2009 Medicaid Transformation Program Review
Federally Qualified Health Clinics

Description

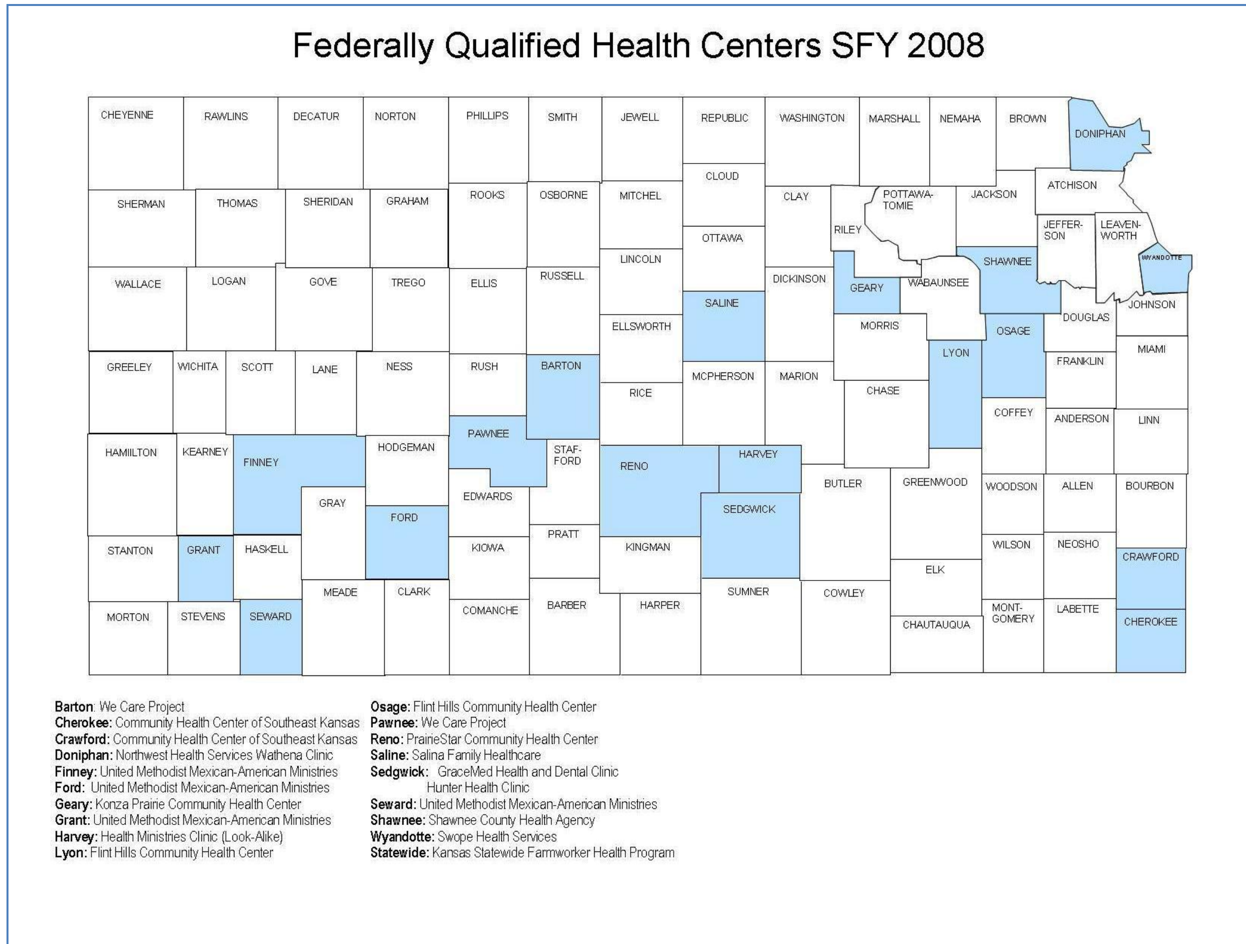
The primary objectives of this review are to describe the role of Federally Qualified Health Centers (FQHCs) in the Medicaid program, to describe the role of Medicaid in supporting this essential piece of the health care safety net, and to review FQHC payment policy and oversight. Other important questions, such as the role of FQHCs in advancing the medical home, or innovations in combining mental and physical health services are addressed in other venues.

FQHCs, also known as community health centers, are federally designated clinics that receive direct federal funding and enhanced reimbursement rates for public insurance to assist in delivering medical care to uninsured and other underserved populations. In 2008, there were eleven Kansas-based FQHCs and one FQHC look-alike. There were also two Missouri-based FQHCs with sites in Kansas. A single FQHC may have multiple locations, or sites. As of 2008, there were 29 FQHC sites in Kansas.

The Federal Community Health Center Program began in 1962 with passage of the Migrant Health Act, funding services for migrant and seasonal farmworkers and their families. In 1964, the broader community health center program began with the Economic Opportunity Act. In the 1970s, Congress permanently authorized health centers as “community health centers” and “migrant health centers” under sections 329 and 330 of the Public Health Service Act. In 1987, the Health Care for the Homeless Program was established, and in 1990 the Public Housing Primary Care Program was established. In 1996, all four programs (community, migrant, homeless, and public housing) were brought under section 330 of the Public Health Service Act.

In 2001, President Bush proposed a significant expansion of the health center system. The goal of the initiative was 1,200 new or expanded community health centers. To meet this goal, federal funding for the program nearly doubled, from slightly more than one billion dollars nationally to more than two billion as of 2008. During this period, five new FQHCs were funded in Kansas. Since the beginning of the Obama administration, an additional two Kansas FQHCs have received funding.

Figure 1 – Federally Qualified Health Centers SFY 2008



Note: The map includes all Kansas counties with FQHC locations. A single FQHC can have more than one physical location. Locations for a single FQHC may be in the same county, in a different county, or in a different state.

Definitions

Safety Net Clinic

The term safety net clinic is used to describe clinics that either through mission or usage serves a high number of uninsured or other underserved populations. The Institute of Medicine in its 2000 report "America's Health Care Safety Net" (Lewin, 2000), defined a core safety net provider as having two characteristics:

- "either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
- a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients."

FQHCs

To be designated a Federally Qualified Health Center; a clinic must

- be governed by a board made up of at least 51 percent FQHC patients representing the population served.
- be located in or serve a federally designated medically underserved area or a medically underserved population.
- provide care to anyone in this designated service area regardless of the patient's ability to pay for their care, using a sliding fee scale;
- be non-profit or public entities;
- provide:
  - comprehensive primary care services
  - referrals
  - and other services needed to facilitate access to care, such as
    - case management
    - translation
    - transportation
- ensure access to specialized medical care

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering FQHC payment policy; however, the Health Resources and Services Administration (HRSA) determines eligibility for designation.

FQHC Look-Alike

Clinics that meet all of the requirements for FQHC status may apply to receive designation as an FQHC look-alike. The benefit of look-alike status is enhanced reimbursement for Medicare and Medicaid services. FQHC look-alikes do not receive an annual grant from the federal government.

Community Based Primary Care Clinic

Beginning in State Fiscal Year 1992, the Kansas Legislature appropriated state funding for community-based projects that serve uninsured and other underserved populations. These clinics must be public or not-for-profit entities, provide primary medical or dental care services, provide a source of ongoing care for their patients, and provide care regardless of a patient's ability to pay using a sliding scale with charges based on income. For SFY 2008, there were 31 state-funded clinics, which included all but one of the Kansas Medicaid enrolled FQHCs.

Rural Health Clinic

Rural health clinics also receive cost-based reimbursement from Medicare and Medicaid. The designation was created in 1977 to assist clinics in rural areas federally designated as underserved. At least a half-time nurse practitioner, physician assistant, or certified nurse-midwife must be on staff to provide patient care services.

Medically Underserved Area (MUA)

This designation involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the

established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

Medically Underserved Population (MUP)

This designation involves application of the Index of Medical Underservice (IMU) to data on an underserved population group within an area of residence to obtain a score for the population group. Population groups requested for MUP designation should be those with economic barriers (low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services.

Health Professional Shortage Area (HPSA)

The U.S. Department of Health and Human Services Health Resources and Services Administration uses shortage designation criteria to decide whether or not a geographic area, population group, or facility has a shortage of medical, dental, or mental health professionals. HPSAs may be designated for underserved geographic areas and population groups. Facilities, including state mental hospitals, correctional institutions, rural health clinics, and FQHCs and FQHC look-alikes may receive HPSA facility designations. The Health Care Safety Net Amendments of 2002 provided for automatic facility Health Professional Shortage Area (HPSA) status for all Federally Qualified Health Centers (FQHCs) and those Rural Health Clinics (RHCs) that meet the requirement of providing access to care regardless of ability to pay.

HPSA scores have been developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25 for primary care and mental health and 1 to 26 for dental. The higher the score, the greater the priority. Facilities with HPSAs may have a score of 0. FQHCs with multiple sites receive a score for the entire entity that applies to all of the FQHC's sites.

Federal 330 Funding

Funding that Federally Qualified Health Centers receive on an annual basis from the federal government under section 330 of the Public Health Service Act. The Public Health Service Act defines grant funding opportunities for the provision of care to underserved populations.

Uniform Data System

The Uniform Data System comprises a core set of information on performance and operations that Federally Qualified Health Centers submit to the Bureau of Primary Health Care, HRSA on an annual basis.

340B Pricing

The 340B Drug Pricing Program limits the cost of covered outpatient drugs to certain federal grantees including federally-qualified health centers and FQHC look-alikes. Participating entities may experience significant savings on the cost of drugs. The program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act.

Encounter Definition

The Kansas Medicaid State Plan defines an FQHC "visit " as a face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), nurse-midwife, dentist, dental hygienist with an "Extended Care Permit" per the Kansas Dental Practice Act, clinical psychologist, clinical social worker, and for KAN Be Healthy nursing assessments only, a registered nurse.

Stakeholders

Kansas Health Policy Authority (KHPA)

The Kansas Health Policy Authority is responsible for management of the Medicaid FQHC program including Medicaid reimbursement. KHPA calculates FQHC interim rates, prospective payment rates, monthly wraparound payments, and FQHC Medicaid cost report settlements.

Kansas Department of Health and Environment (KDHE) (PCO)

The Primary Care Office (PCO) of the Kansas Department of Health and Environment receives federal funding to represent the needs of underserved populations and the health professionals who serve them. The assessment and assistance work of the PCO is focused on helping local communities through health care access planning, data assistance, specific program services, and technical consultation. The Kansas PCO also manages the Community Based Primary Care Clinic Grant Program which provides State funding to primary health clinics, including FQHCs, that serve uninsured and other underserved populations.

Kansas Association for the Medically Underserved (KAMU)

The Kansas Association for the Medically Underserved (KAMU) is the federally-funded primary care association (PCA) for the state of Kansas. PCAs receive federal funding to provide support and technical assistance to FQHCs and to assist communities interested in applying for federal 330 funding. KAMU includes both FQHCs and other clinics that serve the underserved in its membership.

National Issues for FQHCs

Proposed Rule on Designation of Medically Underserved Areas and Health Professional Shortage Areas

On February 29, 2008 the U.S. Department of Health and Human Services published the notice of a new, combined federal method for identifying areas that qualify for the additional subsidies available through FQHCs, RHCs, and other programs described above. The new method called, the Index of Primary Care Underservice, will replace the current federal designations of MUA, MUP, and Health Professional Shortage Areas (HPSA). FQHCs currently must be located in a MUA or MUP.

The new method is intended to better measure access to health care using nine community characteristics that increase need or risk, including:

- percent of population below 200 percent of the federal poverty level
- unemployment rate
- percent of the population 65 and older

- population per square mile
- percent of population nonwhite
- percent of the population Hispanic
- age-adjusted death rate
- low birth-weight or infant mortality rates

The method includes, along with the currently collected practice data for physicians, collected practice data for:

- physicians assistants
- advanced registered nurse practitioners
- certified nurse midwives
- medical residents

The method calculates primary care provider demand by establishing a barrier-free population-to-provider ratio based on physician practice characteristics and age and gender of the population. A barrier-free population-to-provider ratio is a ratio that does not have any barriers to care.

Following a twice-extended comment period, HRSA continues to plan for these changes in the proposed rule. The Patient Protection and Affordability Act of 2010 requires that the U.S. Department of Health and Human Services undergo a negotiated rulemaking process to further develop the rule prior to implementation. After the negotiated process, a new Notice of Proposed Rulemaking will be issued for further review and public comment prior to the U.S. Department of Health and Human Services issuing a final rule.

CMS Proposed Rule on Changes in Payment Provisions for Federally Qualified Health Centers

On June 26, 2008, CMS issued a proposed rule that includes updated payment provisions for FQHCs. The rule would revise the FQHC payment methodology that set Medicare payment at 80 percent of reasonable cost, after the application of deductibles. Beneficiary deductibles and actual, charge-based coinsurance would be deducted from approved reasonable costs, and FQHCs would be paid the balance up to the payment limit. Total payments for Medicare services could not exceed the approved reasonable cost amount.

Status of Funding and Likelihood of Further Expansion

The federal American Recovery and Reinvestment Act (ARRA) provided $1.5 billion for FQHC infrastructure expenditures, including construction, renovation, equipment, and the acquisition of health IT systems. It also contained $500 million for health center operations, including new sites, increased services, and supplemental payments to existing centers to accommodate a spike in uninsured patients.

Two clinics in Kansas received $2.6 million in new federal 330 funding through ARRA beginning April 1, 2009 - the Center for Health and Wellness in Wichita and First Care Clinic in Hays. On March 24, 2009, a total of $3.1 million in expanded funding related to increased demand for services was awarded to Kansas-based FQHCs to be used over a two–year period. On June 29, 2009, $6.7 million in funding for capital improvement projects was awarded to Kansas-based FQHCs to be used for facility and equipment needs.

Potential impact of national health reform legislation – some preliminary observations

The Patient Protection and Affordability Act provides for $11 billion in funding for the expansion of new and existing FQHCs between federal fiscal year 2011 and 2015. Of this, $9.5 billion is dedicated to the expansion of operational capacity, while $1.5 billion is dedicated to capital expenditures for expanded facilities and the construction of new sites.

- The biggest change for FQHCs is near-universal coverage. All but their non-citizen clients will have access to either Medicaid or large subsidies for private insurance, so except for clinics serving large immigrant populations, very few clients *should* be uninsured.

- Nevertheless, there are concerns that a meaningful number of Americans may remain uninsured even after health reforms take full effect, and the package of reforms passed by Congress in March 2010 includes significant new direct funding for FQHCs. The Congressional Budget Office estimates that about 6% of legal residents will remain uninsured after full implementation of the planned reforms.

- Medicaid, in particular, will become a far more important payer for FQHCs. Medicaid will cover all Kansans below 133% of the federal poverty level, which will likely comprise a significant percentage of patient volume at FQHCs and other low-income health clinics. The relationship between FQHCs and the Medicaid program is likely to change, and as for all Medicaid providers, cost control will likely become an overriding issue. Medicaid coverage can be applied retroactively for up to three months, which implies that most clinic costs will be reimbursable through Medicaid if clients are enrolled in the program when they present, or within three months after receiving service.

- In 2008, nearly 95% of Kansas FQHC clients were below 200% of poverty. When reforms are fully implemented, which should occur in January 2014 according to the newly-passed legislation, virtually all citizen clients at FQHCs will either be eligible for Medicaid, eligible for Federally-subsidized private insurance, or eligible for employer-sponsored coverage at premium levels that do not exceed 8-10% of family income.

- Cost-sharing requirements in Medicaid and private plans will be limited for the kinds of primary care services offered in FQHCs.

- Because clients should be insured, revenues at FQHCs may go up substantially, at least in proportion to the cost of services rendered. One question is whether newly-insured clients will seek primary care services in private clinics instead, and whether overall patient volume will increase or decrease as a result. Another question is whether states and the federal government will want to revisit payment methodologies and direct subsidies designed to offset the costs of treating the uninsured. Given the enhanced direct funding included in Federal reforms, it appears the approach at the national level will be to wait and see how clinics fare in the new system, e.g., to determine whether substantial new sources of third-party payment materialize.

- With the increase in health care funding for previously uninsured patients, securing access to providers will become a more dominant issue. FQHCs will also have additional contracting opportunities with insurance companies that participate in the new insurance markets (exchanges) so that they can serve more of the near-poor.

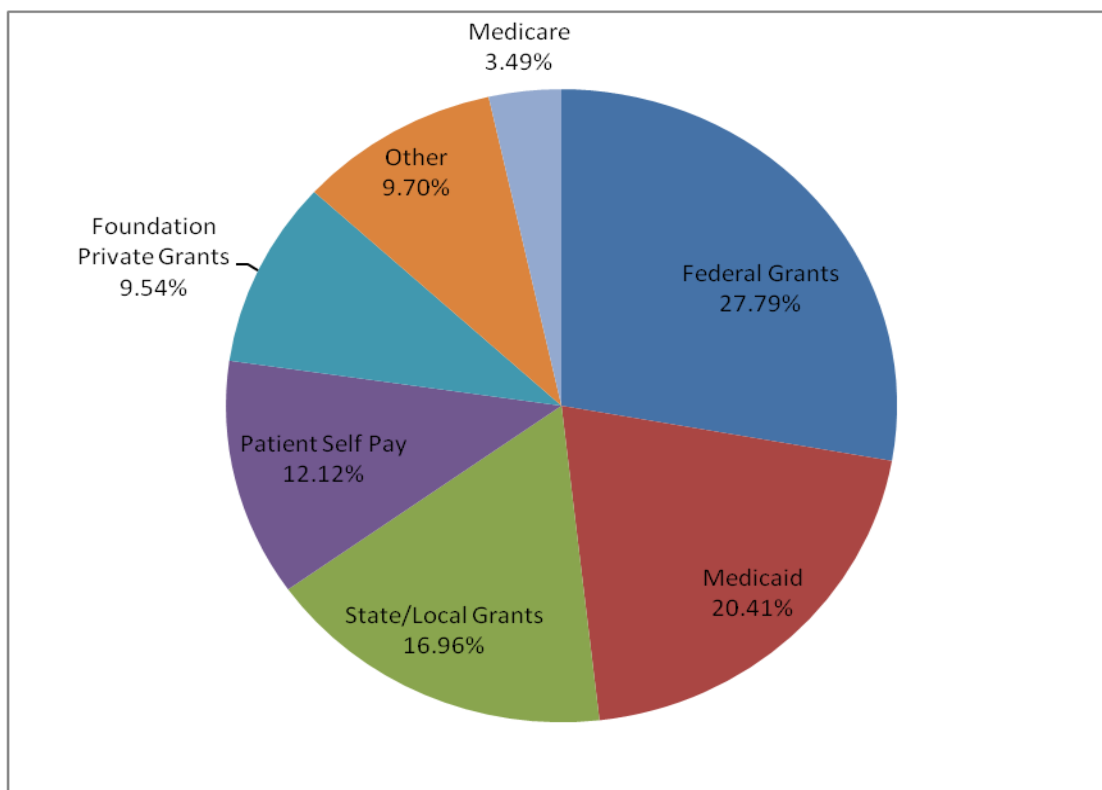
- Because nearly all citizens walking in their doors will be eligible for Medicaid or subsidies, FQHCs (and other clinics) may need to re-evaluate their approach to care regardless of ability to pay, in order to foster participation in public or private insurance for which their patients are eligible.

- Enrollment of eligible citizens in Medicaid, Federal subsidy programs, or employer-sponsored coverage will remain an important determinant of adequate funding for FQHCs. KHPA is currently partnering with FQHCs to increase enrollment of Medicaid eligibles through placement of trained eligibility workers in clinics around the state, development of web-based application, expansion of authority to presumptively enroll likely eligibles at the time services are provided, and construction of new information infrastructure that will facilitate paperless applications and simplify the administrative process for both the state and applicants.

Revenue

Figure 2 displays an encompassing FQHC payer mix. The 330 Federal Grant provided Kansas FQHCs with $9 million for SFY 2007. Over $6.6 million was derived by Kansas Medicaid revenue. State and Local grants generated $5.5 million of the FQHC payer mix. Grant and Medicaid revenue make up more than 65% of the Kansas FQHC revenue, proving to have an important role in sustaining Kansas FQHCs. While the payer mix for Kansas is similar to some other states, the percentage of revenue derived from Medicaid is much less in Kansas than it is for the nation as a whole. FQHCs in Kansas also derive less revenue from private insurance payers than do FQHCs in other states. Conversely, Kansas FQHCs derive a greater than average amount of revenue from Federal, local, and private grants.

Figure 2 – FQHC Total Revenue by Type SFY 2007



Grant Revenue

Since SFY 2006, there have been significant increases in grant funding to primary care clinics, including FQHCs. Grant funding is generated from several different state and federal sources.

State Funding

The Community-Based Primary Care Clinic Program first received funding from the state legislature in SFY 1992 who awarded $886,515 in funding to nine clinics. There were only two FQHCs in Kansas at that time, and neither received state funding. By SFY 2005, the state funding had increased to $1.52 million. Since SFY 2005, there have been significant increases in primary care funding, as well as funding in new areas. These include community-based prescription assistance funding beginning in SFY 2006 and the addition of funding to support dental hub and spokes projects and for state loan repayment beginning in SFY 2008. The number of funded clinics mirrors the growth in funding. The original nine clinics receiving state funding in 1992 had increased to 15 by SFY 2005, and to 31 in SFY 2008. In SFY 2008, all but one of the state's eleven FQHCs and the FQHC Look-alike received state community-based primary-care funding. The remaining FQHCs never chose to apply for state funding, and have since discontinued operations in Kansas.

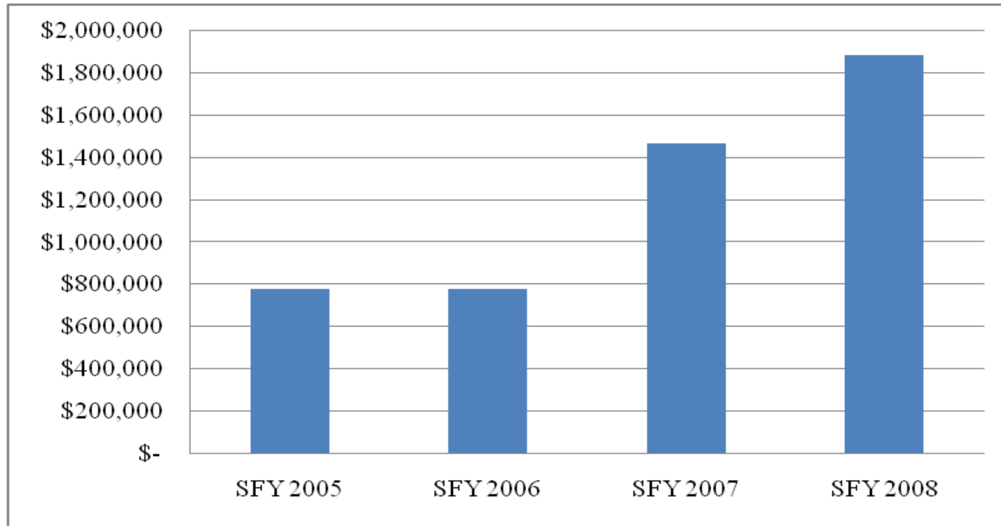
State funds are matched by local or private funds. Figures 3-5 shows the total annual state funding to FQHCs. There are three categories of direct state grant funding to primary care clinics:

- Primary Care
- Prescription Assistance
- Dental Hub Assistance

Primary Care

General primary care funding supports primary medical and dental care services and access to pharmaceuticals. This funding may be used for clinic salaries, contracted professionals, contracted services, pharmaceuticals, and supplies.

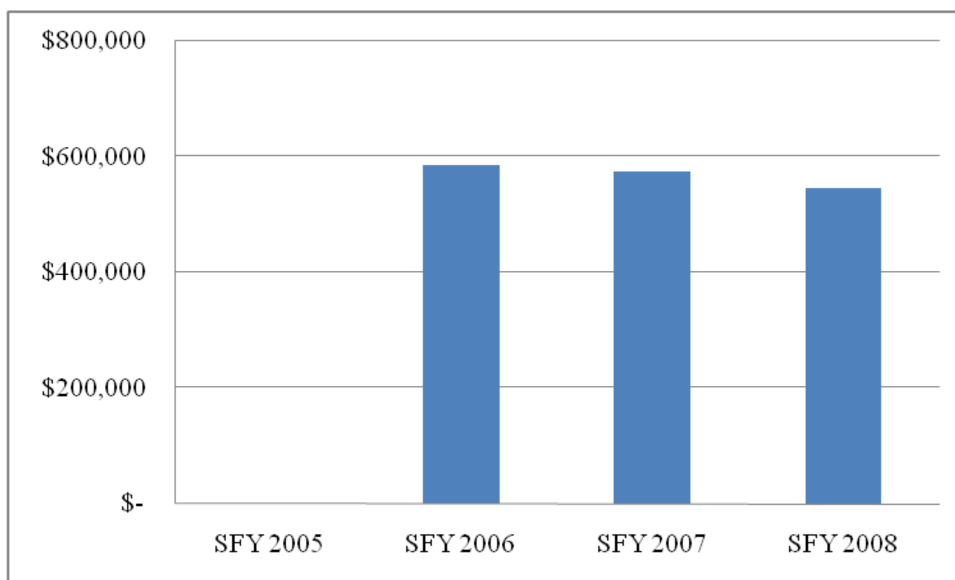
Figure 3 – State FQHC Primary Care Clinic Grant Funding by SFY



Prescription Drugs Assistance

Since SFY 2006, the legislature has appropriated $750,000 annually to fund prescription assistance activities at primary care clinics. FQHCs may use this funding to purchase pharmaceuticals at a reduced cost through the federal 340B pricing structure, provide discounts on dispensing or administrative fees in a 340B program, or to hire staff to assist individual patients in accessing manufacturers' prescription assistance programs.

Figure 4 – State Prescription Assistance Grant by SFY

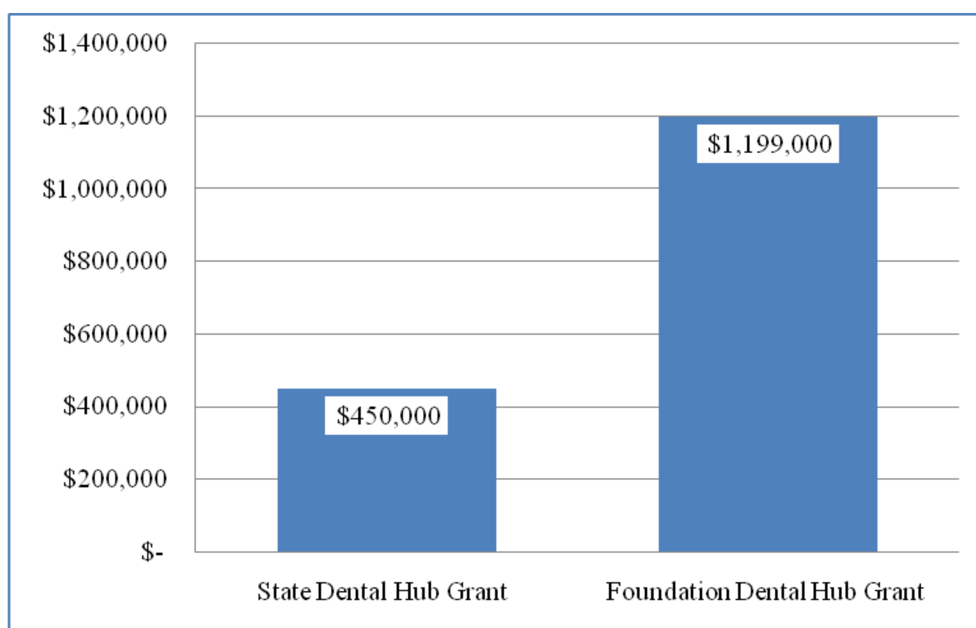


Dental Hub Assistance

Since SFY 2008, the legislature has appropriated $500,000 annually as part of the collaborative governmental and philanthropic dental hub and spoke effort coordinated by the Kansas Association for the Medically Underserved. The goal for this funding is to improve access to dental services throughout the State through funding projects that will provide access to services in remote areas using a hub and spoke model. A hub and spoke model is where local services are provided by dental hygienists (spokes), with the ability to refer to a central hub staffed with dentists.

State Dental Hub Grants are obtained through a competitive grant process. These grants support the establishment of dental clinics and help support projects that are sustainable over time. This revenue is funded in part by the State of Kansas (State Dental Hub Grant) to leverage private and public funds (Foundation Dental Hub Grant). Six health-related foundations and the State of Kansas collectively awarded $1.6 million to FQHCs for the SFY 2007.

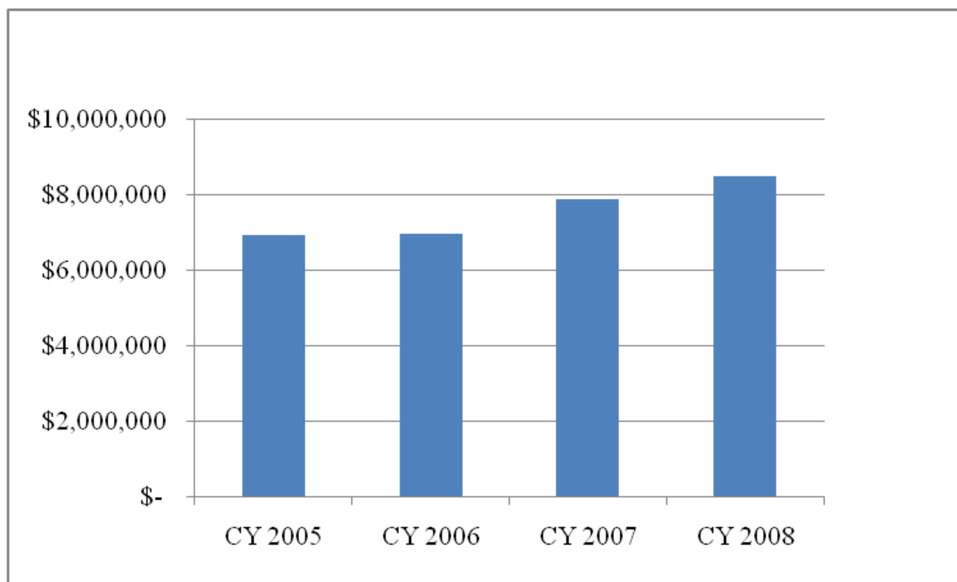
Figure 5 – State Dental Hub Assistance Grants SFY 2008



Federal 330 Grants

Along with enhanced reimbursement for Medicare and Medicaid services, FQHCs receive an annual federal 330 grant to assist in the cost of the provision of services to uninsured and other underserved populations.

Figure 6 – Federal 330 Grant by Calendar Year



<u>Service Revenue</u>

Service revenue is derived from:

- Patient self-pay
- Medicaid
- Medicare
- Other public
- Other primary insurance

Patient Self-Pay

Patient self-pay revenue includes all services and charges where the responsible party is the patient, including charges for indigent care programs. This includes primary insurance co-payments, deductibles, and charges for uncovered services which become the patient's personal responsibility.

Medicaid

Medicaid revenue shown in Figure 2 includes all services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or a Medicaid Managed Care Organization (MCO). The State based Children's Health Insurance Program (CHIP), which is paid through Kansas Medicaid, is included in this category. Charges for which Medicaid is the secondary payer are also reported here.

Medicare

Medicare revenue includes all services billed to and paid by Medicare (Title XVIII) regardless of whether they are paid directly or through a Medicare Administrative Contractor, or a Medicare Managed Care Organization.

Other Public

Other public revenue totals contain all services billed to and paid for by State or local governments through programs other than indigent care programs. The most common would be CHIP, when it is paid for through commercial carriers. Other public revenue also includes family planning programs, breast and cervical cancer control programs, contracts with correctional facilities, and other dedicated state or local programs as well as state insurance plans.

Other Primary Insurance

Other primary insurance revenue includes all services billed to and paid for by commercial or private insurance companies, excluding Medicare, Medicaid, and CHIP.

Indigent Care Revenue

The amount of funds received from state/local indigent care programs that subsidize services provided to the uninsured.

Other Revenue

Other receipts included in the federally approved scope of project that are not related to charge-based services. This may include fund-raising, interest income, rent from tenants, etc.

Figure 7 – Medicaid FQHC Reimbursements 2005 – 2007

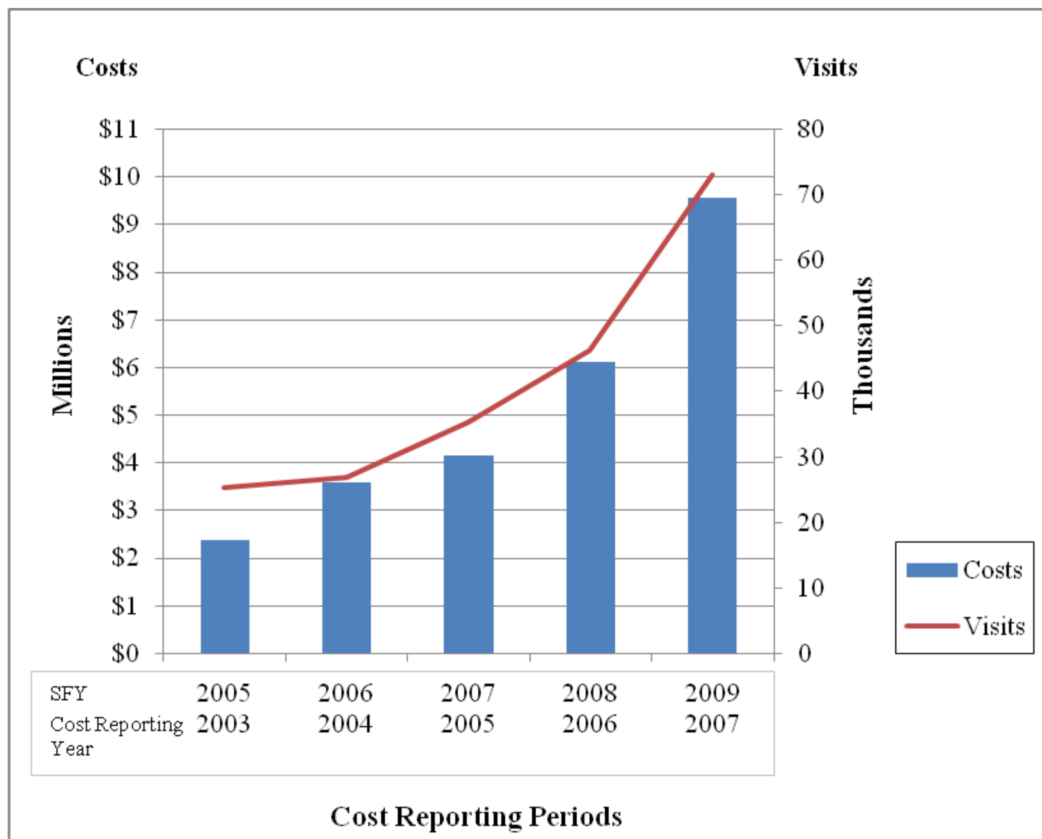


Figure 7 indicates the expenditures paid by Medicaid to FQHCs. The expenditures are indicated for the state fiscal year in which the cost reports were settled. The corresponding cost reporting periods are also noted. The number of encounters has increased consistent with expenditures.

Prospective payment rates are increased annually by the Medicare Economic Index. FQHCs receive the greater of the prospective payment system amount or the actual, reasonable costs of providing the care.

Required Services

FQHCs must provide primary medical care services to the population they serve. FQHCs can also apply for federal funding to provide dental care, mental health and substance abuse, or pharmaceutical services. Guidelines for necessary services as well as other required activities of FQHCs can be found in the Health Resources and Services Administration Policy Information Notice 98-23, which provides the basic outline of federal expectations for FQHC activities. In the area of clinical services, these expectations include basic health services such as:

- primary care
- diagnostic laboratory and radiological services
- preventative services including prenatal and perinatal services
- chronic disease screening and management services.

FQHCs must ensure access to these basic health services and facilitate access to comprehensive health and social services not provided at the FQHC through case management, referrals, and other enabling services such as outreach, transportation, and language interpretation. FQHCs are not allowed to use federal grant dollars to pay for hospitalization or surgery for their patients; however, they must have arrangements in place to refer their patients for specialty services or hospitalization.

FQHC's Role in the Medicaid Safety Net

The growth in the number of FQHCs, and the increase in Federal grant funding, state funding, and Medicaid funding has had a meaningful impact on the utilization of primary care services by Medicaid recipients. With so much in new resources dedicated to the physical safety net over the last few years, the question comes as to the impact of FQHCs on access to care in the state and, in particular, the impact on access for Medicaid beneficiaries. Research at the national level suggests that enhanced funding and expansion of FQHCs had a measurable impact on access to care for the uninsured (Hoadley, Felland and Staiti, 2004); (DeFrancesco, 2004). A similar outcome is expected in Kansas. Nevertheless, it is helpful to examine safety net clinics continuation in the context of the much larger system of support for access to care provided through the Medicaid program.

Figure 8 – Primary Care Services SFY 2008

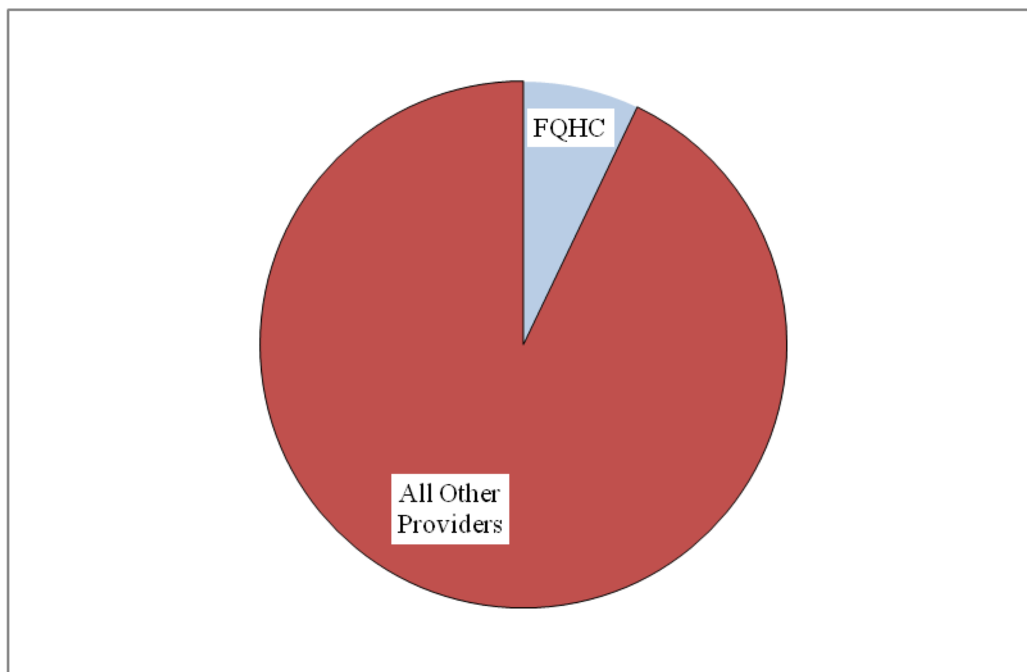


Figure 8 provides a comparison of primary care services provided in an FQHC versus other primary care providers. For the purpose of this report, primary care services are defined as the evaluation and management codes as listed in the 2009 Current Procedural Terminology manual. On a statewide basis, FQHCs provided 6.3% of total primary care services for Medicaid in SFY 2008. Primary care represents perhaps the most important subset of medical services funded through Medicaid.

FQHC's Role Across the State

In 2008, FQHCs were located in 18 of Kansas' 105 counties, including most of Kansas' population centers. The role of FQHCs in the larger safety net varies considerably across the state, not only in relationship to the physical location of clinics, but also in the roles they play in each community's overall approach to providing access to care for Medicaid recipients and the uninsured.

Figure 9 – KHPA Primary Care Services Map

Federally Qualified Health Centers

Unduplicated Medicaid Consumers receiving Primary Care Services at a FQHC and all other Venues FY 2008

SERVED BY: **FQHC** Physicans (number is **bold font**) All Other Primary Care Physicians (number is not bold font)

Statewide totals: **6.32% served by FQHCs** 93.68% **served elsewhere**

CHEYENNE **12.70%** 87.30%
RAWLINS **11.11%** 88.89%
DECATUR **4.88%** 95.12%
NORTON **5.25%** 94.75%
PHILLIPS **4.31%** 95.69%
SMITH **6.76%** 93.24%
JEWELL **9.44%** 90.56%
REPUBLIC **4.98%** 95.02%
WASHINGTON **10.84%** 89.16%
MARSHALL **6.30%** 93.70%
NEMAHA **3.35%** 96.65%
BROWN **4.64%** 95.36%
DONIPHAN **14%** 86%
SHERMAN **3.98%** 96.02%
THOMAS **6.72%** 93.28%
SHERIDAN **4.38%** 95.62%
GRAHAM **5.38%** 94.62%
ROOKS **7.24%** 92.76%
OSBORNE **5.48%** 94.52%
MITCHELL **4.83%** 95.17%
CLOUD **8.09%** 91.91%
CLAY **6.36%** 93.64%
RILEY **1.23%** 98.77%
POTTAWATOMIE **3.48%** 96.52%
JACKSON **4.26%** 95.74%
ATCHISON **5%** 95%
JEFFERSON **1.88%** 98.12%
LEAVENWORTH **.31%** 99.69%
WYANDOTTE **2.10%** 97.90%
WALLACE **8.29%** 91.71%
LOGAN **9.70%** 90.30%
GOVE **2.71%** 97.29%
TREGO **3.18%** 92.82%
ELLIS **4.04%** 95.96%
RUSSELL **6.31%** 93.69%
LINCOLN **10.50%** 89.50%
OTTAWA **1.20%** 98.80%
SALINE **16.20%** 83.80%
DICKINSON **6.67%** 93.33%
GEARY **22.53%** 77.47%
WABAUNSEE **5.79%** 94.21%
SHAWNEE **7.45%** 92.55%
DOUGLAS **.40%** 99.60%
JOHNSON **.41%** 99.59%
GREELEY **6.42%** 93.58%
WICHITA **7.60%** 92.40%
SCOTT **11.23%** 88.77%
LANE **11.07%** 88.93%
NESS **6.78%** 93.22%
RUSH **10.30%** 89.70%
BARTON **9.68%** 90.32%
ELLSWORTH **7.33%** 92.67%
RICE **6.43%** 93.57%
MCPHERSON **7.06%** 92.94%
MARION **3.99%** 96.01%
MORRIS **8.90%** 91.10%
CHASE **15.38%** 84.62%
LYON **19.42%** 80.58%
OSAGE **2.27%** 97.73%
FRANKLIN **1.52%** 98.48%
MIAMI **1.03%** 98.97%
HAMILTON **7.66%** 92.34%
KEARNEY **3.94%** **96.06%**
FINNEY **9.97%** 90.03%
HODGEMAN **7.83%** 92.17%
PAWNEE **11.97%** 88.03%
STAFFORD **18.03%** 81.97%
RENO **6.77%** 93.23%
HARVEY **9.06%** 90.94%
COFFEY **1.17%** 98.83%
ANDERSON **5.40%** 94.60%
LINN **4.17%** 95.83%
STANTON **2.49%** 97.51%
GRANT **9.12%** 90.88%
HASKELL **6.55%** 93.45%
GRAY **32.31%** 67.69%
FORD **4.76%** 95.24%
EDWARDS **12.47%** 87.53%
KIOWA **3.80%** 96.20%
PRATT **3.71%** 96.29%
KINGMAN **3.91%** 96.09%
SEDGWICK **7.06%** 92.94%
BUTLER **3.60%** 96.40%
GREENWOOD **5.44%** 94.56%
WOODSON **9.32%** 90.68%
ALLEN **6.14%** 93.86%
BOURBON **6.77%** 93.23%
MORTON **4.16%** 95.84%
STEVENS **7.16%** 92.84%
SEWARD **1.60%** 98.40%
MEADE **11.31%** 88.69%
CLARK **3.70%** 96.30%
COMANCHE **1.93%** 98.07%
BARBER **3.66%** 96.34%
HARPER **4.87%** 95.13%
SUMNER **7.85%** 92.15%
COWLEY **6.31%** 93.69%
ELK **10.90%** 89.10%
CHAUTAUQUA **10.87%** 89.13%
WILSON **4.89%** 95.11%
MONTGOMERY **4.55%** 95.45%
NEOSHO **4.65%** 95.35%
LABETTE **4.64%** 95.36%
CRAWFORD **23.81%** 76.19%
CHEROKEE **18.28%** 81.72%

★ **FQHC Location**

Bold Number = FQHC
Non bold Number = PCP

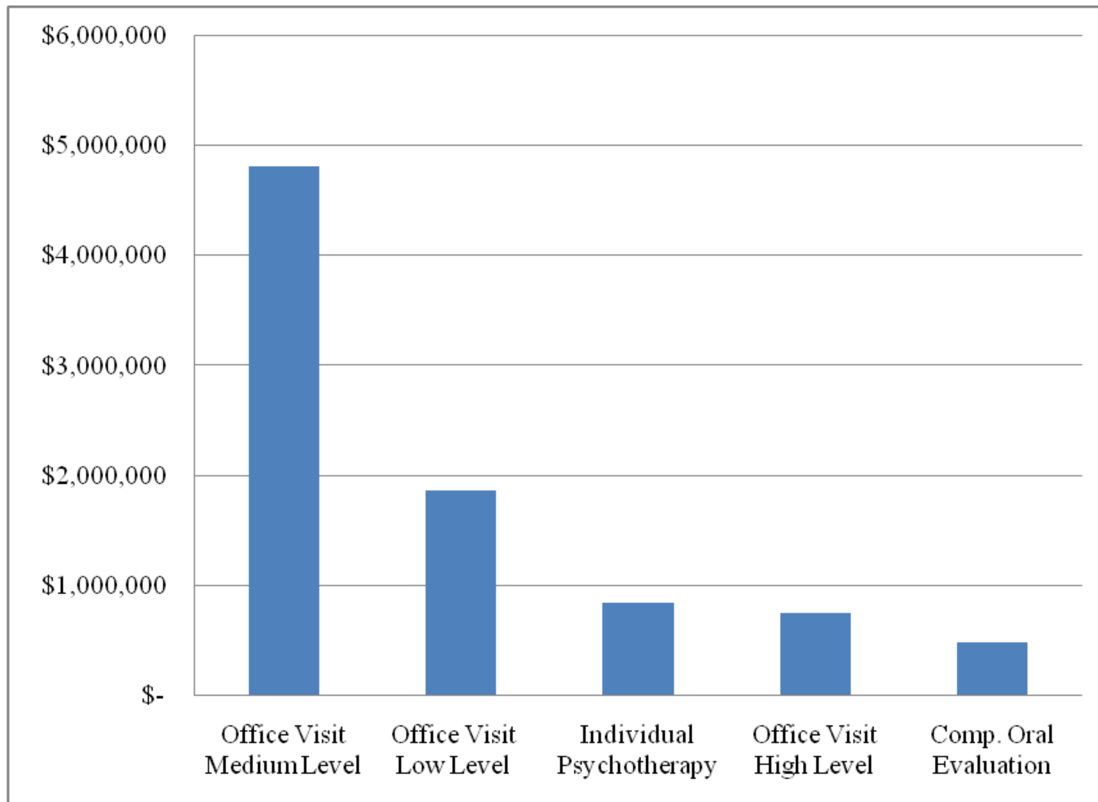
Barton: We Care Project
Cherokee: Community Health Center of Southeast Kansas
Crawford: Community Health Center of Southeast Kansas
Finney: United Methodist Mexican-American Ministries
Ford: United Methodist Mexican-American Ministries
Geary: Konza Prairie Community Health Center
Grant: United Methodist Mexican-American Clinic
Harvey: Health Ministries Clinic (Look-Alike) ★
Lyon: Flint Hills Community Health Center
Reno: PrairieStar Health Center
Saline: Salina Health Education Foundation
Sedgwick: GraceMed Health and Dental Clinic
Hunter Health Clinic
Seward: United Methodist Mexican-American Ministries
Shawnee: Shawnee County Health Agency
Wyandotte: Swope Health Services

Figure 9 displays the relationship between county of residence and the receipt of primary care services for Medicaid beneficiaries across the state. Of the total number of Medicaid recipients from each county who received primary care services in SFY 2008, Figure 9 displays the percentage receiving primary care services in an FQHC. The map also indicates the percentage of beneficiaries receiving primary care services in a setting other than an FQHC. Other settings include local health departments, rural health clinics and private physician offices. These other settings are far more abundant across the state, and it is expected that the other settings would serve more beneficiaries than FQHCs.

The role of FQHCs in primary care varies widely across the state, serving as much as 32% of those receiving Medicaid primary care in Gray County, but less than 10% of primary care recipients in Kansas' largest counties where FQHCs are located. In counties and parts of the state where there are no FQHCs, the percentage of Medicaid encounters is as low as .4% (in Johnson, Douglas and Leavenworth counties); however, it is also clear that many Medicaid beneficiaries from all parts of the state use FQHCs, sometimes driving more than 100 miles to obtain care. Many of the counties with the highest rate of FQHC usage do not have an FQHC.

Population Served and their use of Medical Services

Figure 10 – Top 5 Medicaid FQHC Services by Expenditure SFY 2005-2008 for Medicaid Beneficiaries Combined



The highest expenditure FQHC services reimbursed by Medicaid are dominated by low and medium level office visits, as illustrated in Figure 10. The most dominant diagnoses for these visits –measured by the amounts reimbursed – include chronic diseases such as diabetes and hypertension, but also include preventive care for well-children and high-risk pregnancies [see Figure 11].

Figure 10 represents the type of Medicaid beneficiaries who rely most on FQHC providers. The aged and disabled comprise the fee-for-service (FFS) population, the vast majority of FQHC users. This is consistent with experienced Medicaid programs with expenditures, being highest for the aged and disabled FFS population.

Figure 11 – Top 5 Medicaid Diagnoses by Expenditure SFY 2005 – 2008 Combined

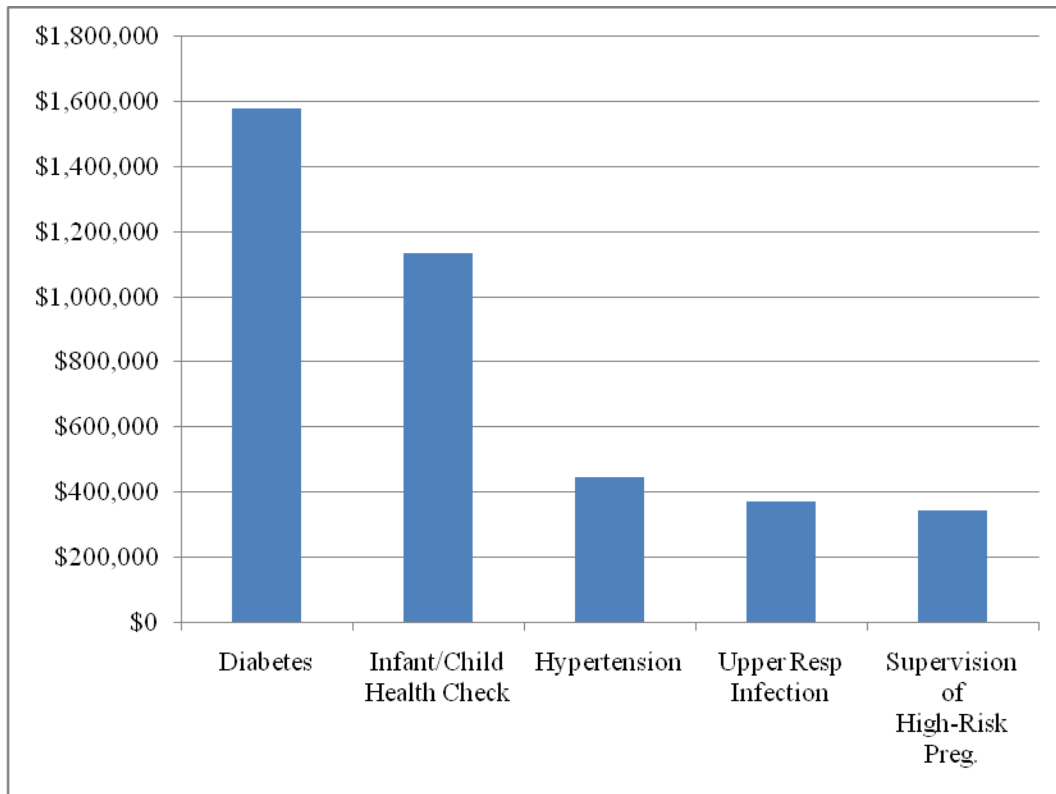


Figure 12 – Total Unduplicated User Count by SFY

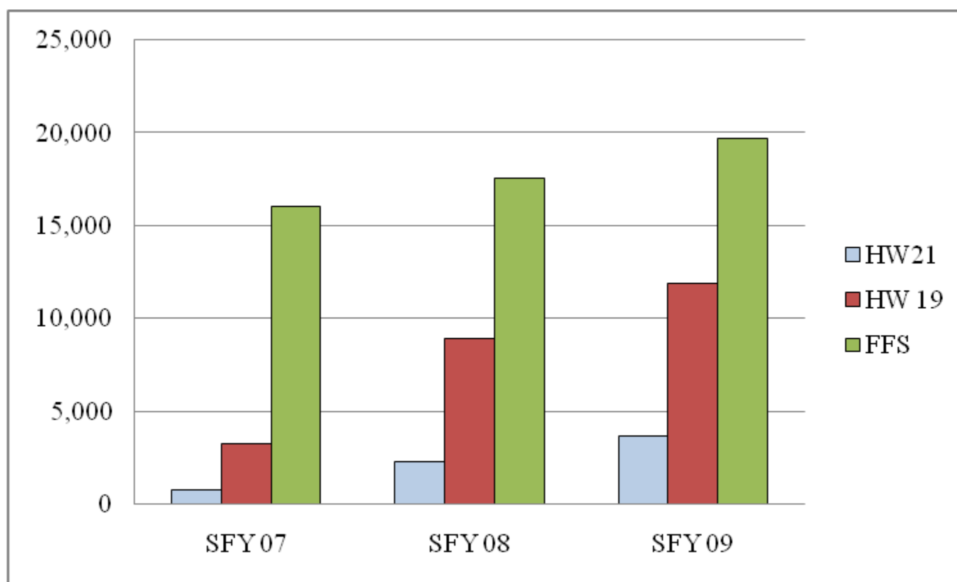


Figure 13 – FQHC Total Cost per Total Patient for Calendar Year 2007 (UDS)

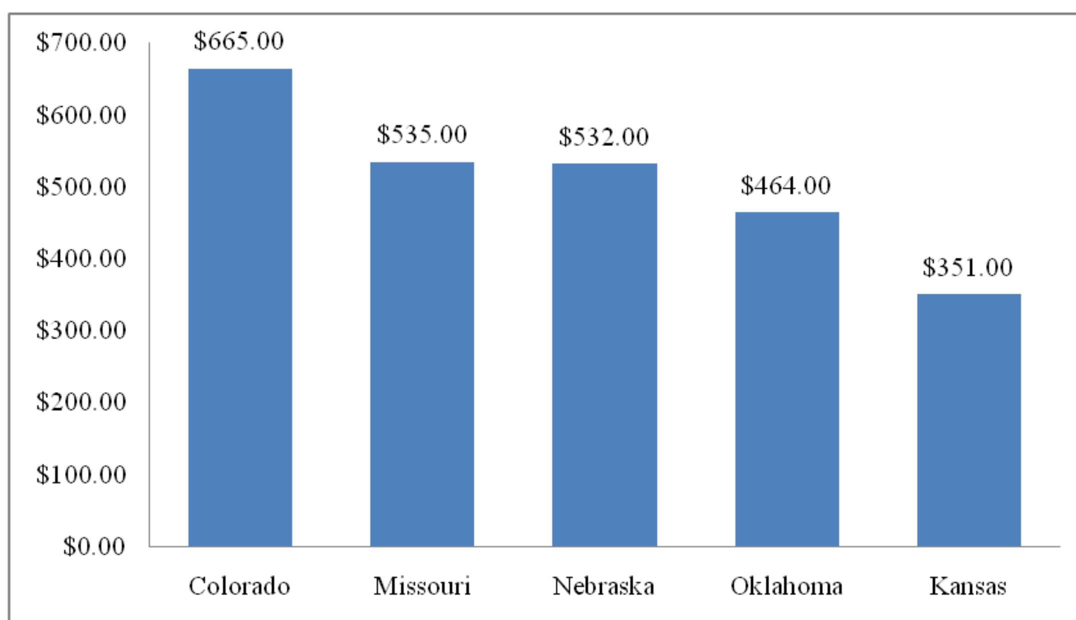


Figure 13 depicts per patient FQHC costs across neighbor states.

Reimbursement

Reimbursement methods to the FQHCs vary by the program in which a beneficiary is enrolled. A beneficiary may be enrolled with Medicaid and placed in one of three programs, which will determine how an FQHC will be reimbursed for the health care they provide. These three programs are

- Fee-for-service
- Managed Care Organization through Title XIX
- Managed Care Organization through Title XXI

Fee-for-service

When health care is provided by an FQHC to a fee-for-service beneficiary enrolled with Kansas Medicaid, the FQHC will receive an interim payment as often as weekly. When an FQHC bills individual claims to Medicaid, the health center is paid a per-visit (encounter-based) interim rate. The interim rate is established using historical costs and encounter data that are specific to each FQHC's unique costs and encounters. Each encounter, within the health center, is paid the same average cost rate for the FQHC, regardless of the level or acuity of the services provided.

This FQHC cost reimbursement method is preferred by health centers because the services provided to Medicaid patients are reimbursed at a reasonable cost level, including the cost of physician and other professional salaries and wages. In contrast, the Medicaid professional fee schedule reimbursement, utilized by the Title XIX and Title XXI MCOs, may routinely be less than the provider's cost incurred for providing the care to Medicaid beneficiaries and it does not correlate directly with the health center's expenses incurred for the services provided. In

addition, the Medicaid fee schedule is not routinely updated, which means, over time, fee reimbursements may fall below costs.

The encounter-based interim rate payments, paid for FFS claims, provide reasonable, cost-based cash flow to the FQHCs throughout the year. Annually, each FQHC is required to file a cost report, from which KHPA calculates a financial settlement. The cost report settlement may result in an additional payment to the FQHC, or, if the FQHC was overpaid during the year, the FQHC must pay Medicaid back. Underpayments typically occur due to a decrease in total health center encounters or an increase in costs in the subsequent period. Overpayments generally occur if a FQHC experiences a significant increase in utilization during the subsequent period, which has the effect of diluting or reducing the average cost per-encounter. Because the interim rates are estimates, cost settlements may vary, depending on the health center's actual costs and total encounters for the cost reporting period.

Each FQHC may participate with Kansas Medicaid as a fee-for-service provider and as an MCO provider; therefore, the annual cost settlement process encompasses all interim and wraparound payments made to the FQHC for all programs in which the FQHC participates. These payments are netted against the amount due, resulting in the settlement amount. The cost report settlement is for the purpose of making a final payment adjustment to the FQHCs. The final payment adjustment is made in aggregate and considers the FQHC's actual and reasonable costs of providing the care to all Medicaid patients during the cost reporting period. As of October 1, 2009, SCHIP (Title XXI) encounters are also included in the cost report settlement.

<u>Managed Care Organization through Title XIX</u>

An FQHC that provides health care for a Kansas Medicaid beneficiary who is assigned to a Managed Care Organization (MCO) under Title XIX will receive a fee scheduled based interim payment as often as weekly, a monthly wraparound payment and an annual cost-based settlement.

Medicaid MCOs pay the FQHC based on the Medicaid professional fee schedule. These individual claim fee amounts are the equivalent of interim payments. This reimbursement method is different from the encounter-based rate (per visit rate) method used by the fee-for-service program. This interim reimbursement method does not provide sufficient cash flow to the FQHCs throughout the year; therefore, KHPA provides a monthly wraparound payment to each FQHC.

On a monthly basis, KHPA utilizes MCO claims data as a basis to adjust or "wrap" Medicaid fee-based MCO reimbursement to an estimated cost level. Wrap payments are an additional interim payment necessary to provide the health centers with cash flow that is targeted to reflect the health center's actual cost of providing the care. Wrap payments increase the interim reimbursement made by the Medicaid MCO to the encounter based rate, similar to the Medicaid FFS interim reimbursement.

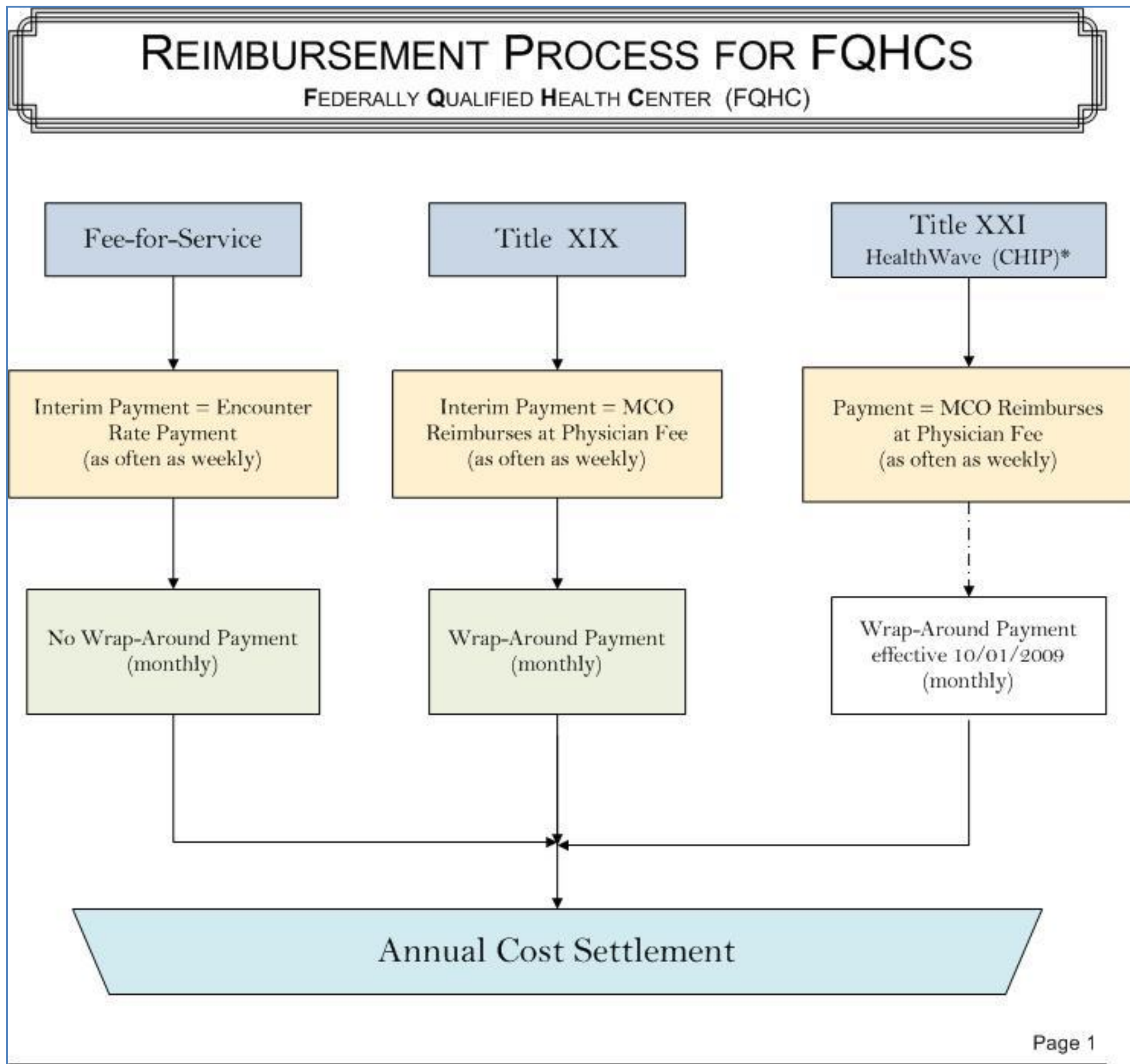
FQHCs file a separate, Medicaid-adjusted, cost report directly to the Kansas Health Policy Authority. The cost report is used for calculating the cost settlement, <u>Managed Care Organization through Title XXI.</u>

Health care provided to a Kansas Medicaid beneficiary who is assigned to a Managed Care Organization under Title XXI (SCHIP) receive a fee schedule payment. For SCHIP Medicaid MCO encounters, the plan initially pays the FQHC based on the Medicaid professional fee

schedule. Prior to October 1, 2009, some managed care plans elected to make a wraparound payment for the Title XXI encounters. Prior to October 1, 2009, the Title XXI encounters were not included in the cost settlement.

CHIPRA required that all Title XXI encounters be wrapped effective October 1, 2009. KHPA began wrapping Title XXI encounters in the regular wraparound process for services provided on and after October 1, 2009. In addition to wraparound payments, Title XXI encounters, for services on and after October 1, 2009, are included in the cost-based settlement process.

Figure 14 – Reimbursement Process for FQHCs



How Does Kansas FQHC Reimbursement Differ from Medicare?

Historically, Kansas Medicaid's FQHC reimbursement method followed Medicare's cost-based FQHC reimbursement method very closely. Medicare shares in the actual costs incurred by the health center to the extent of the FQHC's Medicare utilization. This is determined by the ratio of Medicare encounters divided to total health center encounters. The reimbursement method divides the clinic's total, allowable operating costs for the year by the FQHC's total encounters for all patients served by the health center during the year. The resulting per-visit rate, or average cost-per-encounter rate, is multiplied by the number of Medicare encounters for the cost reporting period, to determine the program's share of the health center's actual costs incurred during the cost reporting period.

The Medicare FQHC program limits FQHC reimbursement to a maximum allowable- cost-per-visit, or cap. Medicare reimburses the actual-cost-per-visit up to the CMS published FQHC cap for the year. Any excess Medicare cost above the aggregate cap is lost. If the health center's actual-cost-per-visit is less than the cap, the actual-cost-per-visit is paid. As a result of the cap, the FQHC may be reimbursed from Medicare at a level that is significantly less than what it cost the health center to provide the Medicare services. In order to fully cover the health center's costs of providing services for Kansas Medicaid beneficiaries, Medicaid does not apply the per-visit cap.

In addition to the per-visit limits, Medicare applies a minimum productivity standard to FQHC services. Healthcare practitioner productivity is measured as the number of FQHC visits per full time equivalent (FTE). An FTE is the number of hours per year a practitioner must work to be considered full time (as defined by the health center), or not less than 1,600 hours per year. Base productivity standards for a FQHC are 4,200 annual visits for each physician FTE and 2,100 annual visits per year for each full time Mid Level Practitioner (MLP). If the productivity standard is not met, Medicare reduces the payment to the base level. Kansas Medicaid does not apply the productivity standards to Medicaid services provided by the FQHCs.

Medicaid covers some services that Medicare does not. For example, dental services are covered and included in the cost-based settlement.

Reimbursement Methods

As noted, Kansas Medicaid FQHC reimbursement has historically followed Medicare's method; however, the Benefits Improvements and Protections Act (BIPA) of 2000 mandated a prospective payment system (PPS) for FQHCs at a national level. The BIPA PPS reimbursement method determined a clinic's encounter rate from base periods, designated as 1999 and 2000. The law provided for an annual update to the PPS rates using the Medicare Economic Index (MEI).

As an alternative to the PPS, states were permitted to offer a cost-based method option for FQHCs. Kansas Medicaid elected to do so and the method is defined in the State Plan. The Kansas Medicaid modified –cost based system (CBS) permits FQHCs to be reimbursed the greater of cost-based or the PPS-based reimbursement. FQHCs may submit a written request for the modified CBS. All Kansas FQHCs have elected the CBS. The PPS rates have not been rebased and, over time, the MEI updates may not keep pace with medical inflation experienced by the health centers. In most cases, the PPS rates are falling below the actual cost per-visit, resulting in a positive amount of reasonable cost-based FQHC reimbursement for most health centers. Due to the PPS system, the interim encounter rates are set at the greater of the PPS rate for the health center, or 90% of the health center's actual cost per-visit, based on the latest

filed health center cost report. Interim payments are then reconciled based on the FQHC Medicaid cost report.

Grants and Donations

For Medicare and Medicaid, health center grants and donations are not offset against allowable expenses. As such, grants and donations that are spent on allowable FQHC expenses create a return on the grant or donation equal to the Medicare and Medicaid payer mix for the health center. This benefit allows health centers to leverage grants and donations to expand services or provide care to the uninsured.

Recent Changes for FQHCs

- *Wrap-Around Payment Process*
  The Children's Health Insurance Program Reauthorization Act of 2009 imposes a change to the Title 21 (CHIP) reimbursement. As of October 1, 2009, KHPA began a wrap-around payment process for Title 21 (SCHIP) claims.

- *American Recovery and Reinvestment Act of 2009 -- Health Information Technology (HIT)*
  The American Recovery and Reinvestment Act of 2009 includes the Health Information Technology for Economic and Clinical Health (HITECH) Act that set forth a plan to advance the use of health information technology to improve the quality of health service delivery in America. The act authorized the Centers for Medicare and Medicaid Services to administer incentives to providers and hospitals to adopt and use interoperable electronic health records (EHRs). The HITECH act also provided regional and state-level grant funding to provide technical assistance to health care providers adopting EHRs, to develop means for these systems to seamlessly communicate, and to develop a HIT workforce that can ensure successful implementation of the HITECH Act programs. While ARRA of 2009 does not have specific funding for health information technology at FQHCs, allocations for health center infrastructure development at FQHCs may be used to fund health information technology projects. In addition, FQHCs may qualify as high-volume or core Medicaid providers, who receive priority funding for HIT implementation from a number of different sources under ARRA.

Conclusion

FQHCs represent an important core in the state's "bricks and mortar" safety net. FQHC's have been supported not only by health care coverage for their beneficiaries, but also through direct financial support to expand FQHC access. Medicaid has been a key source of funding for FQHC health services, as have private donations, patient out-of-pocket payments, and Medicare. The Federal and State grants have provided critical start-up as well as operational funding, helping to extend services to the uninsured. A little over two-thirds of the funding for FQHCs in Kansas is from public sources, including Medicaid, Medicare, State and Federal grants.

- In recent years, FQHCs have received significant financial support from the Kansas Legislature, the federal government, and the Kansas Medicaid program.
- FQHCs are an important and growing component of the health care safety net in Kansas.
- FQHCs are important to the uninsured, but remain a relatively small part of the provision of Kansas Medicaid primary care services.

- The role of FQHCs in the health care safety net varies considerably across Kansas, both in counties in which they are located, and in the remaining counties where they are not

These findings suggest the foremost role of FQHCs in Kansas has been to meet targeted areas of focused need in specific locations around the state. In other states, FQHCs rely more heavily on Medicaid financing for operational revenue, suggesting the potential for a greater role here in Kansas. Although not a focus of this review, we note that Rural Health Clinics (RHCs) play a much larger role providing publicly subsidized care in Kansas than they do in other states, and the prevalence of RHCs in Kansas may explain some of the unique characteristics of FQHCs in the state.

Federal reforms will bring a sea-change in both the amount and sources of funding for FQHCs, with Medicaid playing a new and potentially dominant role. Nevertheless, most of these reforms will not occur until 2014, and Medicaid's new role will be dependent on key policy choices here in Kansas between now and then. In light of this uncertainty, the recommendations below focus on intermediate operational improvements, rather than or any long range vision for FQHCs role in Kansas. Some of the larger policy questions for the safety net in Kansas are currently being addressed by a multi-stakeholder group convened at the request of the Kansas Legislature. The Kansas Health Care Access Work Group, under the leadership of the FQHC's association, the Kansas Association for the Medically Underserved, is preparing a strategic development plan to submit to the Legislature.

Recommendations

1. Educate Stakeholders, Policy Makers, and Legislators
   More education will equip the key players with the knowledge to make informed decisions about the appropriate or ideal role for FQHCs in the health care safety net. KHPA and KDHE plan to place an internet link to each other's website for ease of public access. KDHE will work with HRSA to place an internet link to the annual UDS data for ease of public access to FQHC data. It is recommended that KDHE participate in the quarterly FQHC conference call with the FQHCs and KAMU.

2. Collaborate to Assess Federal Level Policy
   KHPA and KDHE will work with HRSA to assess and interpret federal level policy changes and effect on clinics. The two agencies will share policy information with clinics and KAMU as appropriate. This communication will ease policy implementation and make policy details available in a timely manner.

3. Develop Quality Measures
   KHPA and KDHE will work in partnership to develop quality measures for FQHCs. These measures will be collected at the clinic level. KDHE would like to use these measures to assist in determining grant money distribution.

4. Refine FQHC Reviews and Audits
   KHPA and KDHE agree that a better process must be in place to oversee the utilization, quality of care and cost reports. KHPA's fiscal agent conducts random utilization reviews for all medical providers. KHPA will ensure the FQHCs are reviewed on a more regular basis. KHPA will conduct FQHC cost report audits on a more regular basis.

5. Develop Guidelines for Contracting Health Services
   KHPA and KDHE will partner to develop a set of guidelines for FQHCs to follow when contracting health care. This guideline will outline expectations in the contracts that show a need for the service in the area and indicate gaps in the current FQHC setting leaving unfulfilled need. The agencies will strive to ensure that contracted health is not used to override the FFS program for better reimbursement through the encounter reimbursement methodology.

6. Explore Change to Current Payment Procedures
   Examine the potential for a cost reimbursement methodology that reflects a modified cost-based encounter rate that is applied on a prospective basis, allowing for elimination of the cost settlement process. The revised method may employ an inflation factor to arrive at an adjusted reasonable cost rate. The rate may be periodically rebased.

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