New York State Medicaid Redesign Team (MRT) 1115 Waiver
Community Health Care Association of New York State Comments
October 10, 2022

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to submit comments on the New York State Medicaid Redesign Team (MRT) 1115 Waiver on behalf of the more than 70 federally qualified health centers (FQHCs), also known as community health centers (CHCs), that serves approximately 2.3 million New Yorkers each year at over 800 sites in medically underserved communities.

Background

CHCANYS is the primary care association representing New York State's FQHCs. FQHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services to everyone, regardless of their insurance coverage, immigration status, or ability to pay.

FQHCs are a crucial safety net for New York's residents of both rural and urban areas, working tirelessly to provide healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health and well-being. The majority of FQHC patients are extremely low-income; 90% live below 200% of the Federal poverty level. FQHCs serve populations that the traditional healthcare system has historically failed: 68% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 13% are uninsured, and 4% are unhoused. Nearly 60% of our FQHCs' patients are enrolled in Medicaid, CHIP, or are dually enrolled in Medicare and Medicaid.

FQHCs: The Vehicle to Advance Health Equity

FQHCs are critical to advancing health equity and addressing health disparities and are an accessible and inclusive point of healthcare. Many FQHCs not only provide primary and preventive care, but also connect patients to needed services to address social needs, understanding that addressing social determinants of health is key to improving health outcomes and reducing health disparities. FQHCs are trusted by their communities because they are reflective of the communities they serve, with over 50% of Board members comprised of patients of the FQHC. Because FQHCs are patient governed, they effectively identify community health needs and modify their services to meet those needs. Moreover, FQHCs hire staff from the communities they serve – patients and staff ride the same subway lines, frequent the same grocery stores, and have children who attend school together.

FQHCs have built trust with their communities and have forged longstanding relationships and partnerships with community-based organizations (CBOs), making them critical access points for any efforts or initiatives looking to advance health equity. As the state works hard to embed health equity into all areas of policy, but especially the MRT waiver and related amendments, the State must consider and bolster the unique and important role played by FQHCs in serving a large proportion of New York's Medicaid population.

Align Payment Incentives Through an FQHC Alternate Payment Methodology (APM)

To advance MRT's goals of improving access, quality, and cost effectiveness for New York's most underserved and vulnerable communities, care delivery models must be aligned with value-based payment (VBP) goals. Federal law mandates that state Medicaid programs reimburse FQHCs using a visit-based bundled payment methodology, known as the prospective payment system (PPS), regardless of contractual agreements between FQHCs and Medicaid managed care plans. This traditional visit-based PPS methodology incentivizes volume over value and inhibits development and implementation of innovate care models. However, 42 U.S.C. §1396a (bb)(6) permits an FQHC to be paid under an Alternative Payment Methodology (APM) through a State Plan Amendment (SPA), with the following conditions:

a) the APM reimbursement is not less than what the FQHC would have received under a "traditional" visit-based PPS methodology and

b) each health center individually agrees to participate in the APM.

FQHC APMs allow the State Medicaid program to adopt a different methodology that can support integrated care, incentivize high-quality comprehensive primary care services, allow flexibility to address patients' social determinants of health, and promote increased access to care.

In alignment with Medicaid goals, more than 90% of FQHCs have achieved NYS-specific PCMH designation. The care management, care coordination, and risk stratification elements of the PCMH program have prepared FQHCs for a capitated APM and other value-based arrangements. Without the limitation of payment tied to a narrow billable visit, FQHCs can adopt innovative care delivery modalities such as telehealth, remote patient monitoring, same-day visits for primary care and behavioral health, and team-based care designed to best suit a given patient's needs. Moreover, a capitated APM will empower FQHCs to better coordinate with community partners to provide whole person care, including addressing patients' social needs, which are known to be the root causes of health disparities. CHCANYS requests the State to advance a FQHC capitated APM to align FQHC payment and practices with MRT's drive towards value-based care.

Invest in FQHC-Led Independent Practice Associations (IPAs)

Many FQHCs have formed or joined Independent Practice Associations (IPAs) in partnership with other FQHCs, primary care providers, behavioral health agencies, and CBOs. IPAs are the primary vehicle through which FQHCs can participate in advanced VBP arrangements. IPAs enable FQHCs to better address population health and coordinate with behavioral health organizations and social services agencies. However, FQHC-led IPAs remain self-funded and challenged to develop needed infrastructure. Investments in FQHC-led IPAs are needed to support the data analytic capabilities to effectively manage population health, drive improved outcomes, ensure connectivity with social care needs providers, and be high performers in value-based contracts.

Establish Guardrails in Advanced VBP

Through advanced VBP arrangements, healthcare providers are expected to collaborate and coordinate beyond the healthcare system with community-based organizations to address patients' health related

social needs. This is well suited to the FQHC model of care; however, that work is expensive, time consuming, and largely unfunded. As such, upfront investments to FQHCs and community-based providers are required to do the work needed to succeed under the contracts.

Additionally, if value-based payment is to be used as a tool to advance health equity rather than exacerbate inequities, special consideration must be taken to ensure that safety net providers are supported to succeed through timely data sharing, increased transparency, and clear targets around improving disparities relative to specific populations, with appropriate financial incentives. The state must establish the below guardrails to ensure advanced VBP supports safety net providers and their patients.

1. **Improve Transparency Between Providers & Plans**
   Providers and health plans do not have equal footing when negotiating and implementing VBP contracts. Due to plans' proprietary risk stratification methodologies, it is difficult for FQHCs and IPAs to understand exactly how their patient populations' health and social risk is being measured by the plan. Additionally, medical loss ratio and avoidable hospitalization calculations are not always explicit. Providers often do not receive timely information around patient attribution and patient utilization that occurs outside of the FQHC. For a provider to ensure success in VBP, they must have monthly access to the full range of plan data, including claims, risk score calculation, timely care gap data, and patient rosters.

2. **Adjust Attribution Methodologies to Reflect Reality**
   The discrepancies between MCO attribution, consumer utilization, and VBP contractor rosters make it nearly impossible for FQHCs to effectively manage patient health outcomes. For example, a FQHC can be held accountable for outcomes for a patient auto assigned to the FQHC as their primary care provider, but who receives primary care elsewhere, and for whom incorrect contact information is provided by the MCO. A primary care attribution methodology must include the ability to add patients who have billable encounters at FQHCs and remove patients who have billable encounters at other primary care providers. CHCANYS requests the Department to create and enforce minimum required standards for primary care-centered attribution, including a requirement for periodic reconciliation to actual utilization.

3. **Require MCOs to Contract with FQHC-Led IPAs**
   Currently, MCOs have full discretion on whether to enter VBP arrangements with IPAs and may choose **not** to contract with FQHC-led IPAs if they feel they have sufficiently met VBP contracting targets by contracting with a hospital or a large contracting entity. This is inequitable and leaves FQHCs occasionally unable to participate in VBP arrangements, even when they are willing and capable to do so. To promote primary care integration into VBP arrangements, CHCANYS requests that the State define requirements for MCOs to enter VBP arrangements with FQHC-led IPAs.

4. **Consider Improvement Based Targets**

Improvement-based targets require that a provider show improvement from a population's baseline over time. Improvement-based targets avoid penalizing providers who treat individuals with greater social needs or experience wider disparities, as is the case for many within the FQHC population. In cases where measures are stratified by relevant characteristics (e.g. race, ethnicity, language, etc.), improvement based targets with pay for performance rewards the achievement of equity-related goals without penalizing safety net providers for serving populations with the greatest health disparities. When significant improvements are made and benchmarks are reached, contracts must reward those gains rather than offering all or nothing incentives that require providers to hurdle every benchmark to receive any incentive payment at all.

Contact

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