

POLICIES AND STRATEGIES TO MAKE  
MEDICAID MANAGED CARE WORK  
FOR FQHCs: EXPERIENCES FROM  
TWO STATES

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## INTRODUCTION

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The 2000 Institute of Medicine report, *“America’s Health Care Safety Net: Intact but Endangered,”* examined the impact of Medicaid managed care on the future integrity and viability of safety net providers, such as community health centers. The report warned federal and state policy makers that managed care policies need to explicitly take into account the unique mission of safety net providers, reflected through fair rates and policies, lest the safety net structure be significantly weakened.<sup>2</sup> With this message in mind, the National Academy for State Health Policy (NASHP) visited two states in spring of 2008 with two different kinds of managed care programs (primary care case management and managed care organizations). Our purpose was to examine strategies and policies that states use in their managed care contracts that influence the operations of Federally Qualified Health Centers (FQHCs).

The site visit interviews enabled us to look at how FQHCs in these two states are faring under their state Medicaid managed care programs and how managed care policies affect the mission of the FQHCs. This briefing examines Alabama’s and Michigan’s managed care policies and the relationship between Medicaid and FQHCs, as well as their representative body, the primary care association (PCA).

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## BACKGROUND

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The federal community health center program was initiated more than 40 years ago. In 2007, it provided comprehensive primary care to 16 million people through almost 1,100 different centers across the country.<sup>3</sup> The patients who seek care at health centers represent the most vulnerable members of society: those who have poor health status, are low-income, minority, uninsured, or are covered by Medicaid.<sup>4</sup>

Medicaid payments are central to health centers' operating revenue (37 percent), providing significantly more funding than Medicare and other public insurance (9 percent), private insurance (7 percent), self-pay (7 percent), state and local grants (13 percent), and federal grants (21 percent).<sup>5</sup> Medicaid is important to health centers for two primary reasons:

- the volume of Medicaid patients seeking care at health centers has been increasing over the years, driving operating revenue;
- favorable Medicaid reimbursement rates reflect the operational costs of the visit for the FQHC, not just the time and resources of the provider. This reimbursement methodology mandated by Congress makes Medicaid the best third-party payer for FQHCs.<sup>6</sup>

Managed care is central to the Medicaid delivery system, with more than 65 percent of the Medicaid population in 48 states enrolled in some form of managed care.<sup>7</sup> The two major types of managed care systems used in Medicaid are: primary care case management (PCCM) and managed care organizations (MCO).

Under a PCCM program, the Medicaid agency contracts directly with practitioners that agree to serve as primary care providers (PCP) for Medicaid beneficiaries who enroll with the PCP. The PCP agrees to deliver primary care to all enrollees and coordinate the health care delivered by other providers. The Medicaid agency usually pays the PCP fee-for-service payments for all services delivered by the practice plus a small per-member per-month (PMPM) care coordination fee. In 2006, 28 Medicaid agencies operated PCCM programs.<sup>8</sup>

Under an MCO program, the Medicaid agency contracts with managed care plans that agree to provide or arrange for the provision of an agreed upon set of services (covered benefits) in exchange for a predetermined, pre-paid PMPM or capitation payment. Because the capitation payment does not vary based on the services the MCO provides to its members (also referred to as enrollees), the MCO assumes financial risk for providing all covered benefits.<sup>9</sup> In 2006, 32 states delivered primary care services through contracts with MCOs.<sup>10</sup>

In addition, Medicaid agencies are required to make supplemental or wrap-around payments to FQHCs for their care of Medicaid MCO patients. These state wrap-around payments are intended to cover the difference between the rate paid by the MCO plans and the Medicaid FQHC encounter rate.

To help select the two states for site visits, NASHP looked to its NCA primary care teams. In 2007, teams from six different states were selected through a competitive process by NASHP to work closely with staff to implement project activities that would help better inform state policymaking as it relates to FQHCs. From the states represented by both primary care teams and additional state officials in our National Cooperative Agreement advisory group,<sup>11</sup> NASHP selected Alabama and Michigan for site visits because of their contrasting managed care delivery systems and innovative policies that affect health centers.

Because Michigan is one of our six state teams and Alabama is one of our advisory group members, the site visits gave us an opportunity to learn more about their experiences. Almost all Alabama and Michigan Medicaid enrollees are enrolled in managed care plans that contract with FQHCs. Alabama uses a PCCM delivery system and Michigan uses a MCO delivery system. Their differing policies offer valuable lessons to other states.

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## ALABAMA AND MICHIGAN MANAGED CARE POLICIES

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**S**tate policies have a strong influence on the ability of FQHCs to participate in managed care arrangements. This paper looks at Alabama’s and Michigan’s managed care policies and strategies particularly as they affect FQHCs with regard to:

- Enrollment and assignment,
- Access to providers,
- Monitoring and quality, and
- Financing.

Alabama’s Medicaid PCCM program, Patient 1<sup>st</sup>, covers more than 420,000 Alabama residents and is operated by Alabama’s Medicaid agency under a 1915(b) waiver, allowing the state to require enrollees to participate in the plan. Alabama uses a PCCM structure to contract directly with providers, including FQHCs, to provide Medicaid services. Patient 1<sup>st</sup> links Medicaid recipients with PCPs, promoting the program’s and Alabama’s overall goal of improving health outcomes by providing a medical home to enrollees and containing costs. During the site visit to Alabama, state officials from Alabama Medicaid Patient 1<sup>st</sup> program, among many others, were interviewed.

Michigan, on the other hand, has one of the longest-standing Medicaid MCO programs. Michigan’s mandatory managed care program also operates under a 1915(b) waiver, but the state contracts directly with MCOs, which in turn contract with providers. There are 14 Medicaid MCOs in Michigan that provide health care to more than 1 million Medicaid enrollees. During the site visit to Michigan, state officials from the Michigan Department of Community Health (MDCH) were interviewed, as well as representatives from three of the state’s Medicaid managed care plans including:

- CareSource—a primarily community health center affiliated plan (previously Community Choice Michigan until April 2008),
- Great Lakes Health Plan (GLHP) – a Medicaid-only health plan (part of AmeriChoice, a business unit of UnitedHealth Group), and
- CompCare, a managed behavioral health organization (BHO) that contracts with Michigan’s four largest health plans for services for mild to moderate mental health conditions.

### **ENROLLMENT AND ASSIGNMENT POLICIES**

Medicaid enrollment and assignment policies are as fundamental to FQHC survival as reimbursement policies. The volume of Medicaid patients drives FQHCs’ operating revenues. State efforts to locate and enroll eligible people in Medicaid are very important to FQHCs. Perhaps as important are Medicaid managed care policies that assign beneficiaries to PCPs.

#### **Alabama**

With a few exceptions,<sup>12</sup> nearly all Medicaid recipients are required to enroll in Patient 1<sup>st</sup>. When an Alabama resident is first enrolled in Patient 1<sup>st</sup>, the Medicaid agency assigns the enrollee to a PCP. If the person has been previously enrolled, the assignment is based on where he or she has been seen before; otherwise, the assignment is random. Upon assignment, enrollees receive a list of all other local providers and are given a chance to change their PCP on a monthly basis. Each month, PCPs are provided with a monthly enrollment roster that identifies new enrollees in their panel.



## Michigan

In Michigan, the Medicaid populations enrolled with MCOs include low-income families and people with disabilities.<sup>13</sup> To inform potential members of their choices, Medicaid contracts with an enrollment broker (Michigan Enrolls) that mails a packet of information to beneficiaries to help them make a health plan selection within their service area. The materials are available in several different languages, including Arabic. The cover letter informs the enrollee that if he or she does not choose a health plan, a plan will be chosen for them by Medicaid. At this time, Medicaid beneficiaries also learn about Michigan's policy that allows them the option of seeking care at an FQHC even if an FQHC is not part of the plan's network.

After a plan has been selected (chosen by either the enrollee or Medicaid), Medicaid sends the enrollee's information to the health plan. Health plans then must assign each enrollee to a PCP. Each health plan is unique in its assignment algorithm, but most base the decision on factors such as an established relationship with a provider, geography, or claims history. FQHCs have asked Medicaid to require the health plans to auto-assign beneficiaries to them. Medicaid's position is that the assignment decision belongs to each health plan, but the FQHCs maintain they should be supported through preferential auto-assignment policies because of their federal obligation to serve the uninsured. Medicaid holds regular meetings with health plans and encourages the plans to include FQHCs in their assignments.

### ACCESS TO PROVIDERS

States can use managed care contracts to ensure that Medicaid enrollees have a medical home, also known as a designated, accessible PCP, who provides comprehensive, ongoing health care that is coordinated across other providers. During the site visit interviews, patient access to mental health providers also emerged as an important issue.

## Alabama

More than 1,300 individual PCPs make up the Patient 1<sup>st</sup> network, including 120 FQHC sites. Under the Patient 1<sup>st</sup> contract, PCPs must, among other requirements, maintain hospital admitting privileges,

### Outreach and enrollment partnership with the Detroit Wayne County Health Authority

The Detroit Wayne County Healthy Authority (DWCHA) was established by Governor Jennifer Granholm in 2003 in response to indications of a health care safety net crisis in Detroit and Wayne County. The Health Authority itself was created by an agreement between the City of Detroit, the County of Wayne, and the Michigan Department of Community Health to:

- monitor and report regularly on the effectiveness of the safety net;
- develop and maintain relationships that encourage the participation of all community stakeholders; and,
- coordinate efforts to meet the health needs of the under- and uninsured by assuring access.

The agreement enables the Health Authority to conduct community outreach and health education to vulnerable populations through means such as a grassroots campaign and to convene stakeholders, including FQHCs, to develop sustainable solutions to maintain these services.

For instance, through a unique partnership with the DWCHA, the MDCH supports an innovative outreach campaign to identify and enroll new Medicaid beneficiaries, which will in turn better support FQHCs and other safety net providers. DWCHA hopes that the added Medicaid revenues for FQHCs will enable them to underwrite more care for the uninsured.

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ensure 24/7 access, provide medical care coordination, meet standards of appointment availability, and provide appropriate referrals to specialty care. Alabama Medicaid recipients are allowed 14 office visits per year per beneficiary with some exceptions.

All Patient 1<sup>st</sup> providers, including FQHCs, have access to Department of Public Health nurses and social workers for care management services, paid for by Medicaid through a contract with the Department of Public Health. These care managers work with patients to help them better access and use their providers. There are 300 public health social workers performing targeted care coordination for “non-discriminate users of the emergency room” needing educational reinforcement or other services such as transportation and literacy assistance.<sup>14</sup> Any Patient 1<sup>st</sup> enrollee who receives a referral from his or her provider or the Department of Public Health can receive these services. While FQHCs employ their own care coordinators, they may also use Department of Public Health coordinators. In addition, providers have the ability to enroll their patients into an in-home monitoring program to help manage chronic diseases.

Transportation to providers is a problem for many in Alabama. The state has partnered with one non-profit group, Kid One Transport, to help address that issue. Kid One Transport operates a fleet of nine vehicles serving 30 counties throughout central and north central Alabama with the purpose of providing children and expectant mothers access to health care services throughout the state.

#### *Access to mental health services*

In Alabama, FQHCs cannot bill Medicaid for mental health services provided by psychologists and master-level social workers; FQHCs can only bill if the services are provided by psychiatrists. (The exception to this rule is that both psychologists and psychiatrists can be reimbursed for services provided when an EPSDT referral is made).<sup>15</sup> This situation is challenging for FQHCs because many do not have access to psychiatrists and employ on-site psychologists and master-level social workers to provide the mental and behavioral health services they are mandated to provide. Although the Medicaid agency does not currently pay for services provided by master-level social workers, they indicated that this is a policy that they are working to change.

### **Michigan**

The Michigan Medicaid health plan contract establishes the performance standards for all MCOs. Since the inception of the program, there has been wide interest among MCOs in participating. Medicaid sets an actuarially sound price and awards contracts through a procurement process in which an MCO must demonstrate that they have an adequate provider network that will provide covered services.

While there is no requirement to contract with FQHCs, it is strongly encouraged by Medicaid. One policy that encourages MCOs to contract with FQHCs is if there are several FQHCs in the area and the health plan contracts with at least one, members can be required to obtain services from that specific FQHC with the MCO contract; however, if a health plan chooses not to contract with any FQHC in their area, they must inform their members that they are eligible to get services at the FQHCs without prior authorization.

Not only must a health plan have an adequate network in terms of covered services, it must also offer its beneficiaries a choice of providers. Medicaid requires that beneficiaries have at least two MCOs to choose from and within that, a choice of PCP. For FQHCs, a beneficiary may choose the entire FQHC as the PCP instead of selecting one specific provider. This policy was developed at the request of the FQHCs because of the transient nature of some of their providers.

### *Access to mental health services*

Michigan Medicaid requires that the MCOs cover 20 mental health outpatient visits for the mild to moderately mentally ill. MCOs can contract with a behavioral health organization (BHO) such as CompCare or administer the mental health benefit themselves. FQHCs can provide these 20 mental health outpatient visits per year through their licensed social workers and psychologists, as long as the providers have been credentialed as part of the MCO behavioral network. For the severely mentally ill, developmentally disabled, and children with severe emotional disturbance, the plans refer their patients to the Community Mental Health (CMH) agency.<sup>16</sup>

Medicaid mental and behavioral health managed care policies are a high priority for FQHCs and have received a great deal of attention. A 2000 study of Michigan's FQHCs revealed that one out of two patients has a behavioral or emotional problem, one-third have depression as a primary or secondary diagnosis, and one-third of direct patient provider time is spent addressing behavioral or emotional concerns.<sup>17</sup> In 2005, a workgroup comprised of the MDCH, PCA, and several MCOs was formed to develop solutions to expand access to services by addressing service and delivery issues. The Mental Health ad hoc group worked closely with Medicaid to modify the credentialing process to allow licensed social workers and psychologists to bill for the 20 mental health outpatient visits per year at FQHCs. This included arriving at a solution to communicate encounter data using a National Provider Identifier (NPI) number for these providers.

Michigan Medicaid also worked to expand billable mental health codes for FQHCs. MDCH, PCA, and CompCare met with Centers for Medicare and Medicaid Services (CMS) and HRSA in May 2008 to discuss revising the billable codes to fit the needs of FQHCs and School Based Health Centers. This meeting of stakeholders resulted in approval of existing codes (which had not previously been used in this setting) for plans to choose from specifically for the FQHCs. This included allowing FQHCs to be paid for two different encounters on the same day in the same facility, allowing for a primary care and a behavioral health visit. Many FQHCs have successfully executed revised contracts with CompCare and are now receiving payments

#### **Michigan Medicaid Behavioral Health Policies and FQHCs**

- Licensed social workers and psychologists who have been credentialed as part of the MCO behavioral provider network can bill for 20 mental health outpatient visits per year at FQHCs.
- Medicaid encounter rates are the same for primary care, oral health, and behavioral health services at FQHCs.
- FQHC providers can be paid for two different encounters on the same day (primary care and behavioral health) at a FQHC.
- Non-FQHC patients who need mental health services may utilize the FQHC psychologists and licensed social workers, for which the FQHC will receive reimbursement.
- A new, comprehensive list of behavioral procedural codes allows FQHCs to receive payments for an expanded range of services including screening, brief intervention, and parenting classes.
- CompCare reimburses for telemedicine services between one FQHC in northern Michigan and a collaborating hospital.
- If an FQHC does not employ someone to provide mental health services, CompCare can arrange for someone to come to the center to provide those services.
- If a PCP diagnoses someone as severely mentally ill but cannot get them into Community Mental Health, CompCare acts as a liaison to facilitate the connection. When a patient becomes stable, he or she can migrate back to the PCP for his or her 20 outpatient mental health visits.

for a range of services that they had been providing previously but had not been receiving reimbursement for, including screening, brief intervention, and parenting classes.

Medicaid has made significant inroads to improving access to mental and behavioral health services for its managed care beneficiaries, but stakeholders agree that more could be done. Medicaid has leveraged its ability to bring stakeholders to the table by hosting quarterly mental health advisory meetings that include representatives of CompCare, MCOs and their subcontracted BHOs, FQHCs, and mental health providers. This group is charged with tackling three issues:

- Access to behavioral health services, such as utilizing FQHC non-physician providers;
- Co-occurring disorders, such as policies that better define how these services will be paid; and,
- Improving the referral system so providers better understand the available networks.

### **MONITORING AND QUALITY POLICIES**

Key aspects of Alabama’s and Michigan’s managed care policies include collecting data to give providers feedback about their performance and their patients’ health and to provide incentives for improving the quality of patient care.

#### **Alabama**

Patient 1<sup>st</sup> prepares and distributes a provider profile four times per year, which contains summary information on each PCP’s panel for a 12-month period. A physician advisory group provided input to make the profile user-friendly, readable, and informative. Providers can easily see how their numbers and adjusted scores compare to their peer group on a number of measures. FQHCs each receive their own profile and are compared to the FQHC average. The Medicaid agency indicated that it is currently working with FQHCs to look at measures that better reflect their unique structure and service delivery system.

The first portion of the profile provides general information, such as demographics of recipients, panel size, claims, and cost per recipient. It also includes information on services being utilized, such as EPSDT periodic screenings, emergency room visits, specialty care, and primary care visits. The profile includes a breakdown of pharmacy measures, such as generic dispensing rates and commonly prescribed drugs. Finally, providers are given their scores for three performance measures and one efficiency measure compared against their peer group. These measures are used to help determine what percentage of shared savings providers will receive from Medicaid. (More on this in the Financing section.) Only providers are able to see the profiles—patients do not have access to this information. Patient satisfaction is monitored through a recipient survey and a complaint process.

#### *Supporting PCCM providers with health information technology*

In February 2008, Alabama began rolling out plans for an electronic health record (EHR) funded by a \$7.6 million transformation grant received from CMS. PCCM providers, including 12 FQHCs, are participating in this project, which is designed to support improved patient care. The goals for Alabama’s “*Together for Quality*” CMS-funded initiative are:

1. Create a statewide electronic health information system that links Medicaid, state health agencies, providers, and private payers and that provides them with secure, real time access to individual health information, claims, immunization records, prescription data, and lab results;<sup>18</sup>
2. Develop a clinical support tool using care management data that will enable providers to improve care choices and better manage their patients, especially those with chronic illnesses; and

3. Create a system that allows state agencies and providers to share information electronically to improve patient health and control costs.<sup>19</sup>

The EHR is claims-based and is overlaid with clinical alerts to remind providers that services are needed or recommended for patients in their panel. The EHR is a web-based tool designed to interface with the providers' existing electronic medical record (EMR) systems. Alabama Medicaid reports that some providers are reluctant to have this tool interface with their own EMR systems. At the time of the site visit, Medicaid staff were making face-to-face visits, targeting providers with high Medicaid caseloads, including many FQHCs, to discuss the advantages of a common system and to address their concerns. Mini-grants were available to assist providers to make the connection to the EHR. The tool was launched July 17, 2008. As of late August 2008, nine FQHCs are participating in the *Together for Quality* initiative.<sup>20</sup>

Another component of the *Together for Quality* initiative is a comprehensive chronic care management program for Patient 1<sup>st</sup> enrollees who have a history of complex asthma and diabetes. Department of Public Health care managers are trained to work directly with providers, patients, and families to coordinate care, make house visits, and provide education, while providers work with clinical protocols that employ evaluative tools to measure outcomes.

## Michigan

In Michigan there are two levels of provider feedback: one from Medicaid to the health plans and one from the health plans to the providers. Michigan's Medicaid agency monitors the performance of the Medicaid health plans through 11 performance measures, including childhood immunizations, well child visits, prenatal care, pharmacy encounter data and complaints. It also provides monthly performance reporting to the plans so that they can see how they are doing in relation to one another.

Medicaid uses performance-based auto assignments based on an algorithm (paying claims on time, complaints, etc.) and various HEDIS<sup>21</sup> measures and ranks the plans. Plans can move up or down three tiers (above average, average, and below average) every quarter and plans that are a higher tier get a greater proportion of auto assignments.<sup>22</sup> In addition, plans must be accredited by an outside body such as the National Committee on Quality Assurance or Utilization Review Accreditation Commission.

Many of Michigan's Medicaid MCOs are also supporting efforts to facilitate health information technology and information exchange. Some examples include:

- When Community Care Michigan became Community Choice, FQHCs shared in the sale and used this money to purchase EHRs.
- Great Lakes Health Plan (GLPH) developed an online portal system that allows the PCPs to search their roster at time of appointment, look up a patient, and receive in real-time an update regarding HEDIS measures and services the patient has and has not received. PCPs can use their roster data to sort all of their patients and make queries (i.e. patients who haven't had lead screening). PCPs can also print out letters to members in different languages and check for eligibility.

There are many ways that each plan encourages, supports, and monitors FQHCs in quality initiatives. GLHP uses auto-assignment as a reward for good performance and will remove poor performing practices (based on HEDIS measures) from auto assignment. GLPH stated that complex patients receive extra attention from GLHP social workers. Social workers will contact the provider to collaborate on case management services and contact members if they are missing appointments. Providers, including FQHCs, receive payment incentives to see more complex patients. Also, GLHP provides many incentives based on HEDIS measures. For example, if a woman receives a preventive mammography once a year, her provider would receive an incentive payment, regardless of whether her PCP provided that service directly.

CareSource gives providers clinical performance reports and urges them to use these reports to make outreach contacts to patients due for services. CareSource also supports the provider through both case and disease management programs. In the case management program, members with complex medical conditions are enrolled in case management with a Health Coach. The CareSource Health Coaches regularly meet with FQHC clinical staff and physicians to review cases and provide feedback. Members in the disease management program receive education from CareSource and are encouraged to take the educational materials to their physician visits. Both CareSource and GLHP provide FQHC medical directors with quarterly feedback reports using HEDIS and other measures so they can see how they are doing compared to other FQHCs. In addition, FQHCs are also provided with pharmacy use reports.

## FINANCING ISSUES

Medicaid payments are vital to the viability and effectiveness of FQHCs in carrying out their mission to provide health care services regardless of patients' ability to pay. Congress mandated cost-based payments for FQHCs to cover the operational costs of care, including fixed overhead and infrastructure costs in addition to patient services in order to free limited Federal grant dollars to cover the care for the uninsured. This mandated FQHC cost-based payment (now paid prospectively) has created some tension between FQHCs and Medicaid agencies. FQHCs receive rates that are significantly higher than FFS rates paid to other primary care providers.

### Alabama

Most Patient 1<sup>st</sup> providers—except FQHCs—are reimbursed using traditional FFS payments and a monthly case management fee based on the number of Medicaid recipients in a provider's panel. FQHCs, on the other hand, receive the higher Medicaid prospective payment system (PPS) encounter rate but not the monthly case management fee because Medicaid indicates that FQHCs' cost-based reimbursement already covers the activities included in the case management fee. Although FQHCs are not paid the monthly case management fee, they do take part in provider performance bonuses.

When the Patient 1<sup>st</sup> program was reinstated in 2004,<sup>23</sup> the Alabama Medicaid agency committed to sharing one-half of program savings with those providers who performed well and contributed to the savings. In April 2007, the Medicaid agency made good on that promise, distributing \$5.76 million (based on \$11.7 million savings) to providers based on their performance.

The shared savings distribution is based on a formula with two categories: efficiency and performance. An efficiency bonus is determined through a formula that compares the amount Medicaid spent on behalf of a provider's panel and the expected expenditures. FQHCs were not included in the efficiency bonuses.

#### How Alabama Determines Performance Bonuses

- *Generic Dispensing Rate*: The percentage of generic prescriptions ordered for the provider's panel as compared to the peer group.
- *Visits per Unique Member*: Average number of visits per recipient seen by the provider as compared to the peer group. This measure is annualized and is aimed at reinforcing the medical home concept – if Medicaid has assigned a recipient to a PCP, it is important that the provider is seeing the patient regularly and not often referring him or her elsewhere.
- *Number of Non-Certified Emergency Room Visits*: Average number of recipients that are utilizing the emergency room as compared to the peer group. This measure is annualized.<sup>24</sup>



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The Medicaid agency indicated that they are currently working to include FQHCs in the next round of efficiency payments.

To calculate the 2007 performance savings, Medicaid used three different measures that look at actual utilization by the panel compared to what was expected. FQHCs did participate in performance savings.

FQHCs worked with Medicaid to establish new clinically-based outcome measures that will apply to *all* Patient 1<sup>st</sup> providers in the next waiver period as part of the measures affecting performance bonuses. The new outcome measures are:

- HbA1c Testing,
- Asthmatic Emergency Room Visits, and
- Hospital admission rates per 1000.

### **Michigan**

Michigan's health plan rates are determined based on a rate developed and certified by an actuary and adjusted annually. There is no negotiation between the plans and Medicaid for these rates. Rates are risk adjusted for the Aged, Blind, and Disabled (ABAD) population, region, age, and gender. Payments are made monthly to the plans.

The health plans interviewed pay FQHCs based on Medicaid FFS rates—not the FQHC Medicaid PPS rate. Each year there is a cost settlement and interim payments are made on a quarterly basis between Medicaid and the FQHCs for the difference between what the plan paid the FQHCs and the Medicaid PPS rate—also known as the wrap-around rate, which is required under Federal law.

Michigan Medicaid withholds a small percentage (0.19 percent) annually from the MCO payment to create a pool of about \$5 million to share with the plans for high performance. Distribution of the performance pool is based upon performance ratings based across a number of clinical and nonclinical measures.

Though these bonus awards have various ways of incenting providers, it is up to the plans to decide how to distribute their performance pool to their providers. CareSource pays for performance for certain services on a quarterly basis. For instance, a \$20 bonus is paid to providers for well child visits, mammograms, and other services. FQHCs receive the bonus payment for services rendered at their center for both patients that have been seen at their center, and for patients who are assigned to their center but who receive the service elsewhere.

GLHP has a seven-day turnaround from receipt to payment. Its payment model is based on input from physicians and focus groups and uses Medicaid FFS rates, incentive payments, and PMPM payments, which is a care management fee paid to all providers. The PMPM rate varies depending on four characteristics: open vs. closed panel, member panel size, member panel mix (higher score for greater percentage of ABAD population), and non-emergent use of emergency rooms.

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## HOW DO HEALTH CENTERS MANAGE MANAGED CARE?

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**F**QHCs and PCAs in both Alabama and Michigan indicated that they have a strong, open relationship with their Medicaid agencies. These relationships are fostered through regularly scheduled meetings and a shared commitment to serve vulnerable populations. Common themes to improve state policies include better reimbursement rates and increased assignment of Medicaid managed care patients to FQHCs. Each state had other unique experiences to share.

### ALABAMA

The site visit included an interview with representatives of Health Services, Inc. (HSI), a non-profit charitable organization that began in 1968 and now operates 10 community health centers in both urban and rural areas of Alabama.

The health center representatives interviewed felt that they have strong ties to Medicaid and the Department of Public Health. These ties are due to bimonthly meetings with the FQHC Program Manager. According to many of the interviewees, the addition of a new executive director of the PCA improved state relations.

There are a number of state managed care policies that the FQHCs feel support their mission:

- New Medicaid PCCM enrollees are assigned a PCP that may include a FQHC as their medical home;
- FQHCs take part in shared PCCM savings--\$65,000 in performance savings went to 10 HSI facilities;
- Patient 1<sup>st</sup> staff are easy to reach—names, numbers, and emails are posted online;
- Monthly Patient 1<sup>st</sup> profiles give providers valuable feedback, increase morale, and motivate staff; and,
- The current InfoSolutions/e-prescribing program offered by Patient 1<sup>st</sup> is very helpful because of the ability to track where patients are getting prescriptions written, along with providing other valuable information.

There are a number of policy changes that FQHCs believe would improve their ability to serve their patients:

- Increasing Medicaid reimbursement to dentists;
- Increasing the 14-visit limit for Patient 1<sup>st</sup> beneficiaries on primary care visits. (Many patients come to the FQHC after they have exceeded their 14-visit limit with their regular PCP. The FQHCs are not reimbursed for these extra visits but because of their mission, cannot turn patients away.);
- Helping to better cover the costs of transportation;
- Establishing a Medicaid encounter rate for a licensed social worker or master's level psychologist; and,
- Paying more than one encounter rate for FQHC patients who see multiple providers in the same day under the same roof. (Patient 1<sup>st</sup> counts visits with one or more health professionals that take place on the same day at a single location as a single encounter and pays one rate -- except for dental services).

The executive director of the PCA feels that the PCA relationship with Medicaid and the Department of Public Health is very good. The PCA has been working with Medicaid to determine performance measures for the next period of shared savings, which includes the disease-specific measures for asthma and diabetes. FQHCs' experience in participating in HRSA's Health Disparities Collaboratives<sup>25</sup> has helped to inform that work. The PCA would like Medicaid to provide PMPM case management fees for FQHCs because of the amount and cost of care coordination done by the FQHCs.



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## MICHIGAN

The Michigan FQHCs interviewed included Cherry Street Health Services, Center for Family Health Care, and Detroit Community Health Connection. Also interviewed during the site visit was the Detroit Wayne County Health Authority (DWCHA).

Although the FQHCs would like the state to do more to encourage managed care plans to assign them more beneficiaries, they feel that the following state managed care policies are supportive of their mission:

- FQHCs receive quarterly prospective cost settlements or wrap-around payments based on the previous year's history using a Medical Economic Index (MEI) adjustment. In addition, there is an end-of-the-year payment settlement, but it tends to be smaller than the quarterly adjustments;
- CompCare has been willing to recognize and pay for a variety of different services, especially brief behavioral interventions by non-physicians.

The relationship between Medicaid, the state PCO, and the PCA is described as very strong from all the stakeholders. Strong relations helped facilitate collaboration and problem solving during the early transition years of managed care.

There are a number of policy changes that FQHCs believe would improve their ability to serve their patients:

- In some cases, patients must wait 30 days to change their PCP assignment;
- Although a non-FQHC patient can receive care at a FQHC, the FQHC will not receive the "Medicaid FQHC PPS rate" for that service—there is no wrap-around rate for that encounter;
- Cost reporting settlement is always contentious and has also been delayed;
- Although a comprehensive list of behavioral and mental health codes has been approved, some plans have been slow to adopt and reimburse for these codes; and,
- FQHCs are not allowed to enter into contracts with MCOs outside of their county but often care for patients who live on county borders; FQHCs receive no reimbursement for this service and have to absorb the cost of that encounter.

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## CONCLUSION

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The common theme in both Alabama and Michigan is the existence of strong communication channels—which may not be typical—between state Medicaid agencies, public health departments, FQHCs, and other stakeholders. These communication channels are characterized by regularly scheduled meetings where FQHCs are given the opportunity to speak directly with key state officials about important policy matters. Although agreement on every issue is not possible, there is a feeling that the state values the FQHC role and has developed managed care policies that support that role.

Although FQHCs and PCAs in both states agree that reimbursement issues are always contentious, they have developed valuable partnerships that have helped strengthen FQHCs' ability to serve vulnerable populations. For instance, Michigan's success in forging an agreement between Medicaid and CompCare (BHO) to pay for FQHC mental health services is one that CompCare hopes that other states will see as a strategy to serve patients better and save money.

Although federally funded community health centers were initiated with very little state input 40 years ago, it is clear that state interest and involvement is now critical to their survival. FQHCs in Alabama and Michigan have adapted to managed care climates and are at the table with their state policymakers to insure that their mission to provide health care to vulnerable populations is supported.

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## ENDNOTES

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- 1 The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.
- 2 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000) p. 9.
- 3 U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. "The Health Center Program: 2007 National Aggregate UDS Data." Retrieved 22 December 2008. <http://bphc.hrsa.gov/uds/2007data/National/NationalExhibitAvenue.htm>.
- 4 Ibid.
- 5 Ibid.
- 6 Sara Rosenbaum and Peter Shin, *Health Center Reauthorization: An Overview of Achievements and Challenges* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006) p. 8.
- 7 Carolyn Lawson, Loan Swisher and Joe Del Pilar, *2006 Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2006* (Baltimore, MD: Centers for Medicare and Medicaid, 2006) Accessed 2 October 2008. <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf>.
- 8 Ibid.
- 9 Rawlings-Sekunda and Neva Kaye, *Medicaid Managed Care Policies Affecting Safety-Net Providers and the People They Served, Volume 1: Eligibility and Access Policies* (Portland, ME: National Academy for State Health Policy, 2001).
- 10 U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, *Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs* (Rockville, MD: Office of Rural Health Policy, revised 2006) Accessed online 2 October 2008. [http://www.cms.hhs.gov/mlnproducts/downloads/fqhc\\_rhccomparison.pdf](http://www.cms.hhs.gov/mlnproducts/downloads/fqhc_rhccomparison.pdf), p.42.
- 11 As part of NASHP's National Cooperative Agreement from HRSA's Bureau of Primary Health Care, six states were selected through a competitive process to help guide the project work of this grant, which includes site visits, publications, Webcasts, and conferences. States were selected based upon their demonstration of an active partnership between the PCO and PCA offices. The six states chosen were: Alaska, District of Columbia, Hawaii, Massachusetts, Michigan, and Mississippi. In addition to the state primary care teams, NASHP staff chose 10 of our Academy members, all state officials, to serve as project advisors.
- 12 Exceptions include foster care children, dual eligibles (Medicare and Medicaid), and those with certain medical exemptions, among others.
- 13 Excluded groups are: dual eligibles (Medicare and Medicaid), long-term care population, and the spend-down population (when a person's medical expenses equal or exceed their deductible).
- 14 April 2008 Patient First Manual .39.10.2, [http://www.medicaid.state.al.us/documents/Billing/5-G\\_Manuals/5G-2\\_Provider.Manual\\_April.2008/Apr08\\_39.pdf](http://www.medicaid.state.al.us/documents/Billing/5-G_Manuals/5G-2_Provider.Manual_April.2008/Apr08_39.pdf).
- 15 The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is essentially the package of benefits for children enrolled in Medicaid. Under EPSDT requirements, states must provide comprehensive health and developmental assessments, as well as vision, dental and hearing services, to children and youth up to age 21. EPSDT focuses on prevention-oriented services for the early identification of disabling conditions, but also covers the diagnostic and treatment services necessary for acute and chronic physical and mental health conditions.
- 16 In Michigan, there are 18 Community Mental Health Service Providers also known as Prepaid Inpatient Health Plans (PIHPs). These PIHPs provide mental health services on an at-risk or capitated basis and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf>.
- 17 Michigan PCA Mental Health Financing Issues Workgroup, May 12, 2008 PowerPoint.
- 18 Carol Steckel and Robin Rawls, *Better health care at a lower cost: 'Together for Quality' to transform Medicaid and other state health care systems* (Montgomery, AL: Medicaid for the Montgomery Advisor, February 2007).
- 19 Kim Davis Allen, "Together for Quality" Fact Sheet from Alabama Medicaid Agency. [http://www.medicaid.state.al.us/documents/News/Transformation/TFQ-News/TFQ%20Fact\\_Sheet%209-2-08\\_V2.pdf](http://www.medicaid.state.al.us/documents/News/Transformation/TFQ-News/TFQ%20Fact_Sheet%209-2-08_V2.pdf).
- 20 Email from Kim Davis Allen 8/21/08.
- 21 The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. To read more, see: <http://www.ncqa.org/tabid/59/Default.aspx>.
- 22 See guide to Michigan Medicaid Health Plans, [www.michigan.gov/mdch](http://www.michigan.gov/mdch).
- 23 The original program was operational from January 1, 1997 through February 29, 2004, at which time Medicaid paused the program due to a policy change from CMS in regards to budget neutrality. Patient 1st was originally planned to be operational after 90 days, but Hurricane Katrina delayed implementation of the new program until December 2004. The entire state was operational as of February 1, 2005.
- 24 If a Patient 1st member comes into an ER and the physician deems the case not to be an emergency, there are several possible outcomes: 1) The ER can contact the PCP for a referral and, if affirmed, can proceed knowing that Medicaid will fully reimburse the hospital for their

services. The visit will count against the 14 reimbursable office visits allotted to Patient 1st members like any other visit to his or her assigned PCP would; 2) The PCP can make an appointment to see the patient as soon as is possible; or, 3) If the patient insists upon being seen at the hospital and will not wait for the appointment with the PCP, the patient is then responsible for the bill.

25 The HRSA Health Disparities Collaboratives were developed to transform primary health care practices, improving the health care provided to everyone and eliminating health disparities. After funding one PCA/Clinical Network team in each of five regional clusters the first year, HRSA selected 88 health centers to participate. Collaborative area focuses have included: asthma, depression, diabetes, cardiovascular disease, oral health, and many others. Approximately 800 health centers are participating in the HRSA HDC as of September 2006. To read more: <http://www.healthdisparities.net/hdc/html/home.aspx>.