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
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

Sources: National Health Interview Survey, 2015, Individuals with a usual source of care
https://www.cdc.gov/nchs/nhis/shs/tables.htm
UDS, 2016,

For additional data on CHC characteristics:
https://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf
www.healthpolicy.ucla.edu
CHC Patients’ Health Status

Percent of patients who report ever being told they have:

- High cholesterol: 42%
- Hypertension: 33%
- Asthma: 22%
- Diabetes*: 15%

Percent of patients reporting:

- Health is fair or poor: 32%
- Needed mental health care in the past year: 22%

* Other than during pregnancy.

Additional data can be obtained from:
https://bphc.hrsa.gov/datareporting/research/hcpsurvey/dashboard.html
CHC vs. Other Providers: 3rd Party Revenues

HRSA-funded Health Centers
- Self-Pay/Uninsured: 17%
- Private Insurance: 23%
- Other Public Insurance: 1%
- Medicare: 9%
- Medicaid/SCHIP: 49%

Private Physicians
- Self-Pay/Uninsured: 60%
- Private Insurance: 27%
- Other Public Insurance: 13%
- Medicare: 4%

Sources:
- National Association of Community Health Centers, National Ambulatory Medical Care Survey, 2013
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

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
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

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)
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

Source: CHCS
Medicaid Payment Reform Nationally
States paying for Health Homes (w/ACA support)

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
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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

- Pay-for-Performance: Providers are paid based on the performance of their services.

- Bundled Payments: Payments are made based on a bundle of services provided to patients.

- Shared Savings: Savings are shared among providers and patients.

- Global Payments: Payments are made globally without any specific conditions.

- Financial Reserves: Financial reserves are kept for future payments.

- Payment: Risk Adjusted Total Cost of Care

- Care Coordination: Fully Integrated

- Care Coordination: Integrated Across Care Continuum

- HIE: Real-Time Clinical Data

- Care Coordination: More Integrated Care

- Quality Measurement: Payment Tied to Performance

- HIE: Population Health Management

- Care Coordination: Basic

- Quality Measurement: Reporting Required

- HIE: Use of Certified EHRs and Basic Exchange

- Payment: FFS Architecture

- No Risk

- Full 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.