

State of Maine | 130th Legislature
Joint Standing Committee on Health and Human Services
Testimony of Darcy Shargo on behalf of Maine Primary Care Association
February 22, 2022

Supporting:

LD 1787, “An Act To Improve the Quality and Affordability of Primary Health Care Provided by Federally Qualified Health Centers”

Sponsored by Senator Ned Claxton and Representative Marianne Moore

Senator Claxton, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, I am Darcy Shargo, CEO at the Maine Primary Care Association (MPCA).

MPCA is a membership organization that includes all of Maine's 20 Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHCs). Maine's CHCs make up the largest independent primary care network in the state, providing comprehensive medical, behavioral, and dental care for more than 200,000 individuals or 1 in 6 Mainers. They are at the forefront of delivering care to rural and underserved Maine communities and serve patients regardless of health insurance status or ability to pay.

I have noted at the end of this testimony what the specific merits of this bill are, and you'll hear this echoed by my colleagues and partners today, both in oral and written testimony. While I am before the committee, however, I would like to focus on why this bill is so important to the FQHCs in Maine, and why the timing is *now* to address the issues that this bill outlines.

Specifically, I want to share some important context to this bill:

- We would not be before you if we didn't really need your support - this is the first time our network has ever come before the Legislature with a request for investment via a rate adjustment, or rebasing, as it is described in LD 1787. We need this adjustment immediately, even though we know the Department is setting long term frameworks for rate adjustments, which we have supported.
- This bill outlines a process to address a 20-yr long problem that is not sustainable for health centers; it positions us for success in whatever frameworks the Department puts together for rate setting in the future, as well as for value-based initiatives in Medicaid (including the soon-to-be-launched PC Plus program).
- Our collective sense of urgency has been quickened by the extended duration of the pandemic and the impact of it across our sector, esp. **as we are one of very few provider groups in Maine that has not received any direct state relief.** FQHCs, too, have been on the front lines of the COVID response and face many of the same operational, clinical, and financial challenges as other healthcare providers.
- A similar process has already been done for rural health centers (RHCs) in 2019. **(For a comparison of FQHC rates to other provider types see the attached fact sheet.)**

- Healthy FQHCs are also healthy employers—as you may know, community health centers play a vital role in rural economic development; they provide local jobs, spur local spending, and support local health care access and availability, all of which are critical to robust recovery from this pandemic.
- FQHCs constitute a sound investment; studies show consistently that Medicaid costs are lower at health centers, resulting in major savings to the system.
- Finally, this bill would signify a solid commitment to primary care investment, which DHHS has noted is of importance to them; such an investment is going to be critical to our economy as we work to get back to “the way life should be” post-pandemic.

The bill’s key merits:

- Aims to shore up payment to FQHCs through a one-time rebasing process, thereby allowing health centers to work on a level playing field with other providers (the avg. current gap across health centers between the payment rate and the cost of care is 60%);
- Proposes an updated inflationary index that better captures the unique FQHC service array;
- Helps to clarify application of an existing policy, called Change in Scope, which gives health centers some ability to adjust rates when new services are offered/expanded; and,
- Encourages the Department to work closely with CHCs in future payment initiatives so that the distinctive care model at health centers can continue to advance.

We see this bill as a necessary vehicle to our long-term viability—esp. our ability to contribute optimally to the health care system and to continue to lead in delivering innovative and integrated primary care. I urge you to support LD 1787 (as amended) and I am happy to take questions. Thank you.

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HOW COMMUNITY HEALTH CENTERS ARE PAID

Community Health Centers, also known as Federally Qualified Health Centers (FQHCs), are required to provide all patients with comprehensive services – from primary care to mental and behavioral health to dental care, as well as a host of other services that include transportation, translation, and case management services. In recognition of the critical role that health centers play and the significant value they deliver for Medicare, Medicaid and CHIP patients, and state programs, Congress created a specific payment methodology for community health centers, called the Prospective Payment System, or PPS. This payment system is crucial to the successful relationship between health centers, Medicaid and Medicare, and to health centers’ continued viability.

Health Centers (FQHCs) are a singular type of Medicaid provider:

- FQHCs are required to offer a full range of primary and preventive services, as well as dental, behavioral and vision services.
- Many services offered by FQHCs are often not covered by Medicaid, such as case management, translation, transportation, and some dental and behavioral health services.
- Each FQHC must be located in an underserved area and care for all, regardless of income or insurance status.
- By law and mission, no FQHC can restrict how many Medicaid patients it treats, even if payment is insufficient.

Congress created FQHC PPS to ensure predictability and stability for health centers while protecting other federal investments:

- Starting in 2001, PPS rates were calculated for each FQHC, based on historical costs of providing comprehensive care to Medicaid patients, to ensure each rate is appropriate and accurate.
- FQHC PPS ensures health centers are not forced to divert their Federal Section 330 grant funds, which support operations and care to the uninsured, to subsidize low Medicaid payments. In Maine, Section 330 funds account for approximately 5-15% of a FQHCs operating budget.

FQHC PPS is a bundled payment that drives efficiency, but is not cost-based reimbursement:

- Rather than being paid fee-for-service, FQHCs receive a single, bundled rate for each qualifying patient visit no matter the intensity of service(s) provided. The bundled, encounter rate includes all services that are “in scope.” If a health center provides a service that they did not add to their scope of practice with HRSA, they would bill fee for service. Unlike Rural Health Clinics (RHCs), for example, this rate does not include a facility fee on top of the bundled rate and health centers cannot charge for each service delivered during the encounter.

Service	FQHC Reimbursement	RHC Reimbursement	Physician Reimbursement	Hospital Affiliated Physician
Well Visit (99396)	Included in Encounter	Included in Encounter	\$ 122.14	\$ 122.14
Removal of multiple skin tags (17110)	Included in Encounter	Included in Encounter	\$ 62.17	\$ 62.17
Removal of ear wax (69210)	Included in Encounter	Included in Encounter	\$ 29.32	\$ 29.32
2022 Average Encounter Rate (T1015)	\$ 184.93	\$ 203.47	\$ -	\$ -
Facility Fee	\$ -	\$ 95.47	\$ -	\$ 95.47
Total Reimbursement	\$ 184.93	\$ 298.94	\$ 213.63	\$ 309.10

- Updates to PPS rates have not kept pace with inflation (averaging only 1.2% over the past 10 years) or with changes to the range of services FQHCs provide – indeed on average, PPS only covers 80% of an FQHCs’ costs of caring for Medicaid patients. In Maine, 100% of Maine FQHC Medicaid rates are less than actual costs/encounter (based on analysis conducted in early 2020.)
- In 2020, the MaineCare rate was below costs by 15-100%

FQHCs and PPS cost Medicaid little, and save much:¹

- FQHCs account for less than 2% of total Medicaid spending, yet provide care to one in every six Medicaid beneficiaries nationally.
- FQHC patients have 24% lower total health care costs than similar non-FQHC patients do.

Current law offers states significant flexibility in how to pay FQHCs:

- Instead of PPS, states may implement an Alternative Payment Methodology (APM) to reimburse FQHCs, as long as each affected FQHC agrees, and total reimbursement is not less than it would have been under PPS.
- More than 20 states currently use an APM to reimburse FQHCs for services to Medicaid patients.
- States and Managed Care Organizations (MCOs) can - and currently do - incorporate FQHCs into value-based payment arrangements, including those involving financial risk related to quality, outcomes, and cost.

¹ https://www.nachc.org/wp-content/uploads/2018/05/Medicaid_FS_5.15.18.pdf