

A Healthy Partnership: Medicaid Managed Care Organizations and Federally Qualified Health Centers

By Natalie Ellertson

“Triple Aim” has become the rallying cry to support the proliferation of experiments designed to put our health system on the path to long-term sustainability.

Stakeholders recite the mantra of simultaneously lowering population health costs, increasing quality, and improving patients’ “experience of care” in their search for better ways to measure the performance of health providers and pay them for the outcomes they deliver.

These value-based payment arrangements between payers and providers hold promise if pilot programs and demonstration results are accurate indicators of future potential. For example, the State of Minnesota’s Department of Human Services recently announced that their Integrated Health Partnerships (IHP) — contracts with providers to reduce total care costs and improve quality outcomes for attributed patients — saved \$61.5 million in the program’s second year of operation.

Many of the providers able to jump into value-based arrangements are Integrated Delivery Systems (IDS), networks of practices under a parent holding company that provides a continuum of health care services. IDS organizations are often anchored by large hospitals and have the resources needed to surmount significant entry barriers into value-based arrangements. Participating in value-based arrangements often requires:

- New health information technologies (for example, claims systems, health information exchange infrastructure, population health analytics tools)
- New skills and competencies for providers (for example, care coordination, utilization and/or referral management)
- The ability to sustain sufficient short- and medium-term revenues from legacy fee-for-service contracts to continue operating while earning outcome-based payments

Many providers embarking on their value-based journeys must live with a foot in both the fee-for-service and value-based worlds for several years. Operationally, this poses challenges for even the best-run facilities.

Over the past few years, as many hospital systems have consolidated, they have concurrently purchased significant professional services capabilities, and invested in health information technology (HIT) and clinical management capacity as ways to curb total care costs and improve quality — critical components of value-based contracts. Plus, by providing one-stop shopping services for patients, some have improved the experience of care — the third leg of the triple-aim stool. Payers are increasingly interested in opportunities to shift risk to IDS; contracting with a narrower network of higher quality IDS offers payers administrative simplification and cost savings.

However, long-term success as a Medicaid Managed Care Organization (MCO) requires more than partnering with a narrow IDS-based network to spread investment costs and delegate financial risk. There are key reasons why meeting the unique needs of underserved Medicaid recipients requires a more comprehensive look at value-based payment arrangements with a wider variety of providers. First, many recipients have myriad and chronic physical and behavioral health issues, and thus require care from both medical providers and community-based organizations. Second, inpatient and emergency department utilization are generally higher within Medicaid populations because they experience higher rates of common chronic illnesses and face barriers to accessing preventive care, often due to lower reimbursement rates for physicians who treat them.

Still, true Medicaid sustainability requires fundamentally rebalancing spending towards high-quality accessible primary and preventive care, components of which include:

- Extending mental health and dental service capacity
- Ensuring successful referrals to locally based social services that help people address the social determinants of poor health (a need for stable housing, access to food, treatment for chemical dependency, to name a few)
- Defining “accessible care” to mean delivering services in places where people can take public transportation or walk, and making services available in a variety of languages other than English.

MCOs should look toward FQHCs

While these criteria for truly accessible primary and preventive care are tall orders for many MCO organizations, they describe precisely what Federally Qualified Health Centers (FQHCs) have done for decades. FQHCs have long recognized that Medicaid sustainability rests on achieving the Triple Aim — Plus One: rebalanced spending towards high-quality, accessible primary and preventive care.

FQHCs offer many of the assets Medicaid MCOs need for long-term success:

- They operate in underserved areas.
- They are intensely focused on high-quality, broadly defined accessible primary and preventive care services (many offer co-located mental health and dental services).
- Their collaborations with community-based organizations, including public health agencies, enable them to offer more expansive programming specifically designed to counteract many of the social determinants of poor health like food insecurity and unstable housing.

Because they often are mandatory participants in Medicaid MCO networks, FQHCs can have profound effects on MCO quality measurement scores and related financial performance. Consider their scale: on average, FQHCs serve more than one in seven Medicaid enrollees. In the greater Chicago metro area, FQHCs deliver primary and preventive care services to more than one-third of all people enrolled in Medicaid.

While some MCOs have partnered productively with FQHCs for years in ways that have measurably improved both plan and population quality and financial outcomes, others are just recognizing the vast potential of collaborating with these traditional Medicaid providers. Some plans are also recognizing the risks of marginalizing FQHCs. For example, FQHCs have tended to apply more generic codes to document the services they provide as a result of their unique reimbursement bases. Progressive MCOs have invested in educating FQHCs about the adverse impacts of unspecific and incomplete service coding on both risk analytics and related clinical management. Improving coding specificity within FQHCs will be vital to MCOs for capturing the data needed to demonstrate that screening and other services have occurred that improve population health outcomes and tie to MCO quality-based revenues (ie: premium withhold); and that analytics affecting underwriting and premium setting appropriately reflect population risks. Value-based payment arrangements provide incentive for FQHCs to care more about coding specificity.

State Medicaid programs show no signs of slowing down their use of contract provisions linking MCO financial performance to quality outcomes. On the contrary, the use of premium withholdings tied to attainment of higher quality outcomes is accelerating in states that contract heavily with MCOs to manage Medicaid populations. For example, Michigan's new RFP for MCOs quadruples the premium withhold for MCO quality, and in Illinois, the state is building towards a 2% premium withhold for MCOs tied to quality outcomes.

Modest investments in FQHCs can yield significant results

With modest investments from Medicaid MCOs, FQHCs can make excellent clinical management partners. Some of these needed investments include:

- Sharing timely, accurate patient data so that FQHC providers can understand and influence what is happening to their patients outside their four clinic walls
- Providing technical assistance using newly available patient information in clinic workflows
- Implementing predictable pay-for-value contract structures that front-load funding for the investments needed to build in site-of-service population health management capacity (analytics, care coordination, etc.)

Even modest investments can help deliver significant results, including total cost-of-care reductions and improved clinical outcomes. For example, a network of FQHCs in Minnesota reduced Emergency Department (ED) visits by more than 10% in seven months using historical claims analysis and simple follow-up protocols designed to get patients into primary care after a potentially preventable ED visit.

Better yet would be collaboration between MCOs in specific geographies to standardize value-based contracting approaches with FQHCs and share related population health management capacity-building investments. This would reduce provider abrasion since FQHCs often participate in many, if not all, MCO networks.

Multi-payer collaboration would also enable FQHCs to deliver high-quality services to all patients on the theory that a rising tide lifts all boats. Technical assistance to increase standardization within the FQHC helps reduce care disparities and improve operating efficiency, unleashing additional primary and preventive care capacity.

Collaborative, regionally based investments by multiple MCOs in FQHCs (who participate in multiple MCO networks) to standardize contracting approaches and quality measurement yield multiple benefits:

- Plans get better population health outcomes and related financial rewards.
- Patients get better access to high-quality preventive care and community-based services.
- Traditional Medicaid providers who work in FQHCs have the information and skills they need to improve patient care and satisfaction.

By rebalancing spending towards primary and preventive care, Medicaid programs — including the people they serve and the taxpayers who fund them — are the ultimate winners.

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