FQHC Value-Based Reimbursement Model

FQHC Value-Based Reimbursement Model
Traditional health care delivery has prioritized a fee-for-service (FFS) model that reimburses healthcare providers for each individual service they provide to a patient. This has the effect of incentivizing volume in delivering health care and not necessarily promoting quality health outcomes for patients. Over the last decade health policy makers have sought to move away from volume and toward value. These practices are largely termed "value-based care" (VBC) or sometimes "value-based payment" (VBP). Although value-based care doesn't have a single strict definition, the Agency for Health Care Research and Quality recognize that "Value-based reimbursement models (VBRM) aim to improve quality and reduce costs by creating incentives for providers to deliver high-quality rather than volume-driven care." [1] The goals of VBRMs are to reduce to overall costs of delivering care while improving health outcomes and performance measures.

Federal and state healthcare programs have been implementing payment structures that reflect this movement away from traditional FFS reimbursement and toward value-based payment structures. Texas began the move toward VBRM in Medicaid in 2014 with the Pay 4 Performance program (P4P) with state managed care organizations (MCOs). Today, the state operates under value-based contracting requirements for MCOs and their relationships with healthcare providers; these are also referred to as alternate payment methodologies (APM). Texas Health and Human Services (HHSC) has set ambitious benchmarks for MCOs for their value-based contracting arrangements with providers. By the end of calendar year 2018 (CY18), 25% of MCO medical spending must be in a VBP or APM arrangement with 10% risk-based. By CY21, 50% of MCO medical spending must be in a VBP or APM arrangement with 25% risk-based.[2]

Federally qualified health centers (FQHCs) provide high-quality, affordable, primary and preventive health care services including medical, dental, vision, behavioral health, outreach and enrollment, enabling services, patient education, and pharmacy services to people who otherwise may lack access to medical care due to where they live, lack of insurance, language barriers, income level or their complex health care needs. Some FQHCs are already in VBRM arrangements with MCOs, but recent changes to the way FQHCs are paid create a new opportunity for more FQHCs to enter the VBRM landscape.

Current FQHC Payment Methodology
FQHCs are paid per eligible patient visit in a particular way that accounts for the average per patient cost of providing care called the prospective payment system (PPS). PPS is a bundled rate that includes medical, dental, mental health, patient education and other health center services. More than two thirds of Texas health center patients live below the poverty line ($25,750 per year for a family of 4 in 2019).[3] Higher rates of poverty are associated with more complex health needs and health center patients may seek care for a particular complaint, but require treatment for multiple comorbid conditions.

For example, a Medicaid patient with recurrent sinus infections may be seen initially for a sinus infection, but also have lab work to test for diabetes indicated by the recurrent infections. In the same visit she may be treated for her asthma, receive a flu vaccine, receive education on how to manage her health conditions, and be scheduled for a session with the center's diabetes educator. In an FQHC all of these services fall under the bundled PPS rate are paid to an FQHC as one rate. In a private practice the provider would bill separately for each service. The PPS rate reflects the comprehensive wrap around services FQHCs provide.

Managed Care Organizations (MCOs) are given a monthly per patient per month capitated rate by the state to manage patients in Medicaid and CHIP with the expectation that they are paying providers at the FFS rate. However, because MCOs pay FQHCs their

Continued →

FQHC Value-Based Reimbursement Model

full PPS rate, MCOs are made whole by HHSC for any difference between the PPS rate and the FFS rate through a wrap-around payment.

As of September 1, 2017 for medical services and March 1, 2018 for dental services the wrap-around payment methodology changed in a way that resulted in a collection of detailed claims data for FQHCs that are centralized with the Texas Medicaid and Healthcare Partnership (TMHP) – the Medicaid administrator for HHSC. The detailed claims data have been collecting in a growing data base and can be the foundation for a VBRM with FQHCs. Reliable patient and claims data are essential to any value-based payment strategy.

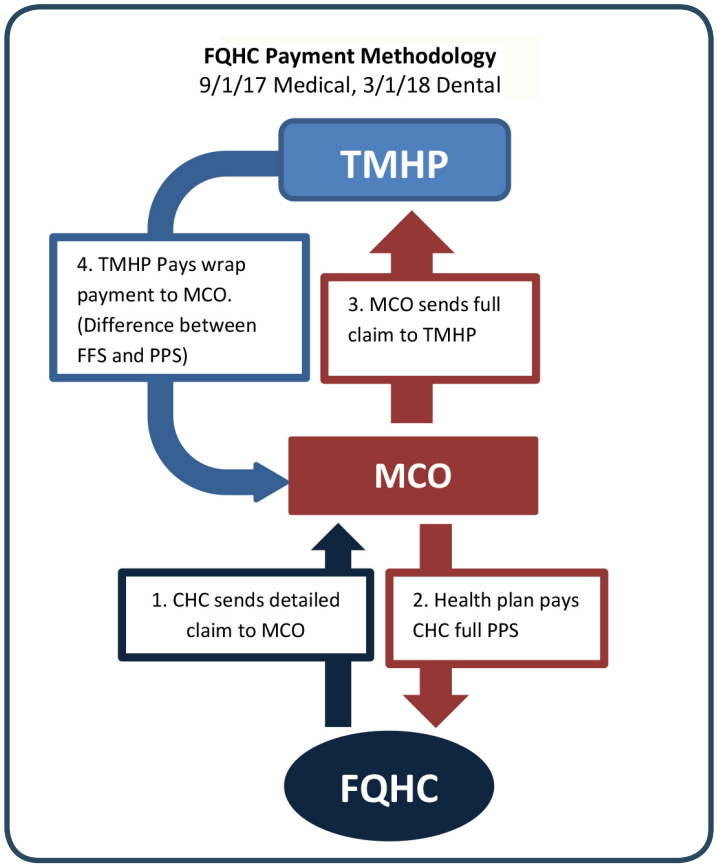
Texas FQHC Experience in Value Based Care in Medicare

Texas FQHCs have a history of success in VBRM. In 2012, Texas health centers formed Essential Care Partners (ECP), a Medicare Shared Savings Program (MSSP) with FQHCs as its only providers of care. Between 2012 and 2018 more than 34,000 Medicare patients were cared for under this MSSP at more than 113 FQHC sites.

In the years 2014-2017, ECP saw a consistent improvement in its overall quality score, rising from 85.31% to 92.06%. FQHCs in ECP consistently outperformed the national average in at least 14 of 32 quality measures year over year. During the five year participation ECP's expenditures per assigned Medicare beneficiary were approximately $1,000 less than the National FFS average. ECP saw a total savings of more than $4.5 million dollars over the five years of its operations. To accomplish similar savings and quality in Medicaid, health centers in a VBRM need continuity of patient eligibility and patient assignment similar to Medicare.

Recommendations

Based on Texas health center experience with VBRM in Medicare, how other states have benefitted from such models in Medicaid, and the changes in the current payment methodology FQHCs have an opportunity to develop an innovative strategy in Texas Medicaid for improving quality while bringing down the overall cost of care. **TACHC proposes developing a pilot project for an FQHC Accountable Care Organization style VBRM. Participation in this project would be voluntary for FQHCs. FQHCs would negotiate with HHSC and MCOs for data transfer and the specific requirements for the project implementation, including continuity of patient eligibility and patient assignment. Legislation will be refiled by Rep. J. D. Sheffield that was unanimously approved in the Texas House in the 85th legislative session (HB 3151, 85th Regular Session) that takes a step toward streamlining Medicaid enrollment.**



[1]Agency for Healthcare Research and Quality, February 2018. https://innovations.ahrq.gov/issues/2013/07/03/value-based-reimbursement-structures

[2]FY18 UMCC /UMCM: MCO Alternative Payment Models (APMs) with Providers, HHSC, 2018 https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/FY18-MCO-UMCC-UMCM-APM-providers-042117.pdf

[3]Office of the Assistant Secretary for Planning and Evaluation, US HHS, https://aspe.hhs.gov/poverty-guidelines

Texas Association of Community Health Centers
5900 Southwest Parkway, Building 3 | Austin, Texas 78735 | (512) 329-5959 | www.tachc.org /TexasCHCs | @TexasCHCs