As public and private payers move toward strategies that pay for value rather than volume, they rarely consider community health centers (CHCs) in the design of alternative payment models. These models seek to move away from paying providers for services or encounters and toward rewarding providers for measurable outcomes. Value-based payments represent an opportunity to improve care to underserved populations and address health disparities, although most payment models have not focused on these goals.

For more than 50 years, CHCs have provided comprehensive, coordinated primary care to medically underserved populations. Although CHCs face obstacles to participating in existing value-based payment models, these safety net providers represent a key constituency for achieving health equity goals and addressing health disparities. In this brief, we highlight the challenges in implementing value-based payment in CHCs, and promising ways to promote value-based care in these centers.

DEFINITIONS
For our purposes, we define a CHC as a center that provides primary care in an underserved area or to an underserved population. Included in this definition are federally qualified health centers (FQHCs), FQHC look-alikes, and rural health clinics (RHCs). We exclude free and charitable clinics, an important part of the social safety net, because they operate largely outside of the health insurance system. Instead, they rely primarily on donations, grants, and a volunteer workforce.

• An FQHC is a nonprofit or public entity that receives federal funding under Section 330 of the Public Health Service Act. The funding, which totaled $5.68 billion in FY23, comes from an annual Congressional appropriation (30%) and a multiyear Community Health Center Fund (70%). Established in 1965, FQHCs are required to provide primary care, emergency services, enabling services, and specialty referrals for medically underserved areas or special populations.
such as migrant farmworkers, people without housing, and residents of public housing. To achieve their mission, FQHCs receive certain benefits that many traditional office practices do not, such as enhanced reimbursement under Medicare and Medicaid, eligibility to purchase prescription drugs for outpatients at reduced cost under the 340B program, and eligibility to apply for National Health Service Corps personnel. Some tribal clinics and urban Indian health organizations also can be designated as FQHCs, even if they do not meet the requirements for Section 330 funding.

- An FQHC look-alike meets all the requirements for Section 330 funding but does not receive that funding. However, FQHC look-alikes do receive similar benefits to FQHCs, and they draw significant support from state, local, and private grants and contracts. Look-alike status is often a precursor to applying for Section 330 funding.

- An RHC does not receive Section 330 funding and requirements differ from those of FQHCs. RHCs were established in 1977 to address an inadequate supply of physicians to serve Medicare and Medicaid beneficiaries in rural areas. They can be for-profit or nonprofit, and they can be independently operated or provider-based (owned and operated by a larger entity, usually a hospital). They must employ a nurse practitioner or physician assistant and be staffed by one at least half of the time. Qualifying clinics in rural and medically underserved communities receive enhanced payments for primary care services from Medicaid and Medicare. They are eligible to apply for National Health Service Corps personnel, and most provider-based RHCs are eligible to participate in the 340B program (but independent RHCs are not). Key distinctions between FQHCs and RHCs, the two of the main types of CHCs, appear in Table 1.

### WHO CHCs SERVE

In 2022, 1,370 FQHCs served 30.5 million patients in more than 16,000 sites across the country. Some FQHCs are funded to serve specific populations, including 299 centers providing health care for people without housing, 175

<table>
<thead>
<tr>
<th>RURAL HEALTH CLINICS</th>
<th>FEDERALLY QUALIFIED HEALTH CENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>For-profit or nonprofit</td>
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<tr>
<td></td>
<td>Nonprofit or public facility</td>
</tr>
<tr>
<td>Services</td>
<td>May be limited to a specific type of primary care practice (e.g., OB-GYN, Pediatrics). Must provide basic lab services on site. No minimum hours required.</td>
</tr>
<tr>
<td></td>
<td>Required to provide care for all age groups. Minimum services required: maternity &amp; prenatal care, preventive care, behavioral health, dental health, emergency care, and pharmaceutical services. Must be open at least 32.5 hours a week.</td>
</tr>
<tr>
<td>Board</td>
<td>Not required to have a board of directors</td>
</tr>
<tr>
<td></td>
<td>Required to have a board of directors – at least 51% must be health center patients</td>
</tr>
<tr>
<td>Staffing</td>
<td>Must employ a nurse practitioner (NP) or physician assistant (PA) and have an NP, PA, or certified nurse midwife working at least 50% of the time</td>
</tr>
<tr>
<td></td>
<td>No specific staffing requirements</td>
</tr>
<tr>
<td>Charges</td>
<td>Not required to charge based on a sliding fee scale</td>
</tr>
<tr>
<td></td>
<td>Required to treat all residents in service area with charges based on a sliding fee scale</td>
</tr>
<tr>
<td>Location</td>
<td>Initially, must be in a non-urbanized area that is a Health Professional Shortage Area, Medically Underserved Area, or governor-designated shortage area. May retain RHC status if designation of service area changes.</td>
</tr>
<tr>
<td></td>
<td>Can be in urbanized or not urbanized areas. Must be in an area that is underserved or experiencing a shortage of health care providers</td>
</tr>
</tbody>
</table>

Adapted from “What is the difference between a Federally Qualified Health Center (FQHC) and a Rural Health Clinic (RHC)?”
serving migrants and seasonal agricultural workers, and 175 delivering primary care to residents of public housing. Across all sites, FQHCs serve about one of six Medicaid beneficiaries. About two-thirds of patients identify as racial or ethnic minorities, including 38% Hispanic/Latino and 21% Black/African American. About half of all patients are covered by Medicaid, 11% are covered by Medicare, 20% have private insurance, and 19% are uninsured. In 2022, **117 FQHC look-alikes** served about one million patients in more than 600 sites, with demographics similar to FQHCs. Compared to FQHCs, FQHC look-alikes see a smaller percentage of uninsured patients and slightly higher percentages of patients with Medicaid and private insurance.

Partly because RHCs do not receive federal Section 330 grants, there is far less information on RHCs and the demographics of their patient populations. In 2023, more than 5,200 RHCs served rural populations in 45 states. The centers are concentrated in the South and Midwest. About 65% of RHCs are provider-based, meaning they are part of a hospital, nursing home, or home health agency, while 35% are operated independently. Nearly three-quarters of independent RHCs are for-profit, compared to just 11% of provider-based RHCs. The National Association of Rural Health Clinics estimates that in 2022, **RHCs served more than 37 million patients**, representing about 11% of the entire population and about 62% of the 60.8 million people living in rural America.

### REVENUE SOURCES

CHCs rely heavily on Medicaid and Medicare as sources of revenue, but the distribution of these sources varies by the type of health center. FQHCs receive substantial funding from the federal government to help cover the cost of providing free and reduced cost care to their patients. FQHCs receive about 12% of their revenues from Section 330 grants, which amounted to an average of **$3.7 million** for each FQHC in 2022. Figure 1 shows the various sources of FQHC revenues. More than one-quarter of their revenues comes from federal, state, and local grants and contracts, which complicates FQHC participation in alternative payment models. Because they do not receive Section 330 grant funding, FQHC look-alikes have a slightly different mix of revenues, with nearly 20% coming from private insurance.

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**Figure 1. Federally Qualified Health Centers revenue sources.**

- Medicaid: $17.8B (42%)
- Medicare: $3.8B (9%)
- Private/Other Third-Party: $5.0B (12%)
- State/Local/Other Grants: $5.2B (12%)
- BPHC Health Center Grants: $5.0B (12%)
- BPHC COVID–19 Supplemental: $3.2B (7%)
- Medicare –$3.8B
- Private/Other Third-Party –$5.0B
- State/Local/Other Grants –$5.2B
- BPHC Health Center Grants –$5.0B
- BPHC COVID–19 Supplemental –$3.2B
- Medicare –$3.8B
- Private/Other Third-Party –$5.0B
- State/Local/Other Grants –$5.2B
- BPHC Health Center Grants –$5.0B
- BPHC COVID–19 Supplemental –$3.2B

Source: Health Center Revenue Sources. 2022 Health Center Program Highlights Uniform Data System Trends, August 8, 2023. Slide 25. Data and Evaluation Office of Quality Improvement Health Resources & Services Administration (HRSA), Bureau of Primary Health Care (BPHC)
However, they also derive a significant portion of their revenues from nonpatient care sources, including 18% from grants and contracts (primarily state, local, and foundation grants).

There is far less information on the precise distribution of revenue sources for RHCs, which do not receive federal grants and are not required to charge on a sliding fee basis. These sources will vary by whether the RHC is independent or provider-based. In general, RHCs are more reliant on Medicare revenues than FQHCs, because rural populations are older and reimbursement can be higher than Medicaid. In 2021, traditional Medicare paid RHCs more than $1.3 billion, covering almost 2.2 million individual Medicare beneficiaries and about 9.3 million visits. In contrast, traditional Medicare paid FQHCs $976 million, covering about 1.8 million beneficiaries and about 8.2 million visits.¹⁵

**PAYMENT METHODOLOGIES**

Acknowledging the important role of health centers in the safety net, Congress established special Medicare and Medicaid payment rules for FQHCs and RHCs.¹⁶ Instead of using a fee schedule for clinician services, Medicare and Medicaid pay FQHCs and RHCs a rate that generally bundles all professional services furnished in a single day into one payment. The FQHC and RHC payment bundles cover professional services but exclude other services commonly provided in conjunction with a visit, such as lab tests and imaging services. FQHC look-alikes are paid similarly.

While these special payment rules provide CHCs with enhanced funding, they can pose challenges to CHC participation in alternative payment models, especially those built on the fee-for-service chassis. Operationally, different billing and reconciliation systems can complicate the transition to value-based payments; financially, federal payment requirements may limit CHCs' ability and willingness to take on financial risk.

**FQHC Payment**

**Medicare**

Since 2014, traditional Medicare has paid FQHCs based on a per-visit national rate. The base rate was set on FQHCs’ reasonable historical costs, adjusted annually for inflation. In 2023, the base rate was $187.19. This rate is adjusted to reflect differences in practice costs across geographic areas. For a new patient or an annual exam, the rate increases by 34%. For Medicare Advantage (MA) enrollees, FQHCs contract with each plan, but they receive supplemental payments from Medicare to make up any difference between the traditional Medicare rate and what the MA plan pays.
Medicaid

State Medicaid programs have two options for paying FQHCs: programs pay using a prospective payment system (PPS) that includes a per-visit bundled payment, based on the historical costs; or they pay through an alternative payment methodology (APM). By federal statute, the APM must be at least what the FQHC would have received under its PPS per-visit rate (or the state must make up the difference), and the FQHC must agree to the APM. As of 2020, about half of the states use an APM to pay FQHCs for their Medicaid beneficiaries.18

RHC Payment

Traditional Medicare pays RHCs a facility-specific rate for each visit, which is calculated annually by dividing the facility’s total allowable costs by the total number of visits.19 The payment rates and limits were changed significantly in 2021 to address historical inequities between independent and provider-based RHCs. The all-inclusive rate for independent RHCs and for provider-based RHCs that are part of a hospital with 50 or more beds is now subject to a national statutory payment limit, which was $126 in 2023. The national payment limit will be increased each year until 2028, when it will be $190. Historically, provider-based RHCs that were part of a hospital with fewer than 50 beds were not subject to the national statutory payment limit. In 2020, Medicare’s all-inclusive rate for these RHCs averaged about $255 per visit. However, since 2021, the payment limit per visit for these RHCs is equal to the greater of their 2020 payment rate (increased by inflation) or the national statutory payment limit.

For Medicare Advantage enrollees, RHCs negotiate rates with each Medicare Advantage plan. However, unlike FQHCs, there is no statutory requirement that Medicare make up the difference between what traditional Medicare pays and what the health plan pays. The National Association of Rural Health Clinics surveyed its members and found that about half reported that Medicare Advantage plans paid less than traditional Medicare.20

Like FQHCs, state Medicaid programs can pay RHCs through the PPS per-visit rate or through an APM. The RHC must agree to the method, and the reimbursement rate must be at least as much as would be paid under the PPS methodology.

Paying for Telehealth

Prior to the COVID-19 pandemic, CHCs delivered most services in-person and could only bill Medicare for telehealth services if the patient was located at the clinic and the provider was in a different location. In response to the pandemic, however, federal regulations were relaxed, a move that has been extended through 2024. Many CHCs pivoted quickly to furnishing telehealth services to patients at any location, including their homes. One study found that nearly one-third of visits to FQHCs from June-November 2020 were conducted by telehealth.21

These changes had implications for CHC revenues because telehealth services (except for mental health visits) are not reimbursed at the standard bundled visit rate. Instead, they are paid a rate similar to comparable telehealth services billed under the Medicare fee schedule. In 2023, that rate was $98.27.22 The disparity between reimbursement for in-person visits and telehealth visits may be a barrier to continued use of telehealth, as by 2022, 87% of medical visits in FQHCs were conducted in-person.23 In contrast, mental health visits, when provided through interactive, real-time telecommunications, is reimbursed at a bundled rate and can be billed as a separate visit on the same day as a clinic visit. In 2022, 46% of mental health visits in FQHCs were conducted through telehealth.24

Medicaid reimbursement policies for telehealth vary by state. As of fall 2023, 37 states and District of Columbia reimburse FQHCs for telehealth services, including 25 states and DC that explicitly state that FQHCs can receive the PPS visit rate when serving as a distant site (that is, when the provider is located at the FQHC and the patient is not).25

QUALITY MEASURES AND VALUE-BASED CARE

One of the hallmarks of value-based payment is holding providers accountable for the quality of care they provide. That feature requires tracking and rewarding achievement of specific quality measures. CHCs often provide services to an entire community, and so clinical quality measures may not fully capture the value of what they provide. It is useful to think of value-based payment as one way to promote value-based care, in which care is designed (or redesigned) to focus on quality, provider performance, and the patient experience.26
FQHCs and FQHC look-alikes are required to report each year on a set of clinical quality indicators (Table 2). Studies have consistently found that they perform as well as, if not better than, private practices on most metrics. In 2022, FQHCs performed better than comparable national benchmarks for four quality measures, including low birth weight, hypertension control, diabetes control, and dental sealants for children. A broader indicator of value-based care is recognition as a patient-centered medical home (PCMH), which reflects the presence of processes to improve access, continuity, and coordination of care. In 2022, 78% of FQHCs had been certified as PCMHs.

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Measuring quality in RHCs is more difficult because they are not required to participate in Medicare quality programs and do not report on a defined set of quality metrics. Further, the diversity of their ownership structures complicates the development of a set of metrics. In 2016, the Maine Rural Health Research Center piloted a small set of primary care-relevant quality measures for RHCs, including child immunization rates, diabetes and blood pressure management, tobacco use interventions, and documenting current medications. The study documented the feasibility of an RHC quality measurement system, as well as key barriers to RHC quality reporting, including data extraction difficulties from clinic records and limited staff time to collect and report data.

**PARTICIPATION OF CHCs IN VALUE-BASED PAYMENT**

In the past decade, the federal government and many states have launched alternative payment strategies that hold providers accountable for quality of the care they provide, rather than simply paying for the volume of care. These value-based payments can take many forms, including shared-savings, shared-risk, bundled payments, or population-based payments (see Figure 2). Many of these alternative payment strategies focus on care delivered in traditional Medicare. To the extent that these strategies are built on the architecture of fee-for-service payments, they are less relevant to CHCs that are paid through bundled, prospectively set rates. And they may be less attractive to FQHCs that derive only a small portion of their revenues from Medicare.

For example, in 2015 Medicare implemented its merit-based incentive payment system (MIPS) that adjusts clinician Part B payments based on certain quality performance measures, but the system is based on fee-for-service claims. FQHCs and RHCs are not required to participate in MIPS. In contrast, Medicare also implemented voluntary advance payment models, such as accountable care organizations (ACOs), in which groups of providers collaborate to coordinate care for traditional Medicare beneficiaries. Depending on the track, ACOs share in the savings and sometimes take on downside risk. CHCs can choose to participate in Medicare Shared Savings Program ACOs, and many have. As of 2023, more than 4,400 FQHC sites participated in a Medicare ACO, along with 2,240 RHCs. Medicare has recently implemented changes to its Medicare

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**Table 2. Clinical quality measures for FQHCs**

<table>
<thead>
<tr>
<th>2023 QUALITY OF CARE MEASURE</th>
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<tbody>
<tr>
<td>Childhood Immunization Status</td>
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<tr>
<td>Cervical Cancer Screening</td>
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<tr>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
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<tr>
<td>Body Mass Index (BMI) Screening and Follow-Up Plan</td>
</tr>
<tr>
<td>Tobacco Use: Screening and Cessation Intervention</td>
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<tr>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>HIV Screening</td>
</tr>
<tr>
<td>Screening for Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>Depression Remission at Twelve Months</td>
</tr>
<tr>
<td>Dental Sealants for Children between 6–9 Years</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
</tr>
</tbody>
</table>

Source: HRSA Uniform Data System. Fact Sheet. Table 6b. Quality of Care Measures. Table 1. 2022 Table 6b: Clinical Quality Measures.

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**CONCLUSIONS**

CHCs are well-positioned to deliver value-based primary care, particularly in underserved areas and to underserved populations. Many already have a population-based focus, provide coordinated and integrated care, and assess and address social determinants of health. However, they face significant obstacles to participating in current VBP models for the following reasons:

- Most VBP programs are designed to move payment from a fee-for-service model to more prospective payments based on quality metrics. They are not designed to work with the enhanced, per-visit bundled rate by which CHCs are reimbursed.
- Many VBP programs have been launched by Medicare, and target traditional Medicare beneficiaries only. But FQHCs and FQHC look-alikes draw only a small portion of their revenues from Medicare and may conclude that participation in these programs is not worth the considerable investment in infrastructure to track and improve quality metrics. RHCs are somewhat more reliant on Medicare revenues but are often explicitly excluded from participating.
- Part of the “value” of care that CHCs provide stems from their ability to address the social determinants of health, provide services that enable care, and promote health equity. But these activities are rarely included in quality metrics and rarely rewarded in VBP programs.

Given these obstacles, it is worth considering other strategies to advance value-based care at CHCs. Because many CHCs serve a significant portion of uninsured patients and draw significant funding from grants and contracts, individual payer-based strategies may not be optimal for these kinds of providers. Instead, nonfinancial incentives such as accreditation or certification could be paired with financial rewards to promote value-based primary care in these settings. Such a strategy could also be used by funders to promote value-based care in the more than 1,400 free and charitable clinics that serve a largely uninsured population. As an example, recognition as a PCMH has become a standard of care for FQHCs, signaling the delivery of patient-centered care and achieving standards of care coordination and ongoing quality improvement. Some public and private payers have linked this recognition with financial incentives or bonuses. Multi-payer strategies that reward CHCs for delivering coordinated, comprehensive primary care to all patients may be the most promising way to promote value-based care, in a system that acknowledges the critical and unique role CHCs play in our social safety net.
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This issue brief was produced in conjunction with a project supported by the Independence Blue Cross Foundation Institute for Health Equity.

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