# Considering Medicaid Payment to Federally Qualified Health Centers

## Medicaid and CHIP Payment and Access Commission

Kayla Holgash

# Role of FQHCs in Medicaid

- FQHCs provide primary/preventive care including services not often found in physician offices.
- Medicaid is the largest source of FQHC revenue.
- Federal Medicaid payment policy is prescribed.
  - Prospective Payment System (PPS)
  - Alternative Payment Methodology (APM)
- FQHCs in managed care organizations must also receive a minimum payment.
- FQHCs are increasingly involved in value-based payment efforts.

# Panelists

- **Nadereh Pourat, PhD,** director of research at the UCLA Center for Health Policy Research
- **Ralph Silber, MPH,** executive director of the Alameda Health Consortium
- **Claudia Schlosberg, JD,** senior deputy and state Medicaid director for the Department of Health Care Finance (DHCF), Washington, DC

THE UCLA CENTER FOR HEALTH POLICY RESEARCH

# Community Health Centers (CHCs)

## Presentation to MACPAC

## October 26, 2017


Nadereh Pourat PhD

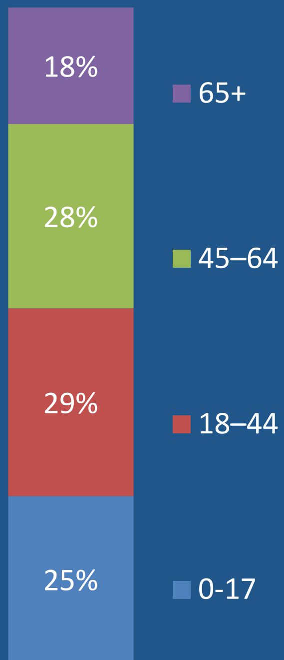
Director of Research, UCLA Center for Health Policy Research
Professor, UCLA Fielding School of Public Health & UCLA School of Dentistry

# CHCs Are Critical Safety Net Providers

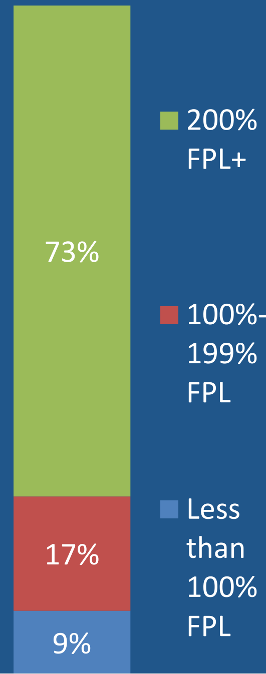
- **Nearly 26 million patients served in 2016**
  - 1 in 12 individuals in the United States
- Essential characteristics
  - Section 330 CHCs receive federal grants from HRSA
  - Provide care to low-income populations regardless of ability to pay
  - Comprehensive & culturally competent primary care and enabling services
    - Primary care, dental, behavioral health/substance abuse, pharmacy, vision, and enabling services

# Patient Characteristics: CHCs vs. Other Providers

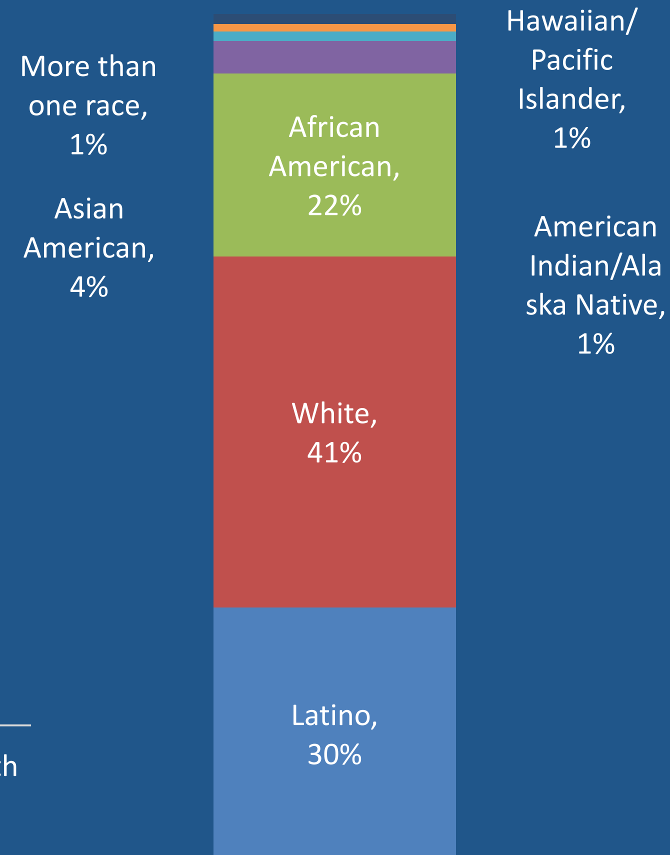
## Age




## Poverty



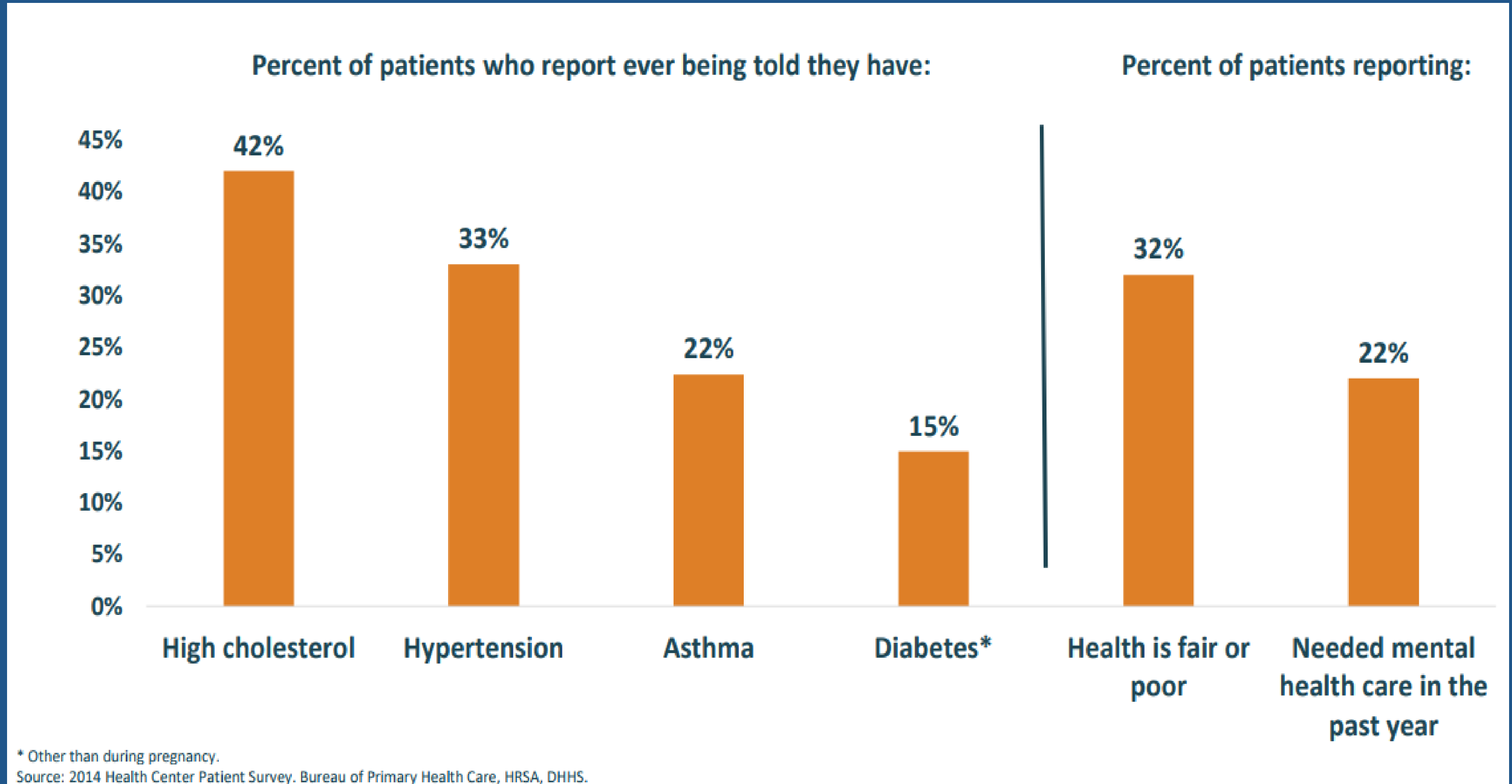

## Race/Ethnicity




Sources: National Health Interview Survey, 2015, Individuals with a usual source of care
https://www.cdc.gov/nchs/nhis/shs/tables.htm
UDS, 2016,
https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

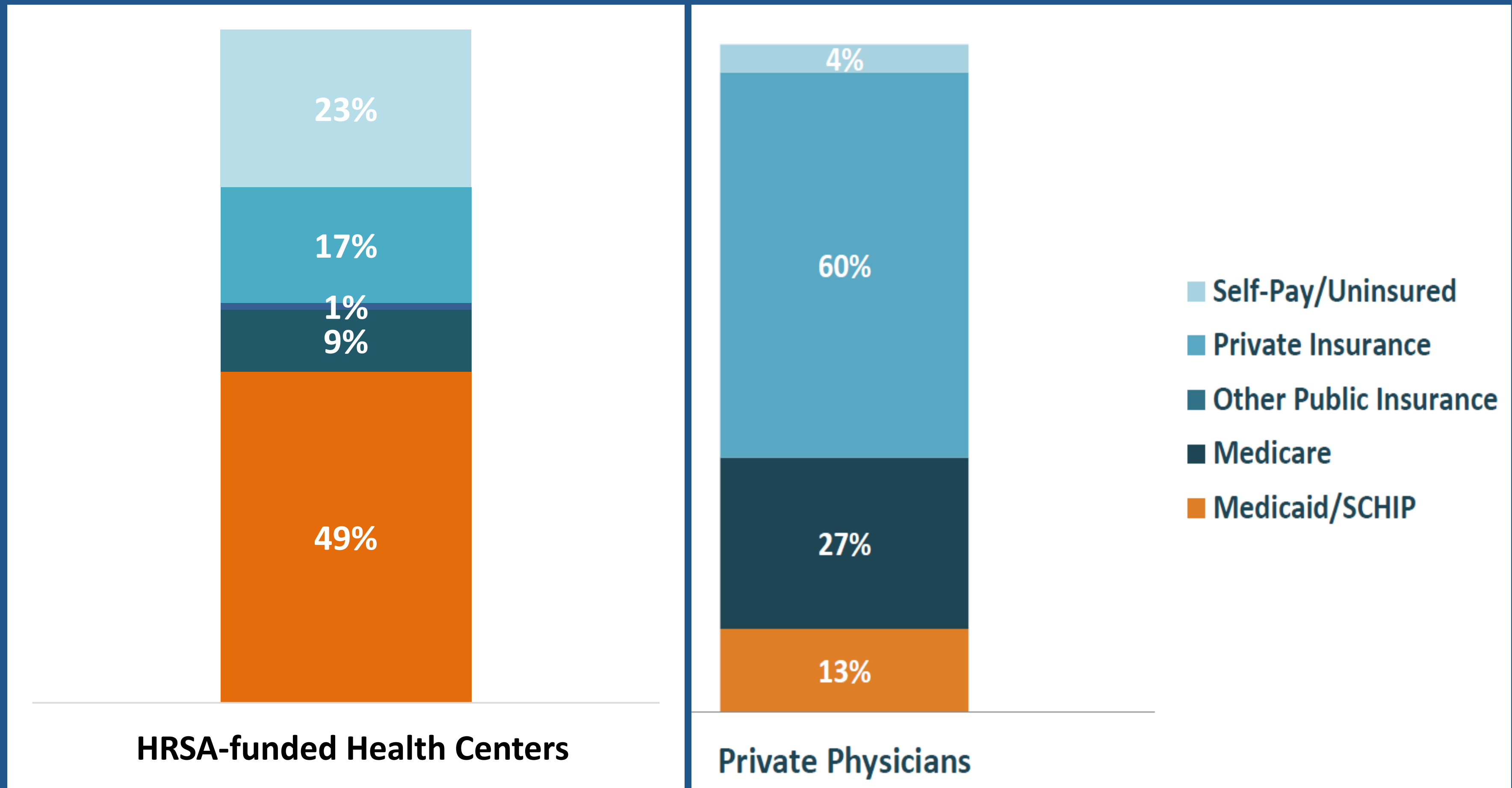
For additional data on CHC characteristics:
https://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf

# CHC Patients' Health Status




Additional data can be obtained from:
https://bphc.hrsa.gov/datareporting/research/hcpsurvey/dashboard.html

# CHC vs. Other Providers: 3rd Party Revenues




Sources: National Association of Community Health Centers, National Ambulatory Medical Care Survey, 2013
http://www.nachc.org/wp-content/uploads/2017/06/Chartbook2017.pdf
UDS, 2016, https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

# CHC Revenues Sources

- Grants
  - Section 330 grants, other grants, donations, charity
- Medicaid/Medicare
  - Managed care vs. FFS
- Private insurance
  - Managed care vs. FFS
- Self-pay
  - Sliding scale fees vs. free

# Revenue Source Drives Incentives & Impacts Service Delivery

- Section 330 grants support delivery of care to the uninsured
- Other grants/donations support infrastructure development and expanded enabling services
- Medicare and Medicaid pay per encounter bundled FFS at the PPS rate
- Managed care contracts could impose performance standards and can include incentives
- High deductible private insurance plans are a challenge

# PPS: Bundled FFS or Per Encounter Rate

- Goal
  - Provide comprehensive patient care per given encounter
- Incentive
  - Similar to FFS
- Challenges
  - Complex patients have more needs
  - Uninsured patients have pent-up demand
  - Enabling services are not billable
  - Barriers in referral to specialists exist

# Alternative Payment Models & CHCs

- Changing landscape of health care delivery
  - Increased market consolidation and system integration
  - Demand by payers and stakeholder for efficiency, high quality care, and improved population health
  - Workforce recruitment and retention
  - Sustainability and financial well-being

- APM: payment is tied to value
  - ACOs, episode-based payments, PCMH, P4P

# Are CHCs Ready for APM?

- 68% are recognized/certified as PCMH
- 95% have an EHR at all sites, 3% at some sites
  - 90% report providers participate in CMS "Meaningful Use"
- Most have co-located mental health, oral health, and pharmacy personnel, as well as enabling service providers
- CHCs have reporting capacity for some quality metrics
- Some have capitated contracts

Source: 2016 UDS from HRSA website:
https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=

# Payment Policy for Federally Qualified Health Centers

Presentation to MACPAC
October 26, 2017

Ralph Silber, CEO
Community Health Center Network

# What is a Federally Qualified Health Center (FQHC)?

- Authorized under Section 330 of the Public Health Service Act, receive grants from HRSA's Bureau of Primary Health Care OR meet all of the requirements of those grants
- Known as Federally Qualified Health Centers in Medicare, Medicaid and CHIP
- FQHCs can be rural or urban
- Meet the particular needs of their communities and tailor their services to their patients

**Some of the Grant Requirements**

- Open to all, regardless of ability to pay.
- Must offer services on a sliding fee scale
- Offer a full range of primary and preventive care, including dental and behavioral health services
- Have a board made up of a patient majority, ensuring each health center is responsive to the needs of its communities
- Be located in a medically underserved area or serving a medically underserved population

COMMUNITY HEALTH CENTER NETWORK

# Who do FQHCs serve?

## Health Centers Serve

1 in 12

people in the US, including:

1 in 6 people receiving Medicaid

1 in 3 low income uninsured

1 in 3 individuals living below poverty

1 in 4 rural Americans

Note: Includes patients of federally-funded health centers and non-federally funded health centers, and expected patient growth for 2017. Sources: NACHC, 2017. Analysis based on 2016 Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS. US Census Bureau. Health Insurance Coverage in the United States: 2016. September 2017. Kaiser Family Foundation. Total Monthly Medicaid and CHIP Enrollment: December 2016. US Census Bureau. Income and Poverty in the United States: 2016. September 2017. Kaiser Family Foundation. Population Distribution by Metropolitan Status: 2016.

# Value of Health Centers to the Medicaid Program

- Provide primary and preventive care to **1 in 6 Medicaid patients.**
- In many communities, CHCs are the only Medicaid PCP.
- Health centers provide care to **16 percent** of the Medicaid population **at less than 2 percent** of overall Medicaid spending.
- Numerous studies over many years have documented lower total cost of care for Medicaid patients receiving care at **CHCs.**
- A recent study of Medicaid primary care providers (PCPs) across 13 states showed that health center patients have **24 percent lower total Medicaid** costs than comparable patients served by other PCPs. (University of Chicago Center for Diabetes Translation Research, 2016)

COMMUNITY HEALTH CENTER NETWORK

# Overview of FQHC Medicaid Payment

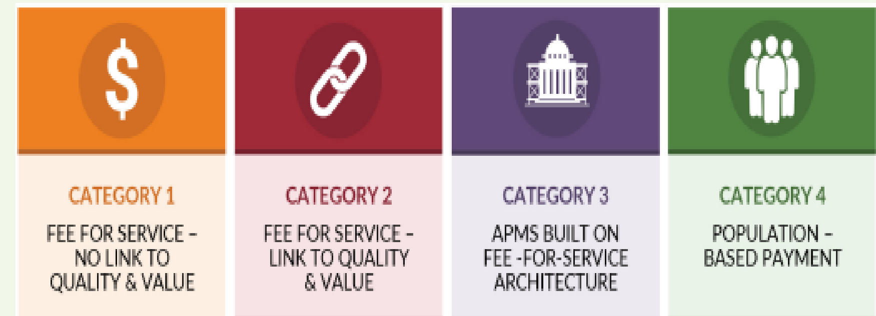
- Congress created the **FQHC Prospective Payment System (PPS)** to ensure that health centers wouldn't have to use federal grant dollars to make up for less than appropriate Medicaid payments.
- Provides **predictable, stable** funding for FQHCs
- The PPS is NOT cost based reimbursement, but a **comprehensive, bundled payment** for each qualifying patient visit
  - Pays for ALL of the services and supplies in a single visit
- Statute also allows for **flexibility** in the way states pay FQHCs via an **Alternative Payment Methodology (APM)**
- Many states are using APMs to allow health centers to participate in value based pay initiatives

# **Overview of FQHC Medicaid Payment**: Value-Based Payment

Health centers nationwide are successfully engaging in a variety of value-based initiatives in both Medicaid and Medicare, *including*:

- Agreements with payers (e.g., MCOs)
- Participation in integrated networks (e.g., ACOs)
- Engagement in state-based initiatives or partnerships

***Alternative Payment Model Framework***

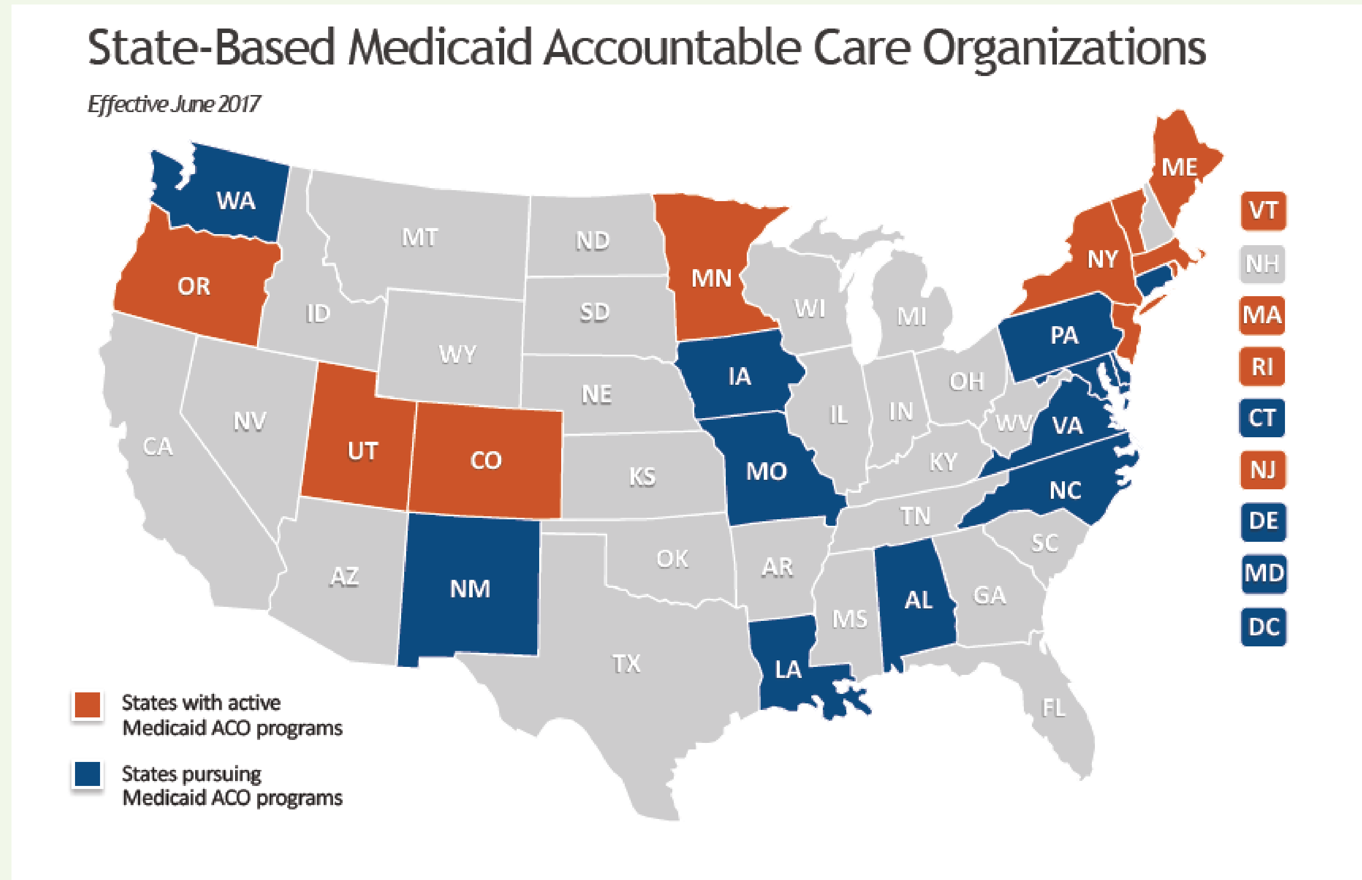



Source: Health Care Payment Learning & Action Network

# Medicaid Payment Reform Nationally

States currently pursuing provider-led (including FQHC-led) ACOs in Medicaid

- Maine
- Minnesota
- Massachusetts
- Vermont
- New York




**FFS + Shared savings /risk**

*Source: CHCS*

# Medicaid Payment Reform Nationally

## States paying for Health Homes (w/ACA support)

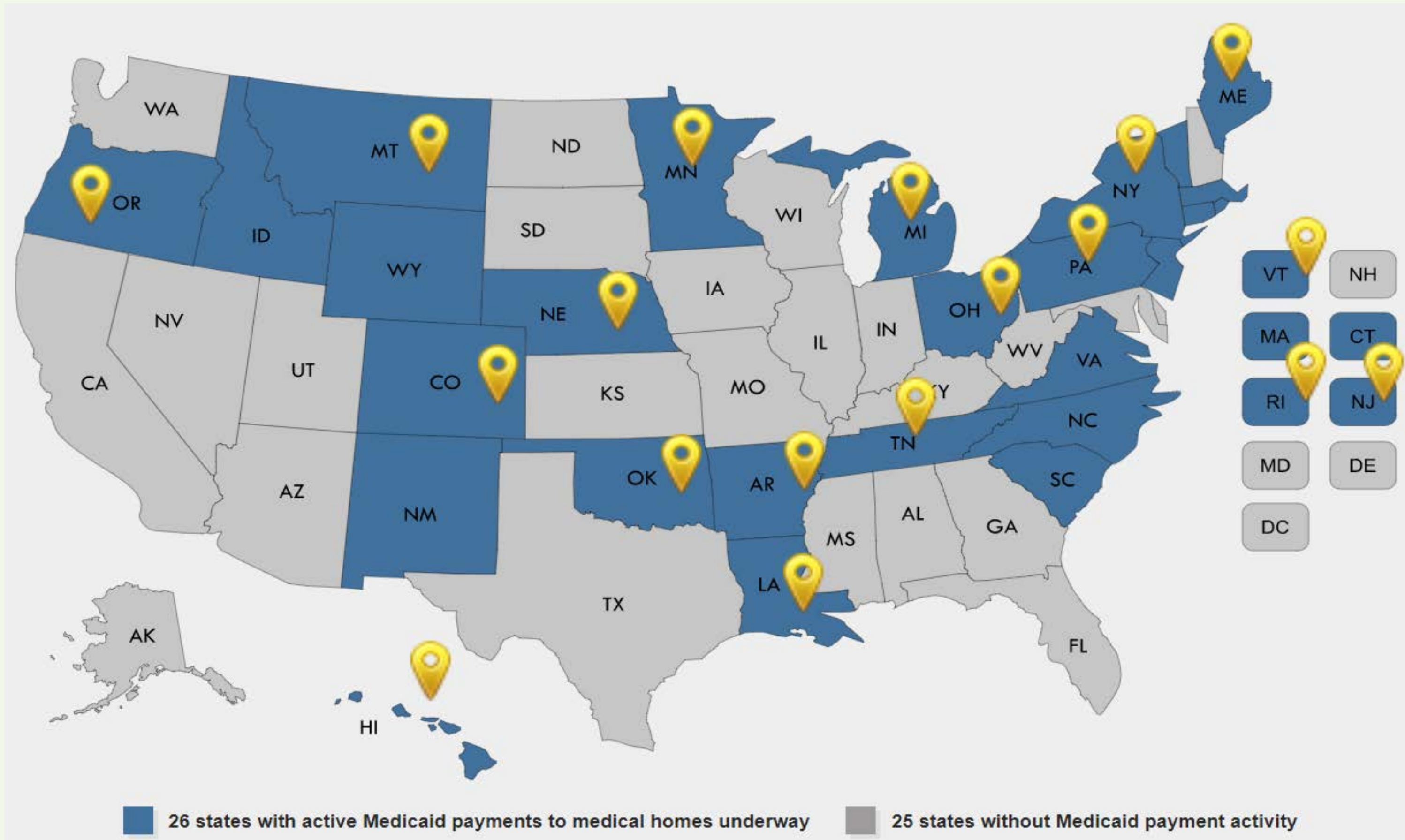
22 states with active Medicaid payments to health homes underway

29 states with no Medicaid payment activity

*Source: NASHP*

# Medicaid Payment Reform Nationally

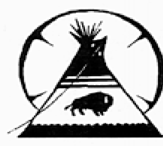
## States are paying for PCMH




*Source: NASHP*

# Community Health Center Network (CHCN) Health Centers and Medicaid Managed Care

- 8 CHC Corporations
- 90 delivery sites
- > 400 PCPs
- 143,000 Medicaid Managed Care Members
- Full professional risk



# CHCN Medicaid VBP Programs

- P4P based on improving HEDIS scores
- Saving sharings with health plans
- Health plan funding for Care Neighborhood - intensive outpatient care program (IOCP)for high cost/high need Medicaid members

# CHCN VBP Outcomes
# HEDIS

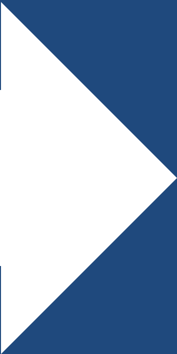
| 2016 HEDIS results | | | |
|---|---|---|---|
| **Measure** | **CHCN rate** | **CHCN compared to overall plan rate** | **CHCN compared to 90th percentile** |
| Cervical Cancer Screening | 66.48% | ⇧ | ≥ |
| Hemoglobin A1c Testing | 89.27% | ⇧ | ≥ |
| 2 Year old immunizations | 82.91% | ⇧ | ≥ |
| Prenatal Care Timeliness | 87% | ⇧ | ≥ |
| Well-Child Visits 3-6 Years | 77.14% | ⇧ | ≥ |
| Controlling High Blood Pressure | 65.32% | ⇧ | ≥ |
| Hemoglobin A1c Poor Control >9% | 36.72% | ⇧ | ≥ |
| Diabetic Retinal Screening | 58.19% | ⇧ | ≤ |
| Timeliness Postpartum Visit | 69.50% | ⇧ | ≥ |

# TOTAL COST OF CARE

- Preliminary results show our Care Neighborhood program leads to 35% reduction in TCC ($2,706 PMPM vs $1,762 PMPM)
- Addressing social determinants of health (transportation, public benefits, food, etc.)
- Supporting appropriate use of physician services (PCP & specialty), behavioral health, pharmacy
- Reduces unnecessary hospital utilization

# Key Takeaways

- Health centers serve as a **comprehensive** and **cost-effective** primary care option for America's most underserved communities and are backbone of Medicaid's primary care delivery system.
- Health centers offer a **comprehensive set of services** that includes medical, dental, behavioral health, and enabling services.
- Congress created the **FQHC PPS** to ensure **predictability and stability** for health centers while protecting other federal investments.
- States and MCOs can and do **incorporate FQHCs into VBP arrangements**, including those involving financial risk related to quality, outcomes and cost.
- There are **opportunities** for FQHCs to further partner with States and MCOs states to explore innovative and **flexible** ways to improve access, quality and health outcomes, while better managing total cost of care.



# FQHC PAYMENT AND VALUE-BASED PURCHASING IN THE DISTRICT OF COLUMBIA

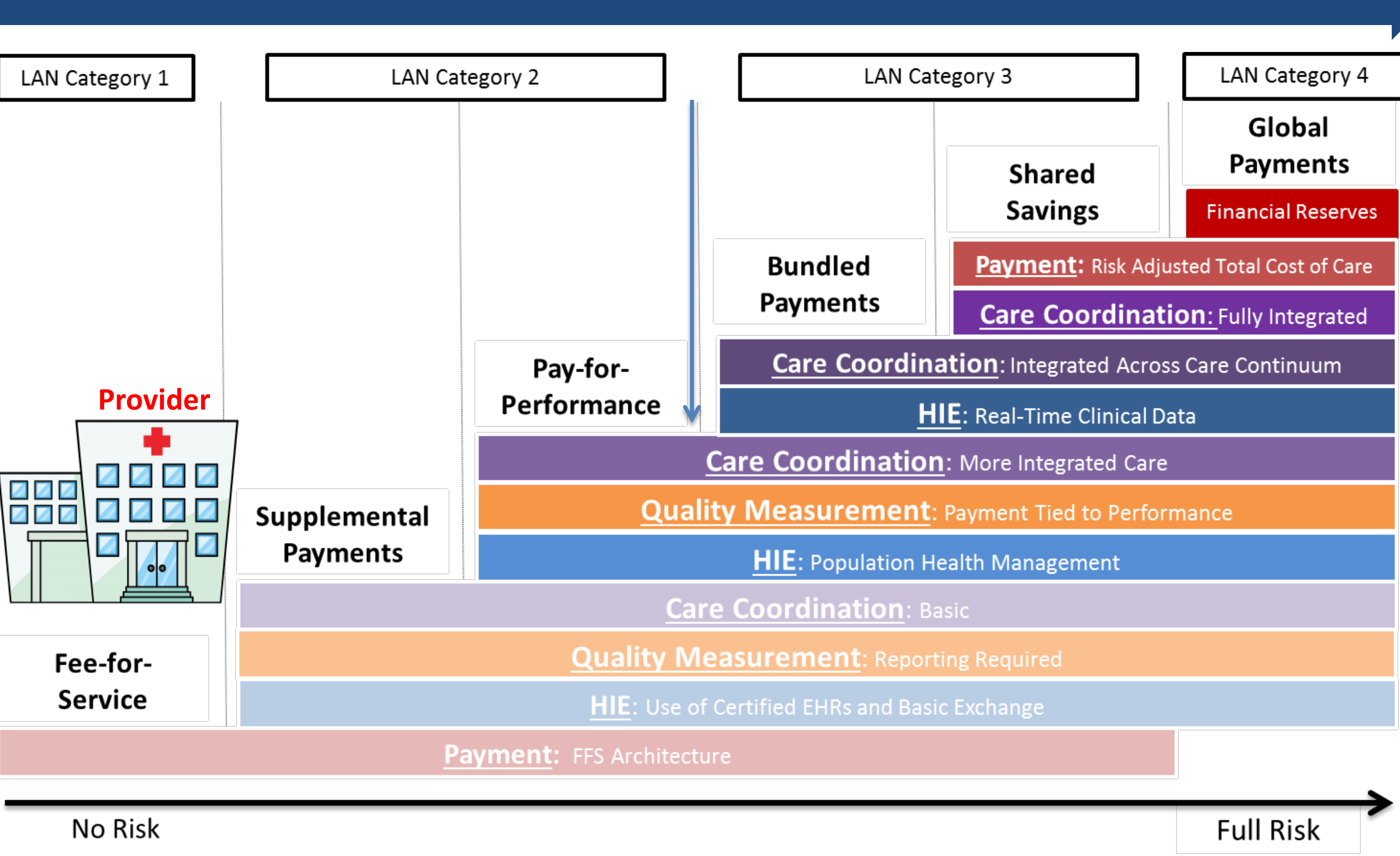
Claudia Schlosberg, JD
Medicaid Director
Department of Health Care Financing

MACPAC Meeting
October 26, 2017

# Medicaid and the District

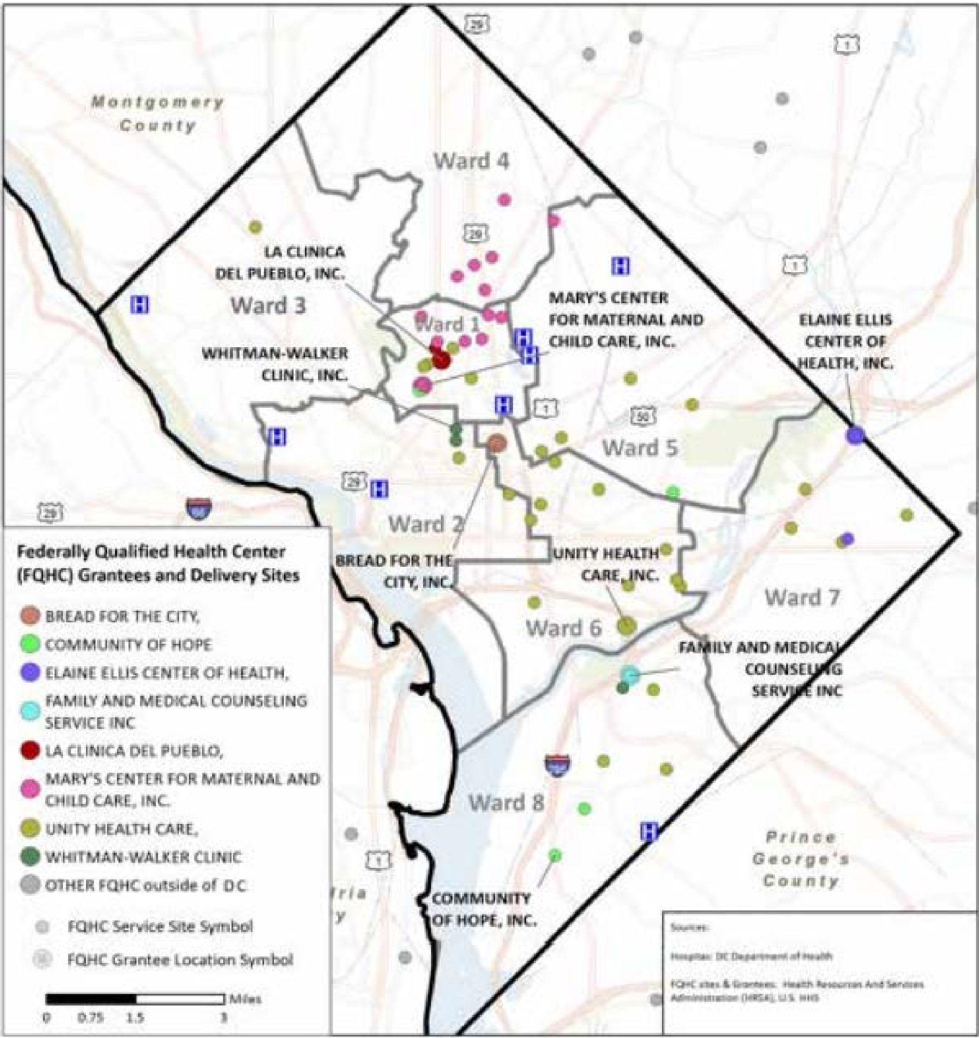
- **Health in the District**
  - **96.2%** of residents with health insurance
  - **12.9%** of District adults reported their health was fair or poor
  - High ED utilization, almost twice the national rate (746:1,000 v. 423:1000)
  - High readmission rate: (65:1,000 v. 45: 1,000)
- **Medicaid**
  - **Over 260,000** residents covered by Medicaid
  - **Nearly 40%** of District residents
  - **7 in 10** District children are covered by Medicaid
  - **Early Adopter**- expanded coverage to all childless adults up to 210%
  - **70% enrolled in MCOs**

# Moving from Volume to Value - Steps Towards Managing Population Health and Risk



# FQHCs Have a Broad Footprint in the District

- **8** FQHC grantees
- **1** Look Alike
- **52 of 56** approved service delivery sites are located in the District
- **178,324** patients served (all payors)
- **36%** of DC Medicaid beneficiaries are served by FQHC



# Goals of New FQHC Payment Model

- Put the reimbursement method on sound legal and regulatory footing
- Provide a fair and adequate reimbursement rate to FQHCs
- Improve health outcomes and reduce health disparities for FQHC patients
- Allow for a person-centered, holistic, and integrated approach to care that meets patients where they are (both literally and figuratively)
- Allow for same-day reimbursement for different types of encounters.
- Lay the groundwork for value-based purchasing by developing a fair and sustainable approach to performance measurement

# New APM Rate Methodology Designed Collaboratively

- Clearly defines services included in an encounter, services that remain fee-for services and identifies allowable costs
- Establishes an APM that includes four separate encounter rates:
  - Medical
  - Behavioral Health
  - Dental
    - Preventive and Diagnostic
    - Comprehensive
- APM allows for same-day reimbursement for visits for one of each encounter type (medical, behavioral health and dental)
- APM caps administrative costs but allows for additional bonus payments based upon performance on mandated measures;
- Wrap payments paid by DHCF —payment process is being automated to match wrap claim with an MCO encounter; establishes an appeals process for MCO denied claims
- APM rates based upon FY 13 audited costs and will be rebased every three years
- Expands list of billable providers beyond five FQHC core providers for behavioral health services

# Stakeholder-Engaged Process to Select Quality Measures

- Stakeholder engagement is an important feature of designing P4P programs
- FQHC Measure Set
  - Developed based on best practices
  - Included measures connected to meaningful outcomes identified by Providers and DHCF
    - FQHCs felt they had direct control over measure selection.
    - Prioritized measures to support improvement in key outcomes and coordination/transitions of care
  - Aligned measures with other value-based initiatives to reduce reporting burden and confusion

# Challenges with the PPS/APM

- Inequitable reimbursement
  - Payments under PPS are notably higher than payments to other primary care providers; PPS is perceived as unfair to providers who offer similar services
  - Incentivizes non-FQHC providers to become FQHCs; increases State budget pressure
- Conflict between PPS and value-based purchasing
  - Reimbursement remains cost-based and volume-driven
  - PPS rate, unless updated, has not kept pace with costs
  - APMs provide more flexibility and can tie payment to quality but allowable only if FQHCs agree; APM cannot pay less than federal PPS
  - Reconciliation back to PPS means FQHCs effectively do not take on downside risk – even when APM is structured as a PMPM
  - MCO levers less effective given wrap payment guarantee
  - Difficult to move to LAN Level 3 and above due to difficulty of sharing risk
  - In a world attempting to better align incentives around quality and cost efficiency across providers, FQHC payment rules pose challenges.

# Questions