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**Community Health Centers and Medicaid Payment Reform:
Emerging Lessons from Medicaid Expansion States**

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at <http://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at rchnfoundation.org.

Executive Summary

Community health centers represent a major source of primary health care for the nation's Medicaid beneficiaries. Because the Federally Qualified Health Center (FQHC) payment system is encounter-based, health centers and Medicaid agencies in ACA expansion states are actively pursuing payment reforms that will enable health centers to adopt strategies that can more effectively respond to the considerable and complex health and social needs of people served by health centers, and more efficiently address the surging volume of patient care. In five expansion states whose alternative payment experiments are underway, health centers and Medicaid agencies are testing payment alternatives, such as global payments, that link payment to performance while ensuring that the FQHC hold-harmless standard is met and that total revenues do not fall below the FQHC floor. These alternative payment approaches enable health centers to test new strategies to address the needs of their patients, while enabling state agencies to align these strategies more closely with broader payment reform efforts.

Introduction

Community health centers play a critical role as Medicaid providers, serving one in five Medicaid beneficiaries nationally in 2015.¹ In order to ensure that health center grants remain used for uninsured populations and services, federal Medicaid law establishes “federally qualified health center (FQHC)” payment rules. These rules established a payment floor on the amount health centers receive for the covered services they provide to Medicaid beneficiaries. This analysis examines how health centers and state Medicaid programs in a number of Medicaid expansion states are working to restructure Medicaid's longstanding FQHC payment system in order to promote efficiency and quality, and more actively integrate health centers into states' broader payment reform efforts.

Background

As the nation's largest single source of primary care for medically underserved communities and populations, community health centers play a key role in the health care system for both Medicaid-insured and uninsured populations. In 2015, 1,375 health

¹ Based on 11.9 million Medicaid patients served by health centers in 2015 and 58.2 million Medicaid enrollees in December 2015. Bureau of Primary Health Care. (2016). 2015 Health Center Data: National Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state=&fd=>; Centers for Medicare and Medicaid Services (CMS). (2016). Total Medicaid Enrollees - VIII Group Break Out Report. <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/cms-64-enrollment-report-oct-dec-2015.pdf>

centers operating in 9,754 sites served 24.3 million patients, 49 percent of whom were insured by Medicaid.² As sources of comprehensive primary health care, health centers are integral to the operation of managed care systems, which serve three in four Medicaid beneficiaries.³ Given the extent of poverty among health center patients, 71 percent of whom have incomes at or below the federal poverty level, Medicaid represents the single largest source of insurance coverage at health centers. In states that expanded Medicaid through the Affordable Care Act, 55 percent of health center patients were enrolled in Medicaid in 2015, but Medicaid accounted for only 34 percent of health center patients in states that did not expand Medicaid.⁴

Research has documented the value of health centers as sources of primary health care.⁵ Research examining 2009 Medicaid claims data from 13 states showed that non-elderly adult Medicaid enrollees who received more than half of their primary care visits at health centers had lower utilization and spending across all measured services (primary care, other outpatient care, prescription drug spending, emergency department services, and inpatient care); total spending was 24% lower compared to those who received most of their primary care from non-health center providers. Although the study predates the ACA, the multi-state findings underscore their potential to create value for Medicaid programs.

Beyond serving Medicaid patients, health centers also are a principal source of care for uninsured patients; in 2015, 24 percent of patients served by health centers were uninsured (**Figure 1**). In addition, health centers provide a range of services for which most patients, including those who are insured, lack coverage, such as adult dental care, care management, patient transportation, and translation services. Federal grants are the principal source of funding for these uninsured services and populations. Grants are also the means by which health centers absorb uncompensated care costs for patients with incomes low enough to qualify for sliding fee assistance, including those with Marketplace coverage carrying substantial deductibles and cost-sharing.⁶

² Bureau of Primary Health Care. (2016). 2015 Health Center Data: National Data. Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state=&fd=>

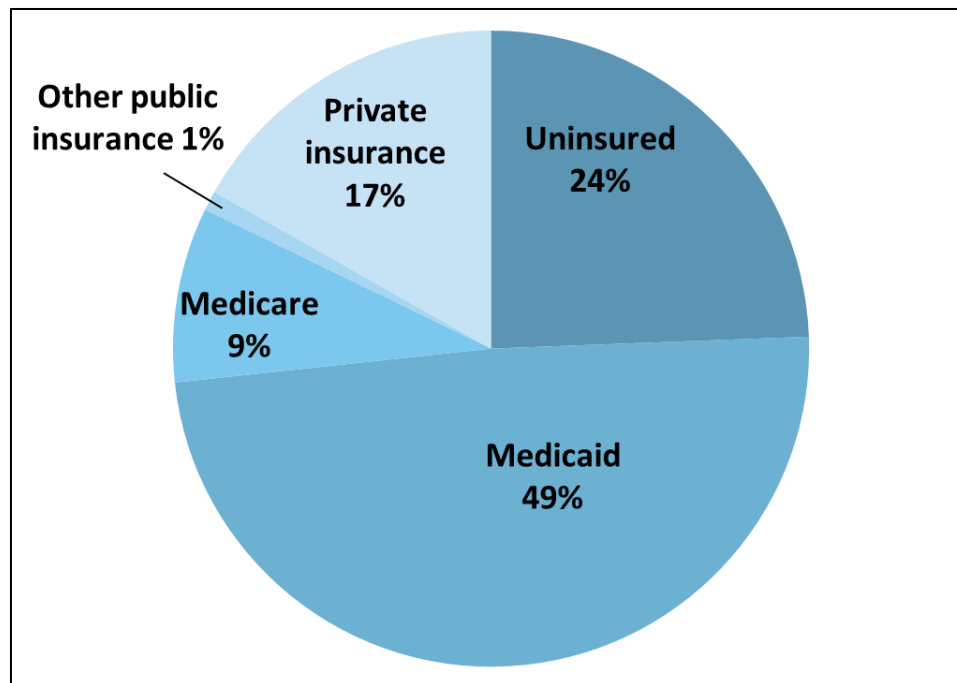
³ Kaiser State Health Facts. (2016). Total Medicaid Managed Care Enrollment. <http://kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/>

⁴ GW analysis of 2015 Uniform Data System (UDS) data

⁵ Nocon, R. S., Lee, S. M., Sharma, R., Ngo-Metzger, Q., Mukamel, D. B., Gao, Y., ... & Huang, E. S. (2016). Health care use and spending for Medicaid enrollees in Federally Qualified Health Centers versus other primary care settings. *American Journal of Public Health*: e1–e9. doi:10.2105/AJPH.2016.303341

⁶ Gunja, M. Z., Collins, S. R., Doty, M. M., & Beutel, S. (2016). *Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February--April 2016*. The Commonwealth Fund.

Figure 1: Community Health Center Patients by Insurance Type, 2015



Federal Medicaid law requires states to use a special “federally qualified health center (FQHC)” method when paying health centers. (This method also applies to Medicare, the Children’s Health Insurance Program, and health plans governed by the ACA’s “essential health benefit” coverage rules). The FQHC payment requirement is designed to better align Medicaid revenues received with the proportion of Medicaid-insured patients served in order to conserve federal grants for uninsured (or under-insured) patients and services. To a significant degree, the methodology has achieved this result; in 2015, the two numbers were close to parity: 49 percent of health center patients received Medicaid, and Medicaid represented 44 percent of health center revenues.

The FQHC payment method, known as the “prospective payment system (PPS),” pegs health center payments to the cost of providing covered services to Medicaid patients. In keeping with traditional fee-for-service care, payments are bundled into an all-inclusive encounter rate, and health center physicians, dentists (to the extent that oral

<http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/affordability-and-network-satisfaction> ; Rae, M., Claxton, G., Cox, C., Long, M., & Damico, A. (2016). *Cost-Sharing Subsidies in Federal Marketplace Plans, 2016*. Kaiser Family Foundation. <http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/>

health care is covered), psychologists, and allied health care professionals, such as nurse practitioners and physician assistants, bill for the services they furnish. States may include in calculating the encounter rate the services of other health professionals, such as health educators, dieticians, and care managers, although many may elect not to do so, and in setting the rate, states can impose upper payment limits. In the case of health centers that participate in managed care plans (in 2015, 28 percent report participation in capitated Medicaid managed care plans), managed care plans may administer PPS on behalf of a state, and are paid additional funds beyond the managed care capitation rate to do so. In other cases, the state agency may administer the PPS rate directly, reconciling health centers' provider network payments against what they would be owed under the PPS rate.

The PPS payment system thus sets a federal floor approximating the cost of treating Medicaid patients. However, federal law also permits states and health centers to negotiate an alternative payment methodology (APM) that permits health centers to test alternative payment approaches, such as global payments, that do not depend on encounter-based billing and therefore offer health centers greater flexibility in how their clinical staff furnish care. Reflecting the core PPS requirement to align Medicaid revenues with the cost of covered services, federal law requires that APM approaches produce the same amount of revenue in relation to patients served that the basic PPS encounter-based system would produce.⁷ As long as they meet this requirement, health centers are able to move away from encounter billing, and states are able to introduce value-based payment principles such as an emphasis on efficiencies that can reduce the volume of encounters over time, as well as shared savings for quality performance.

The question is how this PPS flexibility is being used to modernize the FQHC payment structure and move health centers away from older approaches tied to the volume of encounters.

Methodology

Our analysis of efforts to develop alternative payment systems focused on states that have expanded Medicaid and that, along with health centers, are faced with managing a major surge in the volume of needed care. In consultation with Medicaid payment experts and Medicaid agencies in expansion states during the winter and spring of 2015, we identified four states that were in the process of implementing payment reform, and three that already had begun to implement reforms. Among these states,

⁷ CMS. (February 10, 2010). State Health Official Letter RE: Prospective Payment System for FQHCs and RHCs. <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10004.pdf>

we determined that five states (California, Colorado, Minnesota, New York, and Oregon) were far enough along to merit in-depth interviews. (As of 2016, Washington State’s health centers and Medicaid program also appear to be extensively engaged in alternative payment negotiations). In the five states identified in 2015, we interviewed both state Medicaid agency and health center staff, including the staff of state primary care associations that negotiate on behalf of their state’s health centers.

Results

Medicaid expansion and a decline in uninsured patients created the context for alternative payment negotiations.

The health centers located in the five study states represent 22 percent of all health centers nationally, 29 percent of patients, and 35 percent of all Medicaid patients served by health centers in 2015. **Table 1** summarizes the characteristics of health centers in the five in-depth study states. It shows that despite Medicaid expansion and a major decline in uninsured patients, all health centers continued to serve a significant proportion of patients who remained uninsured. In 2015, approximately one in five health center patients were uninsured in each study state.

Table 1: Total health center patients and changes in insurance coverage in the five study states, 2013-2015

	California	Colorado	Minnesota	New York	Oregon
Number of Patients and Insurance Coverage in 2015					
Total patients	4,065,289	553,807	173,571	1,907,971	369,933
Percentage of Medicaid-insured patients	63%	57%	47%	55%	60%
Percentage of uninsured patients	22%	22%	29%	17%	19%
Changes from 2013 to 2015					
Percentage change in the number of total patients	19%	11%	-1%	13%	14%
Percentage change in the	60%	50%	21%	26%	58%

	California	Colorado	Minnesota	New York	Oregon
number of Medicaid patients					
Percentage change in the number of uninsured patients	-31%	-34%	-23%	-14%	-40%
Difference in percentage of Medicaid patients	16%	15%	8%	6%	17%
Difference in percentage of uninsured patients	-16%	-15%	-9%	-5%	-17%

Health center payment reform is part of a broader delivery reform effort in which health centers were actively involved.

In the five states, health centers were actively engaged in their state’s broader efforts to modernize Medicaid payment structures as an integral part of expansion. All five states placed an emphasis on delivery reforms capable of more effectively managing complex patients, achieving stronger performance outcomes, and improving efficiency. In one state – Minnesota – health centers actually lead one of the new delivery system models (known as the Federally Qualified Health Center Urban Health Network [FUHN]).⁸ In other states, health center pilot payment reforms are occurring within larger delivery system changes. In all states, health centers anticipated playing a role as part of broader managed care initiatives or integrated delivery system formation. Those interviewed in all states recognized the importance of participating in these larger and more integrated efforts to improve quality while achieving more sustainable Medicaid spending growth.

Payment reform negotiations included alternative payment structures, quality and performance improvement, and the use of alternative payment as a means for limiting risk.

⁸ Schoenherr, K. E., Van Citters, A. D., Carluzzo, K. L., Bergquist, S., Fisher, E. S., & Lewis, V. A. (2013). Establishing a coalition to pursue accountable care in the safety net: a case study of the FQHC Urban Health Network. *The Commonwealth Fund*. Publication No. 1710, Volume 28.
http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Oct/1710_Schoenherr_FQH_C_case%20study_v2.pdf

Table A1 (Appendix) summarizes the key elements of the payment reform approaches in the five study states. In all five states, the alternative payment method seeks to combine efficiency and quality improvement goals with the need to ensure that the total amount of payment does not fall below the FQHC PPS encounter-based payment floor. Payment thus remains subject to reconciliation, but payments themselves may be made on a global basis that enables health centers to test service delivery innovations no longer driven by the need to generate physician encounters in order to secure payment. Payment reform in California was the product of state legislation establishing health center payment reform pilots.⁹ In Minnesota, Colorado, New York, and Oregon, by contrast, health center payment reform was an outgrowth of each state's broader effort at payment reform, typically the result of delivery system reform efforts conducted under Section 1115 of the Social Security Act.

But while the PPS system effectively establishes a hold-harmless revenue floor, state/health center negotiations have reflected different approaches to alternative payment methods. The most common alternative approach was a per-member-per-month payment structure for patients receiving their care at a health center included in the payment reform pilot (California, Colorado and Oregon); these alternatives may allow health centers to report fewer face-to-face encounters, while at the same time emphasizing more frequent patient "touches" through expanded use of telephone and texting. Minnesota retained an encounter-based approach in its FUHN network. New York's value based payment reform, a product of negotiations between hospital-led delivery systems and health centers, was under development at the time of our interviews.

In interviews, health center staff voiced specific strategic interest in payment reform. Several expressed a desire to substitute community health workers and for more highly trained and licensed clinical staff in order to reduce clinician burden, and identified a need for more efficient care models targeting specific health conditions to reduce the need for a high volume of face-to-face encounters. Payment reform thus has emerged as a crucial workforce and care redesign strategy and is viewed as a means for promoting recruitment and retention. Given the constant, significant challenge of

⁹ Payment Reform Pilot Program for Federally Qualified Health Centers. (2015-2016). (Article 4.1, Section 14138.1). SB-147, California Legislature. http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB147.

recruiting primary care clinicians to work in medically underserved communities,¹⁰ health center respondents were eager for strategies that would enable them to maintain needed operating revenue while nonetheless identifying approaches that could lower the pressure to treat high numbers of patients through the face-to-face encounter system that lies at the heart of the PPS payment methodology as originally enacted.

The question of how to reconcile alternative payment structures with the PPS payment floor emerged as a central one. As Table A1 shows, the state approaches vary. In three states (Oregon, Colorado, and Minnesota), the state Medicaid agency retained responsibility for reconciling revenues against the PPS risk corridor. Health plans in California's pilot alternative payment program were to assume reconciliation responsibility, while in New York, it appeared that the state would continue to play this role.

Where PPS payment reconciliation was concerned, Oregon appears to be the most interesting example. In that state, negotiations have focused not only on supplemental payments per encounter, but also at an aggregate level. That is, the reconciliation negotiations reflect the hold-harmless requirement of the PPS revenue floor, and have focused on how to ensure that health centers could maintain the overall revenue flow needed to make the workforce and capital improvement investments necessary to achieving change.

In terms of clinical services contained within the alternative payment structure, no two states have taken the same approach. In some states services such as adult oral health, behavioral health, vision care, and enabling services are included in the methodology. In others, the negotiations omit one or more of these services. Pharmacy services remain outside capitation structures.

Quality measurement is an express feature of three models (Colorado, Minnesota, and Oregon); by contrast, the New York approach assumes that as network participants, health centers will be accountable for attaining the broader quality improvement goals used by its system-wide delivery transformation models. Performance is measured for a range of outcomes including reduced use of diagnostic services, reduction in inpatient and emergency care, improvements in the primary care management of chronic

¹⁰ National Association of Community Health Centers. (2016). *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers*. http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf

conditions such as depression, diabetes, vascular disease, and patient satisfaction and communication.

As a result of their involvement in “Patient-Centered Medical Homes”¹¹ initiatives, as well as higher rates of adoption of electronic health records (68 percent of health centers had recognition as Patient-Centered Medical Homes and 98 percent reported using electronic health records in 2015),¹² respondents report that health centers had the knowledge and experience to participate in broader quality improvement incentives or performance-based payment efforts. Several respondents also noted, however, that the ability to reliably collect and report on data tying performance to payment would continue to require ongoing investment in health information systems that could be aligned not only with the delivery systems of which they were a part but also with their states’ information needs. All respondents reported interest in shared savings approaches that reward health centers for quality improvement. Minnesota and Colorado both had adopted a shared savings program at the time of our interviews; Minnesota’s rewarded positive performance and state officials noted that they were considering penalties for sub-par performance in the future.

Conclusion

This analysis, which took place at a relatively early stage in the alternative payment negotiation process, shows that health center payment reform is under way in Medicaid expansion states, in which surging Medicaid enrollment sets the stage for expanded interest in innovations to control spending growth. Expansion states are eager to incorporate health centers into broader payment reform efforts. For their part, health centers are eager for approaches that manage growth and that enable them to test alternative service delivery models that mitigate unmanageable pressures on clinical and support staff and enhance their ability to recruit new staff. Both sides have much to gain from payment reform. In these states, PPS remains the payment floor and operates as a hold-harmless strategy for ensuring that Medicaid revenues continue to approximate the cost of caring for Medicaid patients. Given the continuing need for care

¹¹ Ku L., Shin P., Jones E., & Bruen, B. (2011). *Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform*. The Commonwealth Fund.

<http://www.commonwealthfund.org/publications/fund-reports/2011/sep/transforming-community-health-centers>

¹² Bureau of Primary Health Care, Health Resources and Services Administration. (2016). National 2015 Health Center Data. Electronic Health Record (EHR) Information.

<http://bphc.hrsa.gov/uds/datacenter.aspx?q=tehr&year=2015&state=>

among uninsured and under-insured patients, maintaining health center capacity to meet their federal obligations has emerged as an important consideration in all states.

Alternative payment models can be tied to case payment rates and global payment methods, as can shared savings for performance improvement. Payment reform strategies can be carried out as an integral part of broader health system reform, with states either retaining direct responsibility for negotiating the terms of reform models or taking on an oversight role in the health plan reconciliation process.

Several considerations appear to be important. First, Medicaid expansion and larger delivery system reform considerations appear to create the context for health center payment reform. Both larger-scale reforms set the stage for greater health center involvement in efforts that can maximize the stability and efficiency of large-scale insurance reform. Second, direct negotiations between health centers and state agencies are important, since moving to an alternative payment method is envisioned under the PPS law governing FQHC payments as the product of a negotiated alternative.

Third, the negotiation process touches on a variety of fundamentals: (1) a move away from volume in favor of alternative means for delivering necessary health care; (2) a reconciliation process that limits losses to levels permitted under PPS; (3) voluntary health center participation; and (4) quality metrics that reflect either the broader metrics used in delivery reform or in some cases, metrics tied explicitly to the alternative payment methodology.

The process of health center payment reform is challenging, just as it is for provider payment reform generally. The federal government might promote further advances in Medicaid expansion states through the development of alternative FQHC payment models that can test payment reform. These models can be coupled with information sharing to allow the more rapid spread of reform innovations such as the introduction of global payments coupled with strategies for ensuring that overall revenues remain adequate for robust health center operations and growth. In this respect, efforts in recent years by CMS to accelerate large-scale Medicaid reform might be extended to include the creation of alternative FQHC payment systems that can, in turn, encourage greater health center integration into payment transformation efforts.

Appendix

Table A1: Study State Alternative Payment Models

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
California	A 3-year, 18-county alternative payment model pilot project authorized by state law as part of broader health system transformation. Pilot begins July 2016 ¹³ and is designed to test a per-member-per-month capitation payment method. Participation by about 80 health centers is anticipated.	Health centers can elect participation; health plans in pilot counties required to participate with health centers desiring to do so.	Per-member-per-month payment for prospectively assigned patients.	A supplemental payment (known as a wrap cap) to be carried out by health plans in accordance with state policies	Risk-adjusted payments reflecting both patient characteristics and, eventually, utilization trends.	No specific performance metrics beyond those used by health plans.	No formal governance structure; health centers can elect to participate. ¹⁴
Colorado	Part of the state's Accountable Care Collaborative (ACC) carried out through Regional Care Collaboratives (RCCOs),	Voluntary participation as part of CCO system, with strong	Per member per month payment for patients using a health center as a medical	A supplemental payment administered by health	The per-member-per month payment methodology excludes high	Both overall RCCO and health center specific metrics RCCOs:	Tied to health center participation in RCCO

¹³ Payment Reform Pilot Program for Federally Qualified Health Centers. (2015-2016). (Article 4.1, Section 14138.1). SB-147, California Legislature. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB147.

¹⁴ Personal communication, California Primary Care Association. May 4, 2015.

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
	which combine clinical integration and payment reform. ¹⁵ The PRIME Rocky Mountain Health Plan regional collaborative is designed to test an alternative payment model under a two-year pilot. ¹⁶	encouragement.	home, supplemented by an additional per-member-per-month case management payment and for satisfying performance targets.	plans.	need beneficiaries who are elderly or persons with disabilities.	<ol style="list-style-type: none"> 1) Reduction in high cost imaging 2) Reduction in 30-day all cause hospital readmission 3) Reduction in ER visits 4) Increase in well child visits Health center APM: ¹⁷ <ol style="list-style-type: none"> 1) Adult body mass index 2) Anti-depressant Medication Management 3) Comprehensive diabetes care 4) Patient engagement (Patient Activation Measure (PAM)) 	governance. ¹⁸

¹⁵ <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-13-003-Att.pdf>

¹⁶ <https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-payment-reform-initiative-hb12-1281>

¹⁷ Rocky Mountain Health Plans. Medicaid PRIME <https://www.rmhpcommunity.org/content/medicaid-prime>

¹⁸ Personal communication, Colorado Primary Care Association.

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
						that measures self-management ability.	
Minnesota	Part of the state's Integrated Health Partnership (IHP) accountable care initiative. ¹⁹ One member is a health center-led Federally Qualified Health Center Urban Health Network (FUHN), ²⁰ consisting of 10 health centers operating in 40 sites across the Minneapolis/St. Paul area.	Health centers within the FUHN service area elect to participate.	Health centers continue to be paid on an encounter basis for patients attributed to the health center, with eligibility for shared savings payments.	Retained by the state	A cost-related encounter rate is maintained, with incentives limited to shared savings from quality performance.	<ol style="list-style-type: none"> 1) Improved management of depression to reduce remission at six months 2) optimal diabetes care 3) optimal vascular care 4) optimal asthma care for children and adults 5) patient ratings of providers 6) provider communication with patients 7) office staff 	Health centers govern the FUHN.

¹⁹ <https://www.revisor.mn.gov/statutes/?id=256B.0755#stat.256B.0755.1>.

²⁰ Fournier, J. & Schwartz, P. (Oct 2014). *The FQHC Urban Health Network's (FUHN) Integrated Health Partnership Demonstration Project*. Presentation at Academy Health conference: Payment Reform: Honing the Models and Pushing the Boundaries. <http://www.academyhealth.org/files/HCFO/Fournier%26Schwartz%20-%20Honing%20the%20Model%20Presentation%2010%202014%20-%20FUHN%20Overview.pdf>.

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
						<p>treating patients with respect and courtesy</p> <p>8) the provision of timely appointments, care, and information</p> <p>There are also a number of measures on hospital quality and patient experience.</p>	
New York	<p>Part of the state's §1115 Medicaid Delivery System Incentive Reform Payment (DSRIP) demonstration.²¹</p> <p>Health centers participating in DSRIP-created Performing Provider Systems (PPS). Most PPS entities are</p>	<p>Expectation of health center participation in DSRIP, as members of PPS arrangements.</p>	<p>Health centers continue to be paid on an encounter basis for attributed patients. The goal is to achieve 90% of care tied to value-based</p>	<p>Retained by the state</p>	<p>Alternative payment models remain under development, with PPS encounter rate retained until replaced.</p>	<p>1) Reduced spending on inpatient and emergency department care, 2) PPS-set quality metrics under state policy, with ongoing data</p>	<p>Health center participation in PPS governance, per governing structure chosen by PPS entities under</p>

²¹ New York State Department of Health. (April 2015). Centers for Medicare and Medicaid Services (CMS) Official Documents. https://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/cms_official_docs.htm

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
	hospitals, with one health center—led initiative. ²²		payment by 2019.			collection.	state policy
Oregon	Part of the state’s Coordinated Care Organization (CCO) initiative, ²³ aimed at developing integrated delivery models. Eleven health centers and rural health clinics participate in a 3-year alternative payment system pilot within the CCO initiative. ²⁴	Health centers elect to participate in pilot alternative payment model.	Per-member-per-month payment for patients attributed to the health center, using an 18-month look-back period to determine attribution and utilization,	Retained by the state	Per-member-per-month payment is tied to actual health center experience over the preceding 18-month time period, with adjustments for changes in scope of covered services offered. Health centers also receive a hold-harmless payment	Tied to overall CCO measures, with data collection to permit future quality and access-enabling measures tied directly to alternative payment.	Health centers eligible to participate in CCO governance, but with alternative payment methodology the product of direct state/health center negotiations rather than a CCO/health

²² Goldberg, D. (September 28, 2015). Community-based groups have uncertain role in Medicaid reform.

<http://www.capitalnewyork.com/article/albany/2015/09/8577329/community-based-groups-have-uncertain-role-medicaid-reform>

²³ Oregon Health Authority. (March 1, 2012). Application for Amendment and Renewal Oregon Health Plan Medicaid and Children’s Health Insurance Program. 1115 Demonstration Project. (11-W-00160/10 & 21-W-0013/10). <https://cco.health.oregon.gov/DraftDocuments/Documents/narrative.pdf>.

²⁴ <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-12-008-AtT.pdf>.

State	General description	Health center participation	Alternative payment method: general approach	PPS payment reconciliation	Financial risk mitigation under base payment method	Quality improvement	Governance
					adjusted to reflect the actual volume of encounters in the absence of payment reform, thereby enabling a test of alternative reforms that may reduce encounters without diminishing overall revenue.		center negotiation. ²⁵

²⁵ Personal communication, Oregon Primary Care Association. April 27, 2015