Impact of the medically-uninsured population on the proposed Connecticut Primary Care Modernization Project

The CT Primary Care Modernization project is based on the premise that better health care outcomes in terms of quality, cost and patient experience can be achieved by increasing the portion of total health care dollars that are spent on primary care services while making those primary care providers (PCPs) more accountable for the total cost of care. The enhanced funding paid through primary care bundled payments allows PCPs to redesign their practice models to maximize the efficient use of the full care team to offer patients the most convenient access to their services.

FQHCs must anticipate the financial impact of the medically uninsured whenever they expand services. They have a single model of care that is applied rather indiscriminately to all patients no matter their medical insurance coverage. For example, when they decide to open a new health center site, part of the feasibility study includes the likelihood that this site may qualify for additional Section 330 funding as a new access point. Often it is not but they proceed using reserves and other external sources of funding. The only HRSA funding may be a few thousand dollars under its pay-for-quality program for significantly increasing the number of individuals served.

Because Section 330 funding from HRSA is not directly related to the number of medically uninsured individuals cared for or the intensity of service, the business model for most service expansions (for example adding space to existing sites, increasing the number of providers or adding new services that don't qualify for rate enhancement under change in scope) must take into consideration whether the incremental expense can be covered by revenue from insured patients. If so, the resulting "positive margin" from the insured patients can offset the "negative margin" generated from the enhanced but unreimbursed services for the medically uninsured. As FQHCs enter into value-based payment arrangements for some of their insured populations, service expansion may enhance the probability of earning shared savings that add to the "positive margin".

FQHCs are accustomed to making these financial projections. The CT Primary Care Modernization project is a service expansion opportunity that is being examined with that same rigor. As currently constructed, there will be new revenue from the Supplemental Bundle from participating payers and the potential for additional revenue from the Basic Bundle through more efficient and member-centric use of the care team allowing it to serve a larger panel of patients and earn value-based incentive dollars. As intended, FQHCs will incur new expenses, some of which will be attributed to caring for their uninsured populations. Can those expenses be covered through redeployment of existing HRSA grant dollars intended to be spent on the medically uninsured, improved efficiency and cost shifting from other payers?

Per the 2017 UDS report, 17.0% of CT-based FQHC patients were medically uninsured. Although slightly higher than the previous two years (16.3% in 2015 and 16.1% in 2016), it was lower than 2014 (18.5%) and 2012 (23.0%). The latter reflects the impact of the Affordable Care Act but masks the growing number of "insured" with high deductible plans who received many of their FQHC services on a sliding scale fee schedule without third party reimbursement. Fortunately, unlike disproportionate share hospital payments, there has not been and there is no plan to reduce HRSA funding for FQHCs serving fewer medically uninsured. The number of medically uninsured individuals served by CT FQHCs fell from 75,672 in 2012 to 56,919 in 2015 but have increased to 60,141 in 2016 and 66,093 in 2017 as FQHCs have annually increased the number of all patients served from 329,009 in 2012 to 388,358 in 2017.

CT FQHCs have raised the legitimate concern as to whether they can afford the incremental cost of services designed to be paid by payers through a supplemental bundle without a similar funding stream for their medically uninsured patients. This issue should be examined from several perspectives:

1. How does the anticipated per-member-per-month (PMPM) revenue for their insured patients compare to HRSA funding of the medically uninsured? Statewide, HRSA funding of CT FQHCs increased from $42,477,643 in 2015 to $51,723,469 in 2016 and to $57,563,996 in 2017. This translates into an average PMPM grant support of $62.19 in 2015, $71.67 in 2016 and $72.58 in 2017. Without public access to individual FQHC PPS rates and average billable primary care visit rates (PMPY), only the individual FQHC can calculate the Basic Bundle amount for each of those years. The amount of the Supplemental Bundle is still being determined. It is unlikely, however, that the sum of the two will exceed HRSA average funding of $72.58 PMPM. From an average perspective, one could argue that there is adequate HRSA funding for the medically uninsured to implement the enhanced primary care model envisioned by the CT Primary Care Redesign.
2. A problem with that analytic approach is that HRSA does not distribute its grant funding proportional to the number of medically uninsured individuals that an FQHC serves. As a result, in 2017 HRSA funding of CT FQHCs varied from as low as $33.84 PMPM per medically uninsured patient to as high as $196.95 PMPM as illustrated below based on HRSA UDS reports.

CHC	**2015**		**2016**		**2017**	
	Uninsured patients	HRSA grant uninsured PMPM	Uninsured patients	HRSA grant uninsured PMPM	Uninsured patients	HRSA grant uninsured PMPM
Charter Oak	3,975	$108.51	3,824	$124.52	3,773	$127.76
Community Health Torrington	379	$285.78	1,200	$106.55	1,351	$116.66
CHC Inc.	11,448	$44.66	12,053	$45.87	11,737	$46.97
Comm. Health Services	3,075	$95.93	3,013	$ 92.89	3,264	$102.37
CT Institute	608	$201.28	2,700	$ 46.85	3,219	$38.19
Cornell Scott	4,236	$103.06	3,346	$130.11	5,068	$97.82
Fair Haven	4,455	$49.11	4,201	$72.94	4,165	$94.46
Family Centers	0	N/A	120	$459.69	365	$196.95
First Choice	2,946	$51.87	2,596	$83.16	2,929	$114.30
Generation Family	2,490	$106.77	2,116	$139.90	1,921	$164.82
Norwalk Community	3,995	$41.16	4,239	$44.99	4,428	$54.89
Optimus	10,236	$43.37	10,959	$42.54	12,679	$33.84
Southwest	4,809	$42.35	4,814	$60.29	4,981	$63.85
Staywell	2,910	$50.40	3,253	$70.00	3,535	$103.34
United Community	1,228	$0.00	1,283	$127.32	1,340	$81.17
Wheeler	135	$167.20	455	$128.62	1,335	$54.38
All CT CHCs	56,926	$62.18	60,169	$70.94	66,089	$72.58

3. It is difficult to anticipate the impact of the CT Primary Care Modernization project on future practice growth and payer mix for individual FQHCs. Under a primary care capitation payment approach, practice revenue is dependent on the size of the insured attributed population rather than the number of billable visits to those payers. The impact will in part depend on how effectively the Supplemental Bundle funds are used to enhance patient experience and convenience via alternative access to primary care but also on other market factors. The project can create a competitive advantage for FQHCs in attracting additional attributed patients while also allowing care teams to serve larger panels and provide more support to patients with the most complex needs. Theoretically, given the limited number of non-FQHC PCPs offering affordable primary care to uninsured patients, it is less likely that FQHCs will attract more medically uninsured patients from non-FQHC primary care practices. It is more likely FQHCs will attract new insured patients. That remains to be seen, particularly as some of the patient protections under the Affordable Care Act are compromised.
4. To the extent that primary care redesign enabled by this payment reform model allows other, lower salaried care team members to meet patients' primary care needs and thus FQHCs distribute fixed costs across a larger panel of patients, practices will lower their PMPM cost of providing existing care under the Basic Bundle. That includes for the medically uninsured.
5. Finally, there is the issue of a specific, dedicated funding source for a Supplemental Bundle if it were to be paid for the medically uninsured. It is anticipated that additional HRSA dollars will be distributed to existing grantees in 2019 rather than funding new access points. However, the amount and sustainability of that funding is still uncertain.

For some FQHCs with sufficient PMPM payments, HRSA grant dollars could be reallocated in alignment with the new practice model. More broadly applicable would be allowing FQHCs to cost shift the use of Supplemental Bundle payments to their uninsured populations. Such cost shifting disadvantages FQHCs in shared savings/risk arrangements. This could be addressed by waiving their requirement to assume shared risk instead of merely shared savings arrangement with payers or by reducing a portion of the cost of the Supplemental Bundle when calculating savings or losses proportionate to their uninsured patient mix. However, we doubt that either federal or commercial payers would explicitly authorize this adjustment.

CT FQHCs should evaluate participation in the Primary Care Modernization project from a national perspective as well. Recognizing national payment reform trends, FQHCs in other states are actively pursuing a capitated approach to an FQHC Alternative Payment Methodology (APM) even when faced with the same concern about its impact on the cost of caring for the medically uninsured. Those FQHCs do not have two very unique financial advantages being offered in CT:

1. A multi-payer approach: In other states, the APM only applies to Medicaid beneficiaries and typically is not supported by commercial insurers or CMS for Medicare beneficiaries.
2. A Supplemental Bundle revenue source from at least some payers to underwrite the cost of practice transformation.

Since participation in the CT Primary Care Modernization project is voluntary, CT FQHCs must project the net financial impact with both a short term and long term perspective.