VIEWPOINT

Value-Based Payment Models for Community Health Centers

Time to (Cautiously) Take the Plunge?

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The community health center (CHC) program, which now includes more than 1400 organizations[1] and provides primary care services for more than 24.3 million low-income individuals[2] in the United States, has been a success. The program, an outgrowth of the civil rights movement, began as a pilot in 1965 with the development of 2 prototype health centers.[3] The mission of these initial centers—one in a low-income Boston neighborhood and the other in an impoverished rural Mississippi community—was to provide basic health care services in areas where such care did not exist.

Over the ensuing 50 years, CHCs have become one of the few social programs with bipartisan support. Both the George W. Bush and Barack Obama administrations strongly supported CHCs. Although the direction of the current Congress regarding health care issues remains uncertain, recent evidence suggests that CHCs (often referred to as federally qualified health centers) offer a cost-effective setting for providing care, in part due to their patients' lower use of expensive downstream specialty services.[4]

Despite substantial overall support for CHCs, however, some experts, including the National Association of State Medicaid Directors[5] and the National Governors Association, have begun calling for changes in how health centers are reimbursed. Just as Medicare and many commercial insurers are shifting away from traditional fee-for-service reimbursement in favor of value-based payment methodologies, policy makers and health center leaders have begun to suggest similar changes for CHCs.[6]

> CHCs are an evidence-based strategy for improving health outcomes and slowing cost increases.

Because of the vulnerability of CHCs and the populations they serve, however, CHC payment reform deserves special consideration.

The Existing CHC Payment System

Because CHCs provide care to all individuals, regardless of insurance status or ability to pay, they are entitled to a set level of reimbursement that is linked to the cost of care for Medicaid patients (standard Medicaid rates are insufficient in many settings). CHCs also receive federal grants to cover care for uninsured patients. To be eligible for these payments, health centers must be federally approved and meet 19 requirements, including demonstrating community need, offering a sliding scale fee schedule based on income, and being governed by a majority consumer board.

Under the current payment model, known as the prospective payment system because rates are set prospectively, states work with CHCs to determine a flat rate for qualified Medicaid visits. Prospective payment system rates are influenced by the scope and cost of services, among other factors, and can vary significantly between sites.

In some states, Medicaid directly pays CHCs the agreed-upon rate for each visit. In others, the CHC is reimbursed by a Medicaid managed care plan but also receives a supplementary payment from the state covering the difference between the managed care payment and the prospective payment system rate. Regardless of how the payment happens, federal statute guarantees that CHCs receive at least the prospective payment system rate.[7]

Despite its importance in sustaining the US primary care safety net, the prospective payment system has many of the shortcomings of traditional volume-based reimbursement. For example, CHCs have incentives to schedule reimbursable in-person visits for simple issues, such as blood pressure checks, some of which could be managed more efficiently by telephone or electronic communication. CHCs also cannot bill directly for patient education, case management, or enabling services (such as transportation or housing assistance). Moreover, although many Medicaid managed care plans offer pay-for-performance programs for CHCs, in most instances, the absolute amount of these payments is modest. Thus, visit volume remains the dominant driver of CHC financial stability, impeding the evolution of advanced primary care delivery models.[8]

New Payment Models for CHCs

As value-based payment models have progressed nationally,[9] several states have begun experimenting with similar payment reforms for CHCs.

For example, in 2013, Oregon initiated a pilot in which participating CHCs receive a capitated rate for all Medicaid patients. In this pilot initiative, the state is obliged to reconcile CHC payments to ensure they are at least equal to the revenue health centers would have received through the prospective payment system. However, CHCs that implement alternative forms of patient interaction, such as group visits, care via telephone and electronic communication, and visits with nonbillable

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care team members, may realize lower costs from improved efficiencies. Under Oregon's Medicaid waiver, CHCs also are eligible for bonuses based on measures of quality and resource use.[8]

Initial results among the first 10 participating health centers in Oregon are encouraging. According to an independent evaluation, there have been modest reductions in emergency department and hospital use, as well as improvements in quality, patient experience, and access. Some participating CHCs have also experienced reduced in-person billable clinician visits, presumably by substituting in-person clinician visits with other forms of interaction, including care delivered via telephone or digital means and contact with ancillary care team members. The program has now expanded to several other health centers statewide.

Even though the Oregon demonstration provides CHCs more flexibility in how they deliver care, organizations that fail to use this opportunity effectively have no downside risk because they are guaranteed at least their prospective payment system revenue.

California, which has more CHCs than any other state, plans to implement a similar value-based payment demonstration designed by the state's 2 associations of CHCs along with state policy makers. Like Oregon's demonstration, the California proposal (which has been under discussion for several years and is currently planned to begin in 2018) would provide participating CHCs a capitation for each assigned Medicaid beneficiary, and health centers would be evaluated using standard quality, patient experience, access, and utilization metrics. In the California demonstration, participating health centers would also accept modest downside risk if visits exceed agreed-upon thresholds compared with historical rates. Although CHCs would volunteer to participate in the pilot program, it remains unclear whether regulators will allow this initiative to proceed as proposed because some CHCs could potentially receive less revenue than under prospective payment system.

Looking Ahead

A shift to value-based payment among CHCs could promote higher-quality, more efficient, and more patient-centric care. Because of the vulnerability of patients served by CHCs, however, this shift must be done thoughtfully, while honoring the original intention of the prospective payment system—to protect safety net clinics from the volatility of Medicaid rates.

Nevertheless, allowing willing CHCs to accept capitated payments with limited downside risk could create the right incentives to improve care delivery while promoting greater flexibility in how care is provided. Such reforms would also align with Medicare's bipartisan value-based payment initiative, in which clinician groups must accept some downside risk to qualify as participating in an advanced alternative payment model.[6]

Promoting a robust system of CHCs is just as important now as ever before. CHCs are an evidence-based strategy for improving health outcomes and slowing cost increases. To best foster patient-centered primary care services for safety net populations in the years ahead, policy makers and CHC leaders alike should embrace the opportunity to reform the reimbursement system. Although it will be important to proceed cautiously, it is time to allow willing CHCs to experiment with advanced value-based payment models.

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