



## IMPROVING COMMERCIAL REIMBURSEMENT FOR COMMUNITY HEALTH CENTERS

Federally Qualified Health Centers, also known as FQHCs or Community Health Centers (CHCs), provide a “medical home” where patients receive preventive care, primary care, and chronic disease management. CHCs are driven by mission and legal mandate to offer their services regardless of a patient’s ability to pay.

While fulfilling their historic mission to provide care to the underserved, some CHCs across New York also serve large numbers of patients with private, commercial insurance. Nearly one-half million patient visits – approximately 15 percent of all visits to CHCs in New York State in 2004 – were provided to patients with commercial insurance coverage. For some CHCs, the proportion of patients with commercial insurance is between one-third and one-half.

For many commercially insured patients living in rural or underserved areas, CHCs offer the only point of access to primary care. Other commercially insured patients are making CHCs their provider of choice because of their reputation for outstanding, culturally competent primary care and the wide scope of services they provide.

### METHODOLOGY

For this study, Manatt Health Solutions and RSM McGladrey conducted in-depth analyses of six CHC networks across New York State with high proportions of commercially-insured patients were conducted to examine their experiences with commercial and public payers.

The executive management of each CHC participated in a structured interview. In addition, each participating CHC provided extensive data related to its finances, operations, and quality of care.

### SIX CASE STUDY SITES

- Callen-Lorde CHC
- Family Health Network of Central NY
- Hudson Headwaters Health Network
- Institute for Family Health
- Northwest Buffalo CHC
- Oak Orchard CHC

### CASE STUDY FINDINGS

CHCs receive significantly lower reimbursement rates from private insurers compared with those from public payers. On average, commercial payment rates per visit are \$38 less than Medicaid fee-for-service rates and \$17 less than Medicare rates.

The rates of payment from commercial insurers are inadequate to cover the cost of care. On average, without co-insurance or co-payments, the CHCs lose \$41 on each medical visit they provide to a patient with commercial insurance. Accounting for the enabling services that CHCs provide in addition to medical services, the shortfall in commercial payments is even more severe. Collectively, the six CHCs in this study lost more than \$5.8 million dollars in 2006 on the care they provided to commercially insured patients; the total losses for all CHCs across the state are even more substantial.

While Medicaid and Medicare payments are also below the cost of care, they come much closer to covering the costs of caring for patients.

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## AVERAGE NET REVENUE PER VISIT BY PAYER, 2006

PAYER	AVERAGE NET REVENUE PER VISIT (\$)
Medicaid FFS	111.90
Medicaid MC*	86.03
Medicare	90.27
Commercial	73.72
Self-Pay	32.98
Average	79.23

\* CHCs also receive a “wrap-around” payment for the difference between Medicaid (and Medicare) managed care and fee-for-service payments.

CHCs contract with numerous commercial payers and face large administrative burdens managing many different contracts. These include individual physician credentialing, preauthorization requirements, managing multiple networks of specialists, and managing formularies. Despite recognizing the administrative burdens these contracts present, most CHCs have continued to sign additional contracts in order to provide continuity of care and a stable medical home for their patients.

CHCs report lacking bargaining power in their relationships with commercial plans, and CHCs rarely have the opportunity to negotiate rates with commercial payers. Instead, CHCs reported that they are presented with commercial rates and contract terms on a “take it or leave it” basis. Every CHC interviewed believed that they have insufficient volumes to secure any leverage against the plans. CHCs also attribute their lack of leverage to a lack of good data. Plans rarely provide comprehensive, patient-specific and aggregate data to the CHCs. Furthermore, many CHCs lack the health information technology (health IT) capacity that would support the information capture and data analysis needed to negotiate with the plans.

Without negotiating rates, CHCs cannot explain how their commercial rates are set by plans.

THE COMMERCIAL RATE-SETTING PROCESS IS A “BLACK BOX.” RATES ARE SIMPLY SET UNILATERALLY BY THE PLANS, AND PAYMENT POLICIES ARE USUALLY UNPUBLISHED.

Quality-of-care incentives in managed care contracts are rare, based on unpublished formulas, and generate only modest payments for some CHCs. CHCs report that some of their commercial managed care contracts contain quality incentives or pay-for-performance mechanisms. However, these incentives are not standardized across different plans and there is significant confusion regarding how they work and which plans examine which measures.

CHCs are efficient, low-cost, well-managed providers of primary care. The CHCs in this study generally meet or exceed national benchmarks in terms of productivity and cost control. Their medical costs per encounter as well as their total costs per user are generally lower than the national averages for CHCs, despite the expense of operating in New York. CHCs have implemented a wide range of management strategies to address the commercial payment shortfall, but the benefits of these strategies are largely exhausted.

## RECOMMENDATIONS

CHCs are an integral part of the state’s primary care infrastructure, often serving as the main point of access to care for an array of vulnerable patient populations. However, the ability of some CHCs to continue fulfilling this role is severely jeopardized by low reimbursement rates from commercial insurance plans.

While there are no “magic bullets” to rectify this gap in reimbursement rates, we recommend a variety of strategies to improve commercial reimbursement for CHCs.



**■ REQUIRE THE INCLUSION OF CHCs IN COMMERCIAL INSURANCE PROVIDER NETWORKS AND ENSURE ADEQUATE COMPENSATION TO COVER FEDERALLY MANDATED SERVICES.**

New York State currently requires that health maintenance organizations (HMOs) have “adequate” provider networks. A network must contain a sufficient number and mix of providers capable of meeting the diverse and comprehensive needs of enrollee populations. Most notably, HMOs must have a minimum of three primary care providers accessible within reasonable travel and distance time standards. Networks are reviewed annually by the State to ensure that this standard is being met.

While such an examination is important to a limited number of rural providers, it is inadequate to address the problem more broadly. New York’s Medicaid managed care program has implemented more targeted policies to both ensure patients’ continued access to the enriched delivery model of CHCs and to support the financial viability of CHCs themselves. Under New York’s Medicaid Managed Care program, managed care organizations operating in mandatory counties must contract with at least one CHC operating in their service areas.

The goals that have driven this policy are worthy of consideration in the commercial environment as well. A statutory requirement mandating the inclusion of CHCs in HMO provider networks would bolster the negotiating leverage of CHCs to demand adequate rates. If CHCs were a required component of network adequacy, CHCs, especially those in rural areas, could negotiate on a more level playing field with commercial HMOs. Exemptions to such a new statutory requirement would be made in areas without any CHCs.

A second Medicaid policy worthy of consideration in the commercial context is “wrap-around” reimbursement. Currently, Medicaid funds are provided to “wrap-around” Medicaid managed care plan reimbursement rates, ensuring CHCs are fully reimbursed for their care.

This policy stems from requirements under federal law that CHCs receive adequate Medicaid reimbursement to cover the cost of the wide range of services provided by CHCs. New York should consider similar requirements that would ensure commercial rates are adequate to reimburse for the full range of federally mandated services. This could be accomplished through creation of a “wrap-around” pool.

**■ CREATE A UNIFIED INCENTIVE FUND TO REWARD CHCs THAT PROVIDE SUPERIOR QUALITY OF CARE AND ESTABLISH UNIFORM METHODS FOR MEASURING CARE AND ADMINISTERING THESE FUNDS.**

CHCs should receive a share of the savings that they produce for commercial payers as a result of their excellent care and success in reducing hospitalizations and the costly use of specialists. This does not currently happen.

The CHCs interviewed for this study repeatedly cited a lack of standardized quality measures across different plans. CHCs also reported significant confusion regarding how they work. It does not appear that, as structured, these incentives are effective at influencing behaviors and bringing out desired performance improvements.

In Spring 2005, New York State statutorily established a new “Pay for Performance” program to promote patient safety, quality of care and cost effectiveness by rewarding hospitals, physicians and clinics that provide high quality care. Subsequently, a broad-based workgroup developed consensus on clinical ambulatory and inpatient measures necessary and appropriate to achieve improvement in quality demonstration programs. Within each demonstration, providers who exceed performance benchmarks will receive cash payments. These demonstrations deserve careful scrutiny and, if successful, should be expanded and modified to support CHCs that consistently provide high quality care and achieve satisfactory patient outcomes.

## ■ ESTABLISH COMMUNITY REINVESTMENT STRATEGIES TO FILL THE GAPS IN COMMERCIAL PAYMENTS TO CHCs.

New York State has historically relied upon dedicated funding pools to ensure the provision of necessary health services. A similar strategy could be deployed to address the failure of commercial insurers to adequately reimburse community health centers. New York State should establish a reinvestment mechanism that directs profits from commercial payers for the purpose of financially stabilizing CHCs.

Currently, numerous bills are under consideration by the Legislature that would require reinvestment of HMO and health insurer profits in the health care delivery system. Citing the fact that “many health insurers and health maintenance organizations incur substantial profits and have excess reserves while health care providers in general struggle financially,” Senate Bill 6056 would require that health insurers and HMOs provide funds to improve provision of health services, improve quality of care, workforce, infrastructure, and efficiency. A second bill would apply a percentage of the profits of for-profit health insurers to establish a community health care investment fund that would make grants to address health care disparities and access to health care. Another bill under consideration would require for-profit insurers and for-profit HMOs to provide funds for reinvestment in health information technology in the suburban area around New York City. Yet another bill would set aside “one and one-half percent of the aggregate of all healthcare related premiums and back office charges” to provide assistance to hospitals to upgrade their technology and modernize their infrastructure.

Given the documented inadequacy of commercial payments to CHCs, such reinvestment programs should be modified to provide directed fiscal support to CHCs which are a critical component of the state’s primary care delivery system.

## ■ SUPPORT CHCs IN CREATING MORE EFFECTIVE BUSINESS PARTNERSHIPS WITH COMMERCIAL PLANS AND STRENGTHEN THEIR ABILITY TO DO SO THROUGH INVESTMENT IN HEALTH INFORMATION TECHNOLOGY (HEALTH IT).

Until recently, the CHCs have not generally followed strong business practices in their dealings with commercial payers. For the most part, CHCs have not attempted to negotiate adequate rates with their commercial payers and have simply accepted the rates dictated to them, with no understanding of how those rates were calculated.

While CHCs are motivated first and foremost by their mission to serve their patients, there can be no mission without adequate financial margins to support the provision of high quality care and continual reinvestments in their care management systems.

To enable CHCs to be better negotiators, they need the data, systems and tools to increase their negotiating leverage. For example, CHCs are often hampered by the failure of plans to provide patient-specific and aggregate-level data and handicapped by a lack of information to facilitate their negotiating position. Support for the implementation of health information technologies (health IT) such as electronic medical records (EMRs) will significantly strengthen CHCs ability to manage care. Health IT will also help CHCs generate the data necessary to prove the savings that they produce for commercial payers. EMRs will help prepare CHCs for meaningful participation in quality-based reimbursement. Initiatives to support CHC acquisition and implementation of health IT will enhance the ability of CHCs to improve business practices and negotiate favorably with commercial payers.

## ACKNOWLEDGMENTS

This brief and the full report were written by Manatt Health Solutions with support from the RCHN Community Health Foundation and the Community Health Care Association of New York State (CHCANYS). RSM McGladrey Inc. provided financial analysis.

### For a copy of the full report or more information:

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