



TRANSFORMING COMMUNITY HEALTH CENTERS INTO PATIENT-CENTERED MEDICAL HOMES: THE ROLE OF PAYMENT REFORM

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ABSTRACT: This report examines how changes in the way federally qualified health centers (FQHCs) are financed could support the transformation of these critical safety-net providers into high performing patient-centered medical homes. Through surveys and interviews, the authors explore the current landscape of health center involvement in medical home initiatives, adoption of medical home standards, and receipt of payment incentives. Based on their findings, the authors make preliminary recommendations to encourage health centers to serve as patient- and community-centered medical homes. These include: establishing recommended standards for patient- and community-centered medical homes that apply to FQHCs; structuring payment incentives to promote medical homes; including FQHCs in state Medicaid medical or health home projects; adapting payment approaches, including adding monthly case management fees; and encouraging the Health Resources and Services Administration to use quality-of-care measures in making funding decisions.

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) significantly altered the landscape of American health care policy. In addition to expanding coverage to millions of uninsured and increasing funding to expand community health centers, the Affordable Care Act initiates efforts to change how health care is paid for and delivered in the United States. For example, the law encourages state Medicaid programs to develop medical homes, also known as “health homes,” for Medicaid patients with chronic diseases. More broadly, the law calls on federal and state governments to consider other methods to transform health care delivery, including strategies such as creating accountable care organizations and bundling episodes of care. The large increases in the number of people with health insurance, including Medicaid patients, after the implementation of health reform will require the nation and the states to consider strategies to strengthen primary care services as part of a high performance health system.

This report examines how changes in the way federally qualified health centers are financed could support the transformation of these critical safety-net providers into high performing patient-centered medical homes. Federally qualified health centers (FQHCs), also known as community health centers or clinics, are nonprofit facilities that provide comprehensive primary medical care—and often dental, vision, and behavioral health services—to low-income patients in medically underserved areas, regardless of a person’s ability to pay.

In late 2009, we conducted a survey of state primary care associations, which represent community health centers in their states. We followed up this survey with interviews of selected health center, state agency, and managed care staff about medical home and quality initiatives in their states. In the majority of states, health centers receive payments to serve as primary care providers or medical homes, generally under Medicaid, and more recently have begun to serve as patient-centered medical homes. There was great diversity in the nature of medical home programs, medical home criteria, and stages of development. In some cases, private physicians are eligible for medical home payments, but health centers are not.

FQHCs have long sought to provide quality team-based, comprehensive primary care and typically viewed themselves as serving as medical homes, even before there

were formal definitions for medical homes. Nonetheless, many FQHCs have demonstrated interest in attaining formal recognition as a medical home.

Preliminary data from a George Washington University survey of FQHCs, conducted from 2010 to 2011, indicate that about 6 percent of centers have attained National Committee for Quality Assurance–Patient Centered Medical Home (NCQA–PCMH) recognition, another 12 percent have a pending application, and 40 percent expect to seek recognition in the next 18 months. Some (12%) have received or applied for recognition from a state medical home program and 11 percent are considering another national recognition program. One reason some centers do not consider applying is there is no financial reward for attaining recognition, as some states do not have medical home incentive programs for FQHCs.

We present several financing recommendations to increase the incentives for FQHCs to transform themselves into high-performing medical homes:

- **Establish recommended standards for patient- and community-centered medical homes that apply to FQHCs.** A variety of national and state recognition programs exist for medical or health homes, but they generally focus only on patient-centered medical care. Health centers also seek to provide community-centered services, such as offering access to patients regardless of ability to pay; providing nonmedical services like behavioral, dental, or enabling services (like case management, health education, and translation); and conducting community needs assessments and other prevention-oriented projects. It may be relevant to establish standards that emphasize these broader community-oriented service components.
- **States should include FQHCs in Medicaid health home projects.** Under the Affordable Care Act, state Medicaid programs may establish health home projects for those with chronic health conditions. In the past, some state medical home programs excluded FQHCs because they are paid differently than physician practices. Since FQHCs provide primary care to a substantial and growing number of Medicaid patients, they should be included in all state Medicaid health home projects.
- **Clarify that states may pay FQHCs more than the levels prescribed by the prospective payment system.** Although federal Medicaid policy that governs health center payments does not prevent states from paying FQHCs more than the

prospective payment system (PPS) level, which is based on historical Medicaid costs and then updated, some states appear to interpret the statute as constituting a cap on FQHC payment levels.

- **If states adopt medical or health home incentives, providing monthly case management fees per Medicaid patient is a reasonable approach.** States considering this option could add a monthly medical home case management fee, in addition to regular FQHC reimbursements, as an appropriate way to create a payment incentive for medical home status. This is already used in many states and is the method planned for the Medicare FQHC Advanced Primary Care Practice demonstration project.
- **Clarify how states may increase FQHC payment levels under Medicaid.** Under current federal rules, states may change PPS payments to individual health centers when the centers demonstrate a change in the scope of Medicaid services. However, there is no specific provision for changing the PPS payments when a health center increases the quality or intensity of services it provides.
- **Maintain the all-inclusive per-visit payment rates in Medicaid.** Under federal law, Medicaid payments to FQHCs are paid on a flat, all-inclusive, per-visit (or per encounter) basis. To change the system would require substantially changing all FQHC payment rates, which would take years to develop. Given current state budget problems, in which state Medicaid programs have often trimmed provider payment rates, opening all FQHC payment rates to recalculation could place them at substantial risk of unanticipated reductions.
- **The Centers for Medicare and Medicaid Services (CMS) should ensure that Medicare policies are consistent with medical home goals.** CMS has announced two Medicare advanced primary care medical home demonstration projects, one for FQHCs and one that permits multipayer projects in several states. CMS should continue to develop these projects. CMS is also actively developing policies in related areas, such as those related to Medicare accountable care organizations, and should ensure that the objectives of those policies are ultimately supportive of medical home policies as well.
- **The Health Resources and Services Administration has long encouraged quality of care for FQHCs and supports Section 330 grantees as NCQA-PCMHs, but could consider additional efforts.** The Health Resources and

Services Administration (HRSA) seeks to build on the already strong quality of care delivered by health centers by focusing on quality improvements and ways that payment reforms could affect health centers. HRSA provides grants to subsidize the cost of NCQA–PCHM applications for FQHCs that receive federal Section 330 grants. In allocating funds to grantees, HRSA has not traditionally used quality of care in funding decisions. HRSA is improving information collected about the quality of care at Section 330 grantees under its Uniform Data System. In the future, HRSA could develop incentives to improve the quality of care at health centers or performance as medical homes. It could develop further efforts to help integrate health center coordination in medical home, health home, and advanced primary care projects, working with Medicare, Medicaid, and the Children’s Health Insurance Program—and eventually the health insurance exchanges.

As the concept of a medical home and other paradigms to strengthen the health care infrastructure are implemented, FQHCs will serve as laboratories for innovation to test new care models. Adequate and appropriately structured financial incentives are critical to the success of any model of health care delivery, and the medical home is no exception. In addition to changes to the reimbursement system that would better align incentives, other supports for providers such as training and technical assistance are necessary to bolster and support the infrastructure.

TRANSFORMING COMMUNITY HEALTH CENTERS INTO PATIENT-CENTERED MEDICAL HOMES: THE ROLE OF PAYMENT REFORM

INTRODUCTION

This report examines how changes in the way federally qualified health centers¹ are financed could support the transformation of these critical safety-net providers into high performing patient-centered medical homes.²

Federally qualified health centers (FQHCs), also known as community health centers or clinics, are nonprofit facilities that provide comprehensive primary medical care—and often dental, vision, and behavioral health services—to low-income patients in medically underserved areas, regardless of a person’s ability to pay. In 2010, the 1,124 health centers receiving grants under Section 330 of the Public Health Services Act provided care to 19.5 million patients in more than 7,000 locations. Of these individuals, 7.3 million were uninsured, 7.5 million were insured by Medicaid, and 1.45 million were on Medicare.³

Because the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) will greatly expand the availability of health insurance, particularly Medicaid, to low-income people beginning in 2014, FQHCs are expected to play an even greater role in delivering care to this population.^{4,5} To help health centers meet the anticipated increase in capacity, the health reform law also added \$11 billion in mandatory funding for Section 330 grants from 2011 to 2015.⁶ In addition to boosting funding for FQHCs, the law will increase payment rates for primary care physicians serving Medicaid beneficiaries: in 2013 and 2014, Medicaid providers will be paid at 100 percent of the rate paid to Medicare providers.

Health centers, as well as all other safety-net providers, must plan not only to serve more patients but to meet growing expectations for better-quality care. The patient-centered medical home (PCMH) is a primary care delivery model that has been rapidly gaining momentum as a way to both improve the quality of care and reduce costs, particularly for low-income populations.⁷ As of May 2011, 39 states had developed, or had started planning for, a medical home initiative for residents enrolled in Medicaid or the Children’s Health Insurance Program (CHIP).⁸ Moreover, the Affordable Care Act provides states with the option of establishing Medicaid “health home” projects for those with chronic health problems, including a 90 percent federal match for the first two years.⁹

Through better primary care, better coordination with specialty and hospital care, and stronger patient tracking and monitoring, medical home enhancements could improve health outcomes, reduce unnecessary care and reduce disparities.¹⁰ One study estimated that the U.S. health system could save up to \$175 billion over 10 years if primary care providers shifted to a medical home model.¹¹

The Centers for Medicare and Medicaid Services (CMS) has issued initial guidance to help state Medicaid directors establish medical home programs and has provided planning grants to a number of states.¹² Although the CMS guidance does not create specific criteria for the health home projects that can be developed, it specifies that these projects should include, at a minimum, the following:

- comprehensive care management;
- care coordination and health promotion;
- comprehensive transitional care services, including appropriate follow-up care, for patients moving from acute care settings, such as hospitals, to home-based care, outpatient facilities, or other nonacute care settings;
- individual and family support, which includes authorized representatives;
- referral to community and social support services, if relevant;
- the use of health information technology (HIT) to link services, as feasible and appropriate; and
- coordination with the Substance Abuse and Mental Health Services Administration.

By their nature, health centers already are aligned with the PCMH model in many ways. That is because they have long sought to provide quality, team-based, comprehensive primary care and to help coordinate primary care with specialty and hospital-based care. Most FQHCs are relatively well positioned to establish themselves as medical homes. A recent nationwide survey by The Commonwealth Fund found that 84 percent of FQHCs have capacity in at least three of five domains relevant to PCMH status, although only 29 percent possessed capacity in all five domains.¹³ Health centers are intended to serve as both patient-centered and community-centered medical homes, aiming not only to improve individual health outcomes but to improve population health as well, providing high quality and cost-effective care while reducing disparities based on race, socioeconomic status, and insurance status and type.¹⁴

Community Health Centers: An Investment in Quality Primary Care

A substantial body of research, developed over many years, indicates that community health centers provide good-quality primary care for their low-income patients, help reduce the use of unnecessary specialty, emergency, or inpatient care, and consequently produce cost savings.¹⁵

In a recent study examining the impact of increased funding for health centers under the Affordable Care Act and increased health insurance coverage, researchers estimated that the number of people served at health centers over the next decade will double. The same study, analyzing data from the Medical Expenditure Panel Survey, found that patients using health centers had medical expenditures more than \$1,000 lower than patients not using these facilities. The use of good-quality primary care at health centers, the authors suggest, could lead to a net \$180 billion reduction in medical expenditures in the United States over the next 10 years.¹⁶

While not all health centers can be designated as high-performing medical homes, on the whole the community health center system, by providing good-quality primary care, is contributing to a more efficient health care system.

HOW THIS STUDY WAS CONDUCTED

This report seeks to provide an understanding of the elements of current medical home projects and the reimbursement methodologies used therein. We based our findings on a survey of the state primary care associations (PCAs), the state-based associations of community health centers that represent and coordinate a variety of health center activities, typically including reimbursement, on behalf of health centers, as well as on interviews with 13 safety-net health insurance plans that are members of the Association for Community Affiliated Plans (ACAP). In addition, we also explored several states in greater depth by speaking with PCA leaders as well as state or medical home program officials. Our questions focused on how health centers fit into current medical home efforts, particularly how payment models could be improved to support needed infrastructure changes and to help ensure sustainability of this health care delivery model. (For further detail on how this study was conducted, see [Appendix B](#).)

FINDINGS

Current Landscape and Promising Initiatives

Health centers play an integral role in the vast majority of the current medical home pilots and programs. Survey and interview findings show the diversity among the current medical homes initiatives. Health centers are enthusiastic participants in all types of

programs, from state-led multipayer initiatives to learning collaboratives without financial incentives.¹⁷

Based on interviews, we identified six key activities critical to establishing medical home initiatives:

- defining medical home criteria and objectives;
- forming partnerships;
- modifying payment streams to align with the objectives;
- implementing the changes;
- supporting practice changes; and
- measuring results.

Many of the projects we learned about are still in the initial stages of developing medical home criteria and standards. The process of defining a medical home can be time-consuming and requires the collaboration of many stakeholders and a certain degree of trust. Medical homes can use different tools and resources in their practices, including health information technology (HIT) like electronic health records (EHRs) and patient registries, case management, disease management, quality improvement, and care coordination. Many medical homes programs are targeted at specific populations, such as children or patients with certain conditions, like diabetes. In some cases, medical home initiatives were a component of other quality-improvement projects conducted by a state Medicaid program or a Medicaid managed care organization.

Community Care of North Carolina

Community Care of North Carolina is a public-private partnership that seeks to strengthen primary care through 14 community care networks that serve the vast majority of Medicaid patients in North Carolina. Three of the networks are led by FQHCs; in addition, health centers are included as members of most networks. Providers and networks receive encounter-based, fee-for-service payments and per-member per-month payments of \$2.50 to providers and \$3 to networks. (The payment is increased to \$5 for aged, blind, and disabled patients). Network staff—including a medical director, clinical coordinator, care managers, and a pharmacist—provide case management. The network also provides training, technical assistance, and help with health information technology. Evaluations of the project indicate it has improved outcomes and reduced costs.¹⁸

Some programs stop short of offering financial incentives and focus on training and providing technical assistance to improve care delivery. The vast majority of medical home programs provide at least minimal training to providers or support for a learning collaborative. Education about best practices is an important part of the model; most programs offer technical assistance to varying degrees.

Colorado Initiatives

The array of initiatives within the state of Colorado demonstrates the wide applicability of the medical home concept.

- Colorado is one of five states included in The Commonwealth Fund's Safety Net Medical Home Initiative, which started in 2009 and runs through 2013, that aims to help safety-net primary care clinics become patient-centered medical homes. In Colorado, the project includes 10 health centers and three non-FQHC safety-net clinics. Although no financial incentives are provided, technical assistance is offered through a learning collaborative and participating practices are applying for NCQA recognition.
- The Colorado Children's Health Care Access Program is a pediatric program designed to help provide children enrolled in Medicaid with medical homes. The program provides financial incentives up to \$40 per person per month on top of fee-for-service payments, but FQHCs are not eligible for the enhanced reimbursement.
- A multipayer project coordinated by the HealthTeamWorks (formerly the Colorado Clinical Guidelines Collaborative) is testing the use of PCMH models supported by Medicaid and a number of private insurance plans, as well.
- There is a project in development to bring medical home ideas into the medical school curriculum through the University of Colorado Department of Family Medicine partnered with the Colorado Association of Family Medicine.

Programs can use various performance measures to determine how providers are performing relative to established criteria. The National Committee for Quality Assurance's Patient-Centered Medical Home (NCQA-PCMH) recognition program, first published in 2008 and revised in 2011, is the most widely recognized standard.¹⁹ Some health centers had concerns about the 2008 NCQA-PCMH criteria because of the limitations with respect to the use of advanced practice clinicians, such as nurse practitioners or physician assistants. The 2011 standards include both nurse practitioners and physician assistants as primary care providers and can be applied toward nurse practitioner-led clinics as well as physician-led clinics. These changes make the standards more applicable to the diverse staffing configurations of FQHCs.

In addition to the NCQA–PCMH recognition program, the Accreditation Association for Ambulatory Health Care has a medical home accreditation program²⁰ and the Joint Commission released its Primary Care Medical Home option for accredited ambulatory care centers in July 2011.²¹ Other state programs use selected elements of these measures or have constructed their own original measures. Cooley’s Medical Home Index, which was originally developed for pediatric care, has also been used as the basis for medical home standards.²² We are not aware of any standards specifically designed for FQHCs.

CMS has been supportive of the medical home concept for FQHCs, but it has varied in its guidance regarding national standards for medical homes. In mid-2010, CMS announced a Multi-Payer Advanced Primary Care Practice demonstration project in multiple states, but let states use their own criteria for medical home status.²³ In November 2010, CMS released guidance to states regarding the Medicaid health home option for patients with chronic conditions and again gave flexibility to states in establishing medical home standards.²⁴ Alternatively, CMS announced in June 2011 that its Medicare FQHC Advanced Primary Care Practice demonstration project would be designed with the expectation that participating health centers meet Level 3 NCQA–PCMH standards (i.e., the highest level) by the end of the project. The demonstration project is scheduled to begin in November 2011 and plans to accept up to 500 FQHCs.²⁵

In interviews, we asked several state primary care associations why more health centers did not seek medical home recognition. Several mentioned the potential lack of financial rewards. While some states provided financial incentive payments to those centers that met medical home criteria, not all states had such programs or included FQHCs. Thus, if a state did not provide higher payments for medical home recognition (using NCQA or other criteria), then there was little motivation for an FQHC to go to the expense and trouble of applying for recognition. The Medicare FQHC demonstration project cited in the preceding paragraph has announced it would pay \$6 per member per month for centers that participate. Another barrier cited by PCAs was the cost of obtaining recognition. This barrier has been reduced; the Bureau of Primary Health Care helps support FQHCs that seek medical home recognition by covering the application fees.²⁶ PCAs also noted the advanced health information technology expected in order to qualify as a PCMH. This barrier has also been reduced. Medicaid provides electronic health record incentive payments to clinicians practicing at FQHCs that have a high level of Medicaid patients or needy individuals (i.e., those who receive uncompensated care or sliding-fee scale care for low-income patients). Analyses suggest that almost all clinicians

at FQHCs would qualify for these incentive payments, which is leading FQHCs to seek to upgrade their HIT capacity.²⁷

Washington State Patient-Centered Medical Home Collaborative

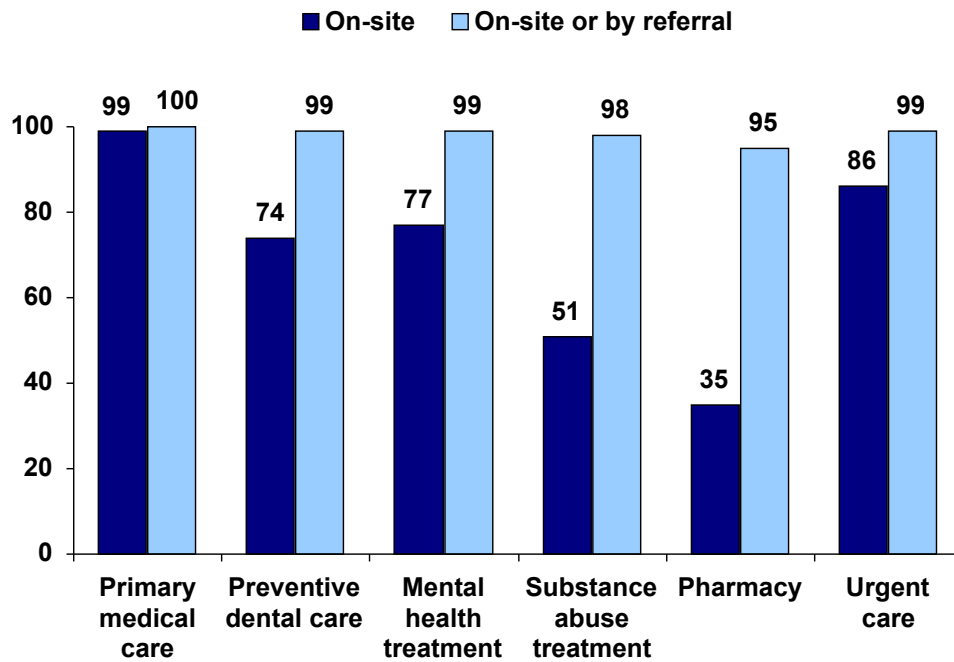
The Washington State Department of Health has been using the collaborative methodology since 1999, focusing on specific conditions like diabetes. In 2008, the state passed a bill to establish a Medical Home Collaborative. The effort did not receive appropriations in 2009 but found funding to continue. The project selected 32 primary care practice teams to participate, including 717 primary care clinicians and five health centers that collectively care for more than 600,000 patients. The practices received ongoing training and support in upgrading skills as PCMHs. The final outcomes of this project have not yet been released.²⁸

There are several ongoing medical home projects across the states. Each typically defines the concept differently, reflecting the evolving nature of the medical home care model and the decisions made in each state. While the variation across programs illustrates there is no shortage of innovations being tested, it can be difficult for health centers and other providers to significantly redesign care delivery systems when different elements are rewarded by different payers. The diversity among medical home programs may inhibit the effectiveness of any particular program. One review of state medical home initiatives noted that the projects vary in purpose and operational criteria, which may make it harder to assess their effectiveness and promote them. The authors of this review stated that, “without stakeholder consensus around a clear operational definition of the medical home, the success and sustainability of medical home projects will be jeopardized.”²⁹

How Health Centers Compare with Other Providers

In contrast with many other types of standard primary care physician practices, health centers provide access to a broader mix of services. Dental, mental health, substance abuse, pharmacy, and urgent care services are often available on-site or through referral networks (Exhibit 1).

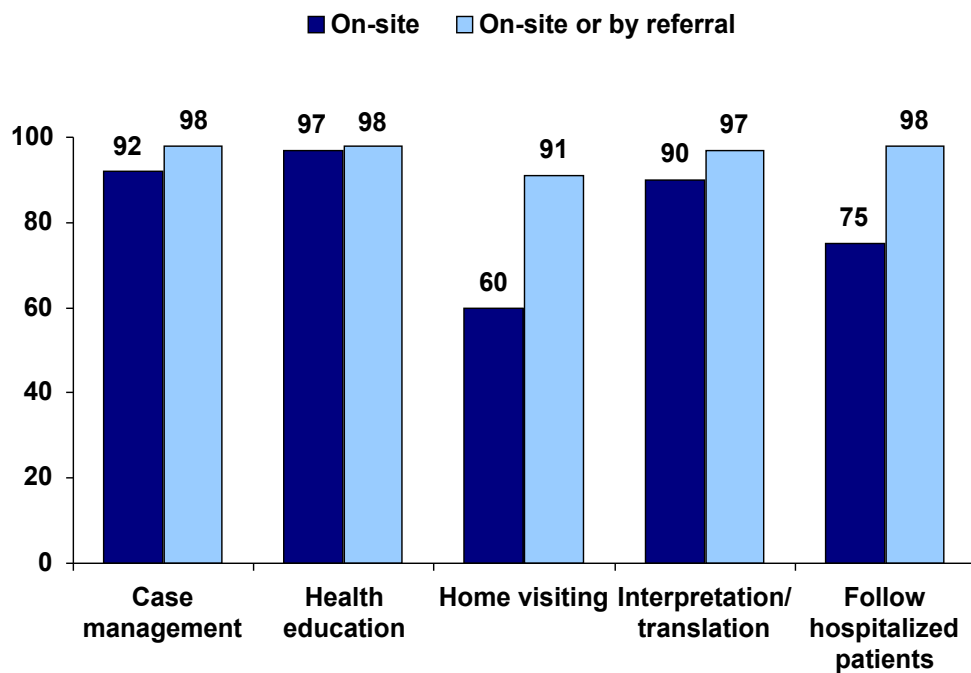
Exhibit 1. Percent of Health Centers Offering Key Services, 2007



Source: George Washington University analysis of Uniform Data System data, 2007.

Many health centers also provide enabling services such as case management, health education, and translation. Continuity of care may be provided through follow-up care to patients who have been discharged from the hospital, whether through home or clinic appointments (Exhibit 2).

Exhibit 2. Percent of Health Centers Offering Key Enabling Services, 2007



Source: George Washington University analysis of Uniform Data System data, 2007.

Interviews with plan administrators from community-affiliated plans and with individuals coordinating medical home efforts confirmed that on many dimensions health centers are viewed as ahead of privately practicing physicians in terms of adoption of the medical home model, especially for low-income patients with complex health and social challenges.

Health centers' focus on the community and their experience with quality improvement and disease management collaboratives provide a foundation for medical home efforts. Health centers are leaders in the adoption of electronic health records, and in many areas form regional health center-controlled networks that support a large number of centers. Health centers are more likely than private office-based physicians to provide team-based, coordinated care and integrate behavioral health and enabling services into patient care.³⁰ Health centers also provide increased access through evening and weekend hours.

Exhibit 3 illustrates how health centers are, in many cases, configured to provide community-centered services that go beyond standard definitions of a medical home.

**Exhibit 3. Standard Medical Home Criteria vs.
Potential Community-Centered Medical Home Criteria**

NCQA PCC–PCMH Criteria	Potential Criteria That Might Apply to Community-Centered Medical Homes
Access and communication	Affordability and willingness to serve patients, regardless of ability to pay
Patient tracking and registry	Service to medically underserved areas or populations
Care management	Nonmedical services, including behavioral, dental and enabling services
Patient self-management support	Cultural proficiency, language services
Electronic prescribing	Community needs assessment, planning, and partnerships
Test tracking	
Referral tracking	
Performance reporting and improvement	
Advanced electronic health communications	

Current Landscape for Payment Incentives for Health Centers

In our survey of PCAs and in interviews of managed care plans and other stakeholders, we found considerable diversity in types of reimbursement incentives. Most of the changes in payment incentives are instituted via Medicaid programs or by Medicaid managed care organizations. Several states, such as Rhode Island, have multipayer demonstration projects (see box).³¹ CMS is supporting a Multi-Payer Advanced Primary Care Practice demonstration in eight states and a FQHC Medicare Advanced Primary Care Practice demonstration project in up to 500 sites across the nation.

Rhode Island Chronic Care Sustainability Initiative

This multipayer initiative seeks to align medical home incentives across most payers, including Medicaid fee-for-service and managed care, all commercial payers, self-employed insurers, and Medicare Advantage. One of the five participating providers is a health center. Providers receive \$3 per person per month, in addition to fee-for-service reimbursements. There is training based on the health disparities collaboratives and a nurse manager is funded in each practice. The program has developed a novel definition of a medical home that emphasizes care coordination. The state plans to expand this project.

There are several methods for reimbursing health centers for medical home elements. The most common is to add a per-member per-month fee to other payments (either fee-for-service or capitated) to practices that attain medical home recognition. Purely capitated models are rare, although some initiatives add separate medical home incentives to capitation. Some programs build on fee-for-service by adding new billing codes to reflect medical home elements or provide special lump-sum payments for

infrastructure and transition costs. Many programs, such as Primary Care Case Management in Medicaid managed care, are hybrid designs that layer a capitated per-member per-month payment on top of a fee-for-service rate schedule. Another hybrid model involves fee-for-service and a pay-for-performance element. In some cases, medical home-related incentives are intertwined with other quality-related payer initiatives, such as diabetes or HIT.

Some programs, such as the Colorado Children's Health Care Access Program (see [Appendix A](#)), include payment incentives to most providers, but not to FQHCs because health centers already espouse many dimensions of the medical home model.

Medicaid/CHIP. As of late 2009, more than 30 states had developed or planned Medicaid or CHIP medical home projects.³² As of mid-2011, 39 states had medical home projects or were planning or considering such projects.³³ The new health home provision of the Affordable Care Act is likely to promote changes in some of the existing projects, as well as further expansions.

FQHCs participate in medical home initiatives through various payers, although Medicaid is the most critical because health centers rely on it for more than 40 percent of total revenue. Based on information collected in our PCA survey, health centers participate in capitated Medicaid and CHIP managed care programs in 30 states (see Exhibit 4). In 25 of these states, FQHCs may receive monthly capitation payments to serve as a primary care provider, which represents a type of medical home payment. Within the Medicaid managed care programs, quality-related bonuses were reported in 15 states, with additional specific medical home incentives in six states.³⁴

Our discussions with Medicaid managed care organization administrators uncovered many payer-specific medical home initiatives involving health centers; the Medicaid managed care plans reported that health centers are a critical piece of their network. Some programs are pilot efforts targeted at specific patient populations (e.g., patients with diabetes or asthma) that fall under the rubric of disease management and quality improvement. Health plan administrators also noted the importance of having and using data. Without HIT and disease registries, it is impossible to effectively become a medical home, as an important aspect of medical home status is the ability to monitor the quality of care for patients with chronic diseases.

Exhibit 4. Federally Qualified Health Center Participation in Medicaid Medical Home, Quality, or HIT Incentive Programs, by Payment Method, 2009

	Capitated Managed Care				Primary Care Case Management (PCCM)			Fee-for-Service	
	Participate in capitated managed care	Receive monthly capitations as primary care providers	Have medical home incentives	Have other quality/HIT incentives	Participate in PCCM	Have other quality/HIT incentives	Participate in fee-for-service	Have medical home, quality, or HIT incentives	
Total	30	25	6	15	25	9	45	4	
Alabama	✓	X	✓	✓	✓	✓	✓	✓	
Arizona	✓	✓	X	X	X	X	✓	X	
Arkansas	X	X	X	X	✓	✓	✓	X	
California	✓	✓	X	X	X	X	✓	X	
Colorado	✓	✓	X	X	✓	X	✓	X	
Connecticut	X	X	X	X	✓	X	✓	X	
Delaware	✓	✓	X	X	X	X	✓	X	
Dist. Columbia	✓	X	✓	✓	X	X	✓	X	
Florida	✓	✓	X	X	✓	X	✓	X	
Georgia	✓	✓	X	X	✓	X	✓	X	
Hawaii	✓	✓	X	X	X	X	✓	X	
Idaho	X	X	X	✓	X	X	✓	✓	
Illinois	✓	✓	X	✓	✓	✓	✓	X	
Indiana	✓	✓	X	✓	X	X	✓	X	
Iowa	X	X	X	X	✓	X	✓	X	
Kansas	X	X	X	X	X	X	✓	X	
Kentucky	✓		X	X	✓	X	X	X	
Louisiana	X	X	X	X	✓	✓	X	X	
Maine	X	X	X	X	✓	X	✓	X	
Maryland	✓	✓	X	X	X	X	X	X	
Massachusetts	✓	✓	X	✓	X	X	✓	X	
Michigan	✓	✓	✓	✓	X	X	✓	X	
Minnesota	X	X	X	✓	✓	X	✓	X	
Mississippi	X	X	X	X	X	X	✓	X	
Missouri	✓	X			✓	✓	✓	✓	
Nebraska	X	X	X	X	✓	X	✓	X	
Nevada	✓		X		✓	X	✓	X	

	Capitated Managed Care				Primary Care Case Management (PCCM)		Fee-for-Service	
	Participate in capitated managed care	Receive monthly capitations as primary care providers	Have medical home incentives	Have other quality/HIT incentives	Participate in PCCM	Have other quality/HIT incentives	Participate in fee-for-service	Have medical home, quality, or HIT incentives
New Hampshire	X	X	X	X	X	X	✓	X
New Jersey	✓	✓	X	X	X	X	✓	X
New Mexico	✓	✓	X	X	X	X	✓	X
New York	✓	✓	X	✓	✓	✓	✓	✓
North Carolina	✓	✓	✓	✓	✓	✓	✓	X
North Dakota	X	X	X	X	✓	X	✓	X
Ohio	X	X	X	✓	✓	X	✓	X
Oklahoma	✓	✓	X	X	✓	✓	✓	X
Oregon	✓	✓	✓	X	X	X	✓	X
Pennsylvania	✓	✓	X	✓	✓	✓	✓	X
Puerto Rico	✓	✓	X	X	X	X	✓	X
Rhode Island	✓	✓	✓	✓	X	X	✓	X
South Carolina	✓	✓	X	X	X	X	✓	X
South Dakota	X	X	X	X	✓	X	X	X
Tennessee	X	X	X	X	X	X	✓	X
Texas	X	X	X	✓	✓	X	✓	X
Utah	X	X	X	X	X	X	✓	X
Vermont	X	X	X	X	✓	✓	✓	X
Virginia	✓	✓	X	X	X	X	✓	X
Washington	✓	✓	X	✓	X	X	✓	X
West Virginia	X	X	X	X	✓	X	✓	X
Wisconsin	✓	✓	X	X	X	X	✓	X
Wyoming	X	X	X	X	X	✓	X	X

Notes: ✓ indicates yes, X indicates no, and a blank indicates that the primary care association did not know. Some additional states proposed or are planning projects, but they were not yet operational. HIT = health information technology.

These data represent the period before federal Medicaid electronic health record incentive payments were made available.

Source: George Washington University Survey of Primary Care Associations; Alaska and Montana did not respond.

While health centers in 45 states participate in fee-for-service Medicaid and CHIP, only four of those states had financial incentives for medical home elements in fee-for-service Medicaid programs. One state used an add-on to the Medicaid rate based on implementation and meaningful use of electronic health records; the available funding has not been disbursed yet and has already been cut by over 25 percent. The other states offer limited programs for health centers involved in a pilot projects and an initiative focused only on care for patients with diabetes.³⁵

Health centers are involved in Medicaid primary care case management (PCCM) programs in 25 states. In PCCM programs, primary care providers—including FQHCs and private physicians—are selected by or assigned to Medicaid members and earn a monthly case management fee (usually \$3 per person per month). In that regard, FQHCs in all 25 of these states earn a “medical home” fee, but not necessarily any additional bonuses or incentives associated with higher performance. Our survey found that nine states offer additional bonuses or financial incentives related to quality or HIT adoption for FQHCs. Results highlight the fact that not all quality improvement and disease management initiatives are based on the medical home model.

Some states have Medicaid medical home payment incentive projects, but FQHCs are not eligible for the incentive payments. There are two reasons for this: first, the payment incentives are typically supplements to regular physician reimbursements but FQHCs are not paid under the physician fee system and therefore excluded; second, some states believe that the FQHC payment methodology constitutes a cap on payments to FQHCs. While such a belief is not consistent with the Medicaid statute, this is cited as a reason for limited offering of incentive payments.

Concerns about Medicaid payment adequacy. In Medicaid, the standard method of reimbursing FQHCs is a standardized payment per encounter, using a prospective payment system (PPS) based on each FQHC’s historical Medicaid costs, which are updated by the Medicare Economic Index or using an alternative rate payment methodology.³⁶ Only five PCAs reported that the current fee-for-service PPS system provides adequate incentives for health centers to improve functions to perform as patient-centered medical homes. Twenty-seven PCAs reported that their state’s PPS system contains no incentives for quality, outcomes, efficiency, or elements of the medical home.

PPS rates are limited to services considered allowable under states’ Medicaid programs and may exclude certain services, such as enabling services, language

interpretation, health education, or case coordination. Current PPS payments per encounter do not provide incentives for better or more efficient medical care. Reimbursement on a per-encounter basis may not be optimal for improving care since many important services fall outside the traditional definition of a face-to-face reimbursable encounter, such as monitoring patients' status, case management, or community-based prevention activities like health education, outreach, or health screenings. Online and telephone communication would also fall outside this definition. Two states highlighted confusion surrounding allowable costs, making the point that unclear policies can hamper innovation. The South Carolina PCA suggested providing additional payments to FQHCs based on savings to the state Medicaid program rather than on a per-encounter basis.

A more technical issue is that the periodic revisions of FQHC prospective payments are not always timely nor do they properly account for changes in services. Adjustments to the PPS rate are permissible when an FQHC changes the scope of services (e.g., adds behavioral health care or dental care), but not when there is a change in the level of care within a given service (e.g., increases in the intensity or quality of services already provided). In addition to federal guidelines that fail to account for quality improvements, state adjustments under these guidelines may be inadequate. In at least five states, the PPS rates have been in place for years, with only incremental increases insufficient to keep pace with the rising costs of providing care. In some states, Medicaid reimbursement is based on average costs, so health centers offering more comprehensive and costly services to their patients are not reimbursed accordingly.

Basing payments on a per-visit or per-encounter basis, rather than on a per-service basis, discourages health centers from providing all of the appropriate—and even necessary—services in a single visit. In some states, there is a limit of one reimbursable visit per day under Medicaid. Thus, even if it would be more convenient to provide two services to a patient in the same visit (e.g., medical and behavioral care or two different medical services), the FQHC will only be paid one flat fee. This undermines the benefits of having various services co-located within the health center. Despite these limitations to Medicaid payment systems, health centers often provide many unreimbursed services to Medicaid patients.

Preliminary Data about FQHCs and Medical Home Recognition

From December 2010 to February 2011, researchers at George Washington University conducted a national survey of Section 330-funded health centers.³⁷ The survey asked about readiness of health centers to make important changes, such as adoption and

meaningful use of electronic health records and recognition of the centers as medical homes. While relatively few health centers have yet obtained medical home recognition, the number should increase substantially in the near future.

Specifically, when asked about recognition as a NCQA–PCMH medical home: 6 percent had been recognized as a Level 1, 2, or 3 medical home; 12 percent had an application pending; 42 percent expected to apply within the next 18 months; and 40 percent had no specific plans to apply. Some were also considering alternative medical home recognition: 12 percent were considering or had received state medical home recognition and 11 percent were considering or had received medical home recognition from another national organization.

Many of the key barriers to medical home recognition were financial in nature. Some health centers did not see any advantage as they were not being offered any payment incentives associated with medical home status. Some were put off by the costs of application, including application fees, as well as the additional operational costs (e.g., health information technology) that might be incurred in gaining recognition.

These barriers are likely to be reduced in the future. The federal government has initiated a Medicare FQHC Advanced Primary Care Practice demonstration and will offer a \$6 per-member per-month fee to FQHCs that sign up, although an eligible FQHC must have at least 200 Medicare patients. In addition, the Medicaid health home initiative will likely expand payment incentives available in states. Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services, also provides funding to help defray the fees associated with medical home recognition.

RECOMMENDATIONS

While there is substantial interest and promise in the developing payment strategies to encourage health centers to serve as patient- and community-centered medical homes, the complexities of FQHC payment methods, the variations in medical home criteria that are used, and the potential shifts in policies related to health reform make it difficult to generate simple and definitive recommendations. Moreover, the implementation of the Affordable Care Act and other health legislation means numerous changes will be made in Medicaid and Medicare payments in the next few years and payment methodologies are likely to become even more diverse. We provide tentative recommendations and a discussion of processes to improve future decisions.

Developing Recommended Medical Home Criteria

In general, identifying health center payment options for incentivizing and rewarding medical home performance is difficult because of the multiple medical home criteria that are now being used or under development. Although the most common standard from the national perspective is NCQA–PCMH, these criteria were largely designed for private medical practices and may not be fully appropriate for health center use. The initial NCQA criteria largely excluded nurse practitioners or physician assistants, but the 2011 standards address these issues by including them as primary care providers and permitting the recognition of nurse practitioner–led primary care practices.

As we have noted, health centers have responsibilities for community-oriented care and may feature different services because of the disadvantaged populations they serve (e.g., availability of interpreters for those with limited English proficiency is quite relevant for FQHCs, but may be less critical for a typical private practice).

Develop recommended standards for patient- and community-centered medical homes. State Medicaid and CHIP programs or managed care organizations use a variety of medical home criteria, sometimes using NCQA standards, sometimes adapted from them and sometimes developed independently, based on their needs and their capability of determining when a health center or provider meets those criteria. CMS has continued to permit varying state standards under the Medicaid health home initiative and under the Multi-Payer Advanced Primary Care Practice demonstration project, but uses the NCQA–PCMH criteria for its FQHC Advanced Primary Care Practice demonstration. Since states are experimenting in this area and there is considerable variation in Medicaid payment methods for providers and health centers, there is no compelling reason or basis to require a single national standard at this time.

In general, medical home standards, such as the NCQA criteria, were designed for mainstream medical practices, which focus attention on individual patients. It is worth considering whether FQHCs need criteria that also take into account the community-centered aspects that are also part of the health center model of care. These include the provision of nonmedical services, such as behavioral, dental, or enabling services; care that is oriented toward low-income communities, such as language services or cultural competency; or community needs assessments and prevention activities that do not involve a specific patient. Some believe that a community orientation to care is ultimately necessary to improve population health.³⁸ But without community-oriented criteria, it is possible that health centers will drift away from those principles and standards.

Medicare. CMS has initiated a Medicare FQHC Advanced Primary Care Practice demonstration project which will offer incentives of \$6 per member per month to FQHCs that join the program and aspire to Level 3 NCQA–PCMH status. While Medicare patients were only 7.5 percent of the total health center caseload in 2010, they represent a growing share of the caseload.³⁹ The demonstration project represents an opportunity to assess the feasibility and impact of medical homes for FQHCs on a national basis.

In April 2011, CMS issued proposed regulations regarding Medicare accountable care organizations (ACOs).⁴⁰ ACOs are intended to create new delivery systems that will lead to more accountable, higher-quality, and efficient care. This has been a much anticipated method to help “bend the cost curve.” However, the proposed regulations have proven to be controversial.⁴¹ One issue of concern to health centers is that the regulations essentially prohibit FQHCs from having a significant role in ACOs because they cannot count as primary care providers.⁴² It may seem paradoxical that CMS is trying to encourage FQHCs to improve primary care for Medicare in the FQHC Advanced Primary Care Practice demonstration, while barring them from participating as primary care providers in the ACO regulations. The shape of the final ACO regulation is yet to be determined and many are hoping for significant changes. At the very least, CMS should be more consistent in the extent to which it wants to support the integration and quality of primary care by FQHCs for Medicare beneficiaries.

Structuring Payment Incentives and Other Options to Promote Medical Homes

To encourage FQHCs (or other providers) to become medical homes, we should promote medical home standards and offer payment incentives for centers adopting those standards. For example, evidence suggests that, although HRSA’s Health Care Disparities Collaboratives improved quality of care in health centers and were relatively inexpensive to adopt, the lack of payment incentives ultimately made them less sustainable and created a disincentive for FQHCs to maintain them.

Medicaid is already the largest and most important revenue source for health centers. Because of the large Medicaid expansions for low-income adults planned under health reform, Medicaid will become even more important in the future. In addition, the likely shortage of primary care clinicians in many areas of the nation will increase the importance of health centers as providers under Medicaid.⁴³ After Massachusetts’ health reform, FQHCs played a larger role in providing primary care to newly insured patients as well as the residual uninsured.⁴⁴

The extent to which states will adopt new Medicaid medical home projects is uncertain. On one hand, the Affordable Care Act provides a 90 percent federal matching rate for the first two years of state Medicaid health home projects for those with chronic conditions. This provides a powerful incentive to develop such programs and CMS has provided grant funding to help states plan their projects.⁴⁵ On the other hand, states are still roiling from state budget deficits and may be unwilling or unable to develop or expand initiatives. States may also be reticent to adopt new health home programs if the federal matching rate drops after just two years. State Medicaid offices also face problems because they are required to implement new initiatives under the CHIP Reauthorization Act, the American Recovery and Reinvestment Act, and the Affordable Care Act, such as initiating Medicaid electronic health record incentive payment programs and increasing primary care payment rates to 100 percent of Medicare levels from 2013 to 2014.⁴⁶ Since states have limited administrative and financial resources, it can be difficult for them to implement multiple changes simultaneously. Thus, required changes are likely to take precedence over optional changes, such as the new Medicaid health home projects.

We presume that the general federal policy for Medicaid and CHIP will continue to accord states with substantial flexibility in how they pay health care providers, including FQHCs. Nonetheless, we have some limited recommendations to help improve information and state options in this area.

Require state Medicaid and CHIP programs to include FQHCs in medical home or other related primary care physician incentive programs, if they are developed. Currently, states have the flexibility to decide whether or not to implement medical home or other quality-related payment incentive programs for providers under Medicaid or CHIP and who to include in such initiatives. Given the great uncertainties and numerous options regarding such payment arrangements, it is premature to mandate any particular set of initiatives for states. But Section 2703 of the Affordable Care Act provides a health home option for state Medicaid agencies and it appears that many states plan to adopt such an option. Given the importance of FQHCs in providing primary care and their emphasis on the control of chronic diseases, they should be included in all such initiatives.

Currently, some states initiate medical home or similar quality-related initiatives that exclude health centers, as appears to be the case in Colorado's initiative. Similarly, Oklahoma developed a medical home initiative that pays primary care physicians a monthly fee between \$3.58 and \$8.69, but does not pay anything additional to FQHCs.⁴⁷

Since health centers provide primary care to a substantial and needy sector of Medicaid patients and will likely become even more important, it makes sense to include FQHCs in Medicaid and CHIP incentive programs. In some cases, states may need to take additional steps to design or adapt their initiatives for FQHCs, since incentive payments applicable to physicians may not apply to FQHCs that are compensated using PPS or other alternative systems. In other cases, states may believe that they are unable to modify FQHC payment methods because of federal statutory requirements. This issue is discussed in the next recommendation.

Clarify that states may pay FQHCs more than the PPS levels. Under Section 1902(bb) of the Social Security Act, states are required to pay FQHCs and rural health clinics using a prospective payment system (PPS), based on historical reasonable costs per visit, inflated by the Medicare Economic Index. Or they may use alternative payment methodologies that are at least as generous as PPS levels. Nonetheless, states have considerable flexibility in determining how much they pay FQHCs and there is substantial variation in FQHC payment levels (e.g., from \$81 per encounter to \$275, depending on the type of visit).⁴⁸ Although the statute does not prevent states from paying FQHCs more than the PPS level, some appear to interpret the statute as constituting a cap on FQHC payment levels.

CMS could clarify that states may make supplemental payments to FQHCs on a per-visit or a per-capita basis, in addition to payments authorized by the PPS or alternative payment methodology system. These supplemental payments could cover services that improve the quality of care and be available to Medicaid or CHIP managed care organizations. This would clarify that state Medicaid and CHIP agencies can pay monthly case management fees to FQHCs that attain medical home status or meet other quality or performance criteria. States already have the right to provide supplemental payments to other health care providers (e.g., physicians or hospitals) and this would clarify that these rights extend to FQHCs as well.

This option provides for substantial latitude to states to develop supplemental payments for medical home status for FQHCs.

States should provide per-member per-month medical home incentive payments. Given that most of the responsibilities for being a medical home require ongoing review and case management of patients, states considering such an option could be advised to add a monthly medical home fee—in addition to regular FQHC reimbursements—as an appropriate way to create a payment incentive for medical home

status. This is comparable to the current approach used by many medical home state initiatives and the approach proposed by CMS in its Medicare FQHC demonstration project. It does not preclude other options that may be appropriate for other pay-for-performance initiatives (e.g., HIT incentives). The monthly fees need not be paid only to FQHCs. For example, in North Carolina's Community Care project, one set of monthly fees was paid to providers, but another set was paid to regional network organizations that provided some of the higher-order case management services for primary care providers in their networks.

If the services are being provided under a capitated managed care plan in Medicaid or CHIP, the monthly fee should be provided in a fashion comparable to that for other providers. In most cases, we expect that the fee would be paid by the managed care organization, not as part of a wraparound payment made by the state.

Case management fees for FQHCs could also include funding for enabling services that are not part of the standard Medicaid benefit package, but that are considered appropriate to ensure the quality and coordination of care for patients.

Other payment models are possible, too. For example, one recent report suggested 10 possible payment models, including developing new PCMH fee-for-service codes, using shared-savings or pay-for-performance approaches, and providing overall comprehensive payment approaches, including pay-for-performance.⁴⁹ While we appreciate the utility and simplicity of a monthly PCMH fee, other approaches will be appropriate in the context of individual state payment methodologies.

Clarify how states may increase PPS levels. Under current federal rules, states may change the PPS payments that health centers receive when they demonstrate a change in the scope of Medicaid services provided. That is, a health center that did not earlier provide dental services or emergency care may seek to have its PPS rate increased after it adds those services. However, there is no specific provision for changing the PPS payments to reflect increases in the quality of services provided, although changes in service intensity could qualify as a scope change.⁵⁰ Thus, for example, if a health center originally provided case management services to a small share of patients on a very limited basis, but then expanded those services considerably to improve patient care, this would not qualify as a justification for a PPS rate increase. In addition, it is not clear how often states recognize or approve scope-of-service increases.

Such a clarification of the rules would generate incentives for health centers to improve the quality of their care, but may not be the most efficient form of incentive as changing PPS levels can be a time-consuming process that requires substantial accounting efforts on the parts of health center and state alike.

Maintain bundled per-visit payment rates. Under federal law, Medicaid payments to FQHCs are paid on a flat per-visit (or per-encounter) basis. In contrast, regular physicians and other health care providers are typically paid based on the actual procedures or services provided. Thus, if multiple services are provided during a single visit, an FQHC may be paid once, but a regular physician would receive payments for each service. Moreover, since FQHCs may provide different types of services under a single roof, one visit might include medical, dental, and mental health care by different clinicians. State Medicaid programs vary in the extent to which they would bundle medical, dental, or mental health claims together or have separate payment levels for each service type at FQHCs. Some believe that the bundling process discourages health centers from providing more than one service per day and, thus, discourages coordination of care.

On the other hand, there are also reasons to support the current statutory system of bundling by visit. To the extent that historical rates were correctly computed, current rates should reflect the number (and mix) of services patients generally receive each visit. Over many years, American health payment policy has tended to move away from piecemeal payment rates toward more bundled rates, believing that unbundled rates provide an incentive to provide unnecessary services. This philosophy has affected development of the Medicare inpatient and outpatient hospital prospective payment systems, capitation rates for managed care, and bundled payments for a number of other services, such as global obstetric fees.

We considered recommending a change to federal rules governing Medicaid payments to FQHCs, but decided against it, largely for pragmatic reasons. Whether based on cost reimbursement or the prospective payment system, for many years the number of visits or encounters has been the basis of FQHC payments. To change the system now would require significantly changing all FQHC payment rates, which would require several years and substantial cost-accounting efforts. Given current state budget problems, in which state Medicaid programs have often trimmed provider payment rates, opening all FQHC payment rates to recalculation would place them at substantial risk of unanticipated reductions.

It may be desirable for FQHC claims to include more information about the types of services provided during a visit, but that is already permissible as a state option in Medicaid. This information could be used to help monitor the types of services provided to patients, comparable to the information available from physician claims.

Medicare Payment Incentives

Changes to Medicare payment policy for FQHCs and medical homes are already in process. Section 10501 of the Affordable Care Act requires CMS to develop a new payment method for FQHCs by 2014, based on a prospective payment system but also taking into account the type, duration, and intensity of services rendered. As a transition step, FQHCs were required to add health care common procedure codes to their claims in 2011. This will help provide data about the services provided by health centers, in a fashion comparable to the data in Medicare physician claims.

The Role of the Health Resources and Services Administration

The Health Resources and Services Administration plays a critical role for health centers, particularly because it administers Section 330 grants, which represent core funding for FQHCs. HRSA provides grant funding to health centers, but not insurance reimbursement. But it also wields of power within the health center community in terms of leadership and technical assistance.

While Medicaid programs provide more revenue to health centers than Section 330 grants, HRSA, particularly the Bureau of Primary Health Care, provides federal leadership to health centers. It not only provides core grant funding to individual health centers, it supports state primary care associations and health center networks and helps direct the mission and management of health centers.

In this capacity, HRSA could do more to improve the quality of care at health centers and to improve medical home performance in three ways:

Grant allocations for quality or medical home performance. Historically, HRSA has provided four main 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 with grants that are about to expire. Under the American Recovery and Reinvestment Act, HRSA also provided increased demand for service grants to boost patient service capacity of all centers and

capital improvement and facility investment grants to improve the infrastructure at health centers through construction, health information technology, or other capital outlays.

HRSA has not historically provided grants to improve the quality of existing services of health centers or to improve their performance as medical homes. While HRSA initiated the successful Health Disparities Collaborative, it did not provide funding to help sustain these projects.⁵¹ In part, this may be because of the challenge of measuring quality in more than 1,000 health centers and making difficult decisions about how to allocate funds. Should funds be targeted to the highest-performing health centers or should they seek to help low-performing centers do better?

It is nonetheless important to note that HRSA does have other policies to promote medical homes and, more broadly, quality. For example, the agency recently announced it would help cover the cost of fees for FQHCs that are seeking to obtain NCQA recognition as a PCMH. This is an extension of its already existing program to cover fees for accreditation by the Joint Commission or the Accreditation Association of Ambulatory Health Care.

The federal health reform legislation boosts FQHC funding, including at least a mandatory \$11 billion increase over five years. HRSA could begin to develop grants designed to improve quality performance at health centers. The agency has begun to collect some annual quality-of-care data under the Uniform Data System reports, although they are still new and may not yet be consistent enough to be used for funding allocations. If there were recommended national standards for patient- and community-centered medical homes, the agency could begin to develop ways to measure these data.

It would take time to develop and refine these standards and to develop a fair system for grant allocation, but such grants could provide an important incentive for health centers to modify practices to improve the quality of patient services.

Develop medical home models that apply to the uninsured. Even though health reform will gradually reduce the number of uninsured people, millions will remain uninsured and a substantial fraction of health center patients will be uninsured and unable to get care elsewhere. To the extent that developing medical home services requires additional efforts or costs and that there are no payment incentives or insurance coverage for those who are uninsured, uninsured patients may continue to get more fragmented and weaker quality services than those who have coverage. More than CMS, HRSA has the responsibility of developing models of care for health center patients who are uninsured.

To the extent practical, it is always desirable to provide comparable services and quality of care to insured and uninsured patients alike, but this could be challenging without the revenue resources and incentives that health insurance coverage brings. HRSA could work with health centers to try alternative, efficient ways to boost quality or improve medical home performance for uninsured patients.

Provide leadership through technical support and training. HRSA can also provide the leadership for transforming care delivery. As it did with the Health Disparities Collaborative, HRSA could establish improving medical home services as a critical goal for health center grantees and marshal necessary training and tools to help health centers to regularly assess and improve performance. It could work with PCAs or health center networks to help build the infrastructure for medical home practices. No other agency is better positioned to help provide this leadership.

CONCLUSION

Adequate and appropriately structured financial incentives are critical to the success of any model of health care delivery and the medical home is no exception. The four medical societies (American Academy of Family Physicians, American Academy of Pediatrics, American College of Medicine, and American Osteopathic Association) that jointly endorsed the PCMH model in 2007 recommended financial recognition of “the added value provided to patients who have patient-centered medical homes”⁵² through payment reforms to reward certain activities that typically receive no financial recognition. In addition to changes to the reimbursement system that would better align incentives, other support for providers, such as training and technical assistance, are necessary to bolster and support the infrastructure. The societies also recommended a shared-savings model that would further enhance the business case for moving to a PCMH approach to primary health care.

Although most health centers function essentially as medical homes and strive to be community-centered medical homes, payments under current medical home initiatives usually do not cover the full cost of practice redesign and infrastructure improvement. For example, the costs for additional clinical or administrative staff to help provide team-based care, case management services, and patient education in prevention and chronic care self-management are not captured under the current payment system.

Community health centers provide access to comprehensive primary care services for roughly 20 million people in medically underserved areas, and this number is expected to grow substantially in future years. States and the federal government are

actively involved in efforts to improve the effectiveness of primary care using patient-centered medical home (or more recently, health home) approaches. While health centers generally provide good quality care and are supportive of efforts to upgrade their capabilities, it will be critical to ensure that they have the financial support and incentives to foster their efforts to improve care for their patients.

Appendix A. State Profiles

State	North Carolina	Rhode Island	Colorado	Washington
Program	Community Care of North Carolina (CCNC)	Rhode Island Chronic Care Sustainability Initiative	Colorado Children's Health Care Access Program	Washington Patient Centered Medical Home Collaborative
Program type	14 networks with PMPM to providers and networks for adopting medical home elements	Multipayer initiative with PMPM payments to practices, a nurse manager in every practice, data sharing, and technical assistance and training.	Certification as medical homes and capitated payments on top of FFS	Learning network
Payers	Medicaid	Medicaid FFS and managed, all commercial payers, the two largest self-insured employers, state employee health plan, Medicare Advantage	Medicaid	No financial incentives in the collaborative, but a multipayer initiative is in the initial stages and will build on the collaborative
Providers				
Participating providers	14 networks	5	93% of all pediatrics providers	33
Health centers participating	All	1	Yes, but FQHCs not eligible for financial incentives	5
Health centers in leadership role?	Yes, 3 networks are led by FQHCs	Yes; collaborative care training based on HRSA Health Disparities Collaboratives	No	Advisory Committee
Elements of Medical Home Definition				
Developed New Definition?	Yes	No	Yes	Yes
NCQA	No	Required	No	No
Cooley Medical Home Index	No	No	Variation used	Yes, in part
Care coordination	Network provides	Nurse manager in each practice	Yes	No
HIT	Network provides	EMRs and chronic disease registry required	No	No
Information Sharing/HIE	At network level	Data sharing via multipayer database	No	No
Targeted to certain populations/conditions	All residents of CCNC network areas; aged, blind, and disabled included as of 11/08	All	Pediatric	All

State	North Carolina	Rhode Island	Colorado	Washington
Feedback to providers	Yes, quarterly for each practice and weekly update on Medicaid patients	Emergency department use and total inpatient days	No	Planned to provide feedback on inpatient use and quarterly quality measures
Incentives and Support Payment Incentives				
Primary care case management	FFS plus \$2.50 PMPM (\$5 for aged, blind, and disabled) to providers	FFS plus \$3 PMPM for all members	Non-FQHCs eligible for up to \$40 extra PMPM in addition to FFS	N/A
Pay-for-performance	No	No	No	N/A
Additional care coordination payment	Network provides	Funding for nurse care manager in each practice	No	N/A
Other payments	\$3 PMPM (\$5 for aged, blind, disabled) to networks	No	No	Health centers got extra payments from community health plan for infrastructure and providers get \$800 per day for learning sessions
Savings estimate	\$231 million in 2005	Not yet available	Not yet available	Not yet available
Technical Assistance and Support				
Training	Network provides	Yes, collaborative model	Yes	Practice coaching
Help with HIT	Network provides	Work group on HIT	No	Technical assistance from department of health
Care coordination	Network provides	Nurse care manager in each practice; chronic care model training	Yes	Each practice develops three disease management plans

Source: Authors' analysis.

Appendix B. Study Methods

Survey

To provide an understanding of the elements of current medical home projects and the reimbursement methodologies used therein, we fielded an Internet survey of primary care associations (PCAs), the state-based associations of community health centers that represent health centers in all states, the District of Columbia, and Puerto Rico, and coordinate a variety of technical assistance programs on behalf of health centers.

We asked about the reimbursement environment in their states, with a focus on medical home-related programs that affect their member health centers. With telephone follow-up targeting initial non-responders, we received responses representing 48 states, Puerto Rico, and the District of Columbia. We were unable to get responses from PCAs representing Montana or Alaska. In some cases, the PCA representatives were unable to answer certain questions and we used other data sources to fill in missing data, where feasible.

Interviews

We conducted telephone interviews with medical home initiative leaders in several states: Colorado, Missouri, North Carolina, Oregon, Rhode Island, and Washington. We talked about the various medical home and quality improvement initiatives under way, how health centers are reimbursed, and how health centers compare with other provider types.

In addition, we interviewed 13 safety-net health insurance plans that are members of the Association for Community Affiliated Plans (ACAP), the national trade association for nonprofit safety-net managed care plans, such as those owned or operated by community health centers or safety-net hospitals. ACAP helped us recruit 13 community health center-owned or -controlled Medicaid managed care plans to tell us about how the medical home concept is being applied in different markets across the nation.

We asked how health centers are reimbursed by their plan and about any medical home-related projects occurring either within their program or in their operating environment. Case management, disease management, and quality improvement programs were also included in the scope of these interviews. While we realized that ACAP members are not necessarily representative of managed care plans nationwide, we expected they would be more aware of innovative payment policies involving FQHCs.

Advisory Group

The advisory group for this project graciously provided expert advice. The group was composed of representatives from health centers, the National Association of Community Health Centers, ACAP, congressional staff, and The Commonwealth Fund. We held an advisory group meeting to frame the project, provide background from a diverse set of views, and assess our initial recommendations to hone in on the most feasible options. A draft of this report was sent to the advisory group for their input and feedback before it was finalized.

Additional Survey Data

In addition, preliminary data from a new survey of health centers has become available. Researchers from George Washington University conducted a national online survey of Section 330-funded health centers to learn about their readiness for important innovations, such as recognition as medical homes and adoption of electronic health records and meaningful use.⁵³ The survey, conducted from December 2010 to February 2011, was fielded to all Section 330 grantees (and to a number of “FQHC lookalikes,” although those data are not presented here). Respondents were contacted by e-mail and asked to complete an online survey. The National Association of Community Health Centers and state Primary Care Associations encouraged their members to respond. The survey was conducted under the auspices of the Geiger Gibson/RCHN Community Health Foundation Research Collaborative. The survey was completed by 713 Section 330 grantees (not including Guam), which corresponds with a 64 percent response rate, although 26 respondents did not answer the questions about medical home status. Initial analyses indicate that the characteristics of responding centers were similar to those of the universe of Section 330 grantees, as reported in the Uniform Data System, suggesting that there was little nonresponse bias.

NOTES

¹ Federally qualified health centers (FQHCs) include health centers that receive Section 330 grants from the Health Resources and Services Administration and some health centers (called FQHC lookalikes) that qualify for but do not receive Section 330 grants. Most, but not all, FQHCs are Section 330 grantees. All FQHCs (including grantees and lookalikes) may receive cost-based reimbursements from Medicaid or Medicare. In this report, we primarily focus on FQHCs that are Section 330 grantees.

² To learn how payments to FQHCs are currently structured, see P. Shin, L. Ku, E. Jones et al., *Financing Community Health Centers as Patient- and Community-Centered Medical Homes: A Primer* (Washington, D.C.: George Washington University, May 27, 2009), http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A186E838-5056-9D20-3D9EA92EB75DAC24.pdf.

³ Analyses of 2010 data from the Uniform Data System annual reports filed by FQHCs to the Bureau of Primary Health Care.

⁴ The law will expand Medicaid coverage nationally to low-income, nonelderly adults with incomes below 133 percent of the federal poverty level. In addition, it will provide income-based tax credits to help low- and moderate-income people purchase insurance from the new state-based health insurance exchanges.

⁵ In Massachusetts, the state's health reform led to caseload increases at health centers, as they served more of the newly insured, as well as large numbers of those who remained uninsured. See L. Ku, E. Jones, B. Finnegan et al., *How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform* (Menlo Park, Calif.: Kaiser Commission on Medicaid and the Uninsured, March 2009); L. Ku, E. Jones, P. Shin et al., "Safety-Net Providers After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, Aug. 8, 2011 171(15):1379–84.

⁶ However, the full-year continuing resolution for fiscal year 2011 reduced Section 330 funds, so the long-term status of funding for health centers has become somewhat uncertain.

⁷ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care* (New York: The Commonwealth Fund, June 2007); M. Lodh, "ACCESS Cost Savings—State Fiscal Year 2004 Analysis," Mercer Governmental Human Services Consulting letter to Jeffrey Simms, State of North Carolina, Office of Managed Care, March 24, 2005.

⁸ N. Kaye and M. Takach, *Building Medical Homes in State Medicaid and CHIP Programs*, (New York: The Commonwealth Fund, June 2009). For an update, see <http://www.nashp.org/med-home-map>.

⁹ Affordable Care Act, Section 2703.

¹⁰ B. Starfield and L. Shi, "The Medical Home, Access to Care, and Insurance: A Review of Evidence," *Pediatrics*, May 2004 113(5):1493–98; M. K. Abrams, "Why Patient-Centered Medical Homes Are Important: Impact on Quality and Cost," presentation at the National Academy for State Health Policy Seminar, March 2008.

¹¹ S. Guterman, K. Davis, C. Schoen, and K. Stremikis, *Reforming Provider Payment: Essential Building Block for Health Reform* (New York: The Commonwealth Fund, March 2009).

¹² C. Mann, "State Medicaid Director Letter 10-24: Health Homes for Enrollees with Chronic Conditions," Nov. 16, 2010.

¹³ M. M. Doty, M. K. Abrams, S. E. Hernandez, K. Stremikis, and A. C. Beal, *Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers* (New York: The Commonwealth Fund, May 2010). The five domains, adapted from NCQA criteria, are: patient tracking and registry functions, test tracking, referral tracking, enhanced access and communication, and performance reporting and improvement.

¹⁴ See primer for in-depth information on how health centers are financed and how they expand on the patient-centered medical home model: Shin, Ku, Jones et al., *Financing Community Health Centers*, 2009.

¹⁵ S. Streeter, S. Braithwaite, N. Ipakchi et al., *The Effect of Community Health Centers on Healthcare Spending and Utilization* (Washington, D.C.: Avalere Health, Sept. 2009); M. Falik, J. Needleman, B. L. Wells et al., “Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers,” *Medical Care*, June 2001 39(6):551–61; C. B. Forrest and E. M. Whelan, “Primary Care Safety Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physicians’ Offices,” *Journal of the American Medical Association*, Oct. 25, 2000 284(16):2077–83; R. M. Politzer, J. Yoon, L. Shi et al., “Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care,” *Medical Care Research and Review*, June 2001 58(2):234–48; B. Starfield, N. R. Powe, J. R. Weiner et al., “Costs vs. Quality in Different Types of Primary Care Settings,” *Journal of the American Medical Association*, Dec. 28, 1994 272(24):1903–8; L. S. Hicks, A. J. O’Malley, T. A. Lieu et al., “[The Quality of Chronic Disease Care in U.S. Community Health Centers](#),” *Health Affairs*, Nov./Dec. 2006 25(6):1713–23; R. M. Politzer, A. H. Schempf, B. Starfield et al., “The Future Role of Health Centers in Improving National Health,” *Journal of Public Health Policy*, 2003 24(3/4):296–306; National Association of Community Health Centers, Robert Graham Center, and Capital Link, *Access Granted: The Primary Care Payoff* (Washington, D.C.: NACHC, Aug. 2007); B. Smith-Campbell, “Emergency Department and Community Health Center Visits and Costs in an Uninsured Population,” *Journal of Nursing Scholarship*, 2005 37(1):80–86; and M. Proser, “Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care,” *Journal of Ambulatory Care Management*, Oct.–Dec. 2005 28(4):321–30.

¹⁶ L. Ku, P. Richard, A. Dor et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, Policy Research Brief No. 19 (Washington, D.C.: George Washington University, June 30, 2010).

¹⁷ See [Appendix A](#) for a chart outlining efforts in the four states profiled.

¹⁸ T. C. Ricketts, S. Greene, P. Silberman et al., *Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000–December 2002* (Chapel Hill, N.C.: University of North Carolina, Cecil G. Sheps Center for Health Services Research, April 15, 2004); and Lodh, “ACCESS Cost Savings,” 2005.

¹⁹ National Committee for Quality Assurance, *Standards for Patient-Centered Medical Home* (Washington, D.C.: NCQA, Feb. 2011).

²⁰ See <http://www.aaahc.org/eweb/dynamicpage.aspx?webcode=mha>.

²¹ The Joint Commission, “Approved Standards & EPs for The Joint Commission Primary Care Medical Home Option” (Oakbrook Terrace, Ill.: The Joint Commission, 2011), http://www.jointcommission.org/assets/1/18/Primary_Care_Home_Posting_Report_20110519.pdf.

²² W. C. Cooley, J. W. McAllister, K. Sherrieb et al., “The Medical Home Index: Development and Validation of a New Practice-Level Measure of Implementation of the Medical Home Model,” *Ambulatory Pediatrics*, July–Aug. 2003 3(4):173–80.

²³ Centers for Medicare and Medicaid Services, “Multi-Payer Advanced Primary Care Practice Demonstration Solicitation” (Washington, D.C.: CMS, revised June 14, 2010), <https://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016>.

²⁴ Mann, “State Medicaid Director Letter,” 2010.

²⁵ Centers for Medicare and Medicaid Services, “Press Release: New Affordable Care Act Support to Improve Care Coordination for nearly 200,000 People with Medicare” (Washington, D.C.: CMS, June 6, 2011, <http://www.hhs.gov/news/press/2011pres/06/20110606a.html>); see also Centers for Medicare and Medicaid Services, “Federally Qualified Health Center Advanced Primary Care Practice Demonstration: Fact Sheet” (Washington, D.C.: CMS, Aug. 31, 2011), https://www.cms.gov/DemoProjectsEvalRpts/downloads/FQHC_Fact_Sheet.pdf.

²⁶ Bureau of Primary Health Care, “Program Assistance Letter 2011–01, HRSA Patient-Centered Medical/Health Home Initiative,” (Washington, D.C.: BPHC, Nov. 12, 2010), <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>.

²⁷ B. K. Bruen, L. Ku, M. F. Burke et al., “More Than Four in Five Office-Based Physicians Could Qualify for Federal Electronic Health Record Incentives,” *Health Affairs*, March 2011 30(3):472–80.

²⁸ “Washington Patient Centered Medical Home Collaborative: The Current Collaborative 2009–2011” (Olympia, Wash.: Washington State Department of Health, Feb. 2011), <http://www.doh.wa.gov/cfh/MH-Coll/publications/MedHmCollFacts11.pdf>.

²⁹ R. J. Stenger and J. E. DeVoe, “Policy Challenges in Building the Medical Home: Do We Have a Shared Blueprint?” *Journal of the American Board of Family Medicine*, May–June 2010 23(3):384–92.

³⁰ E. Hing, R. Hooker and J. Ashman, “Primary Health Care in Community Health Centers and Comparison with Office-Based Practice,” *Journal of Community Health*, June 2011 36(3):406–13.

³¹ M. Takach, *State Involvement in Multipayer Medical Home Initiatives* (Portland, Maine: National Academy of State Health Policy, 2009).

³² Kaye and Takach, *Building Medical Homes*, 2009.

³³ See <http://www.nashp.org/med-home-map>.

³⁴ Because there are typically multiple Medicaid managed care plans in a state, the policies may vary within a given state. For example, this does not mean that all FQHCs are paid on a capitated basis as primary care providers in managed care plans in the 25 states cited or that all the managed care plans in the state pay this way.

³⁵ Under the American Recovery and Reinvestment Act, federal funds were available to support incentive payments for the adoption and meaningful use of electronic health records in Medicaid beginning in 2011. At the time of this survey, these provisions were not yet in effect.

³⁶ States may use an alternative reimbursement methodology for FQHCs, provided that it pays at least as well as a PPS system would pay.

³⁷ The survey was led by Merle Cunningham, Peter Shin, and Anthony Lara of George Washington University.

³⁸ H. J. Geiger, “Community-Oriented Primary Care: A Path to Community Development,” *American Journal of Public Health*, Nov. 2001 92(11):1713–16.

³⁹ Health Resources, and Services Administration, Uniform Data System for 2010.

⁴⁰ Centers for Medicare and Medicaid Services, “Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations,” *Federal Register*, April 7, 2011 76(67):19528–19654.

⁴¹ For example, C. Fiegl, “Medicare ACO Plan Still Needs Work, AMA Says,” *American Medical News*, June 13, 2011.

⁴² S. Rosenbaum and P. Shin, *Medicare’s Accountable Care Organization Regulations: How Will Medicare Beneficiaries Who Reside in Medically Underserved Communities Fare?* Policy Research Brief #23 (Washington, D.C.: George Washington University, April 20, 2011).

⁴³ L. Ku, K. Jones, P. Shin et al., “The States’ Next Challenge—Securing Enough Primary Care for an Expanded Medicaid Population,” *New England Journal of Medicine*, Jan. 26, 2011 364(6):493–95.

⁴⁴ Ku, Jones, Shin et al., “Safety-Net Providers After Health Care Reform,” 2011.

⁴⁵ Mann, “State Medicaid Director Letter,” 2010.

⁴⁶ Under the Affordable Care Act, the additional costs of this mandatory rate increase will be fully federally funded in 2013 and 2014.

⁴⁷ M. Takach, “Payment Options to Support Medical Homes: State Practice,” Webinar presentation for the National Academy for State Health Policy, March 29, 2010.

⁴⁸ D. McKinney, R. Kidney, C. Boselli et al., *2009 Update on the Status of the Medicaid and CHIP Prospective Payment System in the States*, State Policy Report #30 (Washington, D.C: National Association of Community Health Centers, Sept. 2009).

⁴⁹ M. Bailit, K. Phillips, and A. Long, *Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net* (Seattle: Bailit Health Purchasing and Qualis Health, Oct. 2010), http://www.qhmedicalhome.org/safety-net/upload/SNMHI_PolicyBrief_Issue1.pdf.

⁵⁰ Centers for Medicare and Medicaid Services Benefits Improvement and Protection Act of 2000, Section 702, Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics, 2001.

⁵¹ A limited number of health centers were granted \$40,000 annually through the Health Disparities Collaborative Phase 2, known as the Sustain and Spread/Improvement Model. U.S. Department of Health and Human Services, Bureau of Primary Health Care, Health Disparities Collaboratives Sustain and Spread Supplemental Funding, HRSA-05-110, Catalog of Federal Domestic Assistance No. 93.224.

⁵² American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, “Joint Principles of the Patient-Centered Medical Home,” Feb. 2007, <http://www.pcpc.net/content/joint-principles-patient-centered-medical-home>.

⁵³ Merle Cunningham, Peter Shin and Anthony Lara of the Department of Health Policy, George Washington University led this survey. The National Association of Community Health Centers helped encourage its members to participate in the survey.