VALUE-BASED CARE:

A Primer for Outreach and Enabling Services Staff

Health Outreach Partners

HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

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HOW TO USE *THE VALUE-BASED CARE PRIMER*

Target Audience

The *Value-Based Care Primer* is intended for outreach and enabling services staff from health centers across the United States.

Filling the Gap

There are lots of resources on Value-Based Care published to date. What makes this one unique? It is exclusively focused on how Value-Based Care payment and delivery models impact Federally Qualified Health Centers. This resource is intended to provide a basic background and definitions for outreach and enabling services' staff from health centers across the country.

Pro Tip: Many value-based care initiatives are dependent on the state policies and state Medicaid programs, the individual third-party payors, and the regional availability of Managed Care Organizations and Accountable Care Organizations. *The Value-Based care Primer* focuses on national-level trends and initiatives. Check with your state or regional Primary Care Association for specific programs in your health center's service area.

Value-Based Care Primer Learning Objectives

- Define "Value-Based Care" and identify payment and delivery models
- Describe the role of Value-Based Care in outreach
- Provide specific examples of Value-Based Care models and the relevance to health center outreach and enabling services staff
- Link readers to further resources that may be relevant to their health center

SUMMARY

Robust, community-driven outreach models are critical for ensuring access to and utilization of health care services by underserved populations. Under a traditional structure of payment for health services, many outreach activities and other enabling services are non-reimbursable. However, over the past decade, there has been a national shift in the ways in which health care is delivered and reimbursed. New service delivery systems and alternative payment models afford health centers the opportunity to provide patient-centered care in a more flexible manner, including the use of health outreach programs and enabling services provision and other delivery models.

The Value-Base Care Primer aims to review payment reform through focusing on enabling services. It highlights possible roles for health center outreach and enabling services staff in alternative payment models such as shared savings models. *The Value-Based Care Primer* will give examples of how health centers can leverage outreach and enabling services by collecting social determinants of health data and participating in models such as the Patient-Centered Medical Home and Accountable Care Organizations to earn payment while improving access to care for patients served.

Pro Tip: Please reference the Glossary in the Appendix of the *Value-Based Care Primer* for quick definitions of key terms and commonly used acronyms. The Primer is written to be as user-friendly as possible and will define acronyms before using them in each section.

INTRODUCTION

Health Centers were integral in the implementation of the Patient Protection Affordable Care Act (ACA) initiatives promoting access, such as Outreach and Enrollment, care transformation, as well as instrumental in the development and implementation of value-based care programs such as the Patient-Centered Medical Home[35] demonstration, and to a lesser extent Accountable Care Organizations.[1,2] Despite their proven benefit to patient access to primary care and other services in the era of the ACA[3,4], savings to national health care costs,[5,6] and vital place in the landscape of value-based care payment and delivery models, health centers still report needing training and technical assistance (T/TA) support in understanding and getting involved in value-based care programs. This need for training and technical assistance was a key finding in the National Association of Community Health Centers' *National Health Center Training and Technical Assistance Needs Assessment in 2019*.[7] This resource aims to provide a background on payment reform and specifically outline methods and strategies that pertain to health centers' outreach and enabling services programs.

HEALTH CENTERS: A SOLUTION TO RISING HEALTHCARE COSTS

Health care spending in the U.S. is a major concern, and efforts are continuously being made to lower costs and spending while maintaining quality and efficiency in the delivery of care. Health centers have proven to deliver cost savings to the U.S. health care system. Health center average daily cost per patient ($2.09) is lower than the cost of other physician settings ($3.06), and data shows that health centers save an estimated $1,263 per patient annually.[1]

[1] Griffin, P. M. et al. "Balancing Investments in Federally Qualified Health Centers and Medicaid for Improved Access and Coverage in Pennsylvania." *Health Care Manag Sci*, vol. 17, no. 4, 2014, pp. 348-364, doi:10.1007/s10729-013-9265-8.

[2] Johnson, T. J. et al. "Practice Innovation, Health Care Utilization and Costs in a Network of Federally Qualified Health Centers and Hospitals for Medicaid Enrollees." *Popul Health Manag*, vol. 21, no. 3, 2018, pp. 196-201, doi:10.1089/pop.2017.0073.

[3] Taylor, J. "Changes in Latitudes, Changes in Attitudes: Fqhcs and Community Clinics in a Reformed Health Care Market." *Issue Brief George Wash Univ Natl Health Policy Forum*, no. 848, 2012, pp. 1-22.

[4] Katz, A. B. et al. "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects under Reform." *Res Brief*, no. 21, 2011, pp. 1-9.

[5] Pourat, N. and M. W. Hadler. "Ready for Aca? How Community Health Centers Are Preparing for Health Care Reform." *Policy Brief UCLA Cent Health Policy Res*, no. PB2014-4, 2014, pp. 1-6, appendix.

[6] Manchikanti, L. et al. "Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade." *Pain Physician*, vol. no. 1, 2011, pp. E35.

[7] NACHC. National Health Center T/TA Needs Assessment. 2019.

Why is the "Post-ACA Era" Particularly Important to Health Centers?

Since the implementation of the Affordable Care Act in 2010, an estimated 20 million people have gained health insurance through the ACA Marketplace and Medicaid expansion – in which 37 states have adopted expanding Medicaid requirements to low-income adults who are not categorically eligible.[9] FQHCs play a critical role in providing care to Medicaid patients, the publicly insured, and un- and under insured.[10]

Millions of patients will continue to rely on health centers as their primary source of care in the coming years, either as they gain access to insurance through the Marketplace or Medicaid expansion, utilize health centers with their private insurance or because they are under or uninsured. Health centers will need to be responsive to the changing health care landscape and can take advantage of value-based care initiatives for portions of their patient panels depending on their payor mix, state policies, and availability of value-based programming such as Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs).

What is Value-Based Care? Value-Based Care: Value-based programs reward health care providers with incentive payments for the *quality of care* they give, using data and metrics to measure quality improvements and performance. They aim to improve individual and population health outcomes while reducing costs in the long term.[8]

Value-based programs, in order to continue providing high-quality, accessible, affordable and comprehensive health care. Outreach programs and staff can be leveraged to help fully understand and address the needs of these underserved communities. Thus, health centers will continue to have a key role in the identification of effective value-based care approaches that will meet the goals of the Institute for Healthcare Improvement (IHI) Quadruple Aim.[11],[12]

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[8] Centers for Medicare and Medicaid Services. *What are the Value-Based Care Programs?* 2020. Accessed at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

[9] "Status of State Medicaid Expansion Decisions: Interactive Map." Kaiser Family Foundation (KFF). 20 Sept. 2019. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ Accessed October 24, 2019.

[10] Collins, S. et al.. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured." *Commonwealth Fund*, Feb 2019. https://doi.org/10.26099/penv-q932.

[11] Institute for Healthcare Improvement. Quadruple Aim. Accessed at: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[12] IHI Quadruple Aim: Improving the patient experience of care (including quality and satisfaction), improving the health of populations, reducing the per capita cost of health care, and improving provider job satisfaction.

How Does Value-Based Care Affect Outreach and Enabling Services?

Outreach and enabling services are a key part of the integrated model of care and integral to health centers' mission, yet they remain non-reimbursable services. Grant funding for these services is often available for only limited periods (one- to two- year cycles) or for disease specific programming. Furthermore, implementation of the ACA prompted many health centers to prioritize enrollment services. For some this resulted in reduced capacity to provide other outreach-related services such as health education, case management, mobile care and transportation. New service delivery systems and alternative payment models afford health centers the opportunity to provide patient-centered care in a more flexible manner, including the use of health outreach programs.[13]

What are Enabling Services?	**Enabling Services:** Non-clinical services that support the delivery of basic health services and facilitate access to comprehensive patient care as well as social services. Enabling Services include: • Case management • Benefit counseling or eligibility assistance • Health education and supportive counseling • Interpretation • Outreach • Transportation • Education of patients and the community They often serve to "bring patients in the door," but can also bring the care to the patients. In breaking down both common and personal barriers to care, Enabling Services are particularly important for those communities that experience the most acute health disparities in terms of access and outcomes.

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[13] "Outreach and Value-based Care. Impacting Health Care Delivery and Cost through Integrated Community Health Outreach Programs." *Health Outreach Partners.* 2017.. https://outreach-partners.org/wp- Accessed 24 Oct 2019. content/uploads/2017/06/ORValueBasedCare.pdf
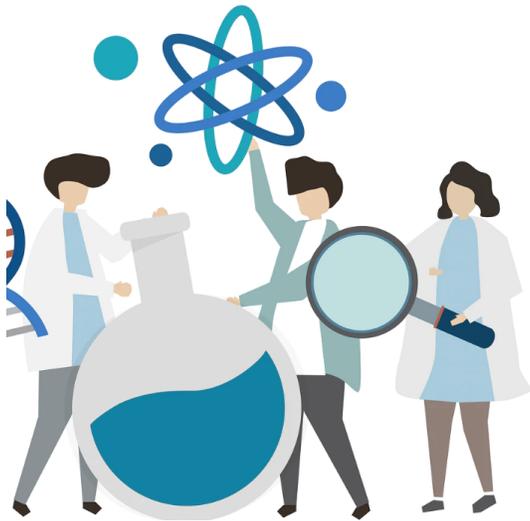
• *The Role of States as Policy "Laboratories"*

When considering policies and programs as they relate to value-based care, it is important to note that there are distinctive ***differences between the states.*** While the federal policies apply to all states, how each state adopts and adapts federal-level policies can vary greatly depending on the state, its voters, politicians, and populations served by its programs. This is why individual states are sometimes referred to as policy "laboratories" to see how the different implementations of a federal policy may impact population health. One salient example is how states had the option whether or not to expand Medicaid and also how to expand it through 1115 Waivers. Further, states have initiated approaches such as Medicaid MCOs and other quality improvement and value-based care initiatives impacting health centers.

• *The Role of Medicaid and Medicare as Policy "Scientists"*

The Centers for Medicare and Medicaid Services (CMS) provide management and oversight for public insurance options. Medicare is health insurance for adults aged 65+ and is administered federally. Medicaid, which is administered by the states in partnership with the federal government, provides health insurance for enrollees based on income or categorical eligibility such as aged, blind and disabled (ABD) status as well as for pregnant women (MPW). In states that expanded Medicaid under the ACA, it now includes low-income, able-bodied adults with incomes up to 138% of the Federal Poverty Level.

Value-based care models of interest to the federal and state governments are often evaluated as pilot programs by CMS. Hence, the federal government plays a key role in changing or piloting public insurance programs.

VALUE-BASED CARE: KEY TERMS, MODELS AND STRATEGIES FOR IMPLEMENTATION

In this section of the Value-Based Care Primer, the resource will delve into five different specific approaches to value-based care for health centers. The purpose of this section is to provide health center outreach and enabling services staff a brief overview of different strategies for consideration to identify value-based strategies for their program or health center.

A. Social Determinants of Health and Enabling Services Data

Social determinants of health (SDOH) and enabling services data are essential to population health initiatives and implementing value-based models. The *Value-Based Care Primer* will explore SDOH data beyond what is traditionally captured through practice management and electronic health record systems. Several new advances have been assisting health centers in collecting data related to "root causes" of health outcomes, sometimes referred to as SDOH, that aim to provide health centers with a better understanding of their patients' non-clinical needs.

ICD-10 Z Code and Documentation of SDOH

Z codes, a class of ICD-10 codes, are used to document health center patients' social determinants and non-clinical needs. The ICD-10 Official Guidelines for Coding and Reporting[14] identify which codes may be assigned as principal, secondary or later diagnosis and outline the different codes descriptions and uses.

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[14] CMS (2019). Official *Guidelines for ICD-10 Coding and Reporting (FY2019)*. Accessed at:
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf

Examples of Z Codes for Health Centers:

ICD-10 Z Code[15]	SDOH Documentation
Z59.0,	Homelessness
Z59.1	Inadequate housing
Z59.5	Extreme poverty
Z75.1	Person awaiting admission to adequate facility elsewhere
Z75.3	Unavailability and inaccessibility of health-care facilities
Z76.2	Encounter for health supervision and care of other healthy child
Z99.12	Encounter for respirator dependence during power failure

Other codes may be applicable to the encounter based upon the documentation. CMS officially recommends to "assign as many codes as necessary to fully explain each healthcare encounter."[16]

Enabling Services Data Collection

Data collection to document SDOH and reimbursement for activities addressing SDOH, such as enabling services, can be challenging for health centers. Also, guidance from CMS and other payors is constantly changing. To help health centers navigate these complexities, there are digital tools available that support SDOH and enabling services data collection and that can interface with the health system's electronic health record. These tools can also pull the correct Z codes and other documentation to ensure that SDOH data is correctly collected and coded. Several examples of enabling services data collection tools that are commonly used by health centers are included below.

Enabling Services Data Collection Tools & Technology & SDOH Information Automation

PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) was developed by NACHC, AAPCHO, Oregon PCA, and Institute for Alternative Futures. PRAPARE is a national effort to help health centers and other providers collect the data needed to understand and act on their patients' social determinants of health. [17]

Training and technical assistance is available for using the tool and PCAs and HCCNs have been involved in interfacing PRAPARE with population EHR systems used by health centers such as EPIC, eClinicalWorks and GE Centricity.

PRAPARE Core Measures

Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress

PRAPARE Optional Measures

Incarceration History	Safety
Refugee Status	Domestic Violence

- *For more information visit*: http://www.nachc.org/research-and-data/prapare/

PRO TIP: PRAPARE is available for free to health centers along with training and technical assistance on how to start using the tool.

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[17] NACHC (2020). *PRAPARE.* Accessed at: http://www.nachc.org/research-and-data/prapare/

CMS Accountable Health Communities Health-Related Social Needs Screening Tool
The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI) developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN, akin to SDOH) Screening Tool.[18], [19]

5 Core Domains of the AHC HRSN	8 Supplementary Domains AHC HRSN
Housing instability	Financial strain
Food insecurity	Employment
Transportation problems	Education
Utility help needs	Family and community support
Interpersonal safety	Physical activity
	Substance use
	Mental health
	Disability

B.   PAYMENT MODELS & DEFINTIONS

Health Centers' Prospective Payment System (PPS) is a special arrangement specifically for health centers to ensure that they receive enhanced Medicaid reimbursement to offset the costs of providing care to the uninsured and publicly insured. The ways in which the PPS system interacts with value-based care models is complicated. However, states are moving forward with identifying payment strategies that incentivize value-based care modeling in which health centers are involved, while working within the confines of the existing PPS structures provided by CMS to support health center finance and operations.[20]

[18] CMS, CMMI (2020). The Accountable Health Communities Health-Related Social Needs Screening Tool. Accessed at: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
[19] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.
[20] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

What is the Health Center Prospective Payment System (PPS)?

The PPS ensures payment rates based on individual costs to provide services and are cost adjusted annually. **Alternative Payment Methodology (APM)** allows for use of different payment structures identified by the state as long as the APM is not lower than the traditional PPS payment.[21] States can set different rates for medical, behavioral and dental services within the PPS.[22]

Quick Review of Health Center Payment Models in Relation to Value-Based Care

While the Prospective Payment System (PPS) guarantees health centers Medicaid payment based on cost, value-based payment models provide health centers with financial incentive to improve quality of care and health outcomes. Value-based payment can include potential risk for loss of payment if the health center does not improve quality and patient health outcomes. Therefore, there is a risk that value-based payments may be less than the PPS payments – creating a potential conflict for health centers seeking to engage in value-based care but that are averse to the risk inherent in value-based models. Most models used by health centers involve reconciling the PPS rate to a value-based care program, referred to as "PPS reconciliation."[23]

Introduction to Payment Models Terms[24]

Fee-for-service (FFS) Payment Structure:

- Payment model where payor reimburses the provider for each billable service rendered.
  - *Advantages:* Ensures adequate reimbursement for services rendered.
  - *Disadvantages:* Incentivizes health systems to provide and bill for more services regardless of demonstrated need.

Capitated Payment Structures:

- A payment system where there is an established per member per month (capitation) payment for specified services provided. These health centers also receive wrap around payment (PPS or APM) from their state to ensure they are. Not under reimbursed.
  - *Advantages:* Incentivizes quality of care and managing population or panel health.
  - *Disadvantages:* May under-reimburse for care of panel that needs more services than is covered in the capitated payment schedule.

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[21] Waldman B, Bailit MH, Dyer MB. "State Medicaid Approaches for Defining and Tracking Managed Care Organizations Implementation of Alternative Payment Models", Robert Wood Johnson Foundation, February 6, 2018.

[22] Ibid.

[23] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

[24] Centers for Medicare and Medicaid Services (CMS). *Managed Care, 2020.* Accessed at: https://www.medicaid.gov/medicaid/managed-care/index.html

Managed Care Organizations[25]

Managed Care Organizations:

- Managed Care is a health care delivery system organized to manage cost, utilization, and quality.

Medicaid Managed Care Organizations (MCOs):

- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services.[26]
- By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.[27]

THE IMPORTANT ROLE OF MEDICAID AND MEDICARE IN PAYMENT REFORM

Medicaid Managed Care Organizations

As more and more states expand or experience shifts in their Medicaid programs, many are trying to address newly insured Medicaid enrollees' social needs to improve health outcomes and patient experience, while decreasing costs.[28] One method by which states are seeking to achieve this "Triple (or Quadruple) Aim" [29] is by contracting with MCOs to provide insurance for Medicaid beneficiaries.[30] In 2016, 59.3% of FQHC Medicaid revenue was derived from Medicaid MCO payments, yet there remains a gap in the evaluation literature about the impact of state policies and

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[25] Centers for Medicare and Medicaid Services (CMS). *Managed Care, 2020.* Accessed at: https://www.medicaid.gov/medicaid/managed-care/index.html

[27] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

[28] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.

[29] Institute for Health Care Improvement, 2019. Accessed at: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[30] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.

Medicaid MCO practices on enrollees' social determinants of health. Health Centers have a strong history of and commitment to serving people who are insured by Medicaid. This is due to FQHC grant requirements to serve patients regardless of ability to pay or payor type. Further, the Medicaid-FQHC PPS and state alternative payment methods ensure FQHCs have appropriate infrastructure to serve a large volume of Medicaid-insured patients.[31],[32],[33],[34] Consequently, FQHCs received over 48% of all revenue from Medicaid reimbursements and served 13,742,263 Medicaid-insured patients across the U.S., according to the 2018 UDS Data. Some hMCOs have a growing focus on identifying and addressing enrollees' SDOH. However, there is wide variation between the states in how the federal law relating to Medicaid policy is interpreted and how state Medicaid offices are contracting with MCOs to provide or incentivize services related to SDOH.[35] Some examples of variations include if MCOs

reimburse for SDOH activities like community health workers and if MCOs are permitted to directly provide additional services addressing SDOH for enrollees. The variations in state Medicaid policies related to Medicaid MCOs impact enabling services and outreach reimbursement.

Medicaid and Medicaid Managed Care Organizations

Health centers care for 1 in 6 Medicaid beneficiaries nationally and they deliver major savings to the Medicaid Program at 24% lower cost of care compared to other

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[31] Manchikanti, L. et al. "Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade." *Pain Physician*, vol. 14, no. 1, 2011, pp. E35-67.

[32] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.

[33] Kulesher, R.R., *Health reform's impact on federally qualified community health centers: the unintended consequence of increased Medicaid enrollment on the primary care medical home.* Health Care Manag (Frederick), 2013. 32(2): p. 99-106.

[34] deShazo, R.D., *Who will care for the newly insured under health reform?* J Miss State Med Assoc, 2011. 52(8): p. 263-9.

[35] Medicaid Payment Policy for Federally Qualified Health Centers. MACPAC. 2019. Accessed at: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf

providers.[36] This is due in part to health centers' strong relationship with CMS and participation in its pilot programs because health centers serve many of the publicly insured. The Medicaid-FQHC prospective payment system (PPS) and state alternative payment methods (APM) ensure an enhanced reimbursement from Medicaid to health centers to enable them to provide care to patients regardless of ability to pay.[3,5,37,38,39,40] According to the 2018 UDS Table 9D on patient revenue, nearly 60% of all Medicaid payments to health centers were from Medicaid MCOs, with roughly 20.3% of all Medicaid payments from capitated MCOs and 39.8% fee-for-service (FFS) MCOs.[34] Nearly 20% of all Medicare payments to health centers were derived from Medicare MCOs in 2018.[3,4]

What do we know about Medicaid MCOs and Health Centers?

A growing body of literature explores Medicaid enrollees' experiences and outcomes in the post-ACA environment, demonstrating that Medicaid expansion has improved access to both insurance through Medicaid to patients at FQHCs as well as their health care service utilization and outcomes.[41,42] These studies found significant results indicating an estimated 5-11% decrease in rates of uninsured patients at FQHCs is associated with Medicaid expansion, while an 8-13% increase in Medicaid patients may be anticipated.[43] From two studies, significant improvements to health screenings, treatments, and outcomes were found, including 3-5% increases in asthma treatments, 4.5-6.7% increase in BMI screening and follow-up, and 2.1% increase in controlled blood pressure for hypertensive patients at FQHCs.[44] These studies suggest that access to insurance through Medicaid expansion will produce payor mix changes for health centers and may positively impact the quality of care and overall health of FQHC patients. However, the Medicaid MCO model's impact on FQHCs and their patients has not yet been investigated at a national level.[45]

[36] Ibid.

[37] Iglehart, J. K. "Health Centers Fill Critical Gap, Enjoy Support." *Health Aff (Millwood)*, vol. 29, no. 3, 2010, pp. 343-345, doi:10.1377/hlthaff.2010.0151.

[38] deShazo, R.D., "Who will care for the newly insured under health reform?" *J Miss State Med Assoc*, 2011. 52(8): p. 263-9.

[39] Kulesher, R. R. "Health Reform's Impact on Federally Qualified Community Health Centers: The Unintended Consequence of Increased Medicaid Enrollment on the Primary Care Medical Home." *Health Care Manag (Frederick)*, vol. 32, no. 2, 2013, pp. 99-106, doi:10.1097/HCM.0b013e31828ef5d5.

[40] Medicaid Payment Policy for Federally Qualified Health Centers. *MACPAC*. 2019. Accessed at: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf Accessed 25 Oct 2019.

[41] Cole, M.B., et al., *Medicaid Expansion and Community Health Centers: Care Quality And Service Use Increased For Rural Patients.* Health Aff (Millwood), 2018. **37**(6): p. 900-907.

[42] Shi, L., M.K. Wharton, and A. Monnette, *Ensuring access to prescription medications in the post-ACA healthcare access landscape: the essential role of FQHCs in the safety net for the underinsured.* Am J Manag Care, 2018. **24**(5 Suppl): p. S67-s73.

[43] Cole, M.B., et al., *Medicaid Expansion and Community Health Centers: Care Quality And Service Use Increased For Rural Patients.* Health Aff (Millwood), 2018. **37**(6): p. 900-907.

[44] Cole, M.B., I.B. Wilson, and A.N. Trivedi, *State Variation in Quality Outcomes and Disparities in Outcomes in Community Health Centers.* Med Care, 2017. **55**(12): p. 1001-1007.

[45] Waldman B, Dyer MB, Angeles J, Trinity M. "State Strategies to Promote Value–Based Payment through Medicaid Managed Care", Federal Medicaid and CHIP Payment and Access Commission (MACPAC), March 13, 2020.

Accountable Care Organizations

ACOs are collaborative groups or partnerships of providers that coordinate to transform care collectively for a shared patient population or across a common geographic region.[46] ACOs share responsibilities for managing a comprehensive set of services for a population. They are evaluated for performance relative to expected costs versus actual costs. They are also evaluated on quality of care and have the potential to share in savings based on quality performance, or conversely accept the risk of collective management of health outcomes for a patient population.[47]

State-Specific Example: In Colorado, FQHCs participate as part of Accountable Care Collaborative and are eligible to receive P4P based on quality performance for:

- Reduced ED visits
- Increased post-partum visits
- Increased well-child visits

(Waldman, 2016)

State-Specific Example:

Minnesota – FQHC Urban Health Network (FUHN) participates in a model as a virtual Integrated Health Partnership; includes 10 FQHCs in the Minneapolis/St. Paul Area

Rhode Island – Three FQHCs individually certified as Accountable Entities and will have potential to share in savings

(Waldman, 2016)

Payment options for ACOs:
ACOs have the potential to share in savings (and accept risk) based on performance for improving quality and outcomes of patients. The ACO model is built on top of a fee-for-service system or a capitation system.[48]

Shared savings through ACOs
There are several examples of FQHCs participating as part of an ACO with a group of providers or forming their own ACO-type of organization.[49]

Pay for Performance (P4P)

Pay for performance (P4P) is associated with meeting performance targets on specific quality measures established with payors, MCOs, ACOs or other entities.[50]

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[46] Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

[47] Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

[48] Ibid.

[49] Ibid.

[50] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Primary Care Capitation

Capitation initiatives allow FQHCs to provide services that are beneficial, but not traditionally reimbursable under fee-for-service, because the services produce cost savings overall to the health center. Primary Care Capitation is a model that provides both flexibility and predictable flow of funds to health centers.[51]

State-Specific Examples:

Massachusetts - FQHCs actively participate in this model; leverages PCMH as foundation. Majority are only eligible for shared savings based on size of patient panel.

Oregon and California - specific FQHC payment reform initiatives that provide PMPM based on expected spending *(Waldman, 2016)*

C.   HEALTH CENTER OPERATIONS AND FLOW

Patient-Centered Medical Homes

Currently **76%** of FQHCs hold an accredited PCMH Recognition *(2018 UDS Data)*

The Patient-Centered Medical Home (PCMH) uses a patient-centered approach to primary care delivery using care coordination models, health information technology, care team utilization to support individual and population health, and quality improvement. PCMH designations are obtained through an evidence-based model and accreditation practice using standards, such as the National Commission for Quality Assurance model.[52] Further, these models support value-based care by enabling health centers to receive supplemental payments for PCMH recognition, which are financial structures incentivizing primary care practice transformation. The models incentivize increased care coordination and team-based care, increased focus on addressing gaps in care, and increased patient

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[51] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.
[52] NCQA. *Patient-Centered Medical Home (PCMH).* 2002.Accessed at: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

engagement in care through collectively developing a care plan with the care team and the patient.[53]

- Nationally, health centers have been leaders in transforming practices to be PCMHs by focusing on whole person care, coordination, and SDOH.
- All health centers are encouraged by HRSA to be recognized or certified resulting in the majority of health centers being certified by an accrediting body, such as the National Commission for Quality Assurance (NCQA) PCMH model.[54]

> **State-Specific Example: Connecticut, Missouri and Oregon** FQHCs are eligible to receive supplemental payments for care management
> *(Waldman, 2016)*

The Advanced Primary Care Practice (APCP) PCMH Demonstration

The PCMH model is an evidenced-based method improving primary care delivery. Consequently, in 2011 the Centers for Medicare and Medicaid Innovation (CMMI) Advanced Primary Care Demonstration[55] (APCP) funded and provided technical assistance for FQHCs to pursue PCMH recognition. Participants were provided a monthly care management fee for eligible Medicare beneficiaries. FQHCs were expected to achieve Level 3 PCMH recognition by National Committee for Quality Assurance standards by the end of the Demonstration period in October 2014.

Map of 434 Advanced Primary Care Practice Sites

Source: Centers for Medicare & Medicaid Services

Because health center programs, by definition, are located in Medically Underserved Areas, serve patients regardless of their ability to pay, and serve other vulnerable populations, FQHC patients are more medically

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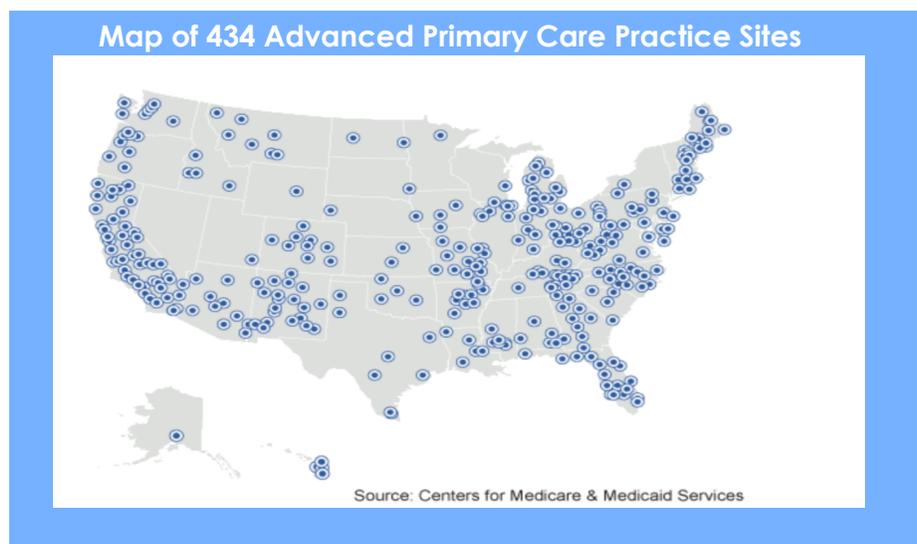
[53] Ibid.

[54] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

[55] FQHC Advanced Primary Care Practice Demonstration. CMS, 2018. Accessed at: https://innovation.cms.gov/initiatives/fqhcs/

complex and experience greater access needs than the general population. Hence FQHC patients benefit from attributes of the PCMH model, such as care coordination, self-care management, and population health initiatives aimed at identifying higher-risk individuals and connecting them to regular care.

Results of the Advanced Primary Care Practice Demonstration

In 2017, RAND Corporation formally evaluated the APCP Demonstration[56] and found 70% of Demonstration sites achieved NCQA Level 3 PCMH recognition compared to 11% of the comparison sites. The study found challenges focusing on Medicare beneficiaries at FQHCs since the majority of patients are often Medicaid insured. Additionally, the study noted that achievement of the formal PCMH recognition was a good first step but did not signify complete medical home transformation (i.e. the full use of care teams, care coordination, quality improvement and other PCMH features). Results of the Demonstration project impacting patient outcomes such as utilization, spending and experience were limited. However, the evidence suggested the impact of Level 3 PCMH recognition to have positive effects on patient utilization, process and spending compared to patients at health centers without PCMH recognition. Patient experience less clearly impacted by PCMH Recognition. More research on the impacts of PCMH recognition are being conducted to fully understand its benefits in the long term.[57]

D. VALUE AND ROLE OF COMMUNITY HEALTH WORKFORCE

Payment for Community Health Workers, Promotoras de Salud and Outreach Staff

Health centers have been key players in changing the healthcare landscape, aiming to improve population health through PCMH transformation and to a limited extent ACO membership.[58] Through both of these value-based care model reforms, health centers are collecting more SDOH and enabling services data through tools like

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[56] Kahn, Katherine L., Justin W. Timbie, Mark W. Friedberg, Peter Mendel, Liisa Hiatt, Emily K. Chen, Amii M. Kress, Christine Buttorff, Tara Lavelle, Beverly A. Weidmer, Harold D. Green, Mallika Kommareddi, Rosalie Malsberger, Aaron Kofner, Afshin Rastegar, and Claude Messan Setodji, Evaluation of CMS's Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration: Final Report. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR886z2.html.
[57] Ibid.
[58] Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

PRAPARE and the CMS Accountable Health Communities data collection tools (reference Part A of this Section of the *Value-Based Care Primer*). Health Centers are also evolving their care management and care coordination programs to better meet patients' social needs.[59] Health Centers are utilizing community health workers, *promotoras de salud* and outreach staff as well as case managers in these population health efforts. Greater focus on linking patient data to understand population health needs, to improve care management and care coordination programs using community health workers is one way health centers are targeting efforts to improve health outcomes.[60]

[59] NCQA. *Patient-Centered Medical Home (PCMH).* 2002.Accessed at: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

[60] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

VALUE-BASED CARE & HEALTH CENTERS

The Health Center Program & Data

The FQHC model is designed to be affordable and accessible, target health disparities, and address SDOH through the provision of enabling services such as outreach, transportation, and language interpretation assistance which are of interest to improving health outcomes for value-based care initiatives.[61] FQHCs are involved in primary care transformation and value-based care initiatives including the PCMH model and ACO membership.[62]

HEALTH CENTER PAYORS – National Overview of Payor Mix

The Health Center Program is comprised of nearly 1400 health centers in every state and territory and forms a medical home safety net providing primary, behavioral, and oral health care and addresses the social determinants of health through enabling services to over 14 million Medicaid enrollees, 6.4 million uninsured, 2.7 Medicare-insured, 1 million dual eligible Medicare/Medicaid patients and 5.2 privately insured annually[63] according to 2018 data. For these 28.3 million patients with public or private insurance served by health centers across the country, there is growing opportunity for reimbursement for traditionally non-reimbursable activities addressing SDOH.

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[61] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.

[62] Griffin, P. M. et al. "Balancing Investments in Federally Qualified Health Centers and Medicaid for Improved Access and Coverage in Pennsylvania." *Health Care Manag Sci*, vol. 17, no. 4, 2014, pp. 348-364, doi:10.1007/s10729-013-9265-8.

[63] HRSA Bureau of Primary Health Care (BPHC). Uniform Data System. 2020. Accessed at: https://bphc.hrsa.gov/datareporting/reporting/index.html

Health Center Payors – Three-Year Trends[64]

Health Center Patients	2016	2017	2018
Percentage of Uninsured Patients	**23.43%**	**22.88%**	**22.62%**
Number of Uninsured Patients	6,059,126	6,216,811	6,419,472
Percentage of Children Uninsured (age 0-17 years)	13.04%	12.70%	12.52%
Number of Children Uninsured (age 0-17 years)	1,044,251	1,066,596	1,093,990
Percentage of Medicaid/CHIP Patients	**49.69%**	**49.64%**	**49.00%**
Number of Medicaid/CHIP Patients	12,850,861	13,490,591	13,905,805
Percentage of Medicare Patients	**9.22%**	**9.40%**	**9.66%**
Number of Medicare Patients	2,384,323	2,555,311	2,741,037
Percentage of Dually Eligible (Medicare and Medicaid) Patients	**3.63%**	**3.82%**	**3.74%**
Number of Dually Eligible (Medicare and Medicaid) Patients (included in above)	939,492	1,038,609	1,062,522
Percentage of Patients with Other Third-Party Payer	**17.66%**	**18.07%**	**18.72%**
Number of Patients with Other Third-Party Payer	4,565,986	4,911,659	5,313,366
Total Insurance Source Patients	25,860,296	27,174,372	28,379,680
Total Insurance Source Patients Aged 0 - 17	8,005,982	8,395,134	8,736,509

The data in the table above shows that rates of uninsured patients, Medicaid and CHIP insured, and Medicare insured are relatively stable over the past three years (2016-2018 [65]). There have been increases in the percentage of health center patients with private insurance.

With more than an average of 80% of health center patients who have insurance, opportunities to engage these different payors to explore value-based options is present for health centers.

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[64] HRSA Bureau of Primary Health Care (BPHC). Uniform Data System. 2020. Accessed at: https://bphc.hrsa.gov/datareporting/reporting/index.html
[65] Note: 2018 UDS data is the most current available health center program data.

Notably, the majority of health center patients are insured by Medicaid (47% or 13,905,805 health center patients nationally, according to the 2018 UDS Reports. This signals an opportunity for health centers to work with Medicaid programs' value-based care initiatives that may impact health center patients.

HEALTH CENTER PAYOR MIX: 2018

■Uninsured ■Medicaid/CHIP ■Medicare ■Dually Insured (Medicaid and Medicare) ■Private

- 22%
- 47%
- 9%
- 4%
- 18%
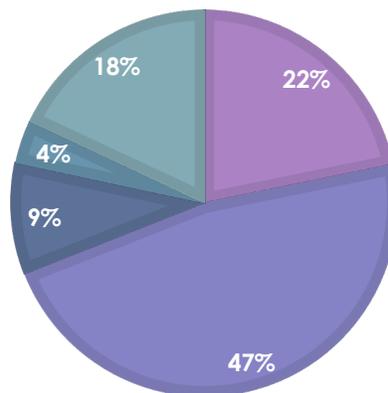
2018 Uniform Data System Table 4 Medicaid Managed Care Enrollment

As you can see, it is important to look at the trends in health center payments to assess where the opportunities for involvement in value-based care may exist for your health center. A key recommendation of this report is for outreach and enabling services staff to look at your health center's UDS data and have a conversation with your Quality Improvement (QI), Health Information Technology (HIT), and health center leadership. When looking at your health center's UDS data, look at UDS Table 4 to assess your opportunity to engage in Medicaid MCO reimbursement for outreach and enabling services activities. The national-level data are included in the below table.

PERCENTAGE OF MCO MEMBER MONTHS BY MCO TYPE IN 2018 FOR ALL HEALTH CENTERS

■ Medicaid   ■ Medicare   ■ Other Public   ■ Private

Private
5%

Other Public
1%

Medicare
4%
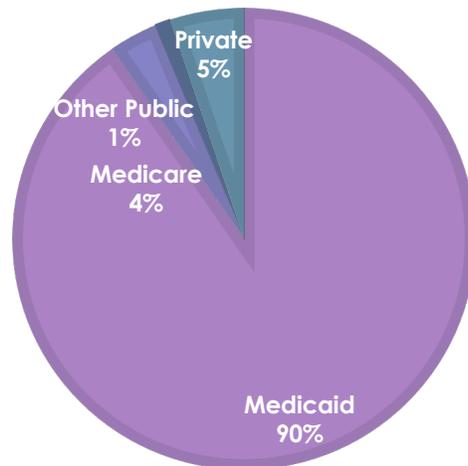
Medicaid
90%

UDS Table 4 presents MCO utilization at Health Centers (2018).[66] At the national level, Medicaid MCOs are the most prevalent payor for both FFS and capitated MCOs at 90% (or 103,189,504 member months) of all MCO member months.

Pro Tip: All Uniform Data System (UDS) Data available at the national, state, and individual health center level at the following HRSA BPHC UDS site: https://bphc.hrsa.gov/uds/datacenter.aspx?q=d
Click the state in which your health center is located and download abridged health center data.

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[66] HRSA Bureau of Primary Health Care (BPHC). Uniform Data System. 2020. Accessed at: https://bphc.hrsa.gov/datareporting/reporting/index.html

RECOMMENDATIONS FOR ENABLING SERVICES STAFF & CONCLUSIONS

CONCRETE RECOMMENDATIONS

- Look at your state and health center's Uniform Data System (UDS) information on payor mix and reimbursement history to identify opportunities to engage in value-based care.
- Talk to your C-Suite Staff and other Health Center Leadership and ask questions based on *Value-Based Care Primer* data:
  - ***Is your health center a Patient-Centered Medical Home?***
    - If so, how can you incorporate outreach and enabling services into care coordination?
    - Do you have community health workers, *promotoras/es* on your PCMH care teams?
    - Is your health center using SDOH data?
    - Do you use an enabling services data collection tool such as PRAPARE or the CMS AHC tool?
    - Does the care team assure patients are accessing resources based of SDOH data collected?
  - ***Is your health center in an Accountable Care Organization?***
    - Are there opportunities to engage in population health management and shared savings programs in partnership with health systems in your region and serving the same patients as your health center?
- Partner with your Primary Care Association (PCA) to identify the state-level policy trends in your state that may support your health center's use of value-based care payment reform to provide reimbursement for your outreach and enabling services.
- Consult your Electronic Health Record (EHR) and Health Information Technology team to see what SDOH data your health center collects and how the data is used.
- EHR teams at health centers may be collaborating with Health-Center Controlled Networks (HCCN) which are involved in using data to promote population health and are commonly involved in programs such as PCMH, ACOs and MCOs.

CONCLUSIONS

The health center model is designed to be affordable, accessible, target health disparities, and address social determinants of health (SDOH) through the provision of enabling services such as outreach, transportation, and language interpretation assistance.[67],[68] Many health centers are also currently engaged in a wide range of efforts to address their communities' additional SDOH needs — from education and economic development to housing and medical-legal partnerships — which may be important strategies to meeting the goals of value-based care models. Additionally, this provides a valuable opportunity for health centers to engage in value-based care and collaborate with other health systems and find ways to reimburse outreach and enabling services activities in which health centers are already involved. Health centers have been very active in the implementation of ACA initiatives promoting access, such as Outreach and Enrollment, care transformation, and value-based care initiatives including the PCMH demonstration and ACOs.[69] Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.[70]

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[67] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.
[68] Griffin, P. M. et al. "Balancing Investments in Federally Qualified Health Centers and Medicaid for Improved Access and Coverage in Pennsylvania." *Health Care Manag Sci*, vol. 17, no. 4, 2014, pp. 348-364, doi:10.1007/s10729-013-9265-8.
[69] Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.
[70] Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

ABOUT HEALTH OUTREACH PARTNERS

Health Outreach Partners (HOP) was founded in 1970 as a small direct-service program supplying rural, isolated communities with outreach workers along the East Coast. It continued expanding its staff to meet the increasing demands of numerous communities along the Eastern seaboard until January 2001. In 2001, HOP leveraged its 31 years of direct service and transitioned into a multi-tiered national training and technical assistance provider. Today, HOP works with health centers and other community-based health organizations across the country to strengthen outreach services, expand access to care, and ultimately improve quality of life for vulnerable and underserved communities.

Mission: *Health Outreach Partners' mission is to build strong, effective, and sustainable grassroots health models by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable, and underserved populations.*

APPENDIX

RESOURCE LIST

Enabling Services Data Collection Implementation Packet

- Association of Asian Pacific Community Health Organizations (AAPCHO). *The Enabling Services Data Collection Implementation Packet*. 2020.

- This Enabling Services Implementation Packet serves as a guide for health centers who wish to codify and track enabling services. The packet was developed as a standardized data collection model to improve data collection on these essential services, and better understand them and their impact on health care access and outcomes.

- Accessible at: https://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/

Outreach and Value-Based Care
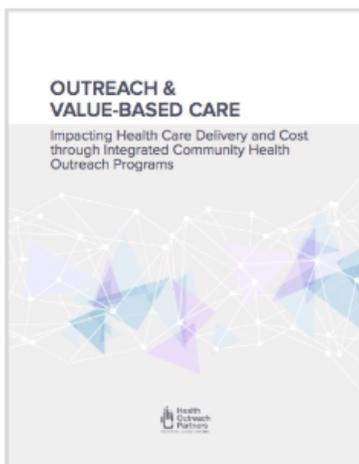
- Health Outreach Partners (HOP). *Outreach & Value-Based Care*. 2017.
- Provides Value-Based Care basics and can be used as the precursor to this resource.
- Accessible at: https://outreach-partners.org/2017/06/12/outreach-value-based-care-impacting-health-care-delivery-cost-integrated-community-health-outreach-programs/

GLOSSARY

330(g) Migratory and Seasonal Agricultural Worker (MSAW): For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, the population served includes:

- Migratory agricultural workers who are individuals whose principal employment is in agriculture, and who have been so employed within the last 24 months, and who establish for the purposes of such employment a temporary abode
- Seasonal agricultural workers who are individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker
- Individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area; and/or
- Family members of the individuals described above.

330(h) Homeless Population: For the purposes of health centers receiving a Health Center Program award or designation under section 330(h) of the Public Health Service Act, the population served includes individuals:

- Who lack housing (without regard to whether the individual is a member of a family),
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations,
- Who reside in transitional housing,
- Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations.

330(i) Residents of Public Housing: For the purpose of health centers receiving a Health Center Program award or designation under section 330(i) of the Public Health Service Act, the population served includes residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public housing agency-developed, owned or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers.

- **Accountable Care Organization (ACO):** A group of health care providers who voluntarily share responsibility for the care delivered and health outcomes of a

defined patient population. ACOs typically include primary and specialty care providers and are held accountable for costs and outcomes.

- **ACS:** American Community Survey (ACS) includes population data collected by the US Census Bureau. Some of these data are included in the UDS Mapper.
- **BPHC:** The Bureau of Primary Health Care (BPHC, "the Bureau") is the specific branch of HRSA within US DHHS that administers the health center program.
- **Care Coordination:** Organization of activities promoting patient health care and other services impacting their health across different providers or organizations.
- **Community Health Worker (CHW):** Health Center staff who connect patients to care and engage in outreach, health education, navigation, and care coordination who are often members of the communities served, culturally aware and speak the language(s) of the community. CHWs, also referred to as *promotoras/es de salud* or outreach workers, are not required to have clinical backgrounds.
- **CHIP:** Children's Health Insurance Plan, a state-run Medicaid program for children.
- **Collective Impact:** Collective impact is a committed group of players across different sectors that come together to achieve a common agenda for solving a specific social problem, using a structured form of collaboration.
- **Community-based Point of Care:** Point of care is the timely delivery of health care products and services to patients where they are located or receiving other services. Delivering care where the community lives, works, or spends time helps alleviate the need for some patients to travel to services.
- **Electronic Health Record (EHR):** Patient health and medical charts maintained in an electronic system. Common EHRs amongst health centers include: Epic, GE, Centricity.
- **Enabling Services (ES):** Non-clinical services that aim to increase access to healthcare and improve health outcomes, and include services such as health education, interpretation, and case management.
- **Enabling Services Data Collection (ESDC):** The systematic collection of data to understand patient needs and to support enabling services (see "Enabling Services.)
- **Federal Poverty Level (FPL):** The threshold of poverty (based on income and family size) determined annually by the U.S. Department of Health and Human Services.
- **Federally Qualified Health Center (FQHC/CHC/HC):** A national program funded under Public Health Service Act 330 to create safety-net primary care providers required to provide care regardless of a patients' ability to pay or insurance status or type serving medically underserved communities. Federally Qualified Health Center (FQHC) is a public or private non-profit health care organization that meets certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.) An organization that meets these criteria is eligible to apply for Health Center Program grant funding from the Health Resources and Services Administration's Bureau of Primary Health Care.
- **Health Information Technology (HIT):** Any technology used to manage information, promote medical care or patient health, such as Electronic Health Records, population health management systems, and other health-related information databases.

- **Health Center Controlled Network (HCCN):** A collaboration of multiple health centers and sometimes PCAs or ACO partners to purchase, develop, tailor, and use an EHR and other HIT together with economies of scale and collective bargaining power gained by partnership.
- **Health Resources and Services Administration (HRSA):** US Department of Health and Human Services branch under which the Health Center Program is administered.
- **Health Center Program:** Any Public Health Service Act, Section 330 grantees. Also referred to as community health centers or Federally Qualified Health Centers.
- **Health Professional Shortage Area (HPSA):** A HPSA is an urban or rural area, population group, or medical or other public facility which has received federal designation as having a shortage of health care providers.
- **Look-a-like:** An FQHC that meets all of the eligibility requirements of an organization that receives a Health Center Program grant but does not receive Health Center Program grant funding.
- **Medically Underserved Area/Population (MUA/P):** A medically underserved area (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts that the Department of Health and Human Services (HHS) has designated as having a shortage of health services for residents.
- **NEMT:** Non-Emergency Medical Transportation
- **MHMR:** Mental Health and Mental Retardation Services facility.
- **Mobility as a Service Framework:** Mobility as a service framework is the idea of customizing and integrating mobility solutions around the needs of communities, including negotiating financial relationships with participating providers. The concept is further explained and defined in "The Future of Rural Transportation and Mobility of Older Adults" report by the Citis and Banatao Institute and Grantmakers in Aging. Published April 2018.
- **MPW:** Medicaid for pregnant women.
- **Patient-Centered Medical Home (PCMH):** A model that promotes the use of care teams to deliver patient-centered, coordinated primary care. By incorporating a variety of staff with a range of skills and expertise, the care team is able to manage the full spectrum of a patient's needs.
- **Primary Care Association (PCA):** State and regional organizations serving health centers. A PCA is a regional, state, or local organization which works in close concert with, and represents the interests of, nonprofit community clinics and health centers and advocates for the health needs of their distinctive populations and geographic areas, most importantly those who face barriers to care due to poverty, language, or geographic isolation.
- **PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences):** A national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. The tool was developed by NACHC, AAPCHO and the Oregon Primary Care Association and is available for health center use.
- *Promotoras/es de Salud:* See "Community Health Worker"

- **Social Determinants of Health (SDOH):** Defined by the World Health Organization (WHO), SDOH are "the conditions in which people are born, grow, live, work and age," and refer to issues such as food insecurity, health insurance access, housing instability, education, legal services, and other factors and needs influencing a person's health.
- **Rural Health Clinic (RHC):** The RHC program strives to be the major provider for primary care services for Medicaid and Medicare patients in rural communities which tend to have health disparities due to geographic isolation and low physician density. RHCs can be public, private, or non-profit entities.
- **Special Population (Special Medically Underserved Population):** HRSA may award funding or designation under sections 330(g), (h), or (i) of the PHS Act for the delivery of services to a special medically underserved population.
- **Uniform Data System (UDS):** The UDS is the specific data collection and reporting requirements for Health Center Program grantees developed by the Health Resources and Services Administration (HRSA) to track the patient population and effectiveness of the health care services of the Health Center Program. The annual data reporting to FQHC administrator and funder, HRSA, that is required under the PHS 330 health center grant requirements.
- **UDS Mapper:** Uniform Data System mapping tool developed by HRSA BPHC and the John Snow Institute.

SOURCES

1. Griffin, P. M. et al. "Balancing Investments in Federally Qualified Health Centers and Medicaid for Improved Access and Coverage in Pennsylvania." *Health Care Manag Sci*, vol. 17, no. 4, 2014, pp. 348-364, doi:10.1007/s10729-013-9265-8.
2. Johnson, T. J. et al. "Practice Innovation, Health Care Utilization and Costs in a Network of Federally Qualified Health Centers and Hospitals for Medicaid Enrollees." *Popul Health Manag*, vol. 21, no. 3, 2018, pp. 196-201, doi:10.1089/pop.2017.0073.
3. Taylor, J. "Changes in Latitudes, Changes in Attitudes: Fqhcs and Community Clinics in a Reformed Health Care Market." *Issue Brief George Wash Univ Natl Health Policy Forum*, no. 848, 2012, pp. 1-22.
4. Katz, A. B. et al. "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects under Reform." *Res Brief*, no. 21, 2011, pp. 1-9.
5. Pourat, N. and M. W. Hadler. "Ready for Aca? How Community Health Centers Are Preparing for Health Care Reform." *Policy Brief UCLA Cent Health Policy Res*, no. PB2014-4, 2014, pp. 1-6, appendix.
6. Manchikanti, L. et al. "Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade." *Pain Physician*, vol. 14, no. 1, 2011, pp. E35-67.
7. "Outreach and Value-based Care. Impacting Health Care Delivery and Cost through Integrated Community Health Outreach Programs." *Health Outreach Partners*. 2017.. https://outreach-partners.org/wp- Accessded 24 Oct 2019. content/uploads/2017/06/ORValueBasedCare.pdf
8. "Status of State Medicaid Expansion Decisions: Interactive Map." Kaiser Family Foundation (KFF). 20 Sept. 2019. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ Accessed October 24, 2019.

9. Collins, S. et al.. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured." *Commonwealth Fund*, Feb 2019. https://doi.org/10.26099/penv-q932.

10. Iglehart, J.K., *Health centers fill critical gap, enjoy support.* Health Aff (Millwood), 2010. 29(3): p. 343-5.

11. deShazo, R.D., *Who will care for the newly insured under health reform?* J Miss State Med Assoc, 2011. 52(8): p. 263-9.

12. Kulesher, R.R., *Health reform's impact on federally qualified community health centers: the unintended consequence of increased Medicaid enrollment on the primary care medical home.* Health Care Manag (Frederick), 2013. 32(2): p. 99-106.

13. Medicaid Payment Policy for Federally Qualified Health Centers. MACPAC. 2019. Accessed at: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf

14. Percent of FQHC patients with Medicaid as their primary source of insurance is from HRSA program grantee data, full 2017 national report Table 4: Selected patient characteristics line 8 (HRSA 2017).

15. Percent of FQHC patients with Medicaid as their primary source of insurance is from HRSA program grantee data, full 2016 national report Table 4: Selected patient characteristics line 8 (HRSA 2016).

16. Han, X., Q. Luo, and L. Ku, *Medicaid Expansion and Grant Funding Increases Helped Improve Community Health Center Capacity.* Health Aff (Millwood), 2017. **36**(1): p. 49-56.

17. Cole, M.B., et al., *Medicaid Expansion and Community Health Centers: Care Quality And Service Use Increased For Rural Patients.* Health Aff (Millwood), 2018. **37**(6): p. 900-907.

18. Cole, M.B., I.B. Wilson, and A.N. Trivedi, *State Variation in Quality Outcomes and Disparities in Outcomes in Community Health Centers.* Med Care, 2017. **55**(12): p. 1001-1007.

19. Shi, L., M.K. Wharton, and A. Monnette, *Ensuring access to prescription medications in the post-ACA healthcare access landscape: the essential role of FQHCs in the safety net for the underinsured.* Am J Manag Care, 2018. **24**(5 Suppl): p. S67-s73.