Thriving CA Community Health Center Embraces a Value-Based Model

AltaMed is a health system that operates more than four dozen clinics in Southern California, from L.A. to Orange County. Serving around 300,000 patients each year, it has a staff of almost 3,000. It also runs the largest Medicare Program of All-Inclusive Care for the Elderly (PACE) in the state (the third-largest in the nation), as well as a pediatric clinic attached to Lo Angeles Children's Hospital.

Thriving health center began as free clinic

While those facts are impressive, AltaMed — a federally qualified health center (FQHC) — is undergoing a change that will expand its role. This robust community health center that began as a free clinic in East Los Angeles in the '60s is growing yet again. In the near future, AltaMed intends to gain licensure to operate its own health plan — which means it will not only provi medical care for patients, but, like insurance companies, will assume coverage risk as well.

If you're a hospital, especially one in a rural or underserved area, you may not be feeling warmly toward FQHCs. After all, hospitals and FQHCs are in direct competition for patients…and therefore for payments. According to *Modern Healthcare,* a policy analyst for an insurance carrier went so far as to try to quantify the picture, saying that 90% of that insurer's primary-ca business was accounted for by FQHCs.

Indeed, AltaMed is not an anomaly: roughly 26 million people nationwide are served by 1,400 community health centers acros more than 10,000 facility sites. And while a hole in federal funding had caused some FQHCs to worry about sliding into the re and perhaps think about closing their doors, Congress recently promised $7 billion over the next two years to fill the gap.

FQHCs at times compete with hospitals for the same patient population

Still, FQHCs overall are not nearly as reliant upon that federal funding today as they were in 1985, when more than 80% of th revenue came from government grants (and only 7% from Medicaid and a mere 1% from Medicare). Fast-forward 30 years. According to consulting firm FQHC Germane, the average FQHC's revenue pie in 2015 was made up of only 18% federal funding, a whopping 44% from Medicaid (Medicare represented 7%), and 19% from commercial insurance and other sources

The fact that FQHCs are undeniably a major player in today's healthcare landscape has some hospitals on edge, especially those that will feel the pinch of loss of revenue from patients that are served elsewhere. Hence the competition commonly see between the two.

Additionally, community health centers have been the focus of disapproval regarding the fee-for-service Medicaid payment model under which many FQHCs operate. Federal law requires cost-based prospective payments to be made to community health centers, regardless of whether or not the individual state uses the capped payment model for Medicaid.

Here at home, for instance, most FQHCs in California receive reimbursement for the difference between the managed-care plan's payment and the fee-for-service rate set at the federal level. This "wraparound" payment is managed by the undertakin of an annual reconciliation process, referred to as "burdensome" by providers and state officials alike.

Value-based model viewed as preferable to fee-for-service when comes to patient care

Dr. Michael Hochman is an assistant professor at the USC Keck School of Medicine and a former employee of AltaMed. He told *Modern Healthcare* that FQHCs would be wise to adopt a value-based payment model like AltaMed's. "With fee-for-service, it's all about getting the Medicaid patients," he said. "If patients are going elsewhere, that's less money for the FQHC."

In turn, this can result in scheduling unnecessary patient visits. But when health centers receive Medicaid reimbursement for these visits, they might not see a reason to curb them. And Hochman pointed out that hospitals can't follow suit since without prospective payment system, their Medicaid reimbursement rates are much lower than FQHCs's in this category.

Alternative payment models that waive the prospective payment system would permit community health centers to bundle healthcare services for patients during the same visit, but they would also require legislators to move to protect safety net programs (this according to Rachel Tobey, director of the research group John Snow; she has been working with Hochman to shift California FQHCs to the alternative payment model).

Tobey told *Modern Healthcare*: "Once you open the door for states to waive PPS protections, if you open it even a crack, you run the risk of driving important safety-net providers out of business."