COVID-19 Catalyzing Health Center Payment Reform: Addressing the Financial Stability of the Primary Care Safety Net in Crisis and Beyond

JUNE 2020

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Support for the Delta Center is provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

THE COVID-19 PANDEMIC has created a severe financial crisis for Federally Qualified Health Centers, or health centers, which serve 22 percent of all uninsured individuals and 19 percent of all Medicaid enrollees nationally. Health centers represent a cornerstone of America's health care safety net, and the need for their services has intensified given the dramatic increase in Medicaid and uninsured populations due to the pandemic's economic impact. However, many health centers are facing service cuts or closure because they receive a majority of their revenue from Medicaid payers based on the volume of face-to-face visits. Face-to-face visits have dropped by 50 percent compared to pre-COVID-19 levels, and an analysis by the National Association of Community Health Centers (NACHC) and Capital Link estimates that a six-month duration of decreased visits will translate into a revenue shortfall of $7.6 billion and more than 100,000 lost jobs. The amount and duration of these revenue shortfalls is likely to persist given the depth of the economic crisis that threatens the U.S. economy.

Drawing from our work with 12 primary care associations (PCAs) through the Delta Center for a Thriving Safety Net, a Robert Wood Johnson Foundation-funded initiative to advance value-based payment and care for health centers and community behavioral health organizations, we outline three key policy steps to help health centers survive in the short term and thrive beyond the COVID-19 crisis. First, to address the most urgent needs of their patient populations, health centers need immediate funds to continue operations at current or expanded service levels. Second, both Medicare and state Medicaid programs should keep in place the emergency payment reforms (i.e., expanded payments for telehealth) that have been implemented, as these offer some revenue stability and important flexibility to deliver care as communities cautiously reopen while acknowledging the potential need for future closures. Third, to allow health centers to address the needs of their expanded patient populations in the longer term, it is necessary to shift to population-based payment reforms that offer health centers the best prospects of flexible care delivery and long-term financial stability.

1. Stabilize the safety net in crisis.

Current revenue shortfalls threaten the financial stability and continuing operations of many health centers despite the fact that most health centers were eligible for the Paycheck Protection Program and received $1.3 billion in payments through HRSA under the CARES Act. In addition, health centers with more than 500 employees, which serve approximately 10 million health center patients, were not eligible for small business forgivable loans. Some PCAs have also asked state governments for stabilization payments to address these financial shortfalls, but state capacity to make these payments is limited given the precipitous drops occurring in state revenues. For example, in California, the PCA asked the state for upfront quarterly payments equal to one fourth of a health center's prior year's per capita revenue; state officials, though sympathetic to the need for financial stability, turned down the request due to state revenue declines. Health center networks are also beginning to engage managed care Medicaid plans to provide network stabilization payments as a potential "win-win" solution of allowing plans to maintain their minimum medical loss ratios during a time of decreased utilization of the health care system while ensuring that a critical part of a plan's primary care network remains financially viable. However, health center leaders suggest state-level encouragement of such arrangements may be necessary. The magnitude and likely persistence of health center revenue shortfalls suggest that health centers will need continued federal financial assistance until herd immunity is reached or a robust system for public health testing and contact tracing is established.

2. Maintain flexibility in times of uncertainty.

In response to COVID-19-related restrictions on in-person visits and temporary clinic closures, many state Medicaid agencies have implemented swift policy reforms to expand eligibility and payment for telehealth and related digital health services for limited time periods. Many state Medicaid programs are paying the same rates for virtual and in-person visits. Many

health centers, along with other providers, have adopted virtual care practically overnight, with about half of all health center visits being conducted virtually as of April 2020. Many health center leaders report that patients and providers alike are finding virtual care suitable and preferable for at least some portion of visits, and they cannot imagine "going back to the old way." These telehealth expansion policies have been critical to health centers' ability to continue serving patients and earn some revenue. Some state PCAs report that the emergency ability to bill for telehealth has helped improve longstanding access issues for rural residents who had been challenged with transportation to clinics well before the public health crisis. While it may be limited to the current time of many states having shelter in place orders, health centers nationwide are also finding that no-show rates for both medical and behavioral health visits have dropped to historic lows, potentially due to the ease of having a visit with a provider without needing to travel. While telehealth certainly cannot substitute for all primary care over the long term, converting these temporary policies into permanent ones would offer health centers much needed revenues through a critical time of uncertainty and greater financial flexibility to meet patient needs in an era when health centers will be serving a larger population of Medicaid beneficiaries and uninsured individuals.

3. Adopt long-term population-based payment reform.

Volume-based payment has often been cited as a hazard to the U.S. health care system, but the recent public health crisis serves as a haunting reminder of the perils of fee-for-service (FFS) payment for health centers. Health centers should seize this critical moment to work toward the adoption of longer-term value-based payment reforms that will allow them to move away from FFS to a payment system that provides needed flexibility to provide optimal care to patients and acknowledges the critical role that health centers play in achieving desired outcomes for the broader health system. There are two central elements to effective value-based payment systems for health centers: 1) per-member-per month (PMPM) payments, which would provide health centers with similar levels of revenue as they have had in the past but replace their current volume-based payment system, and 2) population-based payments that reward primary care for its contributions to improving the efficiency of the overall health care system and patient outcomes. Oregon, Washington, and New Mexico represent prominent state examples of value-based payment reform for health centers that incorporate these two elements. Oregon and Washington health centers that adopted PMPM payments as alternative payment methodologies in recent years have been buffered from the revenue shortfalls experienced in other states. The Illinois PCA accelerated their movement toward a PMPM health center payment reform in the face of COVID-19 as both an emergency strategy and as a bridge to long-term health center payment reform. New Mexico's PCA reported significant benefits from capitated payments and from total costs of care contracts in the current crisis environment. PMPM payments and significant incentive payments for health system performance are also central elements in the Centers for Medicare and Medicaid Services (CMS) Primary Care First (PCF) initiative, targeted toward Medicare Part B providers. As crisis can not only spur reactionary changes but also serve as a catalyst for long-term transformation, understanding PCF and modeling future health center payment in the spirit of Medicare's most significant shift towards primary care-centric value-based payment could guide health centers toward a new era of population-based payment.

Federal and state policymakers have an opportunity to work with the health center community, including NACHC and state PCAs, to sustain health centers through this crisis in the short term and to transform health center payment and care systems in the long term. Health centers will have a need for protracted flexibility and stable revenue to allow them to meet the changing needs of the community during this crisis and into an uncertain future. Immediate financial assistance, preservation of emergency payment reforms, and movement toward population-based, value-based payment will help to sustain America's safety net when individuals and communities need it the most.