

Interim Report:

**Measuring Health Centers against Standard Indicators of
High Quality Performance: Early Results from a Multi-Site Demonstration Project**

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Executive Summary

Standardized performance measurement tools are now in use by hundreds of private employer-sponsored health plans, as well as by the Medicare Advantage program, public employer sponsored plans, and many state Medicaid programs that purchase managed care products for their beneficiaries. Health centers have considerable experience in the area of performance reporting but do not currently participate in a national reporting system that is transparent and standardized to well accepted evidence-based measures of clinical quality and patient satisfaction.

This interim report reviews preliminary but important and promising results from a pilot test of such a system, using grantees under the United Health Foundation's Centers of Excellence program. Our preliminary assessment shows four key findings:

- *First*, with adequate resources and support, health centers can readily adapt to standardized reporting systems that give communities, patients, health care purchasers, program administrators and policy makers access to standardized, transparent, quality of care and patient satisfaction data using measures that are evidence based and that have achieved broad consensus in the field of quality measurement.
- *Second*, health centers compare favorably to national benchmarks used in standard reporting systems that focus on key measures of clinical quality and patient satisfaction. Specifically, health centers are high performers on preventive interventions such as cervical cancer screening and clinical care measures such as diabetes management.
- *Third*: Health centers were able to demonstrate their ability to raise performance levels from period to period, as evidenced by improvements by individual participants on several measures related to clinical performance and patient experience with care.
- *Fourth*: Although health centers care for low income and medically underserved patients, standardized measures of quality and patient satisfaction are highly relevant to their patient populations. Health centers have a special mission, but their services involve activities that are considered to fall well within the ambit of routine primary care for any population.

Further data collection rounds are necessary, but the preliminary results show that health centers compare favorably against primary care providers generally and represent a high quality source of health care for any group of patients, regardless of family income or source of health coverage. It is also important to note that in light of the high risk nature of health center patients, the results produced in this preliminary study, which are not risk-adjusted, actually may understate. Given these findings, the initial and ongoing investments that health centers will need in order to be able to evaluate and report on performance represent an important step in health care quality improvement and health disparities reduction.

Introduction

Measuring the quality of health care furnished by health professionals and health care providers has become a routine expectation on the part of purchasers, patients, government regulators, and the health care industry. Much of the current focus on quality can be traced to the Institute of Medicine's seminal reports, *To Err is Human* and *Crossing the Quality Chasm*.¹ *Quality Chasm* set out a framework for performance improvement that, among other goals, aims to increase the rate of adherence to performance standards for which there is a strong evidence base. The goal of measurement tools, as the IOM has noted, is to promote adherence by health professionals and health care entities to the right care, in the right place, at the right time, and in a manner that is consistent with patient needs and values.

Quality measurement and health centers

Federally qualified health centers (known as FQHCs) include both health centers that also receive federal operating grants under §330 of the Public Health Service Act and centers that qualify for special Medicare and Medicaid payment rates because they meet all §330 grant requirements. FQHCs are the single largest primary health care system in the United States. In 2005 the nation's 952 federally funded health centers furnished comprehensive primary health care in some 3,500 communities to over 14.1 million patients, while look-alike centers furnished care to an additional 1 million persons.

Health center patients reflect the mission of the federal health centers program: to promote access to comprehensive patient-centered primary health care among low income and medically underserved urban and rural residents. In 2005, 64 percent of health center patients were members of racial and ethnic minority groups, 91 percent had incomes below 200 percent of the federal poverty level, and 61 percent are children under age 20 and women of childbearing age. The quality of health center-furnished care has been long recognized,² and health center services have had a documented impact with respect to health conditions recognized as being among the greatest sources of racial, ethnic, and socioeconomic disparities.³

Health centers also have considerable experience in the area of performance reporting. Federal grant rules require that all federally funded health centers furnish the federal government with annual performance reports known as the Uniform Data Set (UDS). The UDS covers a range of reporting elements,⁴ and these elements are used to measure grantee performance.⁵ In addition, most health centers today participate in

¹ National Academy Press, Washington D.C. 2001

² Rosenbaum S and Shin P, "Health Centers Reauthorization: An Overview of Achievements and Challenges," Report of the Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, Washington, DC, March 2006.

³ Shin P, Jones K, and Rosenbaum S, "Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-income Communities," The George Washington University, September 26, 2003.

⁴ Elements collected include total number of users by certain characteristics, total number of encounters by type of provider, and total revenues by major sources of funding.

⁵ The UDS does not apply to FQHCs that do not receive federal operational grants and thus do not have any minimum reporting requirements

managed care provider networks and can be expected to routinely report on performance in accordance with applicable network participation rules. Finally, as of early 2005, 647 health centers (more than two thirds of all health centers) participated in health disparities collaboratives, a comprehensive effort launched by the federal government in 1998 and designed to improve care on measures known for their connection with racial, ethnic, and socioeconomic health disparities.⁶ Health centers that participate in disparities collaboratives have extensive reporting obligations and the results are in the initial stage of dissemination.⁷

At the same time, there exists no national system under which health centers routinely report quality performance data using the reporting systems, such as HEDIS, that are now in widespread use throughout employer sponsored plans. The UDS is designed to give federal administrators and policymakers essential information, but the reporting elements contain limited direct information on performance quality, and the measures are not standardized to expectations of the broader health care system. The collaboratives data are invaluable, but again are not widely available and not standardized to common market measures and reporting methods. This lack of standardized quality performance information means that public and private health care purchasers may be unaware of the quality of care furnished by health centers or their ability to routinely report performance.

The United Health Foundation Project

For several years the United Health Foundation (UHF) has been actively engaged in efforts to assist health centers expand access and improve health care quality, through its Centers of Excellence (COE) Program.⁸ The mission of the COE Program is to increase “access to quality health care for all Americans.” COE provides multi-year support to fund “health care teams that deliver quality-focused, integrated and coordinated preventive, clinical and community-based care services and target important medical challenges within medically underserved communities.”⁹

As of July 2006, the program consists of three grantees, located in New York City, Washington D.C., and Miami, Florida in 2004. A fourth grantee, located in New Orleans, Louisiana, is expected to join the group in 2006. COE grantees were selected based on the quality of their proposals, as well as the high prevalence of health problems in their respective communities that are linked to known racial, ethnic, and socioeconomic disparities, such as HIV, asthma, diabetes, obesity, and cardiovascular disease. The Miami COE grantee,¹⁰ which serves, among others, a large, Creole-speaking population, focuses on HIV/AIDS, depression, and diabetes. The New York COE grantee¹¹ furnishes mostly pediatric care, with a focus on asthma, obesity/diabetes,

⁶ <http://www.healthdisparities.net/hdc/html/about.background.aspx>

⁷ Chin MH, et al. “Improving Diabetes Care in Midwest Community Health Centers with the Health Disparities Collaborative.” January 2004 *Diabetes Care* 27(1):2-8.

⁸ <http://www.unitedhealthfoundation.org/> (Accessed July 19, 2006)

⁹ Id.

¹⁰ Jefferson Reaves Sr. Health Center

¹¹ South Bronx Health Center for Children and Families – a program of The Children's Health Fund and Montefiore Medical Center.

perinatal problems, and HIV/AIDS. The Washington D.C. COE grantee,¹² which serves a predominately low-income African-American community, focuses on asthma, diabetes, cardiovascular disease and perinatal problems. The New Orleans grantee, located in an impoverished area devastated by hurricane Katrina in 2005,¹³ is also expected to focus on key health disparities. (Because UHF will award the New Orleans health center in August 2006, this grantee is not included in this interim report).

As an integral component of its health care improvement mission, the COE Program also has adopted development of a quality performance reporting system that mirrors standardized measurement systems such as HEDIS® and thus permits health care purchasers, policy makers, and patients to view and compare the quality -- and quality improvement -- in health center settings. Toward this end, the Foundation awarded a multi-year grant to the George Washington University School of Public Health and Health Services, Department of Health Policy, to work with grantees on the development of a reporting process, to collect and analyze the findings, to refine the reporting process as needed, and to report on the results and identify their implications for policy and practice. The purpose of the reporting dimension of the COE program is twofold: first, to illustrate the capacity of health centers to participate in a standardized reporting system that parallels the standardized systems currently evolving under public and private insurance systems; and second, to measure quality – and quality improvements over time – on the part of community-based systems of care as they focus on key, evidence-based measures linked to health disparities.

This Interim Analysis reports on findings from the first phase of the COE reporting system. It describes the development and implementation of the standardized reporting system, as well as the first round of reporting.

Methods and Key Findings: the Measurement Process

Developing a standardized reporting tool covering all grantees

By 2005, all three initial grantees had implemented their quality improvement and service enhancement initiatives. In general, each site had:

- Significantly enhanced staff working in key areas of health need.
- Improved patient experience in care
- Enhanced services, reorganized the health care delivery model, and developed collaboration with other community providers
- Implemented IT capabilities to improve the efficiency and effectiveness of care
- Improved community visibility efforts by hiring additional staff to expand patient education and outreach

¹² Unity Health Care

¹³ EXHELth Health Center

Beginning in 2005 GW began its work with the grantees to develop an approach to performance reporting linked to standardized measures of quality. The purpose of this initial collaboration was to develop measures that were evidence based, reliable, valid, and that permitted the collection of relevant data across sites in a manner and using a process that had the uniformity, consistency, and standardization required of widely used quality improvement reporting systems.

The process of identifying appropriate and feasible measures to be adopted by the health centers began with a review of national and industry reporting clinical and patient satisfaction standards. These standards were compared with current health center data collection activities, and a collection tool was then developed and pilot tested and evaluated. Full implementation of the evaluation tool began in November 2005 with a small pilot test and a follow-up with a larger sample size in June 2006.

Review of national and industry benchmarks

The joint review of widely used performance measures in the areas of clinical care and patient experience had the purpose of achieving cross-grantee consensus regarding measures that would be relevant to all projects. The COE grantees, of course, share the general goal of improving health care quality for patients; at the same time, each project emphasized a slightly different set of key project goals. The objective was to align the measurement effort with these cross-project goals, to the greatest degree possible. In addition, a key objective in the development of performance measures for this process was to align them with the evolving effort to achieve industry standardization in performance assessment of health care delivery, in general.

The group was particularly interested in the Ambulatory Care Quality Alliance (AQA) effort, because it is one of the most notable in terms of the range of its stakeholder leaders. The AQA includes the Agency for Health Care Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), National Quality Forum (NQF), National Committee on Quality Assurance (NCQA), Veterans Administration (VA), American Medical Association (AMA) Physician Consortium for Performance the American Medical Association (AMA), the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and America's Health Insurance Plans (AHIP), and employer coalitions among others. As part of the process of reaching industry-wide performance measurement standardization, the AQA had identified a core set of measures from a list developed or used by private and commercial health plans, health care and health advocacy organizations, medical specialty societies, and public and private health benefits purchasers. The group thus selected the AQA tool because of its industry-wide potential and the expectation that the AQA initiative ultimately would prove to be foundational to the expansion of quality measurement in ambulatory care settings

Based on this preliminary research, consultation with UHF regarding current industry trends, consultation with HRSA's Bureau of Primary Health Care (BPHC), and internal consensus-building discussions among the grantees, the group developed a quality measurement tool that relies heavily on AQA measures, as well as both the adult

and child versions of the ambulatory care edition of the Consumer Assessment of Health Plan Survey).

Upon further review, a total of 17 clinical and patient satisfaction measures (10 AQA clinical measures and 7 ACAHPS patient experience measures) were deemed feasible and appropriate. Although the AQA clinical measures of diabetes, asthma, and depression were not the focus of all grantees, the collection of these and other preventive and clinical measures were considered necessary to the broader goal of promoting standardized reporting using accepted and evidence-based measures of health care quality.

Pilot testing the quality improvement measurement tool

Over a six-week time span, the three grantees pilot tested the ten AQA consensus measures and the 7 ACAHPS survey questions; grantees also documented any significant changes or deviations in protocol or method of collecting the requested information. For the patient satisfaction component of the evaluation tool, the first four of the seven ACAHPS measures were selected based on their similarity to questions posed under the federal reporting system used by BPHC.

In addition, for this project, three special measures were used from ACAHPS in order to examine the extent to which health professionals who work at health centers are viewed by patients as committed to the “duty of loyalty” that forms the basis of the professional/patient relationship. This duty that has been translated into what Duff and Hollingshead, in their seminal study of the sociology of medicine, *Sickness and Society*, have termed “committed sponsorship,” a concept that conveys the degree to which health professionals performing at the highest ethical standard advocate on their patients’ behalf. Because trust has been shown to be a basic aspect of a strong physician patient relationship, we sought to capture that aspect of health center performance, particularly in light of the documented difficulties that health center professionals can face in securing specialty and other services available only outside the walls of the health center.¹⁴

The sampling methodology used in this project required grantees to stratify the sample in order to ensure proper representation of patient subgroups of interest – patients with diabetes and asthma, and patients receiving prenatal care. Within each subgroup, grantees randomly selected 25 charts (for each measure) to review, using random digits (from a table or calculator). For the three prevention measures, charts were randomly selected from the entire patient population.

All three grantees pilot tested the ACAHPS questions, using the BPHC patient satisfaction survey methodology. This methodology entails the random choice of day during the pilot testing period by the clinic manager, without informing administrative and clinical staff (except for registration clerk(s)) that the survey is to be administered that day. The manager then leaves a stack of 100 surveys with the registration clerk(s), instructing the clerk(s) to hand out a copy to each patient with an appointment.

¹⁴ Gusmano MK, Fairbrother G, Park H, “Exploring the limits of the safety net: community health centers and care for the uninsured,” *Health Affairs* (2002), 21(6):188-94.

Based on discussions with grantees and the results of the pilot test, we identified three major issues related to standardizing and reporting on measures:

- *Varying capabilities among grantees for electronically collecting patient data.* At the beginning of the effort, it became evident that only one grantee already had in place a system reporting on many measures on an ongoing basis, as a result of its participation in the federal disease collaboratives system. The remaining two health centers were either in the process of implementing or enhancing their patient data collection system. Despite limited pre-existing capacity, all three health grantees were ultimately able to conduct chart reviews that captured the measures.
- *Need to account for varying health center patient populations.* While certain measures may be uniform, the variability between measures and patients in terms of relevance and validity can show up when the time comes to apply actual measures to an actual patient population. This was the case, for example, with the patient satisfaction indicators, for which one grantee stressed the need for relevance with respect to a pediatric population and sought certain modifications in order to maintain relevance. As a result of the pilot, an additional patient satisfaction survey specifically targeting children was developed so that parents or guardians could respond on their behalf. Each grantee was asked to keep a log of changes to the sampling and recording methodology.
- *Varied approaches to surveying patient satisfaction.* Patient satisfaction turned out to present the most complex issues for resolution. The three grantees varied in their approach: one used the Patient Satisfaction Survey developed as part of the health centers disparities collaboratives initiative, while the others were in the process of either developing or administering some type of satisfaction survey. In the end, all three agreed to administer the seven ACAHPS questions using the federal methodology. One site translated the instrument in Creole and Spanish and made these versions available to the other two sites.

Full implementation of the quality improvement measurement tool

Full implementation began in April, 2006. UHF asked that grantees report results of their measurement systems twice a year, with the first report due July 7, 2006. In addition to increasing the sample to a minimum of 100 charts per measure, the group revised the collection instruments to clarify the time period for each of the measures (i.e., 1 – 3 years). Staff also finalized ACAHPS questions in Creole and Spanish and developed a child version of the questions to use in this follow-up round of data collection. Because of the unique nature of this project, the project group also determined that grantees should continue to identify further needed adaptations of questions and measurement protocols as needs arose, with logs of such adaptations

maintained.¹⁵ Further modifications to the tool are expected for the next reporting period scheduled in late Fall 2006.

The final performance measurement tool consisted of three components: (1) access measures; (2) clinical indicators; and (3) patient satisfaction, covering a total of 19 measures. Table 1 sets forth the final tool. Figures 1-7 represent results from both prevention and chronic care AQA measures and two of the ACAHPS patient satisfaction indicators.

Table 1: Quality Improvement Measurement Tool Used in the UHF Centers of Excellence Program

<ul style="list-style-type: none">• Access Measures (2 measures of patient volume):<ul style="list-style-type: none">○ Total unduplicated count of patients○ Total number of encounters/visits• Clinical Indicators (10 AQA measures of quality care):<ul style="list-style-type: none">○ Prevention:<ul style="list-style-type: none">• Cervical Cancer Screening• Tobacco Use• Advising Smokers to Quit○ Diabetes:<ul style="list-style-type: none">• Blood Pressure Management• Lipid Measurement• LDL Cholesterol Level < 130 mg/dL• HbA1C Testing• “Poor Control” of HbA1C○ Asthma:<ul style="list-style-type: none">• Pharmacologic Therapy○ Prenatal Care:<ul style="list-style-type: none">• Screening for Human Immunodeficiency Virus• Patient Satisfaction (7 ACAHPS measures of satisfaction):<ul style="list-style-type: none">○ Personal provider calls back the same day○ Personal provider listens carefully○ Personal provider spends enough time during the visit○ Doctor’s office informs about the wait after appointment check-in○ Personal provider sends to specialist(s)○ Personal provider is informed and up-to-date about the care provided by the specialist(s)○ Doctor’s office follows up with the results from a blood test, x-ray, or other test

Preliminary Findings on Quality Improvement Related to the Initial Submissions Following Full Implementation

Figures 1 through 7 display the initial results from grantee submissions and include both the 2005 pilot data and 2006 estimates. Because the December 2005 rates are based on pilot data of 25 patients, and the June 2006 reports include a minimum of 100 chart reviews, the two set of rates may not be comparable. The purpose of the pilot phase was to assess the technical feasibility of each measure. Therefore, the 2006 data include some changes in the calculation of the rates. In general, the 2006 rates are considered more accurate than the 2005 estimates, because of the larger statistical chart sample used.

¹⁵ For example, the AQA tool often limits the calculation of rates to members who are “continuously-enrolled,” which is a term generally used by health plans. Without such information at hand, health centers used a more minimum number of visits as criteria, which may result in a more limited sample.

Patient Access to Care

All three grantees showed significant expansion of access over the collection time period: not only did encounters per patient rise, but so did the total number of registered patients. Since receipt of UHF funding in 2003, one health center increased the number of total users by nearly 20 percent, from 5,010 to 5,987 patients. Another clinic received its award in 2004 and increased the number of new users in 2005 by 62 percent, from 2,289 to 3,720 patients. The third clinic also received its award in 2004 but saw a decline of 9 percent in 2005 due to changes in eligibility for county services and referral patterns from the local hospital. However, based on 6-month 2006 user data, the number of patients is expected to increase by end of the year.

Clinical Quality Measures

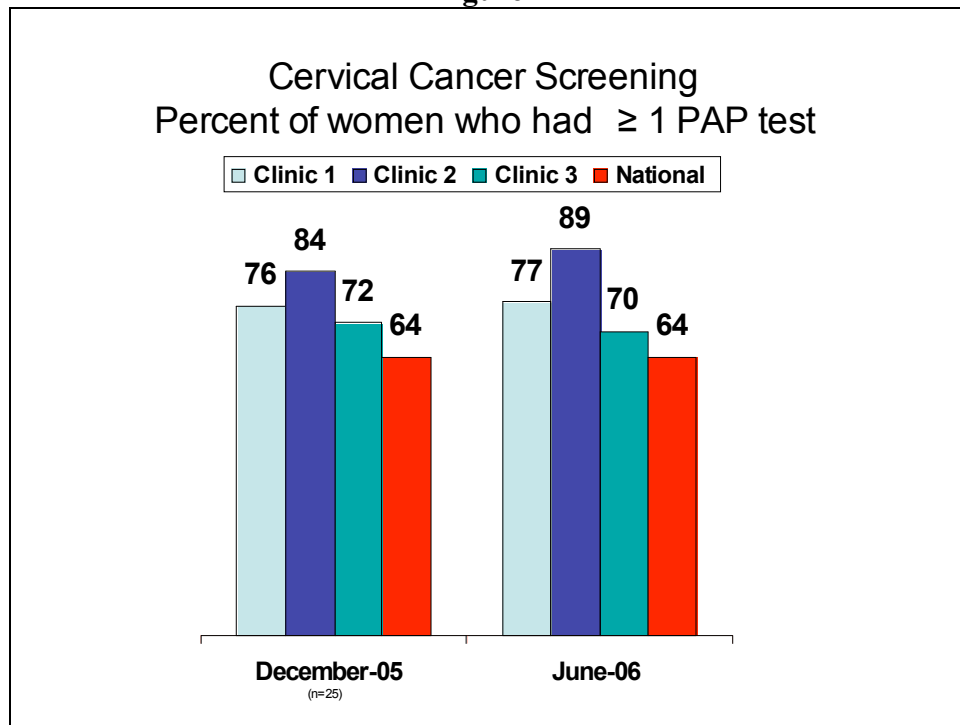
All three grantees were generally able to show both good performance and performance improvement relative to the national Medicaid average rates. Figures 1 through 5 show both performance against the particular quality benchmarks and performance during the 6-week pilot phase in 2005 and full implementation in 2006.¹⁶ The figures illustrate both grantee performance on a patient population-wide measure as well as performance in relation to a subset of patients who suffer from diabetes.

Prevention-Cervical Cancer Screening. **Figure 1** shows that all three grantees were above the national average for cervical cancer screening. All three clinics report more than 70 percent or more of women had at least one PAP test in the past two years. This measure did not raise any significant problems when grantees increased the sample size from approximately 25 to 100 charts.¹⁷ However, none of the clinics had yet integrated the necessary prevention data into their medical record system in such a way that they could easily identify eligible patients for this AQA measure. Therefore, the report of this prevention care measure required extensive chart reviews.

¹⁶ Benchmarks are from NCQA's HEDIS Medicaid reporting system and reflect plan-level performance, whereas the results reported from the three clinics are at the provider level. Comparing these results should be done with caution.

¹⁷ For some of the indicators, the age and conditional limitations defined in the AQA tool resulted in a smaller size.

Figure 1



Comprehensive Diabetes Care. The AQA recommends a set of measures adapted from HEDIS that provide data on comprehensive diabetes care provided to patients. Figures 2-5 show the UHF grantee clinics' results, which compares favorably to the national average, indicating the strength of clinical performance in the area of diabetic care. Specifically, in Figure 2, all three clinics reported the percentage of patients with diabetes mellitus who had low-density lipoprotein cholesterol test over the past year was near or above the national mean of 76 percent. Additionally, Figure 3 also shows the percentage of patients with diabetes who had low-density cholesterol below 100mg/dL or 130 mg/DL was either at or well above the national mean of 48 percent.

Figures 4 and 5 also indicate the quality of care provided to diabetic patients at the clinics is high. Figure 4 shows a relatively high percentage of diabetic health center patients had at least one HbA1c test over the past year. The lowest percentage was 83 percent, well above the national percentage of 75 percent. Figure 5 also supports the evidence of higher quality of care for diabetic patients, in which none of the health centers reported in excess of 35 percent of diabetic patients with poorly controlled HbA1c levels greater than 9 percent.

Figure 2

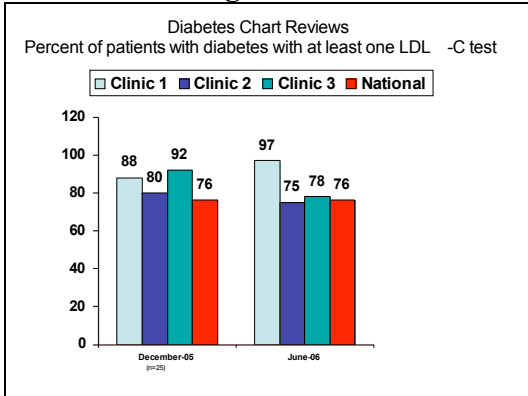


Figure 3

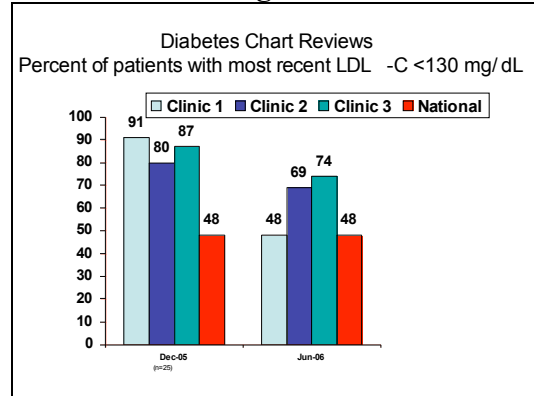


Figure 4

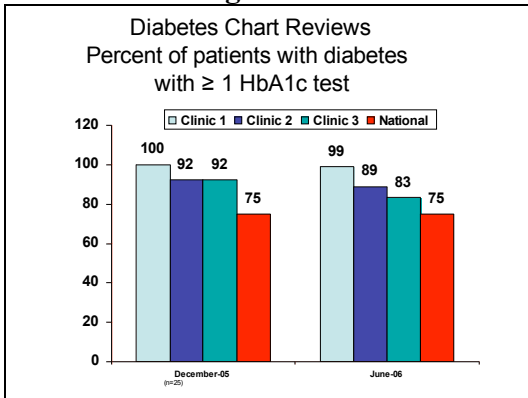
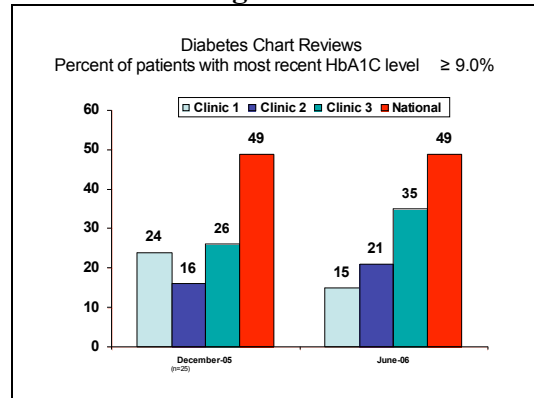


Figure 5



Findings Regarding Patient Experience in Care

The results of the patient satisfaction survey show that, during full implementation, all three health centers performed well against the national satisfaction rate for Medicaid health plans.¹⁸ Because the New York site targets a pediatric population, national child benchmarks are also shown.

Figures 6 and 7 show the results of three questions, for which national benchmark data are available. Although the measure shows health centers may need to address issues related to answering calls on the same day, the other measures indicate patients are satisfied with the care they receive. In 2006, all three health centers exceeded the national average on two of the measures. On one measure did the majority of patients report high satisfaction in 2005 and 2006 across the three sites: the amount of time spent with their provider.

¹⁸ Benchmarks are from AHRQ's National CAHPS Benchmarking Database and reflect Medicaid plan-level performance for adults and children satisfaction, whereas the results reported from the three clinics are at the provider level. Comparing these results should be done with caution.

Figure 6

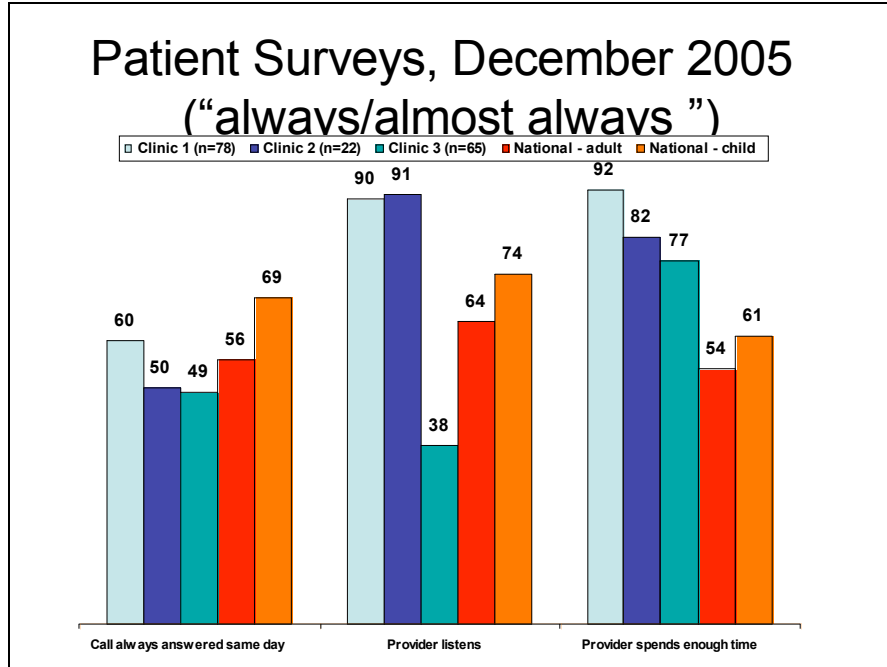
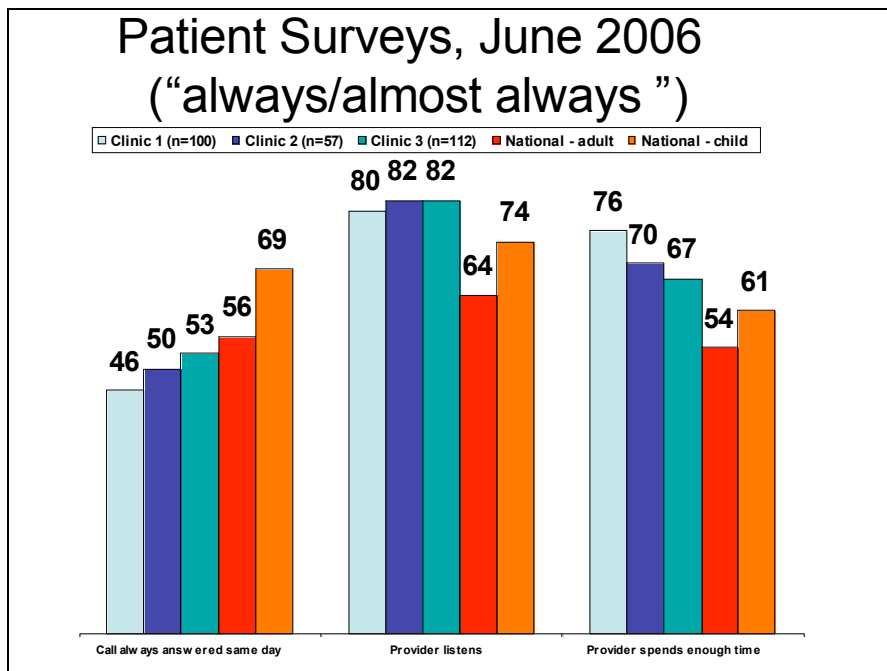


Figure 7



Conclusion

This preliminary report on health center participation in standardized quality improvement and reporting systems as part of the United Health Foundation COE program supports four key conclusions:

- *First*, with adequate support and resources, health centers can readily adapt to standardized reporting systems that, in turn, provide communities, patients, health care purchasers, program administrators the type of comparable and transparent quality of care and patient satisfaction data that are evidence-based, commonly used, and that have achieved broad consensus in the field of quality measurement. With substantial financial support from the United Health Foundation, the grantees were not only able to hire necessary staff and purchase needed health supplies and equipment to begin addressing major access and health problems in their communities, but also to develop the information technology essential to data collection and quality assessment and improvement.
- *Second*, when health center performance on standardized measures compares favorably to national benchmarks on critical measures of clinical quality and patient satisfaction. In the area of preventive interventions (cervical cancer screens) and management of conditions associated with significant health disparities (diabetes) health centers are high performers on most measures.
- *Third*: Health centers are able to raise their performance levels from period to period, as evidenced by improvements by individual participants on several measures related to clinical performance and patient experience with care.
- *Fourth*: Although health centers care for low income and medically underserved patients, the standardized measures of quality and patient satisfaction on which they report are suitable to the patient population as a whole. Thus, although health centers have a special health care mission in relation medically underserved communities, health centers are high performers on measures of value to any patient population.

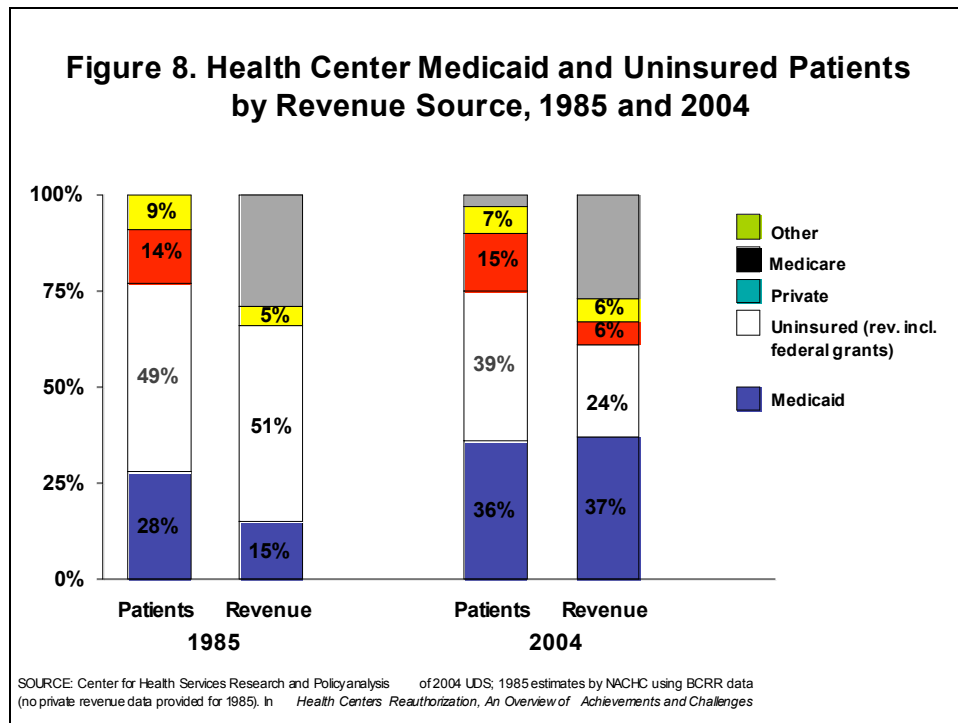
Further collection rounds are needed to continue to improve and refine reporting and gain experience in quality measurement and improvement. In addition, additional analysis is essential to understand the cost of developing and sustaining quality improvement and reporting capabilities as well as the health information technology infrastructure essential to quality improvement.

This study suggests health centers can adopt national performance standards to report on and improve quality of care. At the same time, these early results show that health centers are not simply high quality providers for medically underserved populations, but valuable sources of health care for *any* group of patients. Given the complex health care needs of a disproportionately low income and at-risk patient population, the data are especially impressive, showing that the quality of care provided often exceeds the national average. Had we risk-adjusted the population these health

centers serve, the quality of care estimated most likely would have been substantially greater.

Expanding a pilot program such as this one into a national reporting system for all health centers should be a long term national goal in our view, given the importance to health centers of being able to demonstrate the quality of care to both patients and payers. Health centers depend for their survival on third party payments, in particular, Medicaid; indeed, only 20 percent of health center operating revenues come from grants. And third party payers increasingly insist on performance data.

Whether demonstration of quality will in turn translate into improved payment levels to ensure that health center grant funds remain available for the care of uninsured persons remains a separate and important question. **Figure 8** shows that only the Medicaid program, with its broad coverage, low cost sharing, and special “federally qualified health center” coverage and payment rules, assures a reasonable alignment between revenues and patients.



Private insurance revenues are well below the representation of privately insured patients in the health center population. As Figure 8 shows, in 2004, privately insured patients comprised 15 percent of patients but only 6 percent of revenues.

As Medicaid, Medicare, and the private health insurance industry moves toward the widespread use of performance-based payment structure, health centers’ ability to demonstrate quality may be critical. Performance reporting is rapidly becoming a standard expectation in all third party payment programs, and in the case of private health insurance, may be the key to reversing the existing revenue-to-patient picture, which places per capita private insurance payment levels even below the rate paid by the federal

government for uninsured patients,¹⁹ thereby further straining health centers' ability to furnish care to their uninsured patients. With evidence of solid performance may come the types of financial adjustments essential to permitting health centers to move more decisively into the private health insurance markets that may exist in their communities.

¹⁹ Sara Rosenbaum and Peter Shin, *Health Centers Reauthorization: An Overview of Achievements and Challenges* (Kaiser Commission on Medicaid and the Uninsured, 2006). Available at <http://www.kff.org/uninsured/7471.cfm>