Making Value-Based Payment Work for Federally Qualified Health Centers Toward Equity in the Safety Net

Federally qualified health centers (FQHCs) are essential sources of health care services for patients who have low income or are members of underrepresented racial and ethnic groups, including more than 12 million Medicaid beneficiaries, and are uniquely positioned to address health disparities. However, most FQHCs continue to operate in a payment system that grants little flexibility to tailor care to the complex medical and social needs of their patient populations. As the nation shifts toward value-based payment (VBP), making meaningful progress toward health equity will require successfully engaging FQHCs and other outpatient safety-net clinicians and health Centers in such models.

Shifting FQHCs to VBP is gaining traction. In October 2021, the Center for Medicare and Medicaid Innovation announced that one of its strategic goals for the next decade is to “create more opportunities for [FQHCs and other safety-net providers] to join” VBP models. While an important first step, increasing safety-net representation in existing VBP models will not necessarily translate to greater equity.

This is important because, although the extent of disparities in care may be less at FQHCs compared with other settings, significant disparities remain. For example, racial and ethnic disparities observed across an array of quality outcomes at FQHCs remained unchanged from 2009 to 2014. More recently, racial and ethnic disparities in telemedicine use and vaccine administration and receipt at FQHCs have persisted during the COVID-19 pandemic. It is, therefore, critical that payment reform move beyond general improvements in care and explicitly embed mechanisms for advancing equity in the FQHC setting. Furthermore, the successful implementation of VBP at FQHCs may also enable them to expand their capacity to care for underserved communities, which could have far-reaching implications for disparities involving these populations.

Current Payment Model and Early Reforms

As the foundation of the safety-net primary care system, FQHCs receive funding from the Health Resources and Services Administration (HRSA) to provide comprehensive primary care to patients in medically underserved areas, regardless of ability to pay. FQHCs also provide “enabling services,” nonclinical services that reduce barriers to accessing care (eg, transportation and case management). The cornerstone of reimbursement for FQHCs under Medicaid, which covers approximately 49% of patients who receive care at FQHCs, is the prospective payment system, in which centers receive a single per-visit payment that covers all services provided during a visit. Although this model is slightly more flexible than traditional fee-for-service payments, per-visit prospective payments do not incentivize clinicians and health centers to target care to their communities’ needs through longitudinal services such as prevention and screening, care coordination, or addressing the social determinants of health (SDOH).

Recently, several states have begun experimenting with VBP for FQHCs. As of 2017, 23 states use a VBP method to reimburse at least some FQHCs for services provided to patients with Medicaid coverage. These programs can be implemented by state Medicaid programs through a state plan amendment allowed by the Medicaid statute without requiring a waiver, as long as each affected FQHC agrees to participate and total reimbursement is not less than under the prospective payment system. However, there are few explicit incentives or requirements for FQHCs to integrate equity considerations into VBP.

While these pilots are a step in the right direction, making true progress toward equity will require equity-focused changes to payment models that (1) include dedicated funding to address SDOH, (2) enable community-based care delivery, and (3) enhance quality measurement (eTable in the Supplement).

Dedicated Funding to Address SDOH

Currently, funding for FQHCs to address SDOH comes through a combination of patient revenue streams, time-limited grants, and other revenue-generating opportunities (eg, social enterprises). However, these funding sources are neither guaranteed nor recurring.

VBP could offer a promising solution to address these limitations. This will need to extend beyond existing approaches to social risk adjustment. For instance, Massachusetts and Minnesota both adjust payments to FQHCs based on patients’ social risk, defined by measures of poverty, housing instability, and behavioral health. However, because nonmedical expenditures are not factored into risk-adjustment models, these adjustments only partially subsidize the investments needed to remedy upstream drivers of poor health. Addressing SDOH requires more than just the cost of medical care.

Future approaches could explicitly pay FQHCs to address SDOH, with specific requirements attached to this funding. Fixed per-patient, per-month payments could be stratified based on a measure of neighborhood-level social disadvantage to drive funding to historically underinvested areas with greater social needs. A portion of each payment could be allocated directly for addressing SDOH (“SDOH budget”) to help with budget management, streamline reporting, and promote transparency. Importantly, there is now precedent for using area-level indices of social disadvantage as part of pay-
ment policy in the recently announced Accountable Care Organization Realizing Equity, Access, and Community Health model.39

To ensure funds are used effectively, the HRSA could require that FQHCs systematically screen for, measure, and report social need; currently, nearly 30% of FQHCs do not collect social risk data.30 This could be supplemented with data sourced from other programs, such as the public benefit programs that patients with Medicaid often receive.

These data could be used to measure performance in following up on unmet social needs, another metric to which SDOH funding could be linked. While many states adjust FQHC payments based on clinical performance, none incorporate nonclinical quality measures into VBP models. One way to increase accountability is to restructure a portion of the SDOH budget if FQHCs fail to perform appropriately (“clawback” provision).

**Community-Based Care Delivery**

There is mounting evidence that bringing services into patients’ homes and communities is critical for reaching marginalized populations. However, existing payment systems only reimburse in-person, face-to-face visits and visiting nurse services for some home-bound patients. Restrictions around virtual care were relaxed during the COVID-19 pandemic, but it is unclear to what extent these flexibilities will remain open to FQHCs. VBP may be a way to extend these flexibilities and expand coverage to other modalities such as home visits and mobile clinics. To ensure patients benefit from different types of visits, policy makers may track and link payments to performance on measures of care coordination.

The success of community-based care also depends on the input and expertise of community-based health professionals (eg, community health workers, peer support workers) who may have similar backgrounds as their patients. Despite robust evidence of the benefit of community-based health professionals for patients with chronic conditions or serious mental illness, the current payment system restricts billable encounters to FQHC practitioners, defined as physicians, physician assistants, and nurse practitioners. VBP offers an opportunity to fund community-based health professionals more sustainably, both through the SDOH budget and by allowing FQHCs to include their services for the purposes of cost calculation. There is early evidence that this approach is feasible: Oregon and Washington now allow FQHCs to use alternative health professionals.

**Equity-Focused Quality Measurement**

Quality measurement can be a powerful tool to identify and monitor disparities in care. Some states stratify select quality measures based on race and ethnicity, but this is highly variable. In fact, the HRSA only requires that FQHCs report data on 3 measures (low birth weight, hypertension control, diabetes control) stratified by race and ethnicity. A more standardized approach could require the stratification and public reporting of all FQHC quality measures by race and ethnicity and other factors such as language, rural location, disability, and gender identity. Additionally, this approach should include additional quality measures such as patient-reported outcomes.

Even states that started using stratified measures do not link payment to data collection on individual social characteristics or clinicians’ performance on measures of disparities. As more states shift FQHCs to VBP, they could directly incentivize equity by basing financial incentives on not just performance on aggregate quality measures, but also the reduction of disparities.

Calls to engage more safety-net clinicians and health care organizations in value-based care have opened a policy window to modernize payment for health centers. There is now an opportunity to capitalize on this policy window and advocate for not just increased safety-net representation, but also payment models that prioritize and incentivize equity.

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**REFERENCES**


