoption of health information technologies, and in some cases, the expansion of existing services.

For states whose CHIP programs are operated as part of their Medicaid programs, Medicaid FQHC reimbursement policies apply as well. Under the recent Children's Health Insurance Program Reauthorization Act, the PPS system for FQHCs is extended to separate state CHIP programs, effective October 2009, with the amendments affecting both direct payments by state CHIP agencies and payments related to the provision of care under managed care contracts.

A 2007 survey found that 17 of the 40 states, and the District of Columbia, that responded were using the PPS. Eleven states were using an APM, and ten states used both PPS and APM systems to set payment rates (Figure 10).⁴⁸ In Colorado, FQHCs receive the higher of the two rates, which is often



⁴⁵ Pub. L. 106-554. Taylor, J. (2004).

⁴⁶ Taylor, J. (2004).

⁴⁷ Shin, P., Finnegan, B., Schwartz, R. (2007). State policy report #17: 2007 Update on the status of the Medicaid Prospective Payment System in the States. *National Association of Community Health Centers*. August 2007.

⁴⁸ *Ibid.*

the cost-based APM estimated rate. Results from the survey indicate a wide range in state Medicaid FQHC payment rates for FQHC services, from a low of \$77 (on average) in Pennsylvania to a maximum of \$315 (on average) in Minnesota, due to varying bundle of services covered.

In addition, even though federal policies regarding adjustment of payments to reflect changes in scope of service, states may fail to maintain updating policies. Despite the requirement to have a process in place to adjust rates following a change in the scope of services, 12 states did not have such a system in 2007.⁴⁹ FQHCs generally do not require change of scope approval from HRSA when certain services are already within scope at another site and the change serves to improve or maintain access without additional Section 330 funding. However, in the move to PPS, much of the confusion surrounding a change in scope rests on the lack of guidance on how a state or FQHC should define allowable changes in scope, including adoption and use of information technology. Because states will not make changes to the rate without first having documentation of actual costs (e.g., for a six month period), FQHCs have little financial incentive to make significant changes and risk carrying costs that may not be fully covered.

The PPS system has other limitations that create various challenges. The 2007 survey found that the number of billable visits per day varies between states, and many states do not allow more than one billable visit per day.⁵⁰ FQHCs in states that only pay for one visit per day—regardless of what services are provided during that visit—are much more likely to be at financial risk, especially when providing care to patients with comorbidities or complications. This creates a disincentive to provide multiple services on the same day, despite the fact that it is more convenient for the patient to schedule medical and mental health appointments on the same day.

Managed care supplemental payments (called “wraparound payments”) are another problematic issue within Medicaid. Although the wraparound payment, which represents the difference between the PPS rate and the payment paid by a Medicaid managed care plan, is a required payment, a 2007 survey found that health centers in several states commonly experienced delayed payments. A recent GW study documented an extreme version of this pattern in Puerto Rico, which should be covered by the FQHC provisions of law, yet only seven percent of health center operating revenues in Puerto Rico were from Medicaid, despite 65 percent of health center patients being covered by Medicaid.⁵¹ Similarly, a 2005 GAO report found that some states’ PPS rates failed to reflect the reasonable cost of core FQHC services, as required by law.⁵²

An additional issue involves payments to health centers that are not covered by the FQHC payment formula. There are two dimensions to this problem. The first is the

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

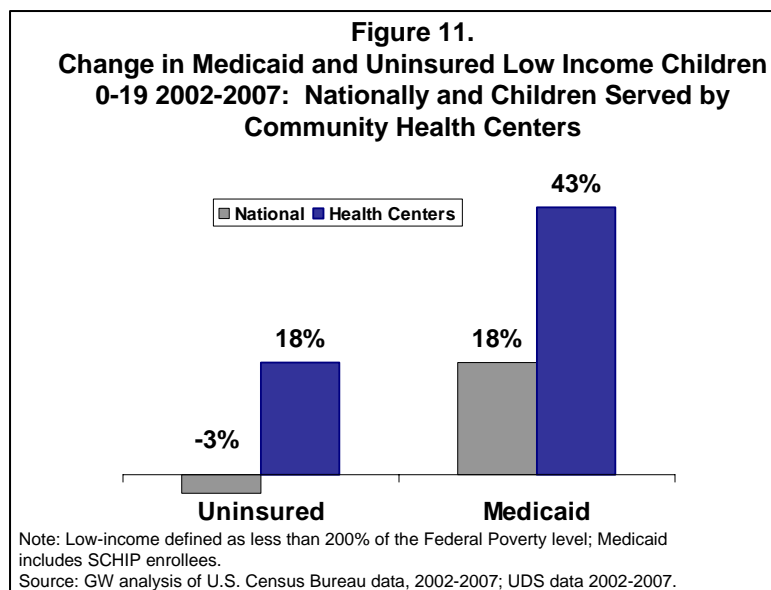
⁵¹ Hayashi, Finnegan, Shin, Jones & Rosenbaum, (2009).

⁵² Government Accountability Office. (2005). Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid’s New Payment System. GAO-05-452. <http://www.gao.gov/new.items/d05452.pdf>

failure to provide payment at the PPS payment rate for covered medical assistance benefits and services that are covered under state Medicaid plans, but are not part of the core FQHC bundle of services. Examples of covered benefits that fall outside the PPS payment structure include dental, vision, and eye care. The second dimension of this problem entails health center service costs that are simply unrecognized under state Medicaid payment systems, regardless of the formula used. These services may be crucial to the success of health care for vulnerable populations—and thus to the successful outcome of care for Medicaid-insured patients—but simply unrecognized by the state Medicaid agency. Translation and non-emergency transportation costs are salient examples of such services, as well as the services of health educators, nutritionists, home visiting teams, case managers and other patient support providers. Although these services may be essential to ensure successful clinical outcomes for at-risk patients, they are frequently excluded from the scope of reimbursable care. Furthermore, states differ regarding what is considered a billable visit. For example, a social worker (who is not a clinical social worker) may not be reimbursed at the PPS rate. These differences extend to optometrists and mid-level providers as well.

A subtler problem, but critical in the context of this analysis, is that PPS rates are not adjusted for the quality of services provided by health centers; payment rates do not include adjustments for quality-enhancing changes that do not alter the scope of service. For example, participating in the Health Disparities Collaboratives, discussed above, would not result in payment enhancements since participating in the HDC changes practice patterns at the health center but *does not* expand the scope of service. In addition, the method of updating the prospective payment rate by the Medicare Economic Index assumes that the services provided by health centers are constant over time, whereas in reality, health centers tend to expand the scope of services they provide over time to better serve the needs of the community, by adding mental health, obstetric, or dental services, for example.

Medicaid and SCHIP financing have significant implications, particularly for children. Even as the number of uninsured children has decreased since SCHIP was implemented, health centers continue to serve as medical homes for uninsured children. Figure 11 shows that, while the number of uninsured children has decreased by three percent since 2002, health centers reported an 18 percent increase in the



number of uninsured children served.

Medicare

Medicare reimbursement issues parallel the Medicaid landscape to some extent, but the approach taken to implementation of the payment system in 1991 has created a situation in which Medicare payments perennially lag behind health center costs. This lag is increasingly problematic as the number of Medicare beneficiaries who receive care at health centers is surging, along with the number of uninsured patients. The number of elderly health center patients has increased by 89 percent since 1996, while the total U.S. elderly population grew by only 12 percent over the same time period. Given that most elderly health center patients are low-income, many of them also rely on Medicaid to cover the cost of care; however, Medicaid agencies are not expected to supplement Medicare payments up to the Medicaid rate, since Medicare is the primary insurer. While the elderly make up a relatively small proportion of health center patients (seven percent), Medicare only accounts for six percent of health center revenues.

As with Medicaid, Medicare pays the FQHC rate for a “core” set of FQHC services, including FQHC Primary Preventive Services (denoted by * in Exhibit 2).⁵³ In addition, FQHCs provide numerous other services which are reimbursed under Medicare, but not at the higher FQHC rate.

Exhibit 2. Covered Benefits Furnished to Medicare Beneficiaries	
<ul style="list-style-type: none"> • Physician Services;* • Services of nurse practitioners, physician assistants, and certified nurse midwives;* • Visiting nurses to the homebound;* • Clinical psychologist and clinical social worker services;* • Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy;* • Medical social services; • Nutritional assessment and referral; • Preventive health education; • Children’s eye and ear examinations; • Prenatal and post-partum care; • Well child care, including periodic screening; • Immunizations, including tetanus-diphtheria booster and influenza vaccine; • Management training services;** • Colorectal cancer screening tests;** 	<ul style="list-style-type: none"> • Screening mammography;** • Voluntary family planning services; • Taking patient history; • Blood pressure measurement; • Weight measurement; • Physical examination targeted to risk; • Visual acuity screening; • Hearing screening; • Cholesterol screening; • Stool testing for occult blood; • Dipstick urinalysis; • Risk assessment and initial counseling regarding risks; • Screening pap smears and screening pelvic exams;** • Prostate cancer screening;** • Diabetes outpatient self-management training services;** • Bone mass measurements;** and • Glaucoma screening.**
<p>* Denotes core FQHC Medicare service ** Must be furnished by FQHC physician or practitioner.</p>	

⁵³ Medicare Benefit Policy Manual, Chapter 13: Rural Health Clinic and Federally Qualified Health Center Services (Rev. 49, 03-31-06). <http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>

Services not included in Exhibit 2 are excluded from the Medicare FQHC system, including some services such as durable medical equipment that may be covered and billed under a separate Medicare benefit. In addition, Medicare does not cover care-related costs such as translation, non-emergency transportation, and other services and supports crucial to the successful management of a Medicare beneficiary who is older or who has disabilities.

In calculating the FQHC payment rate, Medicare does not apply the Part B deductible to the expenses for the services and beneficiary responsibility for 20 percent of billed charges if the FQHC waives collection according to the beneficiary's ability to pay. Unlike Medicaid, Medicare FQHC payments are subject to a hard cap, imposed by regulation in 1991, despite the absence of evidence that Congress intended such a result in the legislative history. In subsequent years, Congress has raised the cap from time to time, but the increases have not kept pace with inflation.⁵⁴ As of 2003, 75 percent of health centers reported that operating costs for their Medicare patients exceeded the federal cap.⁵⁵ In 2008, the Medicare Improvement for Patients and Providers Act of 2008 increased the cap by \$5 per visit and required GAO to study and report to Congress regarding the effects and adequacy of the FQHC payment cap.

Thus, the Medicare program—even more than Medicaid—has not enabled FQHCs to enhance service upgrades, reward quality of care investments, and make other changes to improve the accessibility, quality, or outcomes of care. The exception is ARRA incentives for increased HIT adoption. Demonstrations aimed at testing physician-based Medicare payment reforms are often designed using the Part B Resources Based Relative Value Scale (RBRVS) payment system. Because FQHCs do not bill using the RBRVS payment system, however, the FQHC providers that serve the most medically underserved and vulnerable communities are excluded from participating in these demonstration programs.

Private Insurance

Unlike Medicaid, CHIP, and Medicare, there are no special policies for how private health insurers reimburse FQHCs. Research indicates that private health insurance payments fall well below the average costs for health centers to provide the care and, on average, centers lose money providing care for privately insured patients. Between 1997 and 2005, health centers spent a cumulative \$6.4 billion to treat privately insured patients, but received only \$2.8 billion in revenue, generating a loss of \$3.6 billion over nine

⁵⁴ The FQHC upper payment limit per visit for urban FQHCs increased from \$117.41 to 119.29 for 2009; the rural FQHC cap increased from 109 to \$102.58. The rate change increase reflects only the rate of increase in the Medicare Economic Index, which is generally less than the CPI medical care and services indices and, according to the GAO, does not reflect accurately the care provided by FQHCs. General Accountability Office. (June 2005). Health centers and rural clinics: State and federal implementation issues for Medicaid's new payment system. GAO-05-452. <http://www.gao.gov/new.items/d05452.pdf>

⁵⁵ National Association of Community Health Centers, http://www.nachc.com/client/documents/issues-advocacy/policy-library/medicare-medicare-policy-updates/CMS_Public_Comment_Economic_Impact.pdf, accessed on May 20, 2009.

years.⁵⁶ In 2005, it was estimated that these losses were equivalent to 10 percent of FQHC revenues. A study in New York also found that private insurance payments, even including estimated copayments and coinsurance, fell far short of Medicaid reimbursement rates, which are cost-based.⁵⁷ The net result of these shortfalls from private insurance payment rates is that health centers must divert resources that would otherwise be used to provide care to uninsured patients to subsidize the cost of treating privately insured patients.

The inadequacy of private health insurance payment rates stems from the fact that reimbursement rates are typically set at levels equivalent to those paid to a private physician, and often have similar limitations on the scope of services. Some services that are commonly provided to privately insured patients at health centers, such as behavioral health or dental care services, may be outside the scope of services for reimbursement. Private insurance payment rates do not account for the costs of providing the wide array of additional services that health centers provide, such as enabling services, patient education, and language interpretation. Another concern is that private health insurance often involves high out-of-pocket deductibles, copayment, and coinsurance;⁵⁸ FQHCs serve all patients regardless of their ability to pay. Patients may be charged sliding scale fees below the coinsurance or deductibles that the private plan accounts for when calculating health center payment rates, so health centers may incur a loss treating underinsured patients.

Recent Developments in Health Center Financing

In addition to the \$1.5 billion in infrastructure funding for health centers, ARRA provides billions of dollars to expand and upgrade the health information technology (HIT) infrastructure for many types of health care providers across the nation. FQHCs are eligible for HIT incentive payments if 30 percent or more of their patients are “needy,” including both patients who are uninsured and pay out of pocket, and those who are insured under Medicaid or CHIP. It is expected that most, though not all, health centers will meet this threshold. Health centers that are “meaningful users” of HIT—the interpretation of this term has not yet been established—will be eligible to receive up to 85 percent of the net allowable cost of HIT acquisition, implementation, operation, and maintenance, up to \$63,750 per eligible health professional over a five-year period. These payments are in addition to the FQHC rate and thus designed to operate as an incentive to adopt the technology. Health centers and primary care associations can also benefit from other ARRA HIT subsidies, such as funding to help establish regional systems to share electronic data.

⁵⁶ Shin, P. et al. (2008, February). Health Centers: An Overview and Analysis of Their Experience with Private Health Insurance. Kaiser Family Foundation.

⁵⁷ Manatt Health Solutions. (2007). Improving Commercial Reimbursement for Community Health Clinics: Case Studies and Recommendations for New York. *RCHN Community Health Foundation and Manatt Phelps and Phillips, LLP*.

⁵⁸ Galbraith, A.A., Ross-Degnan, D., Soumerai, S.B., Miroshnik, T., Wharam, J.F., Kleinman, K., and Lieu, T.A. High-Deductible Health Plans: Are Vulnerable Families Enrolled? *Pediatrics* 2009 123: e589-e594.

ARRA also contains provisions to help alleviate the health care workforce shortage. To boost the primary care workforce, ARRA provides \$500 million in funding, much of it to expand the National Health Service Corps, a vital source of support that helps place physicians and other clinicians in health centers and underserved communities. In addition, supplementary funds are available to finance AmeriCorps volunteers, many of whom work at health centers.

Combined with the other changes under the ARRA described earlier, these stimulus funds can help support many of the initial investments for infrastructure or staffing in the next two years that could help support quality improvements under a PCMH model. However, ARRA funds and other one-time disbursements do not provide the critical ongoing support necessary to sustain health center operations into the future.

IV. Health Center Practices in Relation to PCMH Criteria

Health centers, in their legislative and operational structure, adhere to a care model that inherently tracks the key elements of the PCMH concept. Some basic insights on how health centers currently perform under the rubric of patient-centered medical homes can be gained by analyzing existing data about health centers vis-à-vis the domains set forth under the NCQA PCMH criteria (Exhibit 3).

Exhibit 3. PCMH Domains and FQHC Characteristics, 2006 and 2007	
Domains	Medical Home Indicators
1. Access and communication	24-hour coverage on-site (86%) Urgent medical care on-site care (86%) Emergency medical services (43%) Pharmacy services on-site (74%, including provider-dispensed medications) All sites located in a medically underserved area or serve an underserved population
2. Patient tracking and registry	86% maintain disease registries for clinical support 80% in Health Disparities Collaborative (HDC)
3. Care management	92% provide case management services 97% provide health education 86% maintain disease registries for clinical support 80% in Health Disparities Collaborative (HDC)
4. Patient self-management support	92% provide case management services 97% provide health education
5. Electronic prescribing	13% of health centers had a full electronic health record system 60% plan to adopt a system in the next three years
6. Test tracking	13% of health centers had a full electronic health record system 60% plan to adopt a system in the next three years
7. Referral tracking	13% of health centers had a full electronic health record system 60% plan to adopt a system in the next three years
8. Performance reporting and improvement	80% in HDC, which includes these elements 86% maintain disease registries All participate in UDS data system
9. Advanced electronic health communications	13% of health centers had a full electronic health record system 60% plan to adopt a system in the next three years
Data sources: GW analysis of UDS data, 2007, and Shields, Shin, et al. 2007.	

FQHCs have characteristics that correspond with many of the NCQA PCMH criteria in 2006 and 2007. Health centers exist to enhance access, and their community orientation eases communication with patients. Case management and patient education empowers patients to become active partners in their own care, along with the team-based approach to care, enables health centers to manage patient care.⁵⁹ Health centers are at the forefront of quality improvement efforts, supported by their state primary care associations and information networks such as the Health Disparities Collaborative. The data in Exhibit 3 suggest that gaps in health information technology and its numerous applications (e.g., e-prescribing and test tracking) are problematic for health centers, as they are for many other types of medical practices. The HIT programs and incentives fostered under ARRA have the potential to spur broader changes in this area. More recent data are expected later in 2009 as a result of a national survey being conducted by The Commonwealth Fund.⁶⁰

Exhibit 4 shows six additional criteria that do not appear in the NCQA criteria for PCMHs, but reflect operational capabilities that are inherent to a health center model that are not well-captured in a more generalized definition of PCMH.

Exhibit 4. Additional Community-Center Medical Home Criteria and FQHC Characteristics, 2006 and 2007	
Domains	Community-Centered Home Indicators
1. Behavioral/mental health and oral health integration	Mental health/substance abuse staff and services on-site (77%) Dental staff and services on-site (74%)
2. Enabling services	Enabling services staff and services, including case management, and education, transportation (100%)
3. Community accountability through governance	All FQHCs have patient majority boards to ensure services are tailored to meet community needs (100%)
4. Community needs assessment, planning and partnerships	Every FQHC must conduct a periodic community needs assessment as part of federal grant requirements and must demonstrate collaborations with other community organization and health care providers (100%); all health centers must serve federally-designated medically underserved populations or areas
5. Cultural competence	Interpretation/translation services on-site (90%)
6. Team-based care	Relatively high ratio of advanced practice clinicians (nurse practitioners, physician assistants and clinical nurse midwives) to primary care physicians: 0.6 to 1 80% in Health Disparities Collaborative (HDC)
Data sources: GW analysis of UDS data, 2007, and Shields, Shin, et al. 2007.	

⁵⁹ See, for example, Davis, K. & Schoen, C. (1977). *Health and the War on Poverty* (Brookings Institution Press, Washington D.C.; Starfield, B., et al. (1994). Costs vs. quality in different types of primary care settings. *JAMA*, 272(24), 1903-1908; Proser, M. (2005). Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care. *J Ambul Care Mgmt.* 28(4): 321-330.

⁶⁰ GW analysis of 2007 UDS data, and Shields, A., Shin, P. et al. (2007). Adoption of health information technology in community health centers; Results of a national survey. *Health Affairs.* 26(5):1373-83.

These criteria underscore the special obligations related to serving all community residents and the community-wide health focus that are the hallmarks of health centers. The NCQA criteria were designed with a “typical” private primary care practice in mind, and do not include whether the practitioner provided additional services that are vital to patients but that typically fall outside of a standard definition of primary medical care, such as dental or mental health services and translation, transportation and enabling services. But such services are relevant for health centers, given the nature of the populations and communities on whose behalf they operate, as well as the complex needs of the populations they serve. This model can be thought of as a “community-centered PCMH.”

Health centers perform well with regard to the traditional NCQA PCMH criteria, and they also provide additional services to their patients and communities. These services not only enhance the health of the population, but can translate into savings in emergency and chronic disease care. It is critical to create incentives that spur health centers to more fully embody the “community-centered medical home” model.

V. Community Health Centers in the Context of Health Reform

Discussions on reforming the American health care system are ongoing. The Senate Finance Committee has released bipartisan options papers that discuss alternative ways of changing the health care delivery system⁶¹ or to expand health insurance coverage⁶² and leaders of the House of Representatives have said that they will have a proposal on the floor by the end of July. The discussions have included concepts like the PCMH model and development of a Health Insurance Exchange that would be used to make multiple affordable health insurance plans available to the public, but there has been little public discussion to date about changes to the community health center system.

Health centers have demonstrated their ability, when properly resourced, to serve as patient- and community-centered medical homes and to furnish high quality care that meets or exceeds the national average (even without adjusting for the high risk of medical needs within their patient population).⁶³ The key is ensuring that health centers have the sustained resources necessary to adopt and maintain the clinical, administrative, and health information technology changes linked to quality improvement efforts, to recruit

⁶¹ Senate Finance Committee (2009, April 29), Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.

⁶² Senate Finance Committee, (2009, May 14). Expanding Health Care Coverage: Proposal to Provide Affordable Coverage to All Americans.

⁶³ Shin P, Markus A, Rosenbaum S, & Sharac J., (2008). “Adoption of Health Center Performance Measures and National Benchmarks.” *Journal of Ambulatory Care Management* 31(1): 69-75; Falik M, Needleman J, Herbert R, et al. (2006). “Comparative Effectiveness of Health Centers as Regular Source of Care.” *Journal of Ambulatory Care Management* 29(1):24-35; O’Malley AS, et al. (2005). “Health Center Trends, 1994-2001: What Do They Portend for the Federal Growth Initiative?” *Health Affairs* 24(2):465-472.

and retain clinical, administration, and support staff,⁶⁴ to secure the financial capital needed to add additional operating hours and locations,⁶⁵ and to establish reliable referral arrangements for patients in need of specialty care.

Potential financing policies for health centers fall into two major categories. The first is incremental changes to financing methods for the major public payers today: Medicaid, CHIP, Medicare, and the federal grants. The second is new types of insurance mechanisms that might evolve to serve many of those who are currently uninsured or privately insured.

For the current public funding sources for health centers, including Medicaid, CHIP, Medicare and HRSA, one could consider incremental changes to the current financing systems to better accommodate quality improvements under a PCMH model, or a community-centered medical home model. Many different types of expenses are associated with the necessary upgrades and enhancements for physician practices, and these upgrades can be financed through a range of approaches. Some costs, such as the cost of acquiring or upgrading an HIT system, may be one-time investments and might be met in the near term by ARRA. Other costs, such as HIT use and maintenance, generate ongoing operational expenses, as do the costs for additional clinical or administrative staff to provide team-based care, provide case management services, and provide patient education in prevention and chronic care self-management. Medicare, CHIP, and Medicaid could provide incremental payments above the PPS rate for health centers that meet enhanced PCMH criteria or perform quality improvement initiatives, as with the HIT adoption and use increment authorized under ARRA. Similarly, private insurers could adopt the PPS rate with enhancements for PCMH and high performance. Grant funding agencies, such as HRSA or state governments, could provide supplemental awards, similar to the approach used under the disparities collaborative projects, to support the infrastructure costs of improvements and to help health centers support quality initiatives on an ongoing basis. In addition, government agencies and insurers could provide non-monetary support by providing ongoing training and support services, by sharing information, and by helping to develop and support the standardization, networks, and technology and forms necessary to support PCHM models.

Community health centers are uniquely positioned to provide patient- and community-centered medical homes, especially for vulnerable and hard-to-reach populations. Health centers already provide primary and preventive health care, utilize ongoing care management systems, help educate and support patients to self-manage their diseases, use team-based and culturally sensitive care, and have data systems that support clinical decisions. In addition to providing primary care, they also often have dental, mental health and pharmacy services to support their patients. The health center movement could be considered an early adopter of many elements of the medical homes model, and

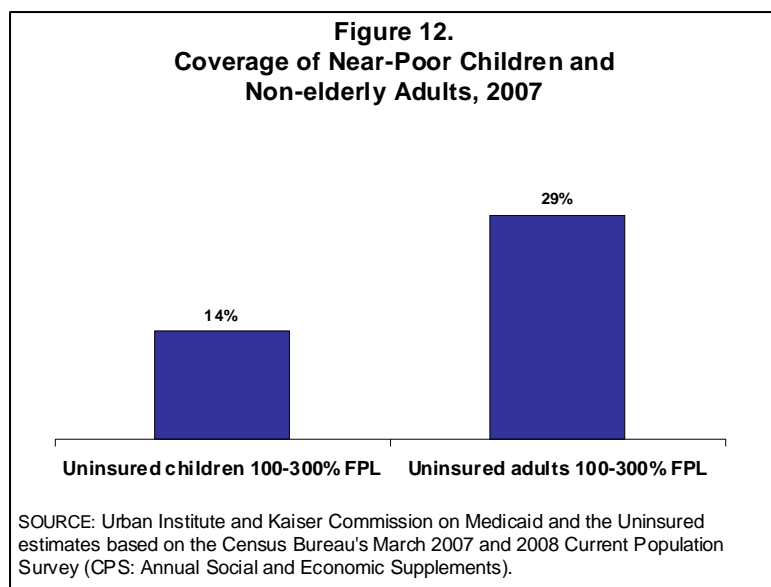
⁶⁴ National Association of Community Health Centers, Robert Graham Center, The George Washington University School of Public Health and Health Services. (2008, August). Access Transformed: Building a Primary Care Workforce for the 21st Century.

⁶⁵ National Association of Community Health Centers, Capital Link. (2008, March). Access Capital: New Opportunities for Meeting America's Primary Care Infrastructure Needs.

health centers should serve as a model and beacon as the health care delivery system is redesigned to enhance quality and value.

In the current health reform debates, one possible approach for insurance expansion is the creation of a government-regulated Health Insurance Exchange that would offer a variety of approved health insurance plans that could be purchased by individuals or by firms, with tax subsidies to help those with low- to moderate-incomes. The details that emerge as reform proceeds about health plans and their health care delivery systems could have important repercussions for those with incomes between 100 percent and 300 percent of the poverty line, particularly if Medicaid expansions are limited to those with incomes below the poverty line.⁶⁶ These individuals have incomes too high to qualify for Medicaid, but too low to afford private insurance without assistance.

Census data indicate that there are millions of uninsured children and adults with incomes in this range. As shown in Figure 12, about 14 percent of children in families with incomes between 100 percent and 300 percent of poverty are uninsured, along with 29 percent of adults with incomes in this range (it is possible that coverage for childless adults with incomes below the poverty line could be made available under the



exchange). Large numbers of the uninsured individuals in this range lack regular primary care providers and, if they gained coverage, would likely turn to health centers for primary care services. However, there are large pockets of medically underserved areas in rural and urban communities that have a shortage of primary care providers under the current circumstances. At least 47 percent of federally-designated medically underserved areas still lack a health center clinic or site.⁶⁷ This demonstrates the gaping need to be filled by increasing health center capacity.

The importance of focusing on health center capacity and quality improvement as part of reform can hardly be overstated. A recent report examined changes in the role of health centers after Massachusetts implemented a successful state health reform initiative, which halved the number of uninsured people in the state. The study found that health center

⁶⁶ Senate Finance Committee. (2009, May 14) Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans.

⁶⁷ General Accountability Office. (2009, April). Many underserved areas lack a health center site, and data are needed on service provision at sites. GAO-09-667T. <http://www.gao.gov/new.items/d09667t.pdf>

caseloads increased, as they provided care to newly insured patients and became even more important as access points for individuals who remained uninsured. Although health center revenues rose because of payments from public insurance programs, their expenditures rose apace, leaving health centers with no net improvement in their financial margins; they still struggled to maintain adequate staffing and services, despite the increased patient caseload that resulted from reform. The situation in Massachusetts highlights the need to maintain financial supports for safety net health care providers as vital components of the health care delivery system, serving both the newly insured and those who remain uninsured. One possible implication is the need for bolstering the primary care system through the continued expansion of community health centers. Another possible implication is that it might be appropriate for health plans that are offered under a government-sponsored Health Insurance Exchange to make enhanced payments to community health centers, paralleling the reimbursement methodologies of Medicaid, CHIP, and Medicare, which are more tailored to health centers and account for the wide range of community-centered medical homes services that health centers provide.

At the very least, three critical lessons for effective reform are apparent. First, as long as such a large portion of their patients are uninsured (and underinsured) and bring no source of insurance payments to support their health care needs, health centers will struggle with balancing the use of their funds to upgrade services and underwriting the cost of caring for the uninsured. Second, there must be payment structures that offer incentives for better primary care and for quality medical homes. Third, the recent influx of funds from the ARRA to support infrastructure and health information technology at health centers will jumpstart the process of transformation and improvement, but care must be taken to ensure that the improvements are sustainable.

TABLE 6B – QUALITY OF CARE INDICATORS

(NO PRENATAL CARE PROVIDED? CHECK HERE: <input type="checkbox"/>)				
SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS (GRANTEES WHO PROVIDE PRENATAL CARE ONLY)				
DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS				
AGE		NUMBER OF PATIENTS (a)		
1	LESS THAN 15 YEARS			
2	AGES 15-19			
3	AGES 20-24			
4	AGES 25-44			
5	AGES 45 AND OVER			
6	TOTAL PATIENTS (SUM LINES 1 – 5)			
SECTION B – TRIMESTER OF ENTRY INTO PRENATAL CARE				
TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR		Women Having First Visit with Grantee (a)	Women Having First Visit with Another Provider (b)	
7	First Trimester			
8	Second Trimester			
9	Third Trimester			
SECTION C – CHILDHOOD IMMUNIZATION				
CHILDHOOD IMMUNIZATION		TOTAL NUMBER PATIENTS WITH 2 ND BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10	Number of children who have received required vaccines who had their 2 nd birthday during measurement year (on or prior to December 31)			
SECTION D – PAP TESTS				
PAP TESTS		TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11	Number of female patients aged 24-64 who had at least one Pap test performed during the measurement year or during one of the two previous calendar years			

TABLE 7 – HEALTH OUTCOMES AND DISPARITIES

	Hispanic/Latino (1)								Non - Hispanic/Latino (2)								Unreported / Refused to Report Race and Identity (h)	Total (i)
	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to Report (g)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to report (g)		
HIV Positive Pregnant Women	<<report total only>> ----->																	
(NO PRENATAL CARE PROVIDED? CHECK HERE: <input type="checkbox"/>)																		
SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO IDENTITY																		
1	Prenatal care patients who delivered during the year																	
2	Deliveries performed by Grantee Provider	<<report total only>> ----->																
3	Live Births < 1500 grams																	
4	Live Births 1500 – 2499 grams																	
5	Live Births ≥ 2500 grams																	

	Hispanic/Latino (1)								Non - Hispanic/Latino (2)								Unreported / Refused to Report Race and Identity (h)	Total (i)
	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to Report (g)	Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian / Alaska Native (d)	White (e)	More than one race (f)	Race Unreported / Refused to report (g)		
SECTION B: HYPERTENSION BY RACE AND HISPANIC/LATINO IDENTITY																		
Patients 18 to 85 diagnosed with hypertension whose last blood pressure was less than 140 / 90																		
6	Total hypertensive patients																	
7	Charts sampled or EHR total																	
8	Patients with HTN controlled																	
SECTION C: DIABETES BY RACE AND HISPANIC/LATINO IDENTITY																		
Patients 18 to 75 diagnosed with Type I or Type II diabetes: Most recent test results																		
9	Total patients with diabetes																	
10	Charts sampled or EHR total																	
11	Patients with HBA1c < 7%																	
12	Patients with 7% ≤ HBA1c ≤ 9%																	
13	Patients with HBA1c > 9% OR No test during year																	