

Public Comment to Medicaid Reform Advisory Group – January 15, 2014

Good morning, my name is Ben Money. I'm President and CEO of the North Carolina Community Health Center Association. Thank you for the opportunity to speak today.

Community health centers are nonprofit, patient-governed primary care practices serving individuals on a sliding fee basis. Also known as FQHCs, community health centers are the medical home for 466,000 predominantly low-income North Carolinians – over half of whom are uninsured. Our health centers operate nearly 180 clinical sites in 66 counties across the state from the outer banks to the Tennessee border.

We are patient-centered medical homes. Health centers treat the whole person - providing coordinated medical, dental, pharmacy, mental health, substance abuse, social work, transportation, outreach and other services under one roof. FQHCs also purchase medications through 340b the federal discount pricing program, creating huge savings for patients.

Furthermore, we know that our model of care can help save Medicaid money. National studies have shown that a Medicaid patient in a community health center is one-third less likely to have an emergency room visit, an inpatient hospitalization, or a preventable hospital re-admission than a Medicaid patient in another care setting. The cost to treat a patient in an FQHC is \$541 per year compared to over \$1,200 for one non-acute hospital ER visit. In our state, pioneering health centers have launched initiatives with their local hospitals to provide primary care services, diversion programs, and other strategies as an alternative to the ER. These efforts need greater support.

We have an opportunity to save more Medicaid dollars by better utilizing FQHCs. In 2012, just under 115,000 Medicaid recipients were served at NC's health centers. This is just 25% of FQHC patients, far less than the national average of 41%.

When reforming the Medicaid program, we offer these suggestions:

Keep what works

Throughout this process, we urge you to fix the obvious problems, focus management on higher cost areas, **but keep what works.**

Make it provider-driven

Providers have the knowledge and expertise to redesign care and decrease overall health care costs. Providers need the flexibility (and appropriate reimbursement) to innovate in ways that demonstrate quality improvement, improved health status, and cost savings.

Transition away from paying for only visits and procedures

The current fee-for-service system prevents resources from being moved along the health care continuum to where it can have the most impact – in primary care. Fee-for-service also doesn't pay for many things that keep people healthy.

Here are a few ideas for how to support value-based care:

- Invest in resources to expand evening and weekend hours at FQHCs to give Medicaid patients an option for care other than the emergency room.
- Champion the establishment of FQHC services embedded in the ER
- Pay for nurse advice phone lines, health education, and outreach resources.

- Pay for tele-health remote patient monitoring to constantly manage patient's chronic diseases to avoid ER visits and hospitalizations.
- Pay for avoiding complications, adverse drug interactions, and hospital readmissions – a sort of “warranty payment” focused on maintaining health - with payments based on condition.
- Auto-assign patients to FQHCs and other clinics that provide "whole person" care.

Create stepping stones that transition to value-based payment

Most practices aren't ready to immediately switch from fee-for-service to a value and outcomes based payment. Medicaid should allow providers a period of time to opt-in to the transition continuum with clear stages and secure financing along the way.

Don't repeat mistakes made in other states

- Allow community health centers that have integrated behavioral health to continue without external management.
- Maintain care coordination at the provider level, not managed remotely or out-of-state.
- Maintain a single Medicaid claims processing system.
- If regions are developed, align processes so they are consistent and seamless,
- Require that providers be paid promptly by the state or its vendors.
- Reduce the administrative burden. Align providers and payers on data and outcome objectives.
- Require common reporting and participation in the NC Health Information Exchange.

- Risk adjust for both clinical acuity and for social determinants of health (such as homelessness, lack of transportation, and low literacy).
- Streamline provider credentialing

Start by laying a roadmap

Medicaid will always need some improvements. **“Fixing” the program is process, not an event.**

Once the roadmap is in place, use all available resources to start addressing the problem of the uninsured.

FQHCs provide the right care, at the right time, for the right cost. Please give FQHCs a seat at the table in reforming Medicaid.

Thank you.