



Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market

ISSUE BRIEF
NO. 848

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DECEMBER 18, 2012

OVERVIEW — The Patient Protection and Affordable Care Act of 2010 and the Supreme Court’s related decision have significantly shifted the health care landscape for safety net providers. Federally qualified health centers (FQHCs) are a mainstay of primary care for the uninsured and those with limited access to care. This paper focuses on the impact of health reform on FQHCs given the significant federal investment in them through grants, Medicaid, and Medicare reimbursement. Where noteworthy, the effect on non-FQHC community clinics is also discussed. The implications of Medicaid coverage expansions (or lack thereof in states that choose not to expand), Medicaid disproportionate share hospital program cuts, discretionary budgets and sequestration, Medicare payment changes, contracting with qualified health plans in state health insurance exchanges, and delivery system reforms are explored.

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The health reform law the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148) and the Supreme Court's related decision have significantly shifted the health care landscape for safety net providers. Over the next decade, an estimated 30 million people will gain health insurance through the ACA, and another 30 million will remain uninsured because (i) their incomes are too low to afford it, exempting them from the mandate to buy it; (ii) they are unauthorized immigrants and therefore ineligible for public or subsidized coverage; or (iii) they choose to forgo coverage and pay a penalty.¹ Undoubtedly many of these 30 million uninsured people will catch the flu, have a baby, develop diabetes, break a bone, need stitches, or develop cancer. They will need access to health care, despite being uninsured.

The estimated 11 million people who will become newly covered by Medicaid in the next decade will need to find a primary care provider who will serve them.² They will be competing not only with those newly insured through the health insurance exchanges but also with some providers' perceptions about patients covered by Medicaid versus commercial insurance. Federally qualified health centers (FQHCs) and other community clinics—by mission, mandate, or both—willingly serve the uninsured and those covered by Medicaid. In the post-health reform marketplace these providers must navigate myriad changes in insurance coverage and payment, managed care contracting, delivery system redesign, and changing relationships with other safety net and private providers in an effort to be providers of choice for the newly insured instead of providers of last resort, while still fulfilling their mission to serve the uninsured.

This paper focuses on the impact of health reform legislation on FQHCs given the significant federal investment in them through grants, Medicaid, and Medicare reimbursement. Where noteworthy, the impact on non-FQHC community clinics is also discussed. The implications of Medicaid coverage expansions (or lack thereof, in states that choose not to expand), discretionary budgets and sequestration, Medicare payment changes, contracting with qualified

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CLINIC NOMENCLATURE

There are many differences and similarities between FQHCs and clinics that are not designated as FQHCs. This section briefly reviews both.

Federally Qualified Health Centers: Community Health Centers and “Look Alikes”

Community health centers were created in 1965 as part of the federal Office of Economic Opportunity (OEO) to provide access points for health and social services in poor and medically underserved communities. Grant funds for community health centers flow from the federal government directly to nonprofit, community-based organizations. Community health center grantees are often called “330 grantees” because of their statutory authorization under section 330 of the Public Health Service Act (PHSA).³ The Health Resources and Services Administration (HRSA), Bureau of Primary Health Care within the U.S. Department of Health and Human Services (HHS) administers the program.

Community health centers receive grant funds from HHS to help cover the cost of providing care to those without insurance and they also bill Medicaid, Medicare, and private insurers for the services they provide to insured patients. To receive section 330 grant funds, a clinic must meet certain statutory requirements. It must:

- be located in a federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP) (for additional information see the Forum’s “Health Care Shortage Designations: HPSA, MUA, and TBA” background paper⁴);
- have nonprofit or public status;
- provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation;
- have a governing board, the majority of whose members are patients of the health center; and

- provide services to everyone in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to family income.

In 2011, community health centers across the United States served 20.2 million patients and provided 80 million patient visits through 1,128 grantees; 36 percent of those patients were uninsured and 39 percent were covered by Medicaid. In 2011, 72 percent of health center patients lived below 100 percent of the federal poverty level (FPL) and 93 percent lived below 200 percent of the FPL.⁵ Medicaid is the largest source of revenue for health centers, followed by federal grants.

In 1990, Congress authorized the FQHC “look-alike” program as a way to increase access to services for more uninsured and Medicaid populations, despite limited federal grant funding. FQHC look-alikes do not receive section 330 grant funding; however, they operate and provide services similar to grant-funded community health centers. They must meet the statutory, regulatory, and policy requirements of section 330 and demonstrate a commitment to providing primary health care services to medically underserved populations regardless of their ability to pay. Although they do not receive federal section 330 grant funds, look-alike status means they share many of the benefits of being a section 330 grantee, such as participation in a Medicaid prospective payment system (PPS) (and a Medicare PPS beginning October 1, 2014),⁶ eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program, and automatic designation as a Health Professional Shortage Area (HPSA), which allows them to hire health care providers through the National Health Service Corps.⁷ As of 2012, about 100 FQHC look-alikes are operating.⁸

Non-FQHC Community Clinics

There are numerous community clinics that are not FQHCs providing care to Medicaid and uninsured populations across the country. They range from free clinics—private, nonprofit organizations that provide medical, dental, pharmaceutical, mental health, and other services to uninsured individuals by licensed volunteer providers for little or no cost—to school-based clinics, rural health clinics, nurse-managed health clinics, local health department clinics, community mental health centers, faith-based clinics, family planning

clinics, and safety net hospital outpatient clinics. (For additional information see the Forum's background paper, "The Primary Care Safety Net: Strained, Transitioning, Critical."⁹)

MEDICAID'S HUGE IMPACT

As the financial lifeblood of the health care safety net, Medicaid funding and policy changes greatly affect FQHCs and non-FQHC community clinics. Clinics are particularly interested in Medicaid coverage expansions, so they have fewer uninsured people to serve, and in higher Medicaid payment rates. The adequacy of Medicaid payments to safety net hospitals who provide specialty and inpatient care to their patients is also a concern.

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Expanded Eligibility and Enhanced Payments

Prior to the ACA, Medicaid coverage for non-disabled adults younger than 65 without children was very limited across states; any coverage states provided came through a Medicaid waiver or a state-funded program. In January 2012, 26 states provided no coverage to this population, 17 states provided limited coverage and/or premium assistance, and 8 states provided full Medicaid coverage.¹⁰ The ACA authorized uniform Medicaid coverage across states by expanding—the so-called Medicaid expansion—coverage to all non-elderly adults (unauthorized immigrants are ineligible for coverage), up to 133 percent of poverty (\$14,856 for an individual; \$30,657 for a family of four in 2012).¹¹ States must provide care through benchmark equivalent health insurance plans, not the full Medicaid benefits package. The federal government will pay 100 percent of the costs for the expansion population in 2014, 2015, and 2016, with a phase-down in subsequent years until it pays 90 percent of the costs in 2020 and beyond.

On June 28, 2012, the Supreme Court decided that the federal government could not withhold all Medicaid funds if a state chose not to expand Medicaid to 133 percent of the FPL as written in the ACA, effectively making the Medicaid expansion optional. The law's intended uniform and expanded coverage for childless adults has therefore reverted to a state-by-state patchwork. As of this writing, nine states have publicly announced that they will not expand their Medicaid programs: Alabama, Georgia, Louisiana, Maine, Mississippi, Oklahoma, South Carolina, South Dakota, and Texas.¹² HHS has issued

guidance that states must expand coverage to 133 percent of the FPL in order to receive the 100 percent federal payment, and that states may choose when and whether to expand coverage (and may later decide to drop that coverage), but 100 percent federal funding is only available in 2014 through 2016.¹³

In states that do expand Medicaid coverage to 133 percent of the FPL, FQHCs and other community clinics will benefit from the reimbursement that serving more insured patients brings. However, they may face increased competition from private primary care providers interested in serving newly insured Medicaid patients, particularly since the ACA requires states to pay primary care providers 100 percent of Medicare payment rates for the Medicaid patients they serve in 2013 and 2014.¹⁴ FQHCs already benefit from preferential Medicaid payment through a prospective payment system based on a clinic's modified costs.¹⁵ Non-FQHC clinics and private primary care providers are paid according to the state Medicaid program's fee schedule. Historically Medicaid has paid the least generously for physician services in comparison to Medicare or private insurers. An analysis of Medicaid physician fee data from 2003 to 2008 showed that nationally Medicaid payments for primary care services were on average about 66 percent of Medicare payments in 2008; the lowest Medicaid rates in the country were in New Jersey, which pays 41 percent of Medicare rates, and in California, which pays 47 percent.¹⁶ A recent analysis of data on office-based physicians from the 2011 National Ambulatory Medical Care Survey Electronic Medical Records Supplement demonstrates that the acceptance rate for new Medicaid patients is positively associated with the average Medicaid-to-Medicare fee ratio in a state, suggesting that raising Medicaid payment rates to 100 percent of Medicare rates will significantly and positively affect physicians' acceptance of new Medicaid patients.¹⁷

While increased rates may entice physicians to serve the newly Medicaid insured, it is unclear how long they will continue to serve them starting in 2015 when the mandate to pay 100 percent of Medicare rates ends and once thousands of other newly commercially insured people from the health insurance exchanges start looking for a primary care provider. Nor is it clear the extent to which the newly insured will seek care at private provider offices versus continuing to seek care at FQHCs. An analysis of safety net providers after health reform in Massachusetts found that "[m]ost patients use safety-net facilities willingly rather than as a last resort."¹⁸

California: Full Steam Ahead

California has a robust community clinic infrastructure: close to 11 percent of all FQHCs nationally are in California. The 121 community health center grantees work through 483 clinic sites; there are 30 FQHC look-alike sites, 25 rural health center sites, and 355 other nonprofit clinic sites. Collectively these clinics serve almost 5 million patients per year, 3 million of whom have incomes below 100 percent of the FPL.*

California has embraced health reform and has been an early implementer of the law. On November 2, 2010, HHS approved California's section 1115 Medicaid demonstration waiver, "Bridge to Reform." The program contains three parts: coverage expansion for low-income adults known as the Low Income Health Program (LIHP), a public hospital delivery system reform program, and mandatory enrollment of Medicaid-eligible seniors and people with disabilities into Medicaid managed care plans. Under LIHP, counties have the option to expand coverage to childless adults ages 19 to 64 with family income at or below 133 percent of the FPL (called the Medicaid Coverage Expansion, or MCE); counties may also elect to implement a health care coverage initiative to provide health insurance to childless adults ages 19 to 64 with income between 133 and 200 percent of the FPL (called the Health Care Coverage Initiative, or HCCI).†

When waiver implementation began, California had approximately 6.5 million uninsured people. Analysis anticipates that Bridge to Reform and ACA implementation will result in a 52 percent drop in the number of uninsured people to 3.1 million by 2016.‡ Of the 3.8 million people gaining coverage through the law, 38 percent would be covered by Medi-Cal (California's Medicaid program), 16

percent would gain employer-sponsored insurance, and 46 percent would gain coverage through the exchange, recently dubbed "Covered California." Of the remaining 3.1 million uninsured, 40 percent would be undocumented, 28 percent would be documented but not subject to the mandate, 21 percent would be subject to the mandate but choose to remain uninsured, and 11 percent would be newly uninsured (that is, lose employer-sponsored insurance).§ As of September 2012, 507,456 people were enrolled in LIHP—481,672 in MCE and 25,784 in HCCI.¶

While expanded coverage could be a boon to California's FQHCs and community clinics, there is some indication that the newly insured may be interested in changing providers. The Blue Shield of California Foundation conducted a representative sample of Californians ages 19 to 64 with incomes below 200 percent of the FPL and found that 6 in 10 were dissatisfied with their care and would like to switch to a new facility.** However, those surveyed were not limited to community health center patients, but also included patients of other community clinics, public hospital clinics, city and county clinics, Kaiser Permanente, and private providers. In addition to concerns about competition for patients from private providers, FQHCs and community clinics are juggling new and perennial issues, including achieving meaningful use of electronic health records and, in some places, interconnectivity with hospitals; pursuing PCMH recognition; integrating primary care and behavioral health services; analyzing the value of contracting with managed care plans in the exchange; working on outreach and enrollment with their counties for LIHP; expanding capacity and upgrading existing capacity; and establishing specialty care arrangements for patients.

* California Primary Care Association, "California Profile of Community Clinics and Health Centers," revised January 18, 2012, available at www.cPCA.org/cPCA/assets/File/Data-Reports/2012-California-State-Profile.pdf.

† Peter Harbage and Meredith Ledford King, "A Bridge To Reform: California's Medicaid 1115 Waiver," prepared for the California HealthCare Foundation, October 2012, available at www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BridgeToReform1115Waiver.pdf.

‡ Peter Long and Jonathan Gruber, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs*, 30, no. 1 (2011): 63-70.

§ Long and Gruber, "Projecting the Impact of the Affordable Care Act on California."

¶ California Department of Health Care Services, "LIHP September 2012 Monthly Enrollment," November 20, 2012, available at www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY8-M03_EnrL_Rpt.pdf.

** Blue Shield of California Foundation, "On the Cusp of Change: The Healthcare Preferences of Low-Income Californians," June 2011, available at www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/On_the_Cusp_of_Change_6_2011.pdf.

The Remaining Low-Income Uninsured Population

According to the Congressional Budget Office, the net coverage effect of the Supreme Court's decision will likely be an increase of 3 million uninsured people (6 million fewer insured by Medicaid and 3 million more insured through the exchanges) with 30 million people uninsured in 2022.¹⁹ As defined in the ACA, individuals with incomes of 100 percent of the FPL and above are eligible to receive government subsidies to purchase health insurance in the health insurance exchanges, but individuals with incomes that fall between 100 percent of the FPL and the state's Medicaid eligibility level for adults will likely remain uninsured in states that do not expand Medicaid. Starting in 2014, individuals must purchase health insurance or pay a penalty, unless they qualify for an exemption. An individual or family is exempt from having to buy insurance or from paying the penalty if (i) their income is so low they do not have to file taxes or (ii) the lowest cost option in the exchange would cost more than 8 percent of their annual gross income. Because nationally 70 percent of community health center patients have incomes below 100 percent of the FPL (\$11,170 for an individual; \$23,050 for a family of four), it is likely that for many the least expensive health plan option in the exchange will cost more than 8 percent of their income, therefore they will be exempt from paying the penalty. Nonetheless, they will remain uninsured and many will need access to health care services.

DSH and Access to Specialty and Inpatient Care

FQHCs and other community clinics rely on safety net hospitals to provide specialty and inpatient services to their Medicaid and uninsured patients, but changes to a key source of hospital funding may threaten access to such care. As with safety net primary care providers, Medicaid is the financial lifeblood of safety net hospitals. Most safety net hospitals receive disproportionate share hospital (DSH) funds distributed by the federal government to state governments and, in turn, to safety net hospitals to partially subsidize the uncompensated care they provide to Medicaid and uninsured patients. In fiscal year (FY) 2011, the federal government paid \$11.28 billion in Medicaid DSH funds to states. Preliminary DSH allotments for FY 2012 total \$11.34 billion.²⁰ PPACA envisioned Medicaid expansions to 133 percent of the FPL across all states, resulting in fewer uninsured and therefore less uncompensated care for safety net hospitals. Section 2551 of the ACA reduces Medicaid DSH payments to states by a

total of \$18.1 billion between FYs 2014 and 2020. Reductions by year are \$500 million in FY 2014, \$600 million for FYs 2015 and 2016, \$1.8 billion in FY 2017, \$5.0 billion in FY 2018, \$5.6 billion in FY 2019, and \$4 billion in FY 2020.²¹ The Secretary of HHS is tasked with developing a methodology to distribute the cuts in a way that imposes larger percentage of DSH reductions on states that have the lowest percentages of uninsured people and states that do not target DSH dollars to hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care (excluding bad debt), among other factors. Some health reform proponents argue that a legislative or administrative change to restore DSH funds to states that do not expand Medicaid rewards recalcitrant behavior. However, safety net providers contend that the low-income uninsured who need specialty and inpatient care in those states are doubly penalized—they cannot afford coverage and their access to care is more limited than in states opting to expand eligibility.

Safety net hospitals argue that they were already under significant financial strain serving the uninsured before the ACA cut DSH funds. They assert that, for those hospitals in states that do not expand Medicaid, the combination of continuing to serve the uninsured and receiving less funding to pay for that care will exacerbate the strain on their finances and negatively affect access and quality. Like safety net primary care providers, safety net hospitals are concerned about how they will serve the remaining uninsured, particularly unauthorized immigrants who are ineligible for coverage through the ACA. Just over one-third of the estimated 30 million uninsured in 2022 will be unauthorized immigrants.²² Almost half of all unauthorized immigrants in the United States live in four states: Nevada, Arizona, California, and Texas.²³

DISCRETIONARY FUNDING IMPACTS: THE COMMUNITY HEALTH CENTER FUND AND SEQUESTRATION

The Congressional Budget Office (CBO) estimates that 30 million nonelderly people will still be uninsured in 2022. The FQHC program is a key component of the federal government's approach to providing care for the uninsured. In the last decade, the section 330 community health centers program has experienced three waves of significant expansion: first, during President George W. Bush's administration, which doubled the programs' budget from \$1 bil-

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lion in FY 2000 to \$2 billion in FY 2008; next, an additional \$2 billion through the American Recovery and Reinvestment Act for FYs 2009 and 2010; and most recently, an additional \$11 billion over five years through the ACA.

The ACA expanded community health center funds to provide access to care for the millions of newly insured and to continue to care for those who remain uninsured. Section 10503 of the ACA created a Community Health Center Fund—a mandatory funding stream—“to provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act.”²⁴ The Fund provides \$11 billion from FY 2011 through 2015 (or until funds are expended) for enhanced programmatic funding and construction and renovation: \$9.5 billion for enhanced funding (\$1.0 billion in FY 2011; \$1.2 in FY 2012; \$1.5 in FY 2013; \$2.2 in FY 2014; and \$3.6 in FY 2015) and \$1.5 billion for construction and renovation. The Fund plus annual discretionary appropriations, would almost double health center capacity, from serving 19 million in 2009 to 37 million in 2019.²⁵

Such a bolus of mandatory appropriations ending in FY 2015 raises concerns about sustainability of expanded capacity and continuity of services for those receiving care at health centers in later years. Because the mandatory appropriations are available until expended, HRSA plans to reserve \$280 million in FY 2013 and additional funds in FYs 2014 and 2015 to sustain the expanded capacity after the five-year funding window.²⁶ Some analysts wonder if this strategy is adequate, given the expected surge in demand for care following the ACA coverage expansions in 2014.

The community health centers program has generally enjoyed protected budget status over the past decade, although current budget challenges may test that good fortune. The final FY 2011 community health center discretionary budget was cut by \$600 million from \$2.2 billion to \$1.6 billion. The FY 2012 discretionary budget is also \$1.6 billion. The Budget Control Act of 2011 increased the nation’s debt limit, codified \$900 billion in spending cuts, created the Joint Select Committee on Deficit Reduction tasked with finding \$1.2 trillion in additional cuts over a decade, and imposed automatic spending cuts through a process called “sequestration” starting January 1, 2013, if the “super committee” failed. The super committee did fail and \$110 billion in spending cuts split evenly between defense and domestic programs are set to begin in 2013 unless Congress and

the administration change the law. While most discretionary programs will experience an 8 percent cut under sequestration, special language was included to cap cuts to community health centers at 2 percent in FY 2013. According to the Office of Management and Budget's interpretation of the Budget Control Act of 2011, though, only a portion of the Health Center Fund will have cuts limited to 2 percent; the community health centers' discretionary appropriation will be cut by 8 percent and the Health Center Fund by 2 percent, excluding funds for homeless and public-housing health centers, which would be cut by approximately 7 percent, for a combined total of \$167 million.²⁷ Mandatory fund dollars have been used to offset discretionary budget decreases in FY 2011 and 2012, which affects the ultimate capacity expansion of community health centers.²⁸

Health center advocates are concerned about the future of the mandatory Health Center Fund as well. The legislative battles over another ACA-created mandatory fund, the Prevention and Public Health Fund, raise questions about the vulnerability of the Community Health Center Fund. The Prevention and Public Health Fund was authorized at \$15 billion for FYs 2013 through 2022 to fund community-based efforts to improve health. In February 2012, it was cut by \$6.25 billion over nine years to help pay for a temporary extension of unemployment benefits and to postpone a cut in Medicare physician payments.

MEDICARE PAYMENT CHANGES OF MODEST IMPACT

In comparison to Medicaid, Medicare represents a relatively small revenue and patient source for health centers. In 2011, approximately 8 percent of health center patients were covered by Medicare and Medicare payments constituted 6 percent of health center revenues.²⁹ Medicare reimburses FQHCs for preventive and primary care services provided to Medicare beneficiaries, although not all primary care services provided by FQHCs are covered by Medicare, such as dental services.³⁰ Medicare has had special payment provisions for FQHCs since 1990. Historically Medicare FQHC services have been paid on an all-inclusive payment rate capped by an upper payment limit set by the Centers for Medicare & Medicaid Services (CMS) and subject to productivity guidelines.³¹ In 2012, the upper payment limit for an encounter at an urban FQHC is \$126.98 and is \$109.90 for an encounter at a rural FQHC.³² A U.S. Government Accountability

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Office (GAO) analysis of 2007 Medicare cost reports submitted by FQHCs found that about 72 percent of FQHCs had costs per visit that exceeded the upper payment limits.³³

The ACA authorized the Secretary of HHS to develop a Medicare PPS for FQHCs to be implemented starting October 1, 2014. According to the Medicare Payment Advisory Commission (MedPAC) “the conversion to a Medicare PPS could encourage FQHCs to serve more Medicare beneficiaries, as it is likely that Medicare payments to FQHCs will increase under the PPS.”³⁴ Although the Medicare PPS methodology is still unknown, given that payments to FQHCs are already significantly higher than payments to other Medicare providers like physician offices and rural health clinics for similar services (a visit to a physician office for an established patient was paid \$68.97 in 2011 and the payment cap to rural health clinics in 2012 is \$78.54), potential spending growth through the PPS and possible increased volume of Medicare beneficiaries served at FQHCs raises overall spending growth concerns for those watching the Medicare program’s bottom line.³⁵

THE BASIC HEALTH PROGRAM AND HEALTH INSURANCE EXCHANGES: UNCERTAINTY AND OPPORTUNITY

FQHCs have had plenty of practice responding to changes in the health care marketplace. Worried that they would lose their Medicaid patients and the revenue that came with them, FQHCs in the 1990s joined the Medicaid managed care contracting bandwagon. At the time Medicaid paid FQHCs based on their costs (it changed to a prospective payment system in 2001), but many states were able to waive the cost-based reimbursement requirement under managed care implementation and many FQHCs suffered financially as a result. Recognizing that health centers needed Medicaid payment protections under managed care to stay financially viable and able to serve the uninsured, Congress in 1997 mandated that state Medicaid agencies make a “wrap-around” payment to FQHCs to cover the difference between their costs for providing care and the rates they were receiving from managed care organizations.³⁶ For FQHCs, the history with Medicaid managed care provides important experience as they anticipate contracting with qualified health plans (QHPs) in the health insurance exchanges almost two decades later.

As with the federal statutes and regulations governing Medicaid managed care organizations' contracting with safety net providers, FQHCs and some other community clinics enjoy special attention as essential community providers in the ACA and in the regulations governing the establishment of health insurance exchanges and the responsibilities of QHPs. According to the ACA, qualified health plans must "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8."³⁷ Those statutory sections refer to entities eligible for the 340B Drug Pricing Program: FQHCs, hemophilia treatment centers, Ryan White HIV/AIDS programs including state AIDS Drug Assistance Programs, Title X family planning clinics, urban/638 tribal programs, and certain disproportionate share hospitals, among others. In March 2012, HHS released regulations describing key components of how health insurance exchanges must operate. The final rule states that a QHP's provider network must have "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards."³⁸

Many FQHCs and community clinics are concerned that the regulation does not require QHPs to contract with any willing essential community provider, and that it gives states considerable discretion in determining the number and type of essential community providers that must be included in the network to be considered adequate. FQHCs are also concerned about what they will be paid by insurers in the exchange. Two sections of the ACA relate to payment of FQHCs and essential community providers who contract with QHPs. Section 1302(g) establishes payment of FQHCs at the applicable Medicaid PPS rate. However, section 1311(c)(2) establishes payment of essential community providers, including FQHCs, at the QHP's generally applicable payment rate. HHS has interpreted these provisions to mean that "a QHP issuer must pay an FQHC the relevant Medicaid PPS rate, or may pay a mutually agreed upon rate to the FQHC, provided that such rate is at least equal to the QHP

issuer's generally applicable payment rate."³⁹ Many FQHCs are concerned that they will lack leverage in negotiating with commercial health insurers and will have to accept payment rates that they consider untenable in order to be included in their networks.

Churning

It is likely that a significant proportion of FQHC clients will move between Medicaid and exchange coverage, because there is significant income volatility among the lowest income populations in the United States.⁴⁰ In those states that do not expand Medicaid, many clients will move between Medicaid, uninsured status, and exchange coverage. One analysis of adults with incomes below 200 percent of the FPL showed that 35 percent of adults would experience a change in insurance eligibility within six months and 50 percent a change within one year.⁴¹ For FQHCs and other clinics, retaining their insured patients will be critical financially. One key opportunity to reduce coverage and access disruption for individuals, and ensure continuity for FQHCs as well, would be to have the same health insurance plans participating in the exchange and Medicaid. Federal and state authorities could make efforts to align requirements in Medicaid and the exchanges to promote participation of Medicaid managed care plans in both markets, for example around provider network issues and the participation of essential community providers.

Another provision of the ACA, the Basic Health Program (BHP), could also promote continuity for the newly insured whose incomes fluctuate enough to affect their coverage. Instead of offering coverage through the exchange, states can create a BHP to provide coverage to those under age 65 who are not eligible for Medicaid or who have access to unaffordable employer-sponsored insurance and who have incomes between 133 and 200 percent of the FPL. Legal resident immigrants with incomes below 133 percent of the FPL who do not qualify for Medicaid because of their residency status can also receive care through the BHP. States must contract with at least one health plan and offer at least the minimum essential benefits under the ACA. Some liken BHP to "Medicaid look-alike" or the Children's Health Insurance Program (CHIP) for adults.⁴² The federal government will pay states 95 percent of what it would have spent on tax credits and subsidies for this population to receive coverage through

the exchange. It is unclear the extent to which states will take up this option; HHS has yet to release regulations on the program. Currently Washington, Massachusetts, and California are the only states implementing a Basic Health Plan.⁴³

DELIVERY SYSTEM REFORMS: POISED TO PARTICIPATE

While much of the ACA focused on providing health insurance to the uninsured, another key theme is getting more value for the federal funds spent on health care by improving the quality of care and reducing its cost. To that end, the health reform law enacted a number of programs with the aim of transforming the delivery of health care to make it more efficient and effective. Efforts with the greatest potential to affect FQHCs are (i) promoting integrated delivery systems through accountable care organizations (ACOs) and (ii) encouraging optimal primary care through patient-centered medical homes (PCMHs) and Medicaid health homes.

Finding Their Way Home

The PCMH is a primary care delivery model that has garnered recent attention as a way to improve the quality of care and reduce costs. About half of the states have enacted payment changes to encourage the creation of patient-centered medical homes in Medicaid and CHIP.⁴⁴ A medical home provides comprehensive primary care, is patient-centered, coordinates patient care across the broader health care system, provides accessible services, and is committed to quality and quality improvement. Meeting national or state qualification standards is an integral aspect of medical homes. Examples of some of the national qualification standards include receiving official recognition from the NCQA and primary care medical home certification by The Joint Commission, the Accreditation Association for Ambulatory Health Care, and URAC.

Long before the patient-centered medical home became a widespread term, health centers provided high-quality, team-based, comprehensive primary care.⁴⁵ As a building block to PCMH, during the late 1990s and early 2000s, health centers across the country engaged in health disparity collaboratives based on the Chronic Care Model to improve the management of chronic conditions like diabetes,

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asthma, and depression. A number of efforts to encourage PCMH recognition among health centers are ongoing, including HRSA's Patient Centered Medical/Health Home Initiative ⁴⁶ and the Safety Net Medical Home Initiative created by The Commonwealth Fund, Qualis Health, and the MacColl Center for Health Care Innovation at the Group Health Research Institute.⁴⁷ The ACA further encourages PCMH achievement for FQHCs by creating the FQHC Advanced Primary Care Practice Demonstration to evaluate the effect of the patient-centered medical home in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries served by FQHCs. The three-year demonstration authorized at section 3021 of the ACA currently includes 500 FQHCs across the country, serving 195,000 Medicare beneficiaries. For agreeing to pursue NCQA's highest level of PCMH recognition (Level 3), participating FQHCs receive a monthly care management fee of \$6.00 for each eligible Medicare beneficiary attributed to their practice, in addition to the usual all-inclusive payment they receive for providing Medicare-covered services. The demonstration began in November 2011.

Despite all the activity promoting PCMH recognition among FQHCs, practice redesign is difficult and not everyone is convinced that NCQA PCMH recognition is the right tool for assessing the achievement of better quality care and reduced costs at FQHCs. An analysis of community health centers in Los Angeles found "no significant association between better performance on the NCQA instrument and provision of better quality care whether quality care was measured as performing more care processes or producing better intermediate outcomes."⁴⁸ Critics argue that PCMH recognition is all about process and does not actually improve care delivery. If PCMH is not sufficient to transform chronic disease care, the question remains: what is?

Section 2703 of the ACA established the state option to create health homes for certain Medicaid enrollees. To qualify, Medicaid enrollees must have a severe and persistent mental health condition, two chronic conditions, or one chronic condition but be at risk for a second. Federal funding is provided for two years at an enhanced (90 percent) match for specific health home services. Seven states have CMS-approved health home state plan amendments: Oregon, Iowa, Missouri, Rhode Island, Ohio, New York, and North Carolina. FQHCs are providers in a number of these efforts.⁴⁹

Encouraging Integrated Delivery Systems

Accountable care organizations represent another ACA attempt to improve health care quality and restrain health care costs. An ACO is a network of health care providers that share responsibility for patient care across the continuum of services. In exchange for being accountable for the costs and quality of care for a defined population, ACOs receive a share of the savings that result from delivering care for less than an agreed-upon expenditure target. CMS is implementing three types of ACOs: the Medicare Shared Savings Program, Pioneer, and the Advance Payment Model. To qualify, an ACO must agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. The proposed rule governing the Medicare Shared Savings program prohibited FQHCs from forming ACOs because of a lack of data elements needed to assign beneficiaries, but encouraged them as participants and proposed a higher shared savings rate for ACOs that include FQHCs. Commenters on the proposed rule expressed concerns about this limitation, and the final rule ultimately modifies beneficiary assignment and benchmarking requirements to allow FQHCs to form ACOs as well as participate in them.⁵⁰

Given the Medicare focus of CMS's ACO programs and the historically limited participation of Medicare beneficiaries at FQHCs, it is unlikely that there will be significant Medicare ACO participation from FQHCs. However, ten states are developing ACOs for their Medicaid populations, efforts that will have more far-reaching effects on FQHCs.⁵¹ While the potential financial rewards are appealing, participation in ACOs comes with responsibilities to bear financial risk and build and maintain the infrastructure necessary to participate. ACO governance is of particular concern to FQHCs, which must be careful about meeting specific federal requirements pertaining to governing board composition.⁵²

CONCLUSION

Long a mainstay of care for the uninsured and underinsured, FQHCs and community clinics are experiencing dramatic changes as a result of the ACA. FQHCs in states that choose to expand Medicaid to non-aged or -disabled childless adults will likely fare better than FQHCs in states that do not, but the potential for increased competition from private providers for the newly insured may be a moderating factor.

Although it is unlikely that there will be significant Medicare ACO participation from FQHCs, ten states are developing ACOs for their Medicaid populations, which will greatly affect FQHCs.

The outcome of federal budget discussions will affect FQHCs in all states. Participation in delivery system reforms holds the promise of improving care coordination and restraining health care spending if the unique circumstances of safety net providers are addressed.

ENDNOTES

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