Medicaid MOA Update and Payment Reform Visioning Session

Where we are today, developing a vision for the future…
The History

- PPS and Medicare cost-based reimbursement were created (2000) in recognition of the populations served and the need to ensure that 330 grants weren’t subsidizing other public payers
- Historically, FQHC reimbursement has enjoyed long-standing, bi-partisan support
MOA Basics

- Defines the rate at which Michigan CHCs are paid by Medicaid
- Negotiated as a group and signed by individual Health Centers
- Differs from the Medicaid Provider Manual, that describes the process for reimbursement (the how)
- Michigan has negotiated 4 MOAs since 2001
MOA Basics

- The original MOA rates were determined with 1999 and 2000 cost data
- The MOA has been updated several times (2003, 2007, 2010 and currently) since its creation:
  - Pharmaceuticals
  - Outreach and Transportation Changes
  - Family Planning Waiver Addition
  - Behavioral Health Code
  - Hospital Visits
  - Dental Changes
  - Obstetrical Billing Changes
  - Carveouts
Negotiation Process

- MPCA provides staff support to the MOA workgroup which is open to Health Center volunteers statewide (approx. 10)
  - This year MPCA has also engaged Health Management Associates (HMA) for additional support
- Workgroup meets in advance of meetings with Medicaid to discuss areas of consideration and review research on potential impacts
- Medicaid, MPCA and the workgroup discuss each area of consideration and various proposals related to the content area to develop the MOA
  - CMS is consulted frequently throughout the process to determine regulatory appropriateness
- Medicaid representatives include those from the reimbursement and policy sections of Medicaid
  - The MOA is ultimately approved by the Medicaid Director
# Current Areas of Consideration

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NATIONAL DEVELOPMENTS
National Perspectives on Health Center Payment

- 13 states reported Health Centers are experiencing problems with PPS
  - Delayed or denied payments (wrap-around, change of scope, reimbursement/encounter rate)
  - Out-of-date reimbursement rates
  - Difficulties resulting from inadequate rate adjustment process/review

- All cited problems ultimately relate back to significant cash flow issues for Centers
National Perspectives on Health Center Payment

- 11 states reported using Medicare rates in various ways to determine Medicaid PPS
  - Medicare cost reports, cost principles, productivity standards, use of Medicare caps to calculate encounter rates, or directly using Medicare rates to set Medicaid rates
National Perspectives on Health Center Payment

- In the past year, 8 states have made regulatory or other written policy changes to PPS/APM
  - North Carolina and Oklahoma expanded PPS eligible providers
  - Oklahoma and Pennsylvania amended criteria/policy related to FQHC change in scope of service
  - Missouri made changes to clarify cost report filing deadlines and formalized deadlines
  - Wrap-around payment methodology changed in New Jersey and Texas
    - In NJ wraparound will only be triggered once claim is approved by MCO;
    - In TX MCOs must pay the full encounter rate to Health Centers
  - Ohio instituted APM for government-operated FQHCs
National Perspectives on Health Center Payment

- 10 states are currently exploring changes to PPS/APM
  - Arkansas is exploring a bundled payment initiative in which payment of a targeted price is based on studying 6 months of claims reviewed against costs
  - Minnesota is exploring expanding types of providers and reimbursing same day mental health and medical visits
  - New Hampshire is exploring implementation of APM
  - West Virginia passed provider-sponsored network legislation to create Medicaid managed care plan owned by Health Centers
  - Montana developing PCMH payment methodology to augment current PPS
  - California governor proposed 10% cut and requirement that managed care plans handle all PPS payments
All Eyes On Oregon

- Piloting a conversion of PPS into a bundled, pmpm (per member, per month) rate
  - MCO or CCO will pay a pmpm rate comparable to any primary care provider
  - State will pay a pmpm wraparound based on prior year’s wraparound payments
  - CHCs report cost, quality and access indicators
  - Pay for Performance or other bonus payments are separate
PAYMENT REFORM
Medicaid Context

- Fiscal Pressure: How to control spending in the face of unrelenting budget shortfalls
  - “Medicaid growth is simply unsustainable and threatens to consume the core functions of state government.”
- Quality Improvement: Making Medicaid a more effective, higher value program
- Health Reform: Preparing for a larger role in an uncertain political environment.
An Outside View

- “In retrospect, PPS provided perverse incentives: the higher the per-unit cost of providing care and the more face-to-face patient encounters, the higher the total revenue”
- “The disparity of reimbursement between FQHCs and other private PCPs caring for the Medicaid population will leave FQHCs non-competitive if these structural supports are eliminated in the future”
The Changing Environment

- We’re starting to see “cracks in the mortar” due to expanded coverage and budget crises
  - Nothing is considered sacred anymore, especially given the federal budget situation
- States are beginning to take steps to modify PPS
  - In some cases modifications amount to rate-cutting for Health Centers
  - In other cases states are making attempts to move toward value-based payment
- Health Centers have historically been reluctant to take risk from payers
  - This is starting to change as FQHCs, payers and states begin to recognize the potential to generate substantial “downstream” savings from an up-front investment
- We’re operating in an increasingly competitive (accessibility and customer service) marketplace spurred by the ACA
Value-Based Payment

- Incentives to promote improved outcomes and enhanced beneficiary satisfaction
- A clear link between payment and service value
- A gradual progression of provider accountability
- A distribution of savings within integrated provider groups
  - Need to reflect those responsible for generating, but also those who willingly sacrifice traditional revenue in order to create savings.
- A more even “balance of power” amongst providers than has been the case traditionally
Keys for Payment Reform Success

- Multi-payer approach
- Up-front investment in re-design, systems (IT and reporting especially) and new staff
- New models of care to address true patient needs
- Evidence-based practice
  - Approximately 30% of healthcare services provided today do not improve health status, providers largely order out of habit
- New quality parameters
  - UDS fails to address the main cost drivers in healthcare
- Provider integration and collaboration
  - Historical power imbalance and poor relationships
- Health plan partnerships
- Financial reserves
DEVELOPING A VISION FOR THE FUTURE
Inspiration

• “We’re re-imagining how the medical home would be structured if we eliminated the incentive to crank visits”
Discussion Questions

- For the next 20 minutes, forget everything you know about current Health Center payment...
  - What types of activities would you provide if sustainable reimbursement existed?
  - What type of payment methodology would help you best care for patients?
  - What kinds of outcomes should reimbursement be based upon?
Questions?

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Sources

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  - Gaylee Morgan and Vern Smith, Health Management Associates
- Aligning Payment with Patient-Centered Work and Value-Based Pay
  - Craig Hostetler, Oregon Primary Care Association
- Turning the Lights on the Medicaid MOA
  - Sharron Gallop, Christine Baumgardner, Rebecca Cienki