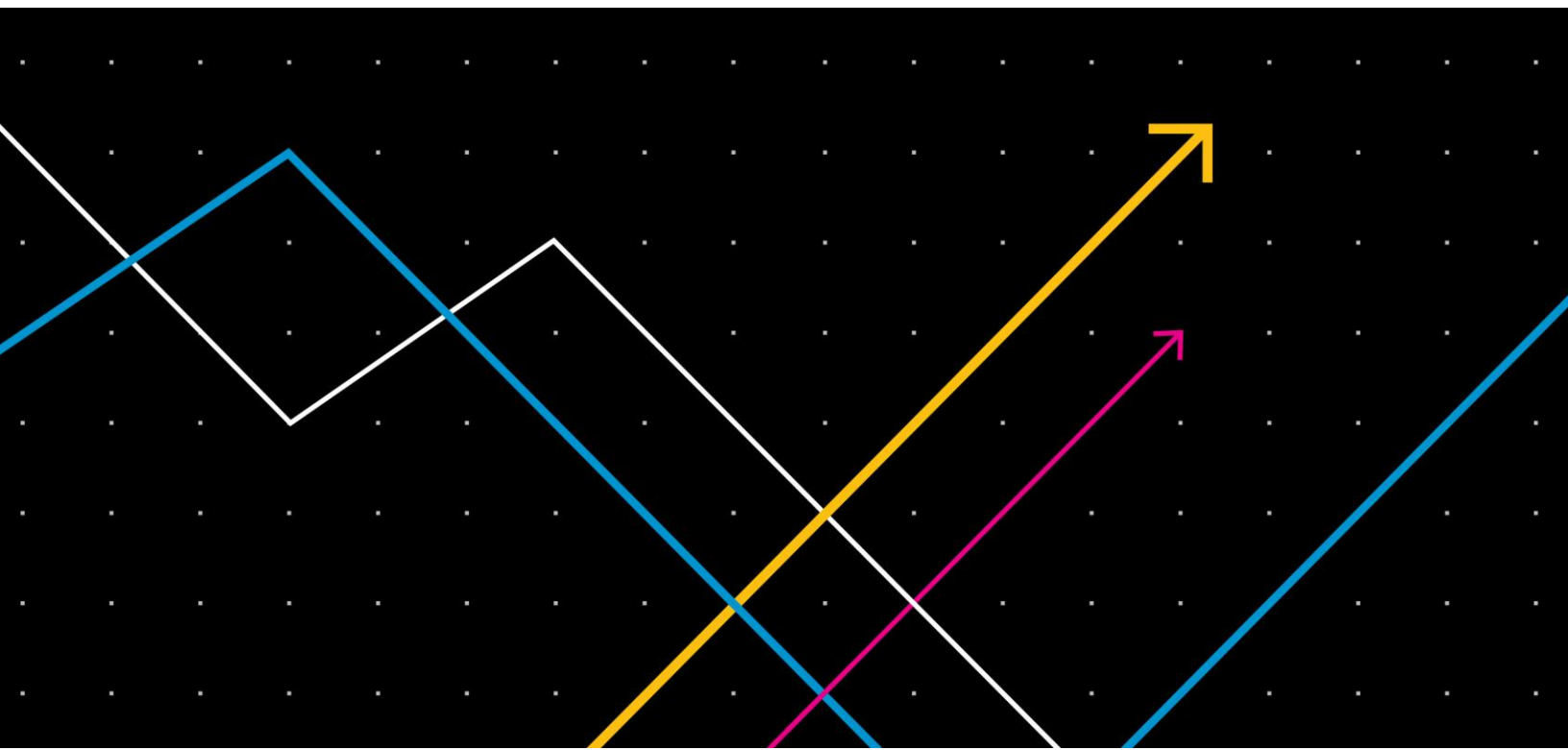




RESEARCH REPORT

Critical Role of New York's Community Health Centers in Advancing Equity in Medicaid

**Investment in Community Health Centers Can Help New York Achieve Its
Health Equity Goals**

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ABOUT THE URBAN INSTITUTE

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Executive Summary

Community health centers are a linchpin of New York's health care safety net, providing comprehensive primary care, behavioral health, and dental and vision services to 2.3 million patients who may otherwise lack access to health care.¹ The COVID-19 pandemic highlighted the crucial role of New York's community health centers in promoting health equity, including their deep ties in underresourced communities, expertise in using culturally effective approaches and addressing structural barriers to care, and nimbleness in rapidly adopting telehealth and assuming the first responder role amid the public health emergency (Ford et al. 2022).² Caring for one in six Medicaid enrollees,³ community health centers are an important partner in New York's efforts to transform its Medicaid program into a more comprehensive delivery system equipped to address enrollees' health-related social needs and reduce disparities, and supported by "health equity-informed advance value-based payment arrangements (New York State Department of Health 2022)."

This report describes the value proposition of community health centers in supporting the state's health equity goals and examines the New York State Medicaid prospective payment system (PPS) as a foundation for a health equity-focused alternative payment model. Key findings include the following:

- With a robust network of over 800 service delivery sites in 52 of the state's 62 counties, community health centers have a strong and thriving presence in New York and are continuously expanding their operations to reach the state's underresourced communities.
- Compared with New York's population, community health centers disproportionately serve people who may face barriers to accessing health care and likely experience health disparities, including people with incomes at or below the federal poverty line, people from racial and ethnic minority groups, those with limited English proficiency, and people without insurance.
- Community health centers have been integral to many of New York's signature initiatives to transform its health care delivery and have expanded their capacity to effectively meet complex patient needs by, for example, integrating behavioral health care, adopting multidisciplinary team-based care and population health management practices, upgrading health information systems, and achieving patient-centered medical home certification.
- Community health centers are an important source of employment and health workforce training opportunities in underresourced communities. Because they often have limited resources to offer competitive salaries, which have risen dramatically recently, community health centers are disproportionately affected by widespread health workforce shortages.

- New York State Medicaid PPS rate methodology includes ceilings on operating costs to cap community health center payments. An analysis of cost reports from over half of community health centers suggests that costs exceed the ceiling by at least 44 percent for most patient visits.
- The supplemental payment program pays community health centers the difference between the average per-visit managed care rates and PPS rates for primary care services. Almost a third of Medicaid payments to community health centers are delayed through the supplemental payment program reconciliation process.

The discrepancy between Medicaid PPS ceilings for community health centers and actual costs per visit presents a barrier to enhancing the integrated and whole-person care so critical to effectively care for underserved patients with complex needs by limiting health centers' ability to add specialty providers or expand access to social care services. Furthermore, the PPS methodology does not reward centers for improving health care access, facilitating patient engagement and high satisfaction with care, and reducing health disparities. Community health centers are eager to work with the New York State Medicaid program to develop an alternative payment model that aligns performance and outcome measures with health equity goals and provides more flexibility to enhance integrated and equitable health and social services. Reevaluating PPS rates to reflect the cost of patient care more accurately is a fundamental first step toward alternative payment arrangements since any community health center payments received through an alternative payment model must be at least equal to PPS rates (MACPAC 2017).

Community health centers are a vital source of care for Medicaid enrollees, particularly those most at risk of experiencing barriers to health care and health disparities, and thus are essential in any health equity initiatives. Conversely, Medicaid is the largest source of revenue for New York's community health centers, underscoring the interdependent relationship and the need for strong alignment and partnership in health equity efforts (Rosenbaum et al. 2022). Greater investment in New York's community health centers through the Medicaid program will expand and strengthen access to comprehensive, high-quality, and culturally effective care in the state's underresourced communities and help New York build a more cost-effective and equitable health care system.

Critical Role of New York's Community Health Centers in Advancing Equity in Medicaid

Following the COVID-19 pandemic and its disproportionate impact on underresourced communities, including people from racial and ethnic minority groups (Artiga, Corallo, and Pham 2020), New York joined many other states in prioritizing health equity in its Medicaid program.⁴ In its recent Section 1115 waiver amendment request, New York outlines a multiprong strategy for reducing longstanding health disparities through how it delivers and pays for health and social services in Medicaid (New York State Department of Health 2022). The first strategy of the waiver amendment, titled “Building a More Resilient, Flexible and Integrated Delivery System that Reduces Health Disparities, Advances Health Equity, and Supports the Delivery of Social Care,” describes a delivery system that (1) recognizes physical, behavioral, and social risk factors that affect a patient’s health and seeks to respond to whole-person needs; (2) improves clinicians’ understanding of factors outside the health care settings that affect health outcomes; (3) prioritizes prevention and early intervention across a patient’s lifespan; (4) effectively integrates health care and social services; and 5) is prepared to address patient and population health needs and ensure access to safety net care in times of crisis (New York State Department of Health 2022). One of the state’s strategies to achieve this transformation is investments in advanced value-based payment models that would support the integration and equitable delivery of health and social care (New York State Department of Health 2022).

New York’s vision for an equitable, comprehensive, and integrated delivery system, as described in the waiver amendment, is very much aligned with the mission, model, and operations of community health centers, which include both federally qualified health centers (FQHCs) and FQHC look-alikes.⁵ Inspired by the social justice movement, the founding principles of community health centers are to provide low-threshold access to primary and preventative health care in underserved and underresourced communities while addressing broader social and environmental conditions that affect health outcomes.⁶ By federal regulations, community health centers must be governed by patient-majority boards and provide culturally effective and high-quality care to all patients regardless of health insurance status or ability to pay, including services that support patient access to care and engagement, such as transportation, translation, and health education.⁷ Community health centers are more likely to accept new Medicaid patients than private clinics (Richards et al. 2014; Shi and Stevens

2007), and access to community health centers has been associated with reduced utilization of expensive hospital and emergency department services and cost savings, including in Medicaid (CPCA 2013; Falik et al. 2001; Michigan State University 2022; Nocon et al. 2016; Richard et al. 2012; Saloner, Wilk, and Levin 2019; Wright et al. 2022). Community health centers have always played a critical role in advancing health equity by serving and earning the trust of populations most at risk of experiencing disparities, but they may not have been recognized for it until recently. Their role and expertise in community engagement were on full display during the COVID-19 public health emergency when health centers across the nation stepped up to facilitate equitable access to vital information, testing, and vaccines in communities disproportionately devastated by the pandemic (Cole et al. 2022; Crane et al. 2022).⁸

Community health centers have a strong and thriving presence in New York, where, thanks to a reportedly supportive and progressive health and social policy environment, health centers expanded from just three sites in 1967 in New York City to 70 FQHCs and look-alikes⁹ with 843 service delivery locations across the state in July 2023.¹⁰ New York's community health centers are an integral part of the state's safety net system, serving 2.3 million patients in 2021, most of whom were living below the federal poverty line, including those with limited access to health care, such as rural populations, migrant workers, and the uninsured.¹¹ Approximately one in six Medicaid enrollees receive care in community health centers, including primary care, behavioral health, vision, and dental services.¹² Like national trends, community health centers were on the front lines of New York's emergency response to the pandemic and brought lifesaving vaccines to people most at risk of experiencing serious health complications and death from COVID-19 (Ford et al. 2022).¹³

Over the years, New York's community health centers have continuously expanded their capacity to meet the growing health and social needs of their patients while keeping up with an increasingly complex health care ecosystem, as demonstrated by their participation in key state initiatives such as the New York State Patient-Centered Medical Home program and the Delivery System Reform Incentive Payment (DSRIP) program (Rosenbaum et al. 2019).¹⁴ Today, community health centers deliver services that have become emblematic of promoting health equity—coordinated, whole-person, and culturally effective care supported by modern technology (e.g., electronic health records, telehealth) and partnerships with other health care providers and community-based organizations. Community health centers serve patients who tend to be in worse health, have higher social risks, and are more likely to be uninsured and underinsured than the general population, and thus may be most at risk for health disparities (Lewis et al. 2019; NACHC 2020; Shin et al. 2014).¹⁵ As such, community

health centers play a critical role in ensuring access to health care services in underresourced communities and advancing health equity for underserved populations (Rosenbaum et al. 2022).

To provide high-quality, comprehensive, and integrated health and social care, New York's community health centers rely on many funding sources, including federal grants from the Health Resources and Services Administration, state and local grants, and public and private health insurance, with Medicaid being the largest payer (table 1 in Rosenbaum et al. 2022).¹⁶ In addition, community health centers have recently benefited from temporary federal COVID-19 relief funds for health care providers to sustain operations during the unprecedented pandemic (Ochieng et al. 2022). The sustainability and growth of community health centers are at risk because of longstanding workforce challenges exacerbated by the pandemic and the end of the public health emergency, which brings about scaled-back relief funding and potential losses of Medicaid revenues (Ku et al. 2023).¹⁷ Since community health centers rely heavily on Medicaid revenue, the Medicaid policy is an important lever for strengthening the reach and impact of community health centers. Conversely, the Medicaid program depends on community health centers for operationalizing its health equity agenda (Rosenbaum et al. 2022).

This report describes the value proposition of community health centers in supporting the state's health equity goals and examines the New York State Medicaid prospective payment system (PPS) as a foundation for health equity-focused value-based payments. The remainder of this report describes the methods used to conduct this assessment and presents key data on the characteristics and evolution of New York's community health centers. The report then describes the Medicaid PPS policy, presents results from an analysis of community health center cost data, and concludes with a summary of key takeaways and policy implications.

Methods

We implemented a mixed-methods approach to (1) describe the evolution and current landscape of New York-based community health centers, (2) examine key features of the Medicaid PPS, and (3) assess how the health center reimbursement matches the cost of services delivered to Medicaid patients. The study's research approach was reviewed and approved by the Institutional Review Board. The following sections describe the study methodology, data sources, and limitations.

Environmental Scan

Between April and July 2023, we collected, reviewed, and analyzed information on New York’s community health centers and Medicaid PPS policy from various data sources, including publicly available information on New York’s State Department of Health website and the New York Health Center Program Uniform Data System (UDS) data from the Health Resources and Service Administration. In addition, we relied on Community Health Care Association of New York State (CHCANYS) data, including annual fact sheets and results from the 2022 membership survey. The survey was fielded to 72 community health centers that are CHCANYS member organizations in November 2022; 56 members participated in the survey for a response rate of 78 percent.¹⁸

Qualitative Data Collection and Analysis

Between May and July 2023, we conducted seven virtual interviews with 13 key informants familiar with community health centers and the Medicaid program in New York, including state Medicaid officials and representatives of primary care providers, health center leadership, financial analysts, and a Medicaid health plan. Informants were identified by reviewing available public information and input from CHCANYS and senior project advisors from the Geiger Gibson Program in Community Health at George Washington University. Interview topics included deep dives into the community health center model of care and practice changes over the last two decades, the role of Medicaid reimbursement and key features of Medicaid PPS policy, and recent policy changes in New York’s health care ecosystem and their perceived impact on community health centers.

We also conducted two virtual focus groups with 11 community health center leaders to discuss their experiences and perspectives on operating in New York and navigating the Medicaid PPS reimbursement. The focus group participants represented a mix of community health centers in terms of the following characteristics:

- The patient population ranged from about 2,500 patients per center to about 60,000 patients per center annually.
- Nearly half of the represented centers were primarily located in the New York City metro area, a third were in Western New York, and one each in Central New York and Capital District regions.
- Thirty-six percent served in rural communities, 27 percent served in suburban communities, and 18 percent served in urban and both urban and rural settings.

- Nearly half of the focus group participants reported that Medicaid patients represented 25 to 50 percent of their caseload, 37 percent served between 51 and 75 percent of Medicaid patients, and the remainder reported that Medicaid patients represented more than 75 percent of their patients.

In addition, we collected input in discussions with members of the project’s advisory working group during three meetings held in April, June, and August 2023. We obtained additional feedback on preliminary study findings from attendees at the CHCANYS membership meeting in July 2023.

All interviews and focus group discussions were recorded and transcribed. The research team analyzed notes, including those from discussions with the advisory working group members and the July membership meeting, for common themes and key insights.

Cost Data Analysis

We analyzed data from ambulatory health care facility (AHCF) cost reports for 47 of 81 (58 percent) community health centers that provided their reports to CHCANYS for the analysis. Eleven of the cost reports collected contained data for 2020, and 36 contained data for 2021. All diagnostic treatment centers, including community health centers, must complete and submit an AHCF to the New York State Department of Health annually (New York State Department of Health 2017). In addition to audited data on operating costs, ACHF reports also contain information such as services offered by the clinic; number of visits, total procedures, and revenue by service type and payer (including ancillary services and nonthreshold visits); contracted services; public charge services; referred services; supplemental payments; and capital depreciation.

Community health centers report operating costs within state-defined expenditure categories: (1) administration, (2) medical, (3) dental, (4) therapy, (5) patient transportation, and (6) ancillary services. Following the methodology used to calculate PPS payments, allocated costs include personnel and other direct and indirect costs. Facility operating costs are allocated to each of these cost centers by the square footage devoted to these services, and other costs are allocated on a prorated basis to the six categories based on direct expenditures. For the six service categories in the New York Medicaid PPS, we calculated costs per visit and then calculated the ratio of those per visit costs to the 2021 rate ceiling in the appropriate region of the state (downstate, upstate urban, and upstate rural) based on the location of the center’s main site. Based on communication with officials in the state Medicaid program, the “downstate” designation applies to health centers whose principal site is in the counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and

Dutchess. Rural ceilings apply to health centers reporting that rural ceilings applied to their rates. Centers whose principal location was in any other county were designated as “upstate urban.”

For administration, patient transportation, and ancillary services, we calculated the cost per threshold visit, regardless of the purpose of the visit. Threshold visits are limited to one per patient per day and are defined as any instance in which a patient enters the health center to receive services, regardless of the number of services received. For medical, dental, and therapy costs, we calculated costs per visit in the appropriate category, as reported on the AHCF.

Limitations

Our findings should be interpreted with several limitations in mind, including the following:

1. The UDS data on community health center characteristics, services, patient population, and other features are aggregated at the grantee level (e.g., the primary recipient of the health center funding from the Health Resources and Services Administration) so that variation across affiliated centers and delivery sites is not fully captured in this analysis.
2. Our cost analysis relied on cost report data from a subset of community health centers that voluntarily submitted their data to CHCANYS, so it may not represent all centers statewide. Cost reports cover either 2020 or 2021, and thus will all be affected by changes in the volume and mode of patient visits during the public health emergency to some degree, but may not reflect more recent increases in health care workforce wages and salaries.¹⁹¹⁹ In addition, while cost reports are subject to audit, there may be some variation in how individual community health centers allocate service costs within the six expenditure categories. Finally, our analysis includes all operating costs in the AHCF reports, but we do not know to what extent some of these costs may not be considered “allowable costs” to calculate centers’ PPS rates.
3. Public documentation detailing New York Medicaid PPS policy is limited, and we relied heavily on input from knowledgeable individuals and policy experts to describe how the payment methodology was designed and implemented, including how centers are assigned to geographic cost ceiling regions.
4. We conducted interviews and focus groups with a small number of informants, and therefore, some important perspectives and experiences might not have been captured, and others may be overrepresented.

How New York’s Community Health Centers Promote Health Equity

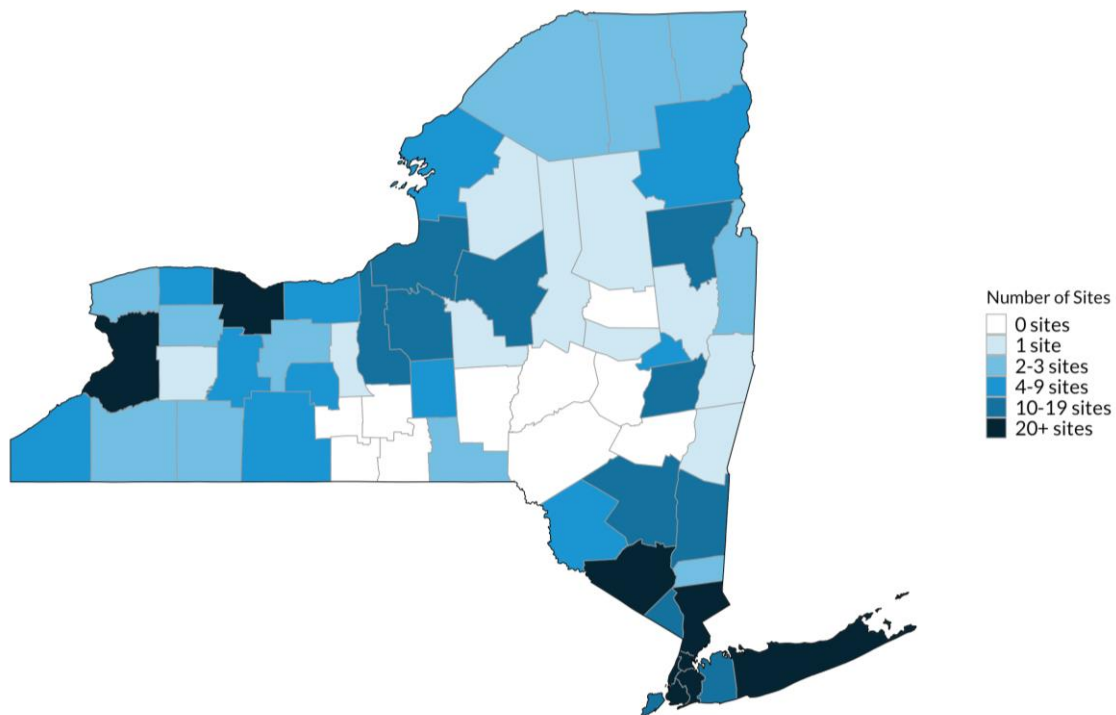
Drawing primarily on data from the UDS, key informant interviews, and focus groups, this section describes key characteristics and the evolution of community health centers in New York, including characteristics and growth in patient population, services offered, and underlying infrastructure that underpins their capacity to deliver equitable care. There is considerable variation across community health centers regarding size, geographic distribution, patients served, and technological sophistication. Community health centers are united by a strong commitment to promoting health equity by providing high-quality and culturally effective care to most underserved New Yorkers and increasing capacity and sophistication to deliver value through integration and coordination of services.

Expanding Delivery Sites to Reach Underresourced Communities

Several focus group participants described New York as a resource-rich state with a long history of investments in the health care system and generous Medicaid benefits that make operating a community health center relatively easier than in less-progressive states. In this context, community health centers have made considerable strides in expanding their footprint across New York, growing from just three sites in New York City in 1967 to 63 FQHCs and seven look-alikes²⁰ with 843 service delivery locations in July 2023 (figure 1).²¹ Community health centers have service delivery sites in 52 of the state’s 62 counties, including almost three-quarters (73 percent) of New York’s rural counties.²² In focus groups, several participants noted that community health centers were often the only health care providers in rural communities and for populations that may otherwise not be able to receive care, such as migrant farm workers and immigrants without documentation. In addition, half of New York’s 252 school-based health centers in 2023 were operated by 26 community health centers.²³

FIGURE 1

Community Health Center Service Delivery Locations, 2023



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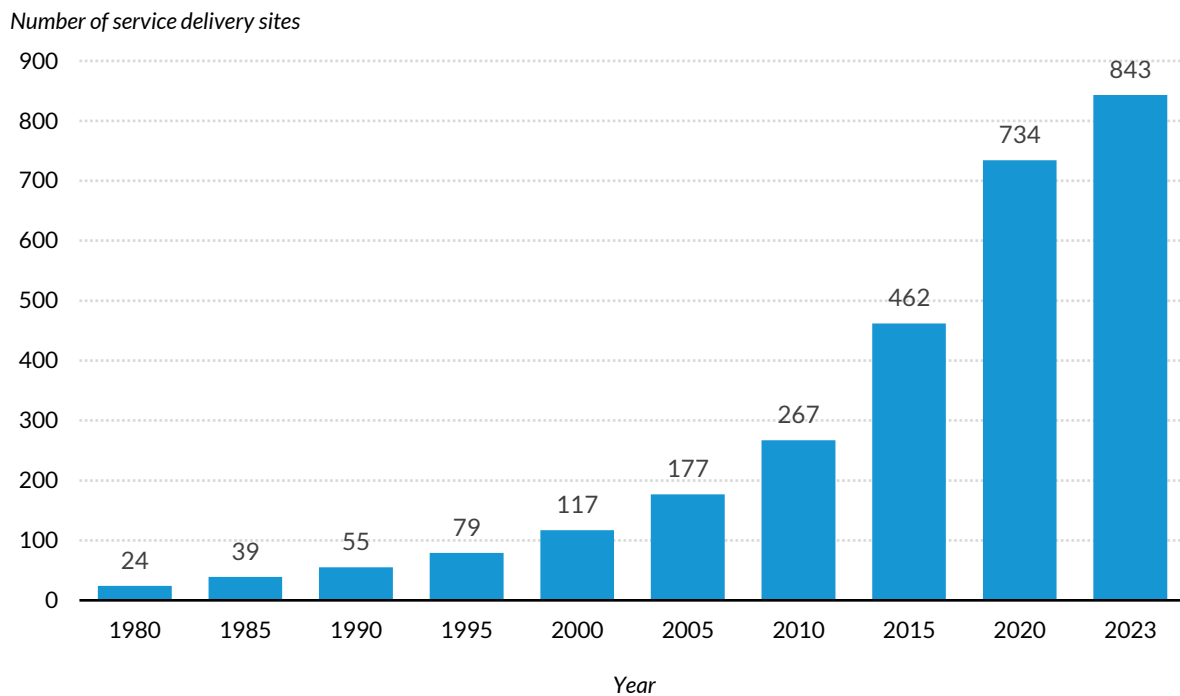
Source: Authors' analysis of data from the Health Resources and Services Administration Data Warehouse: Federally Qualified Health Centers and Look-Alikes in New York State, 2023, accessed July 25, 2023.

Notes: Of the 62 counties in New York, 10 have zero sites, 10 have one site, 11 have two to three sites, 11 have four to nine sites, 11 have 10 to 19 sites, and 9 have 20+ sites (Erie (20), Suffolk (20), Orange (22), Westchester (34), Monroe (41), Queens (51), New York (114), Bronx (143), and Kings (144)).

New York's community health centers expanded service locations steadily, more than doubling the number of service locations every ten years between 1980 and 2010 (figure 2). Following the passage of the Affordable Care Act (ACA) in 2010 and similar to nationwide trends, community health centers in New York experienced more rapid expansion in delivery sites, likely because of increases in direct federal funding and the Medicaid expansion (figure 2; Rosenbaum et al. 2017). The patient population has also grown steadily in this period. Including patients seen at look-alikes, community health centers served 2.3 million patients in 2021 compared with 1.4 million in 2010, an increase of 64 percent (table 1).²⁴ State officials noted that community health centers perhaps expanded too quickly and unnecessarily, which may explain the financial strain some may be experiencing today.

FIGURE 2

Community Health Center Service Delivery Location Growth, 1980–2023



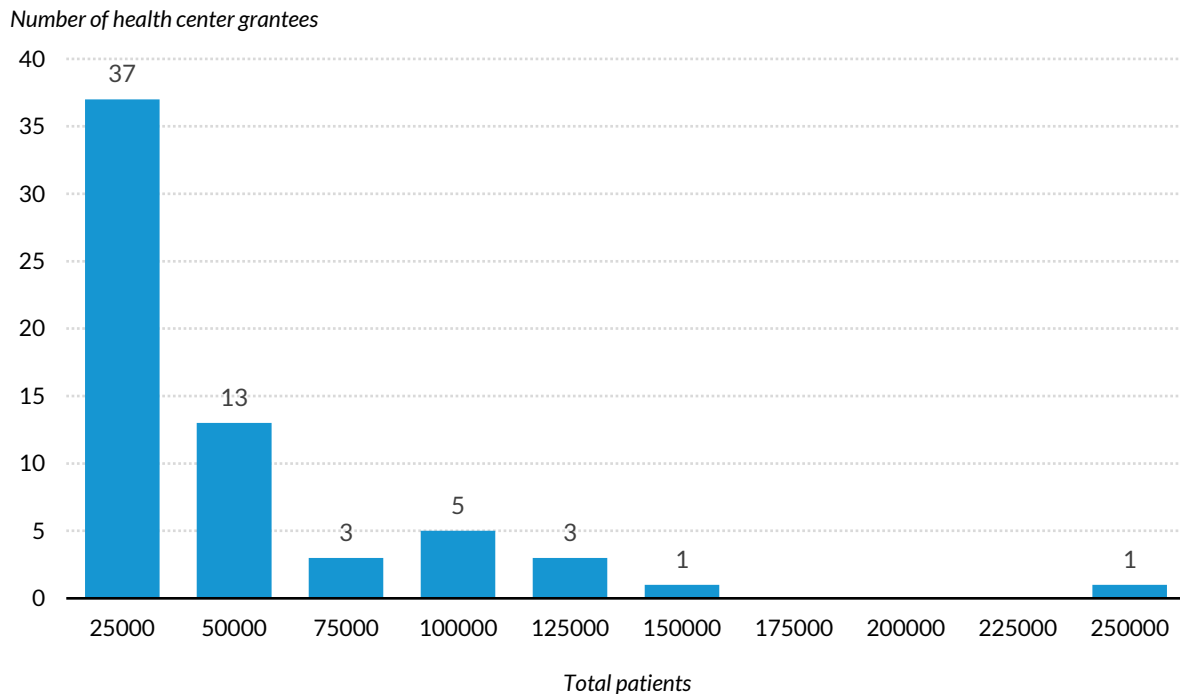
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Source: Authors' analysis of data from the Health Resources and Services Administration Data Warehouse: Federally Qualified Health Centers and Look-Alikes in New York State, 2023, accessed July 25, 2023.

Community health centers in New York vary considerably in size, ranging from smaller centers with two to three delivery sites to large networks spanning several counties and dozens of delivery sites.²⁵ In terms of patients served, most community health centers are small- and medium-sized. Data from New York's UDS report indicate that, collectively, 63 FQHCs served about 2.2 million patients in 2021 (excluding visits at look-alikes), ranging from seeing about 1,000 patients annually to nearly 250,000 patients annually per center (figure 3).²⁶ More than half of community health centers (37) care for less than 25,000 patients a year per center, and another 20 percent (13 grantees) care for 25,000–50,000 patients annually.

FIGURE 3

Variation in Community Health Center Patient Population Volume Served in Federally Qualified Health Centers, 2021



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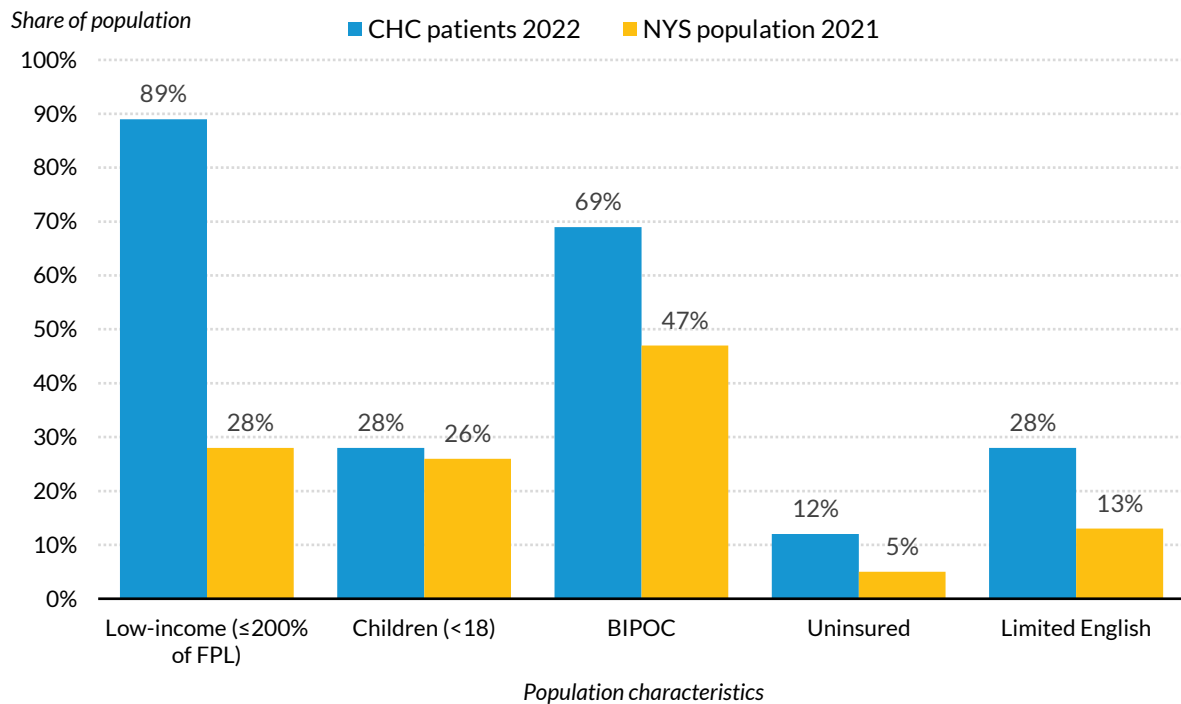
Source: Authors' analysis of 2021 Uniform Data System Report for New York, which includes 63 federally qualified health centers but does not include seven look-alike health centers.

Serving Systematically Underserved Populations

A fundamental mission and common and constant feature of New York's community health centers is their focus on serving the state's most underserved populations, including families in poverty, immigrants without documentation, people experiencing homelessness, and rural communities. Compared with New York's general population, community health centers disproportionately deliver care to people who may be at high risk of experiencing barriers to accessing health care and health inequities, including people with incomes at or below 100 percent of the federal poverty level (FPL; which translates to an annual income of \$30,000 for a family of four),²⁷ those without health insurance, people from racial and ethnic minority groups, and those with limited English proficiency (figure 4).

FIGURE 4

Community Health Center Patients Compared with New York State Population, 2021–2022



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Source: 2021 Uniform Data System Report for New York and the US Census Bureau’s 1-Year American Community Survey data for 2021.

Notes: BIPOC = Black, Indigenous, and other People of Color; CHC= Community Health Center; NYS = New York State; FPL = federal poverty level. Children are defined as individuals under age 18. In the CHC populations, the BIPOC category includes those who did not report their race and ethnicity. Limited English is defined on the Uniform Data System as those best served in a language other than English, and in American Community Survey data as people aged 5 and older reported speaking a language other than English and speaking English less than “very well.”

Table 1 describes shifts in socio-economic and demographic characteristics and insurance status of community health center patients between 2010 and 2021. Over the last decade, the share of community health center patients who live below the poverty line, are people from racial and ethnic minority groups, and have limited English proficiency increased slightly. Reflecting larger demographic trends and a rapidly aging population,²⁸ community health centers cared for fewer children and more than twice the share of older adults in 2021 than in 2010. Several key informants noted that the growth in the Medicare patient population could be attributed to satisfaction with care and the strong relationships patients build with their providers, reflecting community health centers’ capacity to care for people throughout their lifetime and address more complex health needs as patients age. Concerning insurance status, the ACA helped cut the uninsured patients served by community health

centers by half and increased the share of patients with Medicaid or private insurance by more than a quarter between 2010 and 2021 (table 1).

TABLE 1

Community Health Center Patients, 2010–2021

Changes in patient socioeconomic, demographic, and insurance status characteristics

	Share of All Patients		
	2010	2021	Percent change
Total patients	1.3 million	2.3 million	64%
Income			
Income at or below 100% of FPL	68%	71%	4%
Demographic characteristics			
BIPOC	65%	68%	5%
Limited English proficiency	25%	28%	12%
Children (under 18)	33%	28%	-15%
Older adults (65 and older)	7%	11%	57%
Insurance status			
Uninsured	26%	13%	-50%
Medicaid/CHIP	46%	59%	28%
Private insurance	17%	22%	29%

Source: Authors' analysis of Community Health Care Association of New York State fact sheet data from 2012 and 2023.

Notes: FPL = federal poverty level; BIPOC = Black, Indigenous, and Other People of Color; CHIP = Children's Health Insurance Program. BIPOC refers to patients who identify their race and ethnicity as other than non-Hispanic white alone and includes those who did not report their race and ethnicity. Data for Medicaid/CHIP coverage and uninsured rates may reflect the effects of the Medicaid continuous enrollment provision implemented during the COVID-19 pandemic, which required Medicaid programs to keep people continuously enrolled through the end of the public health emergency on March 31, 2023, and resulted in increased Medicaid enrollment during this time.

The considerable diversity of New York's community health centers is also reflected in patient composition (table 2). For example, in 2021, about 70 percent of community health centers had incomes at or below 100 percent of FPL on average; this ranged from about 20 percent of patients for some centers to nearly all patients for others (table 2). Similarly, while the share of uninsured patients remained below 10 percent for about half of community health centers, a quarter of health centers served disproportionately more uninsured people, with some reporting that a quarter to nearly half of their patient population (46 percent) lacked health insurance. While Medicaid is the largest insurer, covering 56.8 percent of all community health center patients on average, this ranged from about a quarter of Medicaid-insured patients for some centers to over 80 percent for others (table 2).

TABLE 2

Variation in Patient Characteristics across Community Health Centers, 2021*Share of community health center patients by income and insurance status*

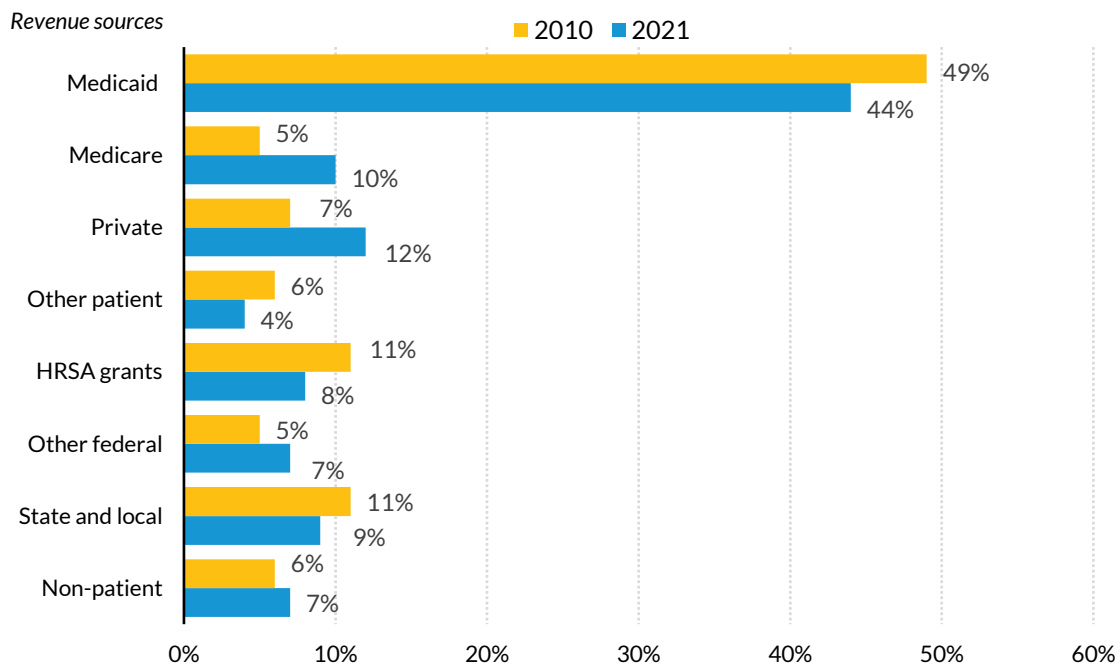
	Average	Minimum	25th percentile	50th percentile	75th percentile	Maximum
Income						
Income at or below 100% of FPL	69.4%	20.4%	54.0%	72.4%	85.5%	99.0%
Insurance status						
Uninsured	11.8%	1.1%	4.7%	9.1%	15.8%	46.2%
Medicaid/CHIP	56.8%	25.1%	49.3%	58.4%	64.0%	81.0%
Medicare	11.3%	1.9%	7.9%	10.9%	14.0%	25.4%
Private insurance	20.4%	4.2%	14.5%	17.3%	23.4%	46.4%

Source: Authors' analysis of 2021 Uniform Data System Report for New York.**Notes:** FPL = federal poverty level; CHIP = Children's Health Insurance Program.

Medicaid is the largest source of New York-based community health center revenues, although the share of Medicaid reimbursement decreased slightly from 49 percent of total revenue in 2010 to 44 percent in 2021 (figure 5). Despite temporary increases in federal funding made available by the ACA and during the pandemic, federal funding as a share of total community health center revenues has shrunk over the last decade and could continue to decline unless federal policymakers prioritize investments in community health centers. Similar decreases are observed in state and local funding streams and other patient revenues, which include other public health insurance and self-pay. On the other hand, reimbursement from Medicare and private insurance has grown considerably between 2010 and 2021. Revenue from nonpatient sources, which include private grants and contracts and interest income, grew modestly as a share of total revenue.

FIGURE 5

Community Health Center Revenue Sources, 2010 and 2021



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Sources: Authors' analysis of Community Health Care Association of New York State fact sheet data from 2012 and 2023.

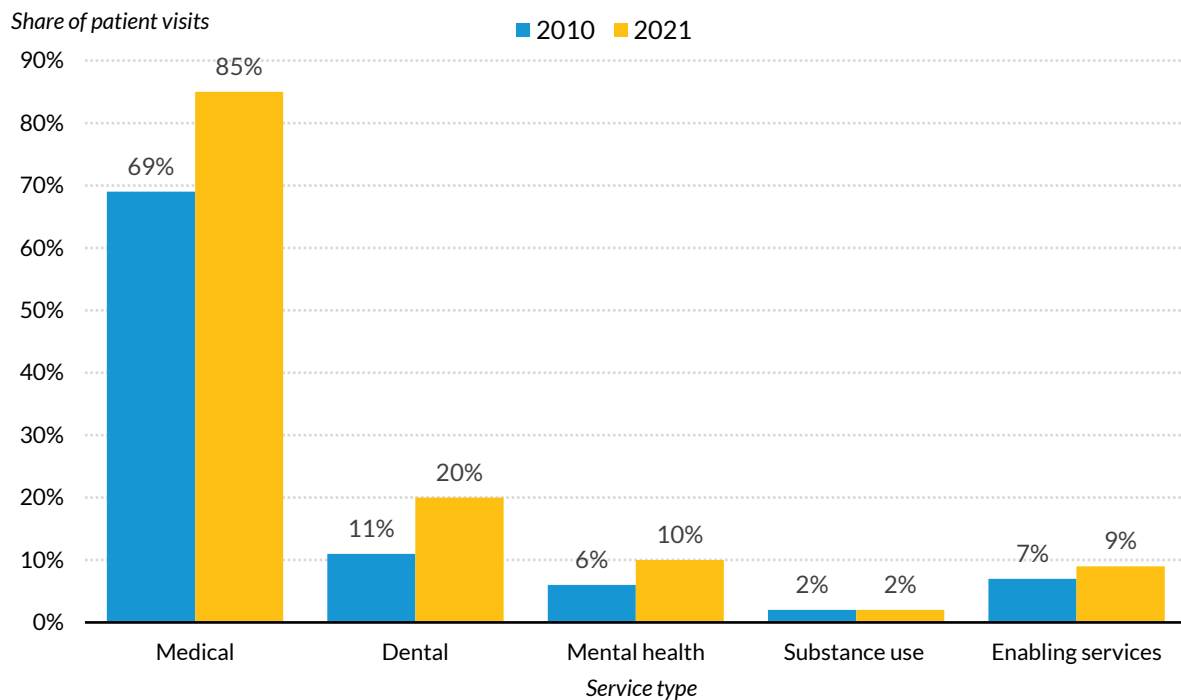
Notes: HRSA = Health Resources and Services Administration. Other patient sources include other public insurance and self-pay. Other federal funding includes opportunities such as Affordable Care Act investments, COVID-19 relief funds, Ryan White, and other miscellaneous federal funding. State and local funding includes grants, contracts, and uncompensated care funds. Nonpatient revenues include fundraising (such as private grants and contracts from philanthropic funders), interest and investment income, rental income, and other.

Growing Sophistication and Capacity to Meet Patient Needs

Many of New York's community health centers have considerably expanded their capabilities and capacity to deliver high-quality, coordinated, and integrated care. While primary care and medical services represent a large share of patient visits, community health centers were more likely to offer dental services, mental health, and enabling services (e.g., case management, health education, transportation) on the same day to their patients in 2021 than in 2010 (figure 6).

FIGURE 6

Community Health Center Services as Share of Patient Visits, 2010 and 2021



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Sources: Authors' analysis of Community Health Care Association of New York State fact sheet data from 2012 and 2021 Uniform Data System Report for New York.

Notes: In 2010, 5 percent of total visits were reported as "other visits" not shown in the figure. Enabling services include a wide range of services that support patients in accessing care and maintaining health, such as case management, outreach, health education, transportation, assistance in enrolling in public benefits and accessing community-based social services, and translation and interpretation services.

Informants reported that New York's community health centers have increasingly focused on integrating behavioral health services, adopting team-based care approaches, and expanding their capacity to focus on prevention, community-based outreach, and social determinants of health (table 3). Focus group participants noted the vital role of community health workers and patient navigators in engaging and supporting people with complex care needs. According to some, the emphasis on providing community-based, culturally effective, and integrated health and social care services under one roof allows community health centers to deliver high-impact care, increasingly regarded as a model for achieving equity.²⁹ Some informants suggested that the value community health centers bring to New York's health care system was spotlighted through initiatives such as DSRIP, and many felt that community health centers had gained greater recognition in recent years from patients, other health care providers, health plans, and the larger health and social sectors in New York. Several focus group

participants reported that their centers’ performance on quality metrics, including diabetes and blood pressure controls, was better than the performance of primary care providers in the same health plan network and suggested the difference could be explained by the community health center approach to primary care which seeks to engage, educate, and support patients.

TABLE 3
Enabling Services, 2022

Share of community health centers reporting various enabling services

Community outreach or community events	91%
Medical insurance enrollment and patient navigation	88%
Assessment and referral to social/community-based services	80%
Community Health Worker/Community Outreach Specialist services	64%
Translation services	59%
Nutrition services	46%
Social service case management or eligibility determination	45%
Supported housing or housing placement programs	45%
Programs for refugees	16%
Homeless shelter	16%

Source: Community Health Care Association of New York State 2022 membership survey.

I have a lot of patients that tell me that [they] used to go to a private doctor's office, and we [community health center] are much better and much more accessible. We're much more full-service; we meet all of their needs, including social, dental, [and] behavioral health needs. They stay with us because we care for them regardless of their insurance status, and we reflect their culture or their language.
-Focus group participant

However, there is also considerable variation among community health centers in services offered (table 4). While three-quarters of community health centers offer dental services, the share of visits for dental services ranged from about 10 percent to nearly 60 percent across the centers in 2021 (table 4). Though all community health centers offer some behavioral health services, averaging around 10 percent of patient visits for mental health and 2 percent of substance use services in 2021, about a quarter of health centers disproportionately provide behavioral health services on site. Similar trends

can be observed for vision and enabling services, with half of community health centers reporting that at least 3 percent of all patient visits included these services (table 4).

Several informants noted that complex licensure requirements, including having to obtain certifications from multiple state regulating agencies (e.g., Department of Health, Office of Mental Health [OMH], Office of Addiction Services and Supports [OASS]), may have inhibited greater integration of behavioral health services in community health centers. However, some community health centers benefited from simplified and more flexible licensure thresholds as part of the DSRIP initiative, designed to promote integrating mental health and substance use services with primary care.³⁰ Furthermore, per enacted fiscal year 2023–2024 state budget, community health centers will be allowed to provide up to 30 percent of mental health and 30 percent of substance use services as a share of total annual visits without having to obtain an OMH or OASAS license (New York State Department of Health 2023).

TABLE 4
Community Health Center Services as Share of Visits, 2021
Distribution of services among community health centers

	Average	Minimum	25th percentile	50th percentile	75th percentile	Maximum
Service type						
Medical services	83.1%	52.1%	76.4%	84.9%	91.1%	100.0%
Dental services	21.8%	0.0%	9.8%	22.1%	28.9%	59.5%
Mental health	9.9%	0.4%	3.2%	5.5%	12.1%	50.4%
Substance use	2.2%	0.0%	0.0%	0.3%	2.0%	36.3%
Vision services	4.3%	0.0%	0.0%	3.2%	7.6%	17.6%
Enabling services	8.9%	0.0%	0.8%	3.9%	11.4%	55.1%

Source: Authors' analysis of 2021 Uniform Data System Report for New York.

Notes: Patients may receive more than one service during a visit. Enabling services include a wide range of services that support patients in accessing care and maintaining health, such as case management, outreach, health education, transportation, assistance in enrolling in public benefits and accessing community-based social services, and translation and interpretation services.

At the same time, New York's community health centers have been upgrading their health information technology and improving data analytics to effectively participate in advanced delivery and payment system models (tables 5 and 6). Today, all community health centers use electronic health records, and the majority can exchange patient health information with other health care entities, including hospitals and emergency departments (table 5). During the pandemic, community health centers rapidly expanded their telehealth capabilities, and the majority reported the capacity to deliver both primary care and mental health services to their patients via telehealth, as well as an array of other health services and patient education (table 5). New York's community health centers have also actively

participated in various state initiatives to improve access to and quality of primary care and move to value-based payment models. Nearly all community health centers that completed the CHCANYS 2022 membership survey reported achievement of the patient-centered medical home (PCMH) certification, and over 40 percent of survey respondents reported participating in accountable care organizations (table 6). Many community health centers that completed the survey reported participating in value-based payment arrangements with Medicaid-managed care plans, with nearly 70 percent reporting having a value-based payment contract in 2022 (table 6).

TABLE 5

Adoption of Health Information Technology by Community Health Centers, 2021

Electronic health records	100%
Health information exchange	87%
Labs or imaging	87%
Hospitals/ emergency departments	75%
Specialty providers	70%
Other primary care providers	44%
Telehealth	100%
Primary care	98%
Mental health	95%
Chronic conditions	68%
Substance use disorder	60%
Nutrition and dietary counseling	57%
Oral health	30%
Consumer health education	24%

Source: Authors' analysis of 2021 Uniform Data System Report for New York.

Notes: Categories under health information exchange describe the types of providers community health centers exchange information with, and those under telehealth show the types of services delivered by telehealth.

TABLE 6

Community Health Center Participation in Advanced Delivery and Payment Models, 2022

PCMH certification	96%
NCQA/PCMH Distinction in Behavioral Integration	24%
Member of an ACO	42%
Medicare ACO	91%
Medicare Advantage ACO	22%
Commercial ACO	22%
MCO VBP arrangements	69%
Upside risk only	79%
Upside/downside risk	45%
Full capitation	21%

Source: Community Health Care Association of New York State 2022 membership survey.

Notes: PCMH = patient-centered medical home; NCQA = National Committee for Quality Assurance; ACO = accountable care organizations; MCO = managed care organization; VBP = value-based payment.

Promoting Equity through Jobs and Workforce Training

Community health centers are an important source of economic activity and employment in underresourced communities and differentiate themselves as employers who can offer meaningful mission-driven job opportunities and career advancement from entry-level jobs through homegrown talent development and training (Ku et al. 2022). In 2021, community health centers employed over 20,000 New Yorkers, including over 13,000 full-time clinicians and ancillary staff, and generated an estimated \$6 billion in total economic output (MGA 2023).³¹ Based on a 2022 CHCANYS membership survey, many community health centers reported training clinicians and ancillary staff, such as community health workers, and participating in various health workforce training programs (table 7). Clinician training in community health center settings provides opportunities for trainees to better understand social drivers of health and inequities and develop skills to effectively address them (Taylor et al. 2022). Community-based medical residency programs are also a prominent US strategy to address health workforce shortages in underserved areas.³²

TABLE 7

Community Health Center Participation in Health Profession Training Programs, 2022

	Share of CHCs participating
Physician training programs	
National Health Services Corps loan repayment	84%
National Health Services Corps scholarships	46%
Informal rotation programs	46%
J-1 visa waiver program	34%
Residencies programs	30%
Doctors Across New York	32%
Fellowship programs	20%
Nursing and other health profession training programs	
National Health Services Corps nursing	38%
Licensed Practical Nurse/Registered Nurse training	21%
Community Health Worker training	13%

Source: Community Health Care Association of New York State 2022 membership survey.

Notes: CHC = Community Health Center. The J-1 visa waiver program allows foreign medical graduates to practice for three years in health professional shortage areas in the US. Doctors Across New York is a state-funded loan repayment program in exchange for three years of service in underserved communities.

One informant noted, however, that workforce training programs are administratively complex and expensive to operate (e.g., meeting residency program requirements or reducing staff productivity) and may thus contribute to a considerable share of the center's operational costs. Importantly, informants repeatedly emphasized that they face challenges in hiring and retaining staff, particularly following the COVID-19 pandemic and mass burnout felt by clinical and nonclinical health workers (National Council for Mental Wellbeing 2021; Rotenstein et al. 2023).

While workforce challenges loom large across the health care sector, community health centers may feel them more acutely because salaries they can offer on nonprofit budgets may not necessarily be competitive. Several focus group participants reported losing clinicians, including nurses and dental hygienists, to better-paid positions at local hospitals and private clinics. Many noted vacancies related to the inability to pay competitive salaries, particularly regarding hiring specialists such as dentists and neurologists. Others added that nursing salaries increased by as much as 50 percent in two years, and raising the minimum wage in New York adds to labor costs and puts more pressure on community health center budgets. While informants assured us that community health centers are committed to supporting equity, including through paying living wages to their employees, they are also concerned that absent major workforce development investments and funding increases, they will not be able to fully staff their existing clinics, let alone bring in additional services.

Medicaid PPS

The Medicaid Prospective Payment System was established by federal law in 2000, requiring states to set the Medicaid per-visit reimbursement rates for community health centers based primarily on their average costs for providing services that are “reasonable and related to the cost of furnishing such services” (MACPAC 2017).³³ Following the law, New York set the initial PPS rates based on the average costs incurred by community health centers in fiscal years 1999 and 2000. The base PPS rate was calculated using allowable capital cost per visit and allowable operating costs per visit, with operating costs further classified into six expenditure categories (box 1). Average per-visit costs are calculated by dividing costs across expenditure categories by total number of patient visits. The average per-visit costs are then compared with ceilings, which are based on the average operating costs of a peer group comprised of other diagnostic and treatment centers located in the same region, which New York classified as downstate, upstate urban, and upstate rural (table 9). PPS rates for community health centers that began operating after 2001 are set using the peer groups based on the average costs of community health centers and other facilities operating in the same rating area. The PPS rates are annually adjusted by the Medicare Economic Index (MEI) to account for growth in practice costs and can be further modified per changes in the scope of services.³⁴ More details on key features of New York Medicaid PPS can be found in Appendix A.

BOX 1

Key Features of the New York State Medicaid Prospective Payment System

- Prospective payment system rates for each community health center were established based on average annual costs for services delivered in 1999 and 2000.
- Prospective payment system rates for community health centers that opened after 2001 were established using a “peer group” methodology, calculated as the average annual operating costs of select community health centers and other diagnostic and treatment centers in the same area.
- Community health center operating costs are divided into six expenditure categories: (1) administration, (2) medical, (3) dental, (4) therapy, (5) patient transportation, and (6) ancillaries.
- Each expenditure category has a fixed rate ceiling, calculated as 105 percent of the applicable peer group’s average operating costs in the same expenditure category.
- Rate ceilings are further adjusted based on geographic variation in expenditures into three groups: (1) downstate, (2) upstate urban, and (3) upstate rural, and are annually adjusted by the Medicare Economic Index.
- Community health centers can file a rate appeal based only on a change in the scope of services or capital cost changes.

Sources: Key informant interviews; “Cmty. Healthcare Assoc. of N.Y. v. N.Y. State Dep’t of Health,” 921 F. Supp. 2d 130 (SDNY 2013), accessed September 14, 2023, <https://casetext.com/case/cmty-healthcare-assoc-of-ny-v-ny-state-dept-of-health>; “Rate Appeals for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs),” New York State Department of Health, accessed August 1, 2023, https://www.health.ny.gov/health_care/medicaid/rates/apg/providers/.

Comparing Patient Care Costs to PPS Payments

To assess how community health center patient care costs compare to PPS ceilings, we analyzed AHCF cost report data for 47 community health centers, representing slightly over half (58 percent) of 81 centers that completed AHCF reports in 2020 and 2021. The patient counts for the centers in these reports total just over 1.3 million. According to CHCANYS data, approximately 2.3 million patients were served by all community health centers statewide in 2021.³⁵ We then compared the costs to 2021 PPS ceiling rates per visit in the appropriate region of the state (table 9).

TABLE 9

New York State Medicaid PPS Ceiling Rates per Visit, as of October 1, 2021

Cost Category	Downstate	Upstate urban	Upstate rural
Administration	\$49.63	\$27.06	\$31.23
Medical	\$147.43	\$88.74	\$89.06
Dental	\$130.51	\$85.22	\$99.56
Therapy	\$163.37	\$121.96	\$123.26
Patient transportation	\$1.20	\$0.33	\$1.13
Ancillaries	\$25.21	\$7.04	\$24.53

Source: “FQHC Ceilings,” New York State Department of Health, accessed November 10, 2023, https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_ceilings.htm.

Note: Downstate ceilings apply to health centers whose principal site is in the counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. Rural ceilings apply to health centers reporting that rural ceilings applied to their rates. Upstate urban ceilings apply to centers in any other county.

Figures 7 through 12 report the detailed range of per-visit costs relative to the ceiling in each cost category. Figure 12 reports the distribution of total costs per threshold visit relative to a constructed total ceiling for each center. To construct the total ceiling, we added the ceilings for administration, transportation, and ancillary services to a center-specific weighted average ceiling for medical, dental, and therapy visits. For these figures, the height of each bar represents the number of total visits in each range of the cost-to-ceiling ratio.

A value of 1 or less indicates that the center is operating at or below its Medicaid PPS ceiling across all patients (represented by blue bars in figures 7 through 13). A value greater than 1 indicates that the center’s per-visit costs exceed the 2021 PPS ceiling rates (represented by yellow bars in figures 7 through 13). Our results indicate that for most centers and visits included in the analysis, operating, health care delivery, and enabling services costs exceed applicable PPS ceilings in most cost categories. Table 10 reports summary statistics from these data across six cost categories.

TABLE 10

Summary Statistics on Costs per Visit Relative to New York Medicaid PPS Ceiling Rates, 2021

Reported across cost categories, results weighted by number of visits

	Administration (n=47)	Medical (n=47)	Dental (n=40)	Therapy (n=44)	Ancillary (n=47)	Patient transportation (n=27)	Total cost (n=47)
Mean	2.25	1.58	1.94	1.25	0.72	0.94	1.62
Minimum	0.41	0.28	0.78	0.07	0.01	0.00	0.23
Median	1.70	1.45	1.77	1.11	0.40	0.27	1.44
75 th percentile	2.72	2.04	2.20	1.42	0.63	1.06	1.97
90 th percentile	3.43	2.12	3.36	1.92	1.35	1.80	2.30
Maximum	9.33	3.33	3.97	8.21	8.67	9.50	4.07

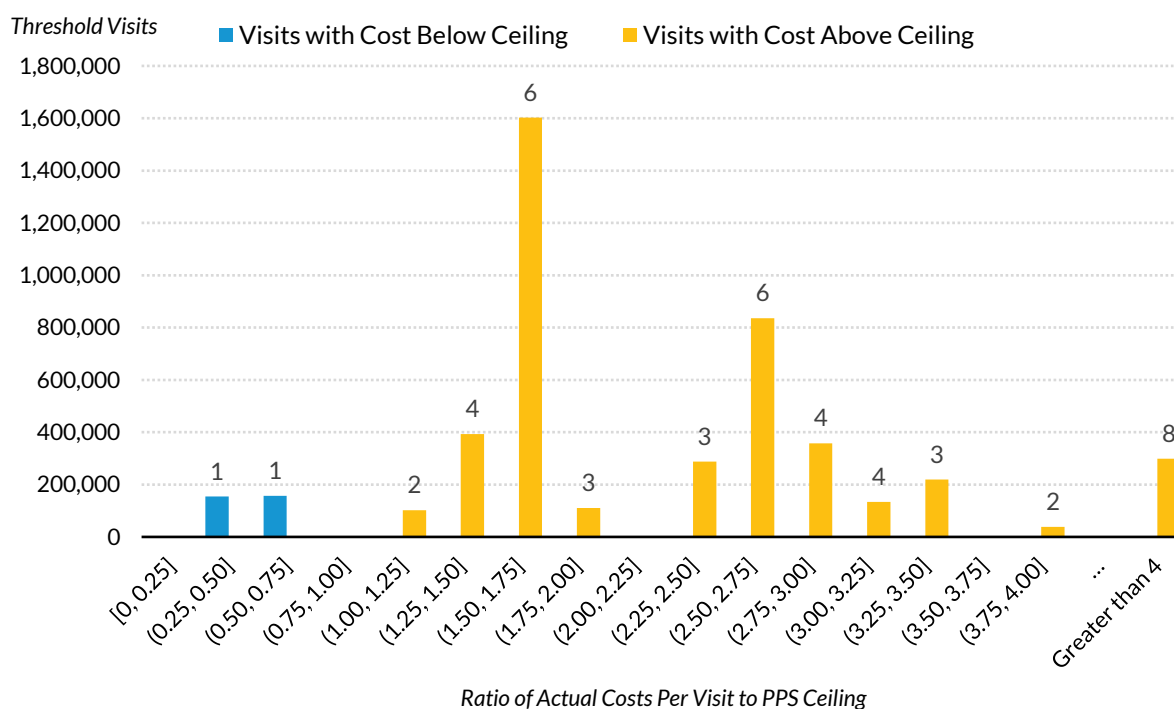
Source: Authors’ analysis of AHCF cost reports for 47 community health centers in New York State.

ADMINISTRATION COSTS

Figure 7 reports these cost-to-ceiling ratios for administration costs, which include staff and materials costs not directly used in patient care. Only two centers (represented in the blue bars) out of 47 in the sample were operating below their ceiling rates in this cost category. Combined, these two centers accounted for approximately 311,000 threshold visits, or 6.6 percent, of the nearly 4.7 million visits across the centers represented. The first column of table 10 above reports that administration cost ratios ranged from a minimum of 0.41 to 9.33 times the center's ceiling. The mean administrative cost ratio across all visits was 2.25, and the cost ratio for the median visit was 1.70.

FIGURE 7

Administration Costs per Threshold Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

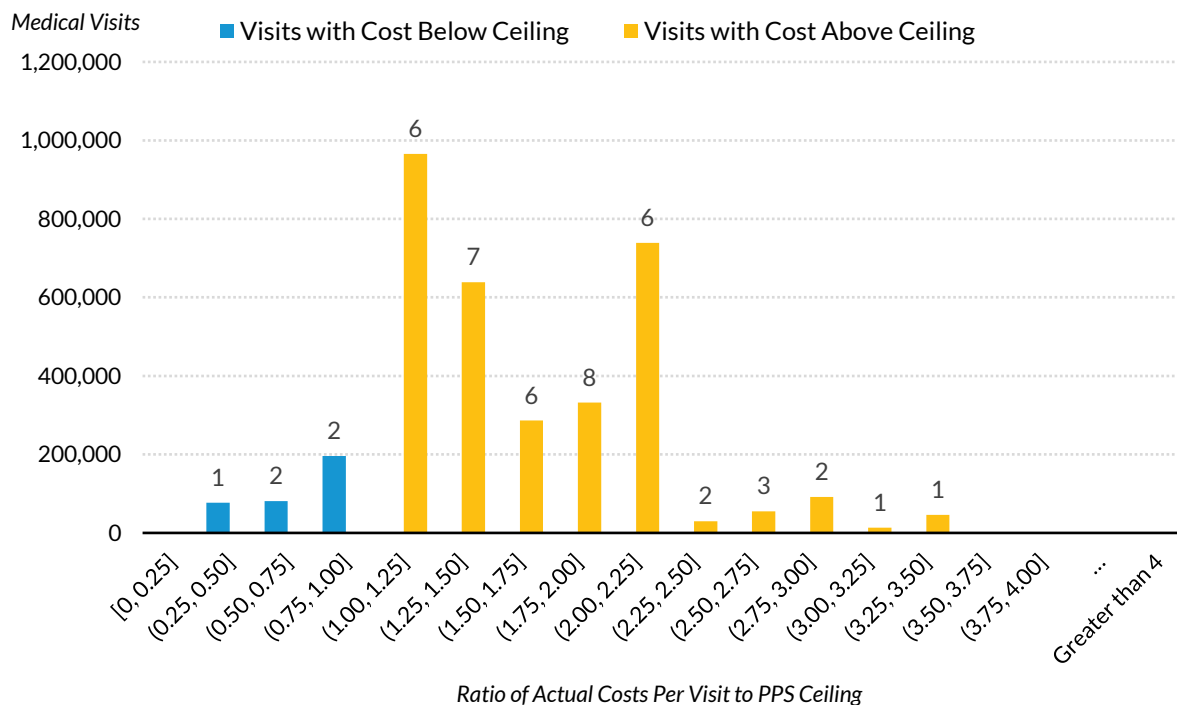
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

MEDICAL VISITS

Figure 8 reports findings for medical visits, which include primary and specialty care other than mental health. As with administration costs, most centers (42 out of 47 reporting medical visits, represented by

yellow bars) had medical costs at or above the ceiling rate. The five centers (represented by blue bars) operating below their ceilings delivered about 10 percent of the visits across the reporting centers. As shown in table 10 above, the mean cost ratio for medical costs was 1.58 times the PPS ceiling, while the median ratio was 1.45. The maximum cost ratio was 3.33.

FIGURE 8
Medical Costs per Medical Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

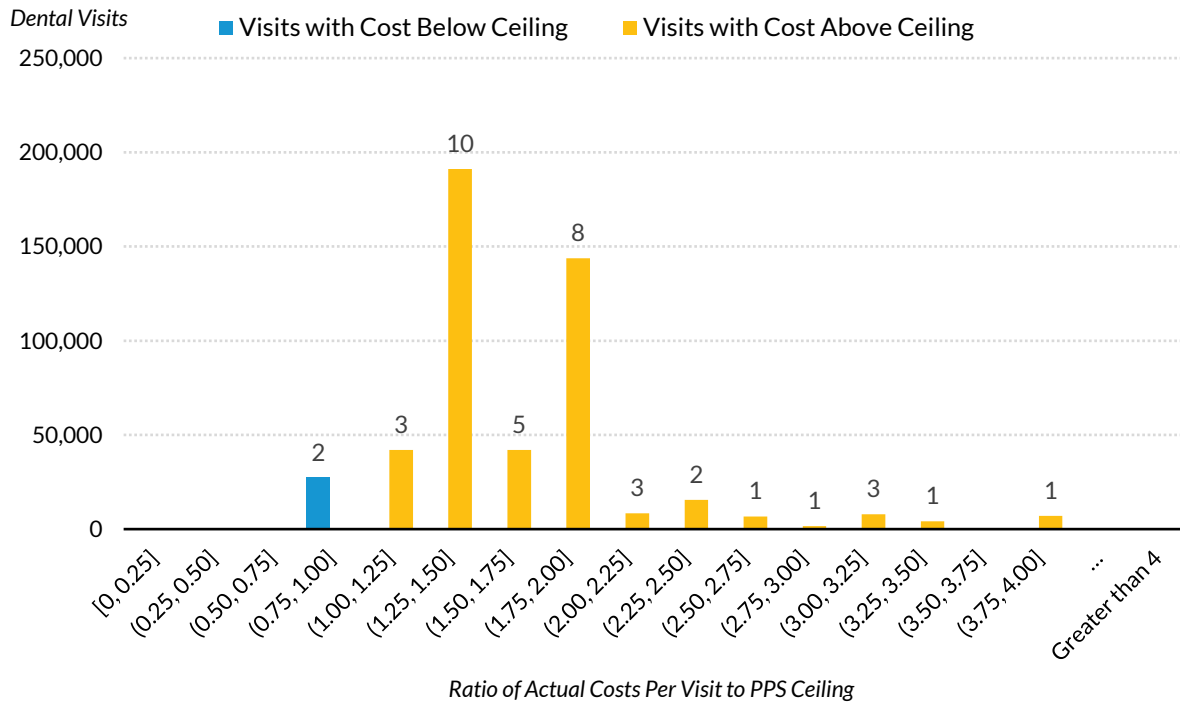
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

DENTAL VISITS

The distribution of dental cost-to-ceiling ratios was similar to that of medical costs. Figure 9 shows that only 2 of the 40 centers providing dental care (delivering 5.5 percent of all dental visits) were operating below their ceiling (blue bar). The remaining 38 centers providing dental care were operating above their ceiling (yellow bars). The maximum ratio for dental costs was 3.4, while the mean was 1.94 and the median was 1.77 (table 10 above).

FIGURE 9

Dental Costs per Dental Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

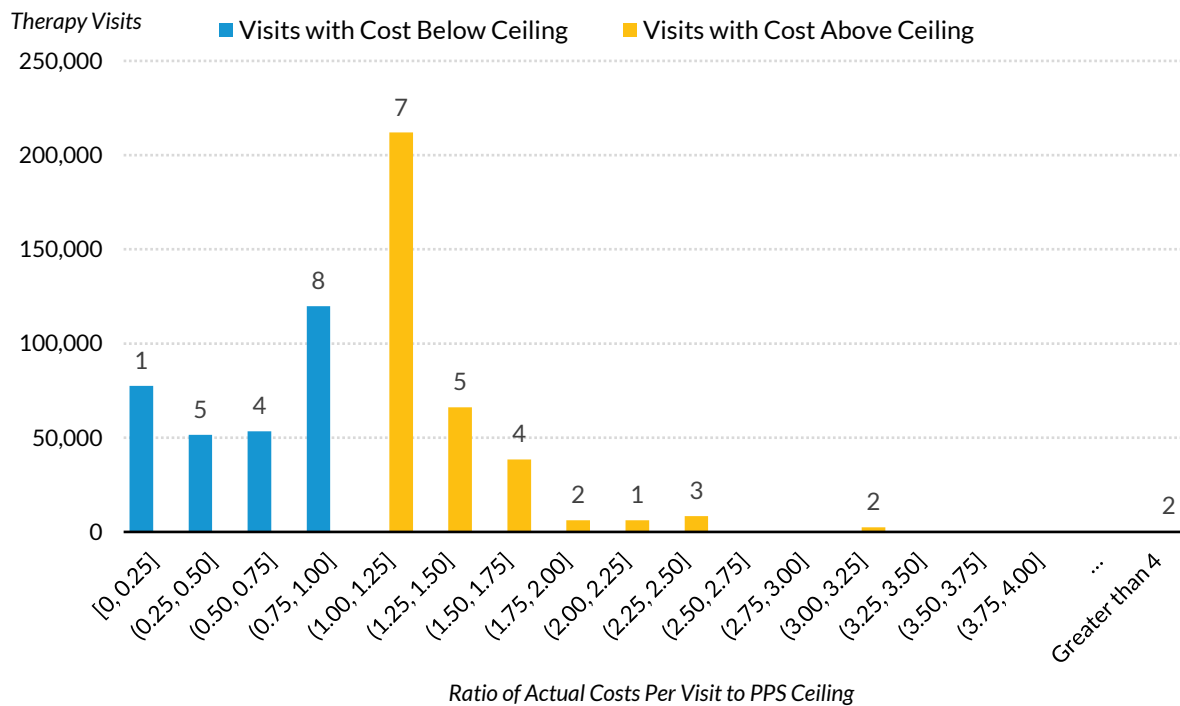
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

THERAPY VISITS

Figure 10 shows that among the reporting centers that provided therapy services (mental health plus physical, occupational, speech/hearing, and vocational therapy), a larger share of visits was delivered at costs below their ceilings than for medical or dental visits. Approximately 47 percent of therapy visits were delivered in the 18 centers operating below their PPS ceiling, represented in blue bars. Table 10 above shows that the distribution of cost ratios was wider, ranging from a low of 0.07 to a high of 8.21 times the PPS ceiling. However, because the high ratio values represent a very small number of centers and visits, the median (1.25) and mean (1.11) per-visit cost ratios were closer to 1 than the ratios of either medical or dental services.

FIGURE 10

Therapy Costs per Therapy Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

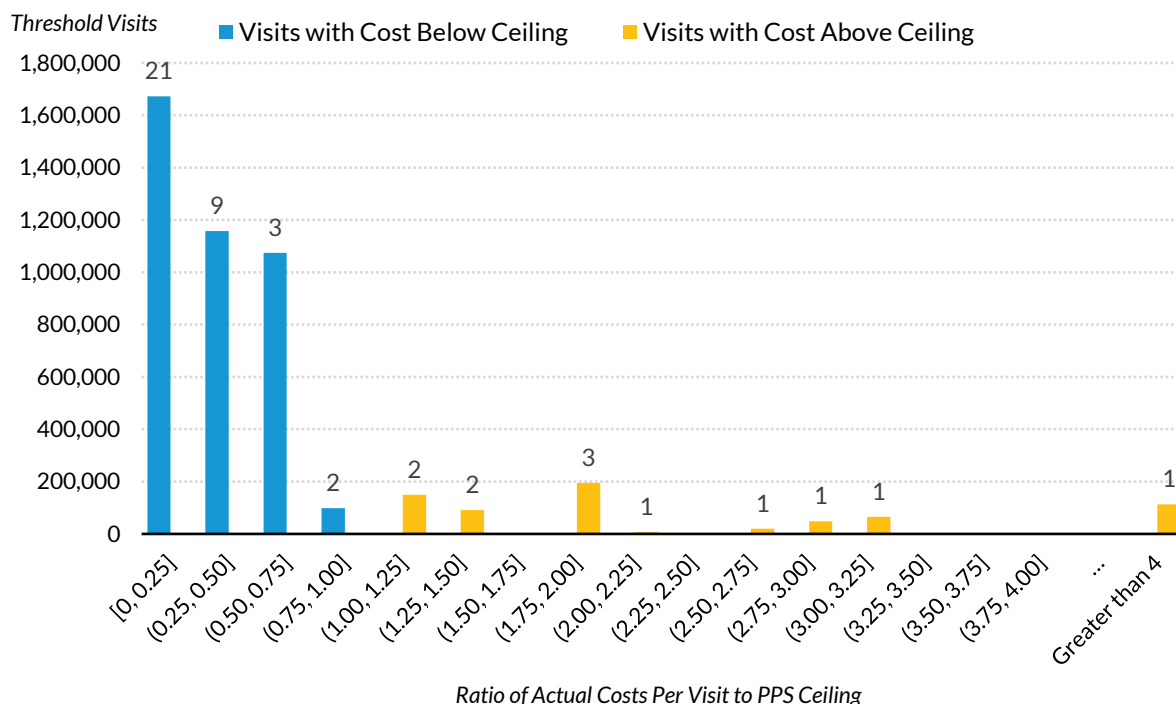
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

ANCILLARY COSTS

Figure 11 reports on ancillary costs (pharmacy, x-ray, lab tests), showing that most centers (35 of 47, providing 85 percent of visits) operate below their respective ceilings. While the maximum cost ratio is 8.67 times the ceiling rate, the ancillary costs of the mean visit were 0.72 times the ceiling, and the median visit cost was 0.40 times the ceiling.

FIGURE 11

Ancillary Costs per Threshold Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

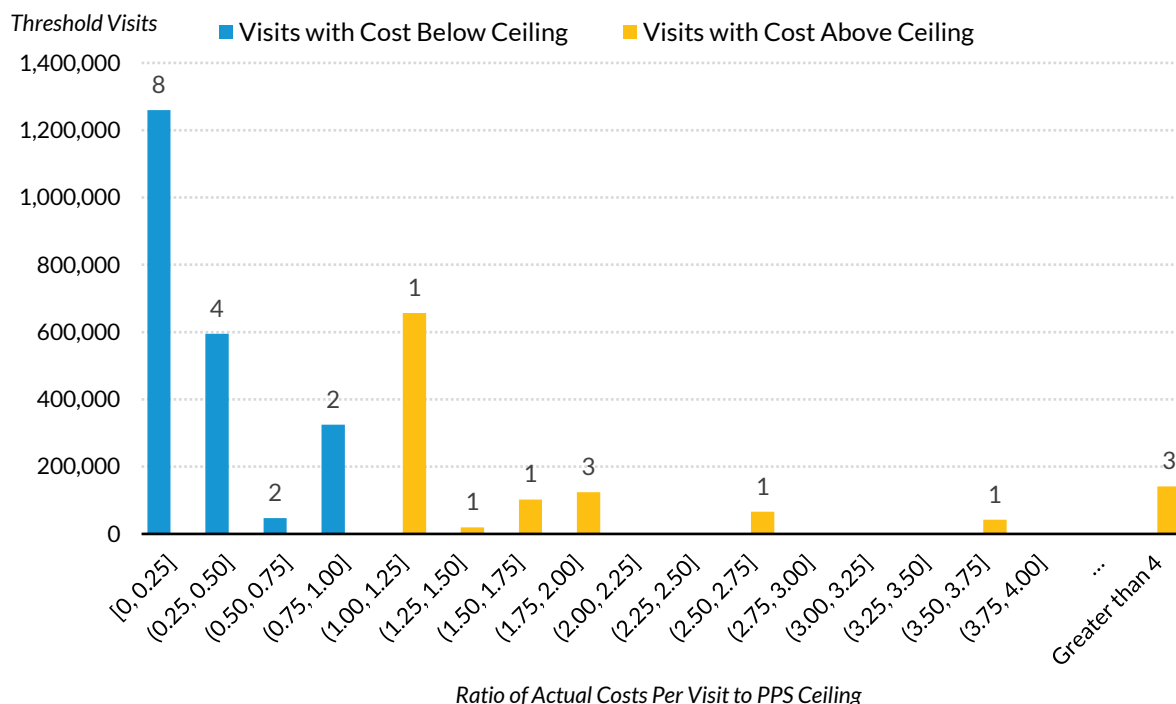
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

PATIENT TRANSPORTATION COSTS

Figure 12 reports findings for patient transportation costs. Twenty centers do not have such costs, and among the 27 that do, slightly more than half (16 of 27 centers) operate below their per-visit ceiling, serving 66 percent of visits where transportation costs are present (blue bars). Table 10 shows that while at the high end among the 27 centers that provided transportation, one center had per-visit transportation costs that were more than nine times the ceiling, the average visit's costs were just below (0.94) the ceiling and the median cost ratio for patient transportation was 0.27.

FIGURE 12

Patient Transportation Costs per Threshold Visit Relative to PPS Ceiling, 2021



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Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

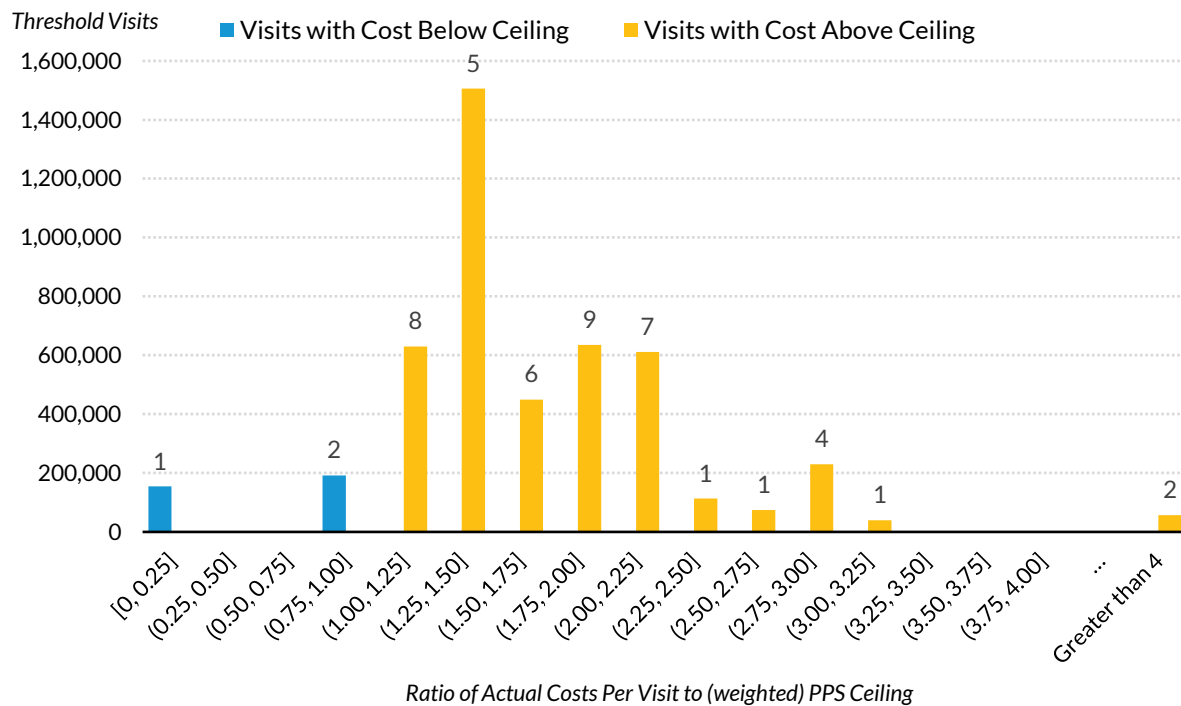
Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, yellow represents centers that report costs at or above the ceilings in this category, and black represents centers that reported no costs in this category.

TOTAL COSTS

Finally, figure 13 combines all operating costs and compares them to a total ceiling rate across cost categories. For each center, the combined ceiling was calculated by applying the shares of medical, dental, or therapy visits to their respective ceiling rates and adding the ceilings for the other three categories (administration, ancillary, and transportation), which apply to any type of visit. Three centers, with 7.4 percent of all visits, operated below their combined ceilings (blue). On average, threshold visits across the 47 centers cost 1.62 times the combined PPS ceiling rate, and the median visit costs 1.44 times the combined threshold. This means that for most patient visits, costs exceed the combined PPS ceiling by at least 44 percent.

FIGURE 13

Total Costs per Threshold Visit Relative to Combined (Weighted by Visit Type) Ceiling, 2021



URBAN INSTITUTE

Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

Notes: The number of centers in each cost ratio interval is reported above the respective bar. Blue represents centers that operate under cost ceilings in this service category, and yellow represents centers that report costs at or above the ceilings in this category.

Across the 47 reporting centers, (1) medical services accounted for 52 percent of total operating (noncapital) costs, (2) administration accounted for 30 percent, (3) therapy services accounted for 7 percent, (4) dental services accounted for 7 percent, (5) ancillary services accounted for 3 percent, and (6) transportation accounted for less than 1 percent. Thus, for the first four service categories that account for 96 percent of costs, most centers spend more per visit than the PPS ceiling, and the average per-visit rate is above the ceiling. This suggests that the annual MEI adjustment to ceilings has not sufficiently kept up with the growth in practice costs.

REGIONAL VARIATION

Table 11 reports statistics on the ratio of total costs per visit to the PPS ceiling for each center, weighted by the fraction of the center's threshold visits that were medical-, dental-, or therapy-related. These calculations indicate that health centers whose principal site was in one of the 12 downstate

counties had somewhat lower cost-to-ceiling ratios than centers in upstate counties, while centers in upstate counties had the highest cost-to-ceiling ratios. The mean visit in downstate counties had costs that were 1.43 times the PPS ceiling, while the mean visit in both urban and rural upstate counties had more than twice their respective ceilings.

TABLE 11
Summary Statistics on Costs per Visit Relative to New York Medicaid PPS Ceiling Rates, by Rate Region, 2021
Results weighted by the number of visits

	Statewide	Downstate	Upstate urban	Rural
N	47	30	13	4
Mean	1.62	1.43	2.05	2.03
Minimum	0.23	0.23	1.24	1.69
Median	1.44	1.33	2.11	1.79
75 th percentile	1.97	1.52	2.11	1.95
90 th percentile	2.30	2.02	2.84	2.87
Maximum	4.07	4.07	4.03	2.87

Source: Authors' analysis of AHCF cost reports for 47 community health centers in New York State.

Note: Downstate ceilings apply to health centers whose principal site is in the counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. Rural ceilings apply to health centers reporting that rural ceilings applied to their rates. Upstate Urban ceilings apply to centers in any other county.

Our analysis of community health center costs relative to PPS ceilings indicates that if the PPS rate ceilings were rebased to reflect the 105 percent of the mean cost per visit, as was the case when the PPS was established (table 10), several of the ceilings would have to be raised substantially, while others could be reduced. For example, the ceiling on administrative costs would have to increase by 125 percent (mean ratio multiplied by 1.05, minus 1), while the ceilings for medical, therapy, and dental services would have to increase by 66, 104, and 31 percent, respectively. On the other hand, ceilings on ancillary and patient transportation costs could be reduced by 24 and 1 percent, respectively. Our analysis shows, however, that rebasing to that level would leave many centers operating at a loss. Were the PPS system rebased so that 75 percent of visits could be delivered for below the maximum reimbursable rates, ceiling rates would have to increase by 172 percent for administrative costs, 6 percent for patient transportation costs, 104 percent for medical visits, 120 percent for dental visits, and 42 percent for therapy visits, while ceilings for ancillary costs could be reduced by 37 percent. The findings reported in table 11 suggest that relative increases in ceilings in upstate urban areas may need to be greater than those in downstate counties.

Our findings suggest that the operating costs of many community health centers in New York exceed the established PPS ceilings, but because of data limitations described in the Methods section on

page three, we cannot definitively estimate the total cost difference or the variation in how individual community health centers may be affected. The results, however, indicate that a more thorough and complete analysis of health center costs may be warranted to fully understand the scale of investment needed to update the cost ceilings to levels that accurately reflect the cost of providing services.

DISCUSSION

Community health center informants suggested that discrepancies between costs and PPS rates may be driven by several factors, including how rates and ceilings are calculated, geographically adjusted, and what services are included (see Appendix A for more details). Some community health center representatives in focus groups reported that the Medicaid shortfall poses a major barrier to enhancing and expanding services critical for promoting health equity, such as improving health information systems, integrating additional specialty services, or hiring more community health workers, interpreters, and nutritionists. As an example, one informant described that instead of hiring a psychiatrist, a health center might only be able to hire a social worker, which would reduce access to care for patients with mental health conditions who may also be most affected by health disparities.

Strategic investment in community health centers through the Medicaid program would allow them to expand their reach among underserved populations. Many informants believed this could be accomplished by updating the PPS rates based on more recently incurred operating costs. State officials acknowledged that PPS rates were set a long time ago and probably need to be updated, but they also noted that community health centers have the option to participate in an alternative rate-setting methodology known as the ambulatory patient groups, which has been available since 2010.³⁶ State officials noted that under the ambulatory patient group methodology, community health centers are guaranteed to receive payments that are at least equal to their PPS rate but may be paid more. State officials noted that 16 community health centers currently participate in the ambulatory patient group program and view it as a viable alternative to the PPS methodology. However, the low uptake of the ambulatory patient group program among community health centers suggests that most centers do not see it as such.

In addition, community health center informants also recognized that a PPS model tied to the volume of patient visits is limited in rewarding high-quality care or accounting for nontraditional services that are critically important in serving underserved populations, such as community outreach, patient navigation, and linkages to community resources. One informant expressed this idea as the need for an alternative payment approach that allows the health center to choose how to spend its resources in a way that makes the greatest impact. Overall, community health center respondents were open to

pursuing alternative payment models that would provide centers more flexibility to invest in services outside of the office visit or reward them for providing high-quality and equitable care. Medicaid officials expressed support for advanced payment models for community health centers that would encourage more integration of primary care and behavioral health care with services that address health-related social needs.

Supplemental Payment Program

While our discussions with key informants focused greatly on their experiences and concerns with the PPS policy, we also touched on their experiences with the Medicaid managed care supplemental payment program, also known as a “wrap” program.³⁷ Like other states with Medicaid managed care, each managed care organization (MCO) in New York negotiates its contract and payment rates with community health centers or an independent practice association in its network. Because of federal regulations, community health centers are guaranteed a reimbursement at least equal to their established PPS rate; the supplemental payment program pays each community health center for any difference between total MCO payments and what the center would have been paid under the PPS (MACPAC 2017).

Per a recent directive from the Medicaid agency, MCOs and community health centers must contractually agree on payment rates for mental health and substance use services that are at least equal to their full PPS rates from those services.³⁸ Mental health and substance use services are therefore excluded from the wrap program, and if MCO payments to a community health center for these services are lower than their negotiated PPS rate, the community health center must file a complaint with the New York Department of Health for the state to take action against the MCO. However, according to key informants, there is no clear mechanism established or communicated to community health centers on how to get their full payment for mental health and substance use services in the event of partial or no payment by MCOs (i.e., wrap billing codes were never established for these services). For this reason, some community health centers reportedly approach MCOs directly to recoup these payments through settlement rather than filing a complaint with the state. Indeed, state officials noted that no community health center has ever filed such a complaint as of early 2023.

To participate in New York’s supplemental payment program, community health centers must file a Managed Care Visit and Revenue report annually and claim their wrap payments for eligible services within 90 days of the service date.³⁹ Available data suggest a considerable share of Medicaid payments to community health centers is delayed. Almost a third (31 percent) of Medicaid payments to

community health centers in 2020 were supplemental wrap payments, of which 10 percent were payments for services delivered in 2019 (table 2 in Rosenbaum et al. 2022).

Informants across the board agreed that the supplemental program is administratively burdensome and delays a significant portion of community health centers' payments, which may pose a financial strain, particularly on smaller centers. According to the Centers for Medicare & Medicaid Services, states may require MCOs to make full PPS payments to community health centers by submitting a state plan amendment to the Centers for Medicare & Medicaid Services.⁴⁰ New York Medicaid officials expressed support for requiring New York's MCOs to reimburse community health centers in their networks at full PPS rates for all services in addition to already-established requirements for behavioral health services. This would eliminate the administrative burden for both community health centers and the Medicaid agency and improve cash flow for the centers, providing them with more flexibility to readily invest in services, staffing, and infrastructure (Rosenbaum et al. 2022). Given that some community health centers have reportedly had challenges getting the full PPS payments for mental health and substance use services from MCOs as currently required, a transition away from the supplemental payment program could be supported by establishing mechanisms to ensure MCOs compliance and for community health centers to claim full payments in the event of partial or no MCO payment.

Policy Implications

Our analysis highlights unique opportunities to align New York's objective of creating an equitable health care system with policies and payment approaches supporting that goal. Because community health centers are a critical source of care for underserved populations with limited ability to pay for their care, investments in community health centers should be central to health equity efforts. Medicaid reimbursement is an important source of community health center funding, and available research suggests that care delivered to Medicaid enrollees at community health centers is more cost-effective than when delivered by other providers (Michigan State University 2022; Nocon et al. 2016; Richard et al. 2012). Many New York community health centers are well-positioned to effectively address deep racial and ethnic disparities in health care and health outcomes. Several actions could strengthen and expand community health centers' capacity and reach to support New York's objective of creating an equitable health care system. These include but are not limited to (1) updating the PPS rates, (2) developing an alternative payment model specific to advanced primary care, and (3) requiring managed care plans to make full PPS payments for all services delivered by community health centers.

Updating the PPS rates, also known as rebasing, would be an important first step to simplifying payment and adding transparency to primary care financing in New York State. Our findings suggest that PPS rebasing could focus on parity across rating regions and reconsider the inflation factor. Additionally, rebasing would serve as a starting point to develop advanced payment models for community health centers since any payments received through an alternative payment model must be at least equal to PPS rates (MACPAC 2017), and health centers may be more willing to take on risks if the baseline payments more realistically reflect actual costs. For example, a bill passed by the Maine legislature in 2022 requires that MaineCare rebases the Medicaid PPS rates for community health centers before establishing an alternative payment model.⁴¹ Informants noted that any adjustments to PPS rates should not result in reductions from current payment levels for any community health centers. Kansas Medicaid adopted this approach when rebasing PPS rates in 2021.⁴²

The second step to realizing the promise of community health centers in support of New York's health equity objectives is developing an alternative payment model specific to advanced primary care. New York State has shown sustained interest in developing advanced and equity-focus payment models as part of its strategy for reducing disparities, including its participation in the DSRIP program and, most recently, through its 1115 waiver amendment (New York State Department of Health 2022). Other states, including California, Iowa, Oregon, Massachusetts, and Minnesota, have tested alternative payment models for community health centers that may prove insightful for New York (Bailit Health and NAMD 2016; Hostetter and Klein 2022). New York's alternative payment models could center equity by including temporary upfront payments to support capacity building (particularly for smaller and less-resourced community health centers), assessing providers' improvements against their historical data, or risk-adjusting performance targets for community health centers (SHVS 2020).⁴³

Lastly, the Medicaid managed care supplemental payment program represents an area of common ground between community health centers and the Medicaid agency. Requiring MCOs to reimburse community health centers in their networks at full PPS rates for all provided services would reduce the administrative burden for both the state and community health centers. This could also include creating a process to ensure MCO compliance and a pathway for community health centers to recoup full payments in case of partial or no MCO payment. Importantly, this policy change could build goodwill between both parties, help them test out an emerging partnership, and begin the work toward Medicaid payment reform.

Conclusion

New York's community health centers are a critical source of care for the state's most underserved residents, serving more than 2.3 million patients, of whom more than half are Medicaid enrollees. Community health centers have evolved over the last two decades to deliver more patient-centered, holistic, and integrated care supported by modern technology, enhancing the skills, expertise, and value they bring to promoting health equity. Medicaid is the largest source of revenue for New York's community health centers, underscoring the need for strong alignment and partnership in health equity efforts (Rosenbaum et al. 2022). Strategic investment in New York's community health centers through the Medicaid program should start with closing the gap between Medicaid payment rates and the costs of delivering services. This will enable centers to expand and strengthen access to comprehensive, high-quality, and culturally effective care in the state's underresourced communities and help New York achieve its health equity goals.

Appendix A. Additional Details on the PPS Methodology

In addition to concerns among community health centers that the cost of services that centers provide exceeds their Medicaid PPS rates, key informants reported that the PPS methodology is not transparent and is inconsistent in how it is applied to community health centers, which may unfairly favor newer centers. In addition, key informants are concerned that regional ceilings may not accurately reflect differences in actual operating costs. Others noted services that community health centers provide today are more expansive than when the PPS methodology was first developed and are therefore not fully captured in expenditure categories on cost reports that form the basis for having PPS rates justified or adjusted. Key features of New York's Medicaid PPS for community health centers, as well as areas of concern shared by informants, are shown in appendix table 1 and further discussed below.

TABLE A1

Key Features of New York State Medicaid PPS for Community Health Centers and Areas of Concern

Key features	Community health centers' concerns
PPS rate setting	
- PPS rates for each community health center were established based on average annual costs for services delivered in 1999 and 2000 - PPS rates for community health centers that opened in 2002 or later were established using the so-called "peer group" methodology, calculated as the average annual costs of similar community health centers and other diagnostic treatment centers in the same region - Community health centers can file a rate appeal based on change in scope of services or capital cost changes	- Methodology for calculating legacy PPS rates has not been updated since the rates were first established and does not fully reflect the package of services delivered today. - Methodology for calculating peer group rates is not well-documented and understood, and according to some informants, is not reconciled with actual costs, resulting in general perceptions of rate inequity between the original and newer community health centers. - Rate appeals process is difficult to navigate, lengthy, and administratively burdensome.
Cost ceilings	
- Operating costs are categorized as (1) administration, (2) medical, (3) dental, (4) therapy, (5) patient transportation, and (6) ancillaries. Each category has a fixed rate ceiling. - Rate ceilings are further adjusted based on geographic variation into three groups: (1) downstate, (2) upstate urban, and (3) upstate rural - Ceilings are annually adjusted by the MEI	- Expenditure categories reportedly do not capture the full range of services that community health centers provide (e.g., care coordination) - Methodology for calculating upstate/downstate cost ceilings is not well-documented and understood and has not been updated since the cost ceilings were first established, resulting in ceilings that do not accurately reflect geographic variation in costs - MEI adjustments are not keeping up with actual inflation

Sources: Key informant interviews; “Cmty. Healthcare Assoc. of N.Y. v. N.Y. State Dep’t of Health,” 921 F. Supp. 2d 130 (SDNY 2013), accessed September 14, 2023, <https://casetext.com/case/cmty-healthcare-assoc-of-ny-v-ny-state-dept-of-health>; “Rate Appeals for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs),” New York State Department of Health, accessed August 1, 2023, https://www.health.ny.gov/health_care/medicaid/rates/apg/providers/.

Notes: PPS = prospective payment system; MEI = Medicare Economic Index. Community health centers in New York are also eligible to participate in an “alternative rate setting methodology” program. See more at https://www.health.ny.gov/health_care/medicaid/rates/fqhc/.

PPS Rate Setting

As noted in the Methods section on page three, documentation detailing New York Medicaid PPS methodology is not publicly available, and we relied heavily on input from informants to describe how the payment methodology was designed and implemented, which suggests a need for more transparency. According to the New York State Medicaid provider manual, the PPS rate is defined in Public Health Law 2807(8) as “an all-inclusive, cost-based threshold visit rate based on the average of each facility’s 1999 and 2000 reported base year costs, trended forward annually using the Medicare economic index (New York State Department of Health 2021).” According to informants, the state uses two different methodologies for setting PPS rates depending on when a community health center began operating: (1) PPS rates calculated on actual average costs for each center that existed before 2001, and (2) PPS rates calculated using average costs of similar “peer” centers and other diagnostic and treatment centers in the same region for community health centers that opened after 2001. According to several informants, the peer group rates have never been reconciled to actual costs the new centers incurred in the first year(s) of operations, nor is it known how the state selected “peer” community health centers and other noncommunity health centers to derive these rates. As a result, many informants perceived that the rates for community health centers established after the initial rate setting activity may be set higher than the PPS rates for the original group of community health centers.

Per federal legislation, community health centers in New York can appeal their rates because of changes in scope or capital improvement costs.⁴⁴ Some informants noted that the process could be burdensome and complex and requires considerable financial acumen to determine whether a rate appeal may be beneficial and result in rate increases. Many community health center leaders reported hiring a consultant to help them prepare projections as part of the Medicaid cost report preparation process to understand whether their rates will be increased if they choose to appeal. Informants explained that they can appeal their rates based on changes in the scope of services only until their rates reach the cost ceilings (explained further in the next section). As a result, when a community health center’s rates are at the cost category ceiling, the only way to appeal the PPS rate is through capital improvements, such as building new facilities. This affects especially larger community health

centers since capital costs are spread over the entire annual visits performed by a center to establish the rate add-on, and thus, the same capital expenditures would result in a much larger increase in the PPS rate of a small health center because of fewer visits.

The regulation allows community health centers to appeal a PPS rate based on a full year of actual cost data, if available, or on budgeted costs.⁴⁵ If budget estimates are used, the rates are further rebased using the cost report for the first year of operation. Informants noted that using the projected costs might be risky because if the actual visit volume is lower than the budgeted volume, the PPS rate might decline rather than be increased. Out of this concern, community health centers may wait to file the rate appeal only after the new facility has been operating long enough to use actual costs. However, the informant also noted that this causes a considerable delay in adjusting the rates because the rate appeal process can take an entire year or more. Other informants spoke about multimillion-dollar infrastructure investments that had little or no impact on increasing their PPS rates. As such, the rate appeal process may not be viable to bring PPS rates closer to incurred operating costs for many community health centers.

Cost Categories and Ceilings

According to informants, New York State's Medicaid program imposes cost ceilings for certain services and providers, including services provided by community health centers. Community health centers must document their costs within six distinct expenditure categories: administration, medical, dental, therapy, patient transportation, and ancillary services (table 9). Ceilings are based on the average operating costs of peer community health centers and other diagnostic and treatment centers in the region and are calculated as 105 percent of the applicable peer group's average costs in the applicable cost category.⁴⁶ Furthermore, to account for regional differences in costs, the state developed different ceiling rates for community health centers located in downstate (which is generally understood to be New York City metro area), upstate urban, and upstate rural areas. Community health center payments may not exceed the cost ceilings for each expenditure category, which is increased annually using the MEI.

Informants consistently reported several concerns with cost ceilings. For one, the methodology for regional adjustments to ceiling rates is not publicly available, and as such, it is not clear why, contrary to common knowledge, some rates for upstate rural providers are much higher than could be reasonably expected. For example, the PPS ceilings for ancillary services (such as radiology exams and labs) are nearly the same between downstate and upstate rural community health centers, but the ceiling for the

same service is more than three times lower for upstate urban providers (appendix table 2). One informant speculated that the number and type of community health centers and other facilities included in the peer group for calculating upstate rural rates may have artificially inflated the upstate rural ceilings. Furthermore, others noted that operational costs have changed dramatically over the last two decades, further driving the disparity between upstate and downstate ceilings. Today, operating a center in an upstate region may be more expensive than downstate because of high staffing costs to attract providers to practice in upstate communities. Another informant believes that inconsistency in the original PPS rate and peer group methodologies, including regional adjustments, partly explains why many community health center costs are well above the ceilings today. As this informant commented, “The inequity with upstate and downstate [rates] is really driven by the inequity with how the peer group ceilings were set.”

Another concern that informants frequently raised is that the cost categories are inflexible and, over the years, have grown out of alignment with the enhanced services that community health centers provide. For example, informants noted that it is not always clear which services are included under each category, which may result in variation across community health centers reporting certain costs. Several informants noted that this lack of clear definition may benefit centers because they can move costs across expenditure categories to maximize their PPS rate. For example, if a certain service could be accounted for in two expenditure categories, but rates in one of the categories are already at or above the ceiling, community health centers might include this service in a category below the ceiling. More importantly, informants reported that cost categories were established more than 20 years ago and do not accurately account for the increasingly expanded, integrated, and coordinated services that community health centers provide today. For example, one informant recounted efforts to exclude intrauterine devices from the cost-based reimbursement process because they were prohibitively expensive and not included in the PPS rate. Other informants noted that services such as providing doula support to pregnant patients, initiating smoking cessation programs, or offering colonoscopies as part of preventative primary care are not recognized under the current PPS system. Some informants said that while these services are not included in their PPS rate, the underlying expectation from managed care plans is that community health centers should offer additional enhanced services because they are paid more than other primary care providers.

Informants unanimously agreed that the MEI is an insufficient trend factor incapable of keeping up with inflation and growing medical practice costs. Some informants suggest identifying another trend factor that better reflects growing health care costs, which has also been recommended by the Government Accountability Office shortly after the federal Medicaid PPS methodology was first

established (GAO 2005). While informants noted that discussions must be mindful of state budgetary constraints when selecting any new trend factor, state officials noted that annual rate increases, even modest, are a unique feature of federally established PPS reimbursement, which guarantees that Medicaid payments for community health centers are increased each year by Medicare's measure of inflation (MACPAC 2017).

State officials pointed out that community health center Medicaid payment rates may be higher than private primary care practice rates and are annually increased by MEI, which may put community health centers in a better financial position than private primary care practices participating in Medicaid. Community health center informants, however, rebuked these sentiments, referring to the fact that in New York, only the ceilings (not the PPS rates) are annually adjusted by MEI, and as such, any PPS rates that are below current ceilings will not be adjusted until they are at or above the ceilings. Additionally, informants argued that community health centers serve populations that are more likely to have multiple chronic health conditions and unmet social needs than a typical private practice patient. To offer comprehensive services that meet the needs of complex patients, community health centers must rely on multiple sources of funding (including grants and private donations) that may be less predictable, stable, and sustainable than Medicaid reimbursement. The constant need to fundraise, string different funding streams together, and report to multiple grantors requires considerable administrative time and cost that could be instead devoted to enhancing patient care.

Some informants noted plans to scale back on services or close sites soon. Yet others were worried that some community health centers may be forced to prioritize volume and basic services to sustain operations. As one informant described it, filling a dental chair with four kids who need sealants is more cost-effective than one adult with bad teeth. Yet another informant pointed out that community health centers can barely meet the needs of all patients today and that many patients have to wait weeks, if not months, for appointments. Informants were keenly aware of and uncomfortable with the idea that if some community health centers are forced to scale back their operations, the most underserved New Yorkers will be disproportionately affected by reduced access to health care.

We've already started reducing services and closing sites. We don't have an alternative. There's no money, right? We can only lose so much per location because we don't have a safety net, like a large health system or somebody that's backing our banks. And so, the COVID dollars are gone, the inflation is up... the [staffing] turnover continues to increase... We're trying to bring patients back [for primary care visits], but now we don't have the time or resources to bring our patients really back into the office because now we're cutting our resources to do that engagement work.

—Focus group participant

Notes

- ¹ Authors' calculation using 2021 Uniform Data System report for New York, available at "New York Health Center Program Uniform Data System (UDS) Data," data.HRSA.gov, accessed November 8, 2023, <https://data.hrsa.gov/tools/data-reporting/program-data/state/NY>; "NYS Community Health Center Facts 2023," CHCANYS, accessed on September 12, 2023.
- ² "Community Health Centers: Primary Care Innovators Health Equity Leaders Facts 2022," CHCANYS, accessed on September 12, 2023; "Higgins Announces WNY Clinics to be Among the First to Receive Direct Federal Allocation of COVID Vaccine," Office of Congressman Brian Higgins, February 16, 2021, <https://higgins.house.gov/news/documentsingle.aspx?DocumentID=1835>.
- ³ Authors' calculation using the 2021 Uniform Data System report for New York.
- ⁴ Julianne Akard, "Improving Health Equity in Medicaid: State Policy Innovation and Research," AcademyHealth (blog), March 2, 2022, <https://academyhealth.org/blog/2022-03/improving-health-equity-medicaid-state-policy-innovation-and-research>; "Medicaid Health Equity Requirements: What States Are Incorporating & Incentivizing," RTI Health Advance, February 2, 2023, <https://healthcare.rti.org/insights/how-are-states-integrating-health-equity-data-in-medicaid-programs-part-2>.
- ⁵ FQHCs receive funding from the Health Resources and Services Administration (HRSA). While look-alikes operate like FQHCs and must meet the same program requirements, they do not receive HRSA funding. For more information, see "About Health Centers," HRSA Health Center Program, accessed November 8, 2023, <https://bphc.hrsa.gov/about-health-centers>.
- ⁶ "About Dr. H. Jack Geiger and Dr. Count Gibson," Geiger Gibson Program in Community Health, accessed on July 27, <https://geigergibson.publichealth.gwu.edu/geiger-and-gibson>; "Community Health Centers: Chronicling Their History and Broader Meaning," The George Washington University, accessed July 27, 2023, <https://www.chcchronicles.org/stories/community-health-centers-chronicling-their-history-and-broader-meaning>; Kersten Burns Lausch, "Federally Qualified Health Centers Reduce Health Disparity and Improve Health Outcomes," *Health Affairs*, September 18, 2022, <https://www.healthaffairs.org/sponsored-content/federally-qualified-health-centers-reduce-health-disparity>.
- ⁷ "How to Become a Health Center," HRSA Health Center Program, accessed August 4, 2023, <https://bphc.hrsa.gov/about-health-centers/how-become-health-center>.
- ⁸ "Health Center COVID-19 Survey: National Summary Report," HRSA Health Center Program, accessed July 27, 2023, <https://bphc.hrsa.gov/data-reporting/health-center-covid-19-survey>.
- ⁹ Look-alike health centers provide primary health care services to underserved populations and meet Health Center Program requirements, but they do not receive federal award funding. For more information on look-alikes, see "Health Center Program Look-Alikes," HRSA Health Center Program, accessed November 8, 2023, <https://bphc.hrsa.gov/funding/funding-opportunities/health-center-program-look-alikes>.
- ¹⁰ Author's analysis of data from HRSA Data Warehouse, available at "FQHCs and LALs by State: Federally Qualified Health Centers and Look-Alikes," data.HRSA.gov, accessed July 25, 2023, <https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs>; Key informant interviews.
- ¹¹ Authors' calculation using 2021 Uniform Data System report for New York.
- ¹² Authors' calculation using 2021 Uniform Data System report for New York; "NYS Community Health Center Facts 2023," CHCANYS.
- ¹³ "Community Health Centers: Primary Care Innovators Health Equity Leaders Facts 2022;" "Higgins Announces WNY Clinics to be Among the First to Receive Direct Federal Allocation of COVID Vaccine."

- ¹⁴ Key informant interviews.
- ¹⁵ “Community Health Care Association of New York State Facts 2020,” CHCANYS, accessed November 10, 2023.
- ¹⁶ “NYS Community Health Center Facts 2023,” CHCANYS; “New York Health Center Program Uniform Data System (UDS) Data.”
- ¹⁷ Meredith Deal, “Future of Community Health Centers Hangs in the Balance as Financial Uncertainty Abounds,” Chartis, June 30, 2023; “Senate Finance and Assembly Ways and Means Joint Legislative Hearing: HealthState Fiscal Year 2023-24 Executive Budget Health and Medicaid,” CHCANYS February 28, 2023.
- ¹⁸ Correspondence between the Urban Institute and CHCANYS, August 21, 2023.
- ¹⁹ Imani Telesford, Emma Wager, Paul Hughes-Cromwick, Krutika Amin, and Cynthia Cox, “How has health sector employment recovered since the pandemic?” Peterson-KFF Health System Tracker, July 20, 2023.
- ²⁰ Look-alike health centers provide primary health care services to underserved populations and meet Health Center Program requirements, but they do not receive federal award funding. For more information on look-alikes, see “Health Center Program Look-Alikes,” HRSA Health Center Program, accessed November 8, 2023, <https://bphc.hrsa.gov/funding/funding-opportunities/health-center-program-look-alikes>.
- ²¹ Authors’ analysis of data from HRSA Data Warehouse; key informant interviews.
- ²² Rural counties were identified by the New York State Department of Health in 2021 and are defined as counties with a population of less than 200,000 using data from the US Census Bureau, available at “New York State Rural Counties and Towns,” US Census Bureau, accessed August 2, 2023; Author’s analysis of data from HRSA Data Warehouse.
- ²³ Authors’ analysis of New York’s SBHC Data available at “School-Based Health Centers Fact Sheet (SBHC),” New York State Department of Health, accessed on August 3, 2023, <https://www.health.ny.gov/statistics/school/skfacts.htm>, and “SBHC Provider Directory 2023,” health.ny.gov, accessed August 3, 2023.
- ²⁴ Authors’ analysis of “New York State FQHC Facts 2012,” CHCANYS, accessed November 10, 2023, and “NYS Community Health Center Facts 2023,” CHCANYS.
- ²⁵ Authors’ analysis of data from HRSA Data Warehouse.
- ²⁶ Authors’ analysis of 2021 Uniform Data System report for New York.
- ²⁷ “2023–2024 Federal Income Guidelines,” New York State Department of Health, accessed August 2, 2023, https://www.health.ny.gov/prevention/nutrition/wic/income_guidelines.htm.
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- ²⁹ HHS Press Office, “HHS Awards Nearly \$90 Million to Community Health Centers to Advance Health Equity through Better Data,” August 8, 2022, Washington, DC: US Department of Health and Human Services, <https://www.hhs.gov/about/news/2022/08/08/hhs-awards-nearly-90-million-dollars-to-community-health-centers-to-advance-health-equity-through-better-data.html>; “Community Health Centers Advance Health Equity,” CHCANYS, accessed November 10, 2023.
- ³⁰ “DSRIP Project 3.a.i Licensure Thresholds,” New York State Department of Health, accessed October 5, 2023, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_threshold_guidance.htm.
- ³¹ “NYS Community Health Center Facts 2023.”

- ³² “Federal Programs and Policies Improving Access to Quality Health Care Services in Underserved Areas,” Office of the Assistant Secretary for Planning and Evaluation, accessed September 14, 2023, <https://aspe.hhs.gov/topics/health-health-care/federal-programs-policies-improving-access-quality-health-care-services-underserved-areas>.
- ³³ State Plans for Medical Assistance, 42 U.S.C. §1396a (2022).
- ³⁴ “Rate Appeals for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs),” New York State Department of Health, accessed August 1, 2023, https://www.health.ny.gov/health_care/medicaid/rates/apg/providers/.
- ³⁵ “NYS Community Health Center Facts 2023.”
- ³⁶ “Federally Qualified Health Center (FQHC),” New York State Department of Health, accessed November 10, 2023, https://www.health.ny.gov/health_care/medicaid/rates/fqhc/.
- ³⁷ “NYS Managed Care Supplemental Payment Program for FQHCs Policy Document,” New York State Department of Health, accessed August 1, 2023, https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_policy_document.htm.
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- ³⁹ “NYS Managed Care Supplemental Payment Program for FQHCs Policy Document,” New York State Department of Health.
- ⁴⁰ Vikki Wachino, “RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care,” April 26, 2016, Baltimore: CMS.
- ⁴¹ *An Act To Improve the Quality and Affordability of Primary Health Care Provided by Federally Qualified Health Centers*, Chapter 747 Public Law, *State of Maine* (2022): S.P. 625–L.D. 1787
- ⁴² “KMAP General Bulletin 21004: RHC / FQHC PPS Rebase,” Kansas Department of Health and Environment, Division of Health Care Finance, January 2021.
- ⁴³ Tricia McGinnis, Anne Smithey, and Shilpa Patel, “Harnessing Payment to Advance Health Equity: How Medicaid Agencies Can Incorporate LAN Guidance into Payment Strategies,” Center for Health Care Strategies (blog), February 16, 2022.
- ⁴⁴ “Rate Appeals / New Providers,” New York State Department of Health, accessed August 25, 2023, https://www.health.ny.gov/health_care/medicaid/rates/apg/providers/.
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