



SUPPORTING HEALTH IT ADOPTION IN FEDERALLY QUALIFIED HEALTH CENTERS: *Setting the Course for Quality-Based Reimbursement*

ABSTRACT

Medicaid and Medicare reimbursement for health IT in FQHCs is legally permissible, prudent policy and a necessary first step in building the infrastructure and capacity for improvements in patient care and positioning health centers for quality-based reimbursement.

As the health care industry moves toward quality-based reimbursement, it is crucial that the nation's Federally Qualified Health Centers (FQHCs) and the vulnerable populations they serve are not left behind. FQHCs have been at the forefront of national efforts to improve primary care delivery. However, FQHCs are poorly positioned to respond to emerging quality-based reimbursement mechanisms, which assume the availability of clinical information powered by sophisticated health information technology (IT). Because FQHCs typically are unable to expend up-front capital on health IT in anticipation of enhanced payments for demonstrated quality improvements, the full benefits expected from quality improvements cannot be achieved without significant investment in FQHC capacity and infrastructure. Existing reimbursement rules for FQHCs under Medicaid and Medicare permit reimbursement for health IT investments with a direct clinical impact, and provide a vehicle for policy makers to guide such investments to support state and federal goals. Policymakers and FQHCs should leverage Medicaid and Medicare reimbursement to promote the types of health IT investments that will best prepare FQHCs for quality-based reimbursement and ultimately improve patient care.

INTRODUCTION

FQHCs provide primary care to approximately 15 million people per year, most of whom are poor, uninsured and/or living in medically underserved areas. Roughly 70 percent of FQHC patients have family incomes at or below the federal poverty level, 40 percent are uninsured, 36 percent have Medicaid, and nearly two-thirds are racial and ethnic minorities.¹ A significant and growing number of health center patients have chronic illnesses² and health center patients are, in general, more likely to have a chronic illness than patients of office-based physicians.³ In spite of this complex patient population, health centers have consistently demonstrated improved health care outcomes for their patients, and a high quality of care.

In many ways, FQHCs are well positioned to lead the way in improving health care delivery. Through participation in quality improvement efforts such as disease management collaboratives, FQHCs have been at the forefront of national efforts to improve primary care delivery.⁴ FQHCs also have a relatively consolidated reimbursement base, with the bulk of revenues coming from state and federal sources including Medicaid, federal block grants and Medicare.⁵

Finally, FQHCs have a history of reporting quality indicators through the use of electronic patient registries and reportable performance measures to their federal funders.⁶

Health IT is crucial to continued improvements in FQHC operations and in clinical care. Yet FQHCs face unique challenges in crossing the digital divide. Operating with limited reserves, limited access to capital, and constrained

¹ National Association of Community Health Centers, "The Safety Net on the Edge," (August 2005), <http://www.nachc.com/research/files/snreport2005.pdf>.

² National Association of Community Health Centers, "Access Denied," (March 2007).

³ National Association of Community Health Centers, "A Sketch of Community Health Centers Chartbook 2006," (2006), p. 15.

⁴ For more information about the role of community health centers in the Health Disparities Collaboratives see <http://www.healthdisparities.net/hdc/html/home.aspx>. See also J. Corrigan, A. Greiner, and S. Erickson, eds., *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, (Washington, National Academies Press, 2002), http://www.nap.edu/catalog.php?record_id=10565#toc.

⁵ National Association of Community Health Centers, "A Sketch of Community Health Centers: Chart Book 2006," (2006), <http://www.nachc.com/research/Files/Chart%20Book%202006.pdf>

⁶ For an overview of current FQHC federal reporting requirements, see Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, "UDS Reporting Instructions for Section 330 Grantees," (2006), <ftp://ftp.hrsa.gov/bphc/pdf/uds/2006udsmanualfinal.pdf>.

STRATEGIC FRAMEWORK FOR HEALTH IT ADOPTION IN FQHCs

revenue streams, these safety-net providers often lack the resources necessary to invest in health IT and fully participate in community health information exchange. A recent California study of community health centers found that only 5 percent of surveyed centers had fully adopted Electronic Health Records (EHRs) and 23 percent had begun planning to implement EHRs.⁷ These adoption rates are well below the 17-25 percent of physicians in ambulatory care settings who have adopted EHRs.⁸

In recent years, private foundations working together with FQHC leadership have invested over \$100 million in supporting health IT adoption in FQHCs.⁹ These efforts have resulted in improvements in basic infrastructure, capacity and readiness for health IT adoption in participating FQHCs, and have contributed significantly to education, awareness and policy development in the field. However, this work also has pointed to the need for a scalable revenue source to underwrite both the debt service on upfront capital and the ongoing operational costs of health IT adoption and use to help FQHCs prepare for quality-based reimbursement.

Notwithstanding the potential value of health IT, access to the capital necessary to make the required investments and ongoing reimbursement for the costs of health IT stands as an insurmountable barrier to health IT adoption and implementation. The problem is not with existing law. In fact, a close reading of federal law governing Medicaid and Medicare suggests that such costs may actually be required to be reimbursed. However, despite growing efforts at the state and federal level to encourage health IT adoption and use, and to transition Medicaid and Medicare toward quality-based reimbursement, policy makers have not encouraged FQHCs to leverage this funding, and FQHCs largely have not pursued it. These funding opportunities, coupled with strategic investment and adoption strategies, are key enablers for FQHCs to improve the health status of their vulnerable patients and to prepare for market shifts toward quality-based reimbursement.¹⁰

The primary purpose of health IT investment for FQHCs is to achieve four service delivery goals, all of which are integrally connected to the FQHC's mission of improving the health status and quality of care of vulnerable patients. The goals are the following:

- ◆ Deliver coordinated and more efficient preventive and primary care: Health IT can provide integrated clinical and administrative information at the point of care and inform treatment decisions to improve quality, avoid medical errors, reduce variability in care, reduce costs and improve use of resources.
- ◆ Manage patient populations with chronic diseases: Health IT facilitates aggregation and analysis of timely and detailed patient health information to improve outcomes, track patients longitudinally, ensure continuity of care, support patient compliance with recommended treatments, and inform treatment decisions.
- ◆ Improve community health status: Health IT facilitates a unified approach to collection and reporting of de-identified patient information to support population health improvement, including quality measurement, patient safety, research and clinical trials, public health reporting, and biosurveillance.
- ◆ Advance consumer role: Health IT can provide patients access to and control over their personal health information to empower patient decision making and support the delivery of care that is customizable to the patient.

FQHC operations may necessitate the use of many different types of applications, including practice management systems, EHRs, disease registries, and telehealth applications. Adoption of particular applications, and the sequence of adoption, is driven by factors both internal and external to the health centers. In order to best facilitate improvements in patient care, health centers need accessible data, internal infrastructure to support processes and operations, as well as the technical capacity for external connectivity to facilitate data collection, transport, normalization, and decision support processes. To prepare

⁷ George Washington University Medical Center, Massachusetts General Hospital, The Robert Wood Johnson Foundation, "Health Information Technology in the United States: The Information Base for Progress," (October 2005), <http://www.rwjf.org/files/publications/other/EHRReport0609.pdf>.

⁸ Id.

⁹ Over \$100 million has been spent in the past four years by four foundations alone: the California Health Care Foundation; the Colorado Health Foundation; the Community Clinics Initiative, a project of the Tides Foundation and the California Endowment; and the RCHN Community Health Foundation.

¹⁰ Quality-based reimbursement initiatives, also commonly referred to as provider pay-for-performance programs, are becoming more common, with approximately 107 programs currently in operation nationwide. Although these programs are most common in the commercial sector and (to a somewhat lesser extent) Medicare, they have also begun to emerge in Medicaid. See Center for Health Care Strategies, "Rewarding Performance in Medicaid Managed Care," (March 2006), http://www.chcs.org/usr_doc/MedicaidP4PBrief.pdf.

FQHCs for new quality-based reimbursement approaches and to improve the quality of patient care, FQHCs should adopt state-of-the-art health IT systems, including certified EHRs, which will enable sharing information with other providers who are making similar investments in their health IT systems.¹¹

Transforming FQHCs' health IT infrastructure will require a significant investment, including substantial changes in workflow, communication, and decision making. A continuum of health IT strategies is available to FQHCs seeking to implement such changes. Under an FQHC-based approach, an individual health center can invest in health IT systems with limited point-to-point external connections, e.g., clinic-based EHR to local laboratory interface ("Center-Based Investment Strategy"). This approach will allow an FQHC to automate its clinical and administrative processes, improve care and ready itself for participation in broader community-based health information exchange initiatives. By definition, however, a Center-Based Investment Strategy does not promote information sharing between and among multiple care delivery sites that may be treating a patient and therefore only goes so far in fostering improved, better-coordinated patient care.

A second investment strategy involves multiple FQHCs agreeing to share health IT services and applications, including but not limited to EHRs, through a hosted application service provider (ASP) (the "Network-Based Investment Strategy"). The Network-Based Investment Strategy spreads the investment risk among multiple participating health centers, generates cost savings through economies of scale, and most importantly, can contribute to patient care improvements by allowing for sharing of computable (as opposed to simply viewable) information between neighboring health centers and initiation of community-based population health programs.¹² Properly implemented, a Network-Based Investment Strategy provides a common, cost-effective and standardized platform for data integration with labs, pharmacies and hospitals.

The third and most advanced investment strategy that can be pursued by FQHCs involves pursuing a Network-Based Investment Strategy in combination with the development of a community-based health information exchange (HIE) platform, capable of accessing more complete and timely patient information at the point of care from a wide variety of health care stakeholders, including labs, pharmacies, hospitals, physician practices and payers (the "Community-Based Investment Strategy"). The Community-Based Investment Strategy is the most promising in terms of providing for

improvements in health status and the quality of patient care and producing real efficiencies in the ways in which health care services are delivered because it enables health information, regardless of where it is provided, to be organized and shared across health care delivery sites. This strategy, however, is also the hardest to achieve as it involves creation of multi-stakeholder entities—often referred to as Regional Health Information Organizations—that develop community-wide rules governing how health information will be shared and used.

The likelihood of achieving the full potential benefits from EHR adoption in the most efficient manner is increased as FQHCs move across this continuum toward a fully interoperable infrastructure that allows for the secure movement of health information. However, each point across the continuum represents incremental progress toward building the necessary IT infrastructure and capabilities to support improvements in health care delivery and patient care. For many FQHCs a fully interconnected health information exchange will not be available or possible. Therefore, FQHCs should seek to adopt strategies that are as far along the continuum as their circumstances, resources and capacity allow, and federal and state policymakers should ensure that Medicare and Medicaid reimbursement is leveraged to help FQHCs develop the infrastructure and capacity that will enable them to participate fully in the quality-centric reimbursement environment that is likely to emerge as information sharing across health care settings becomes more commonplace.

LEGAL AND REGULATORY BASIS FOR PROVIDING MEDICAID AND MEDICARE REIMBURSEMENT FOR HEALTH IT IN FQHCs

Medicaid and Medicare are important sources of reimbursement for FQHCs, accounting for 43 percent of all FQHC revenue nationwide (37 percent from Medicaid and 6 percent from Medicare).¹³ In recent years, both programs have begun to explore quality-based reimbursement as a way to contain costs and improve health care services and outcomes through limited demonstration projects. A major barrier to taking such initiatives to scale is the lack of technology preparedness by Medicaid-dependent providers, including FQHCs. Fortunately, current reimbursement rules for both programs offer opportunities to overcome this barrier. While existing reimbursement rules are different for Medicaid and Medicare, both programs permit reimbursement for a large array of

¹¹ The Certification Commission for Healthcare IT (CCHIT) is a not-for-profit corporation supported by the federal government charged with certifying health IT systems against a set of conformance criteria, including functionality, interoperability, security and reliability. The health IT systems, include: EHRs for the ambulatory and inpatient settings, the network components for health information exchange as well as personal health records in the future.

¹² R.H. Miller and C.E. West, "The Value of Electronic Health Records in Community Health Centers: Policy Implications," *Health Affairs*, 26, no. 1 (2007): 206-214.

¹³ National Association of Community Health Centers, "Fact Sheet on Health Centers and Medicaid," (August 2006) available at <http://www.nachc.com/research/Files/Medicaid%20Fact%20Sheet%2008.06.pdf>.

health IT investments. Such resources have largely gone untapped, however, both because of ambiguity and confusion related to Medicaid rules, and because of a federal cap on Medicare reimbursement affecting 75 percent of FQHCs.¹⁴ The reimbursement rules governing each program as they relate to FQHCs and health IT are discussed further below. Medicaid, the single largest revenue source for FQHCs, is a joint state and federal program. In recognition of FQHCs' unique role as providers for low-income, medically vulnerable and under-served populations, FQHCs are entitled to enhanced reimbursement rates under federal Medicaid rules. Under federal rules, states are given the option of adopting either a reimbursement methodology known as the prospective payment system ("PPS") or an alternative payment methodology that produces at least an equivalent result.¹⁵ Most state Medicaid programs reimburse FQHCs based on the PPS. Each FQHC's PPS rate is calculated based on the average costs of the clinic during fiscal years 1999 and 2000 "which are reasonable and related to" the costs of furnishing FQHC services.¹⁶ The rate is trended annually based on the percentage increase in the Medicare Economic Index.¹⁷ Federal law requires that the rate for any fiscal year after the base years be "adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year."¹⁸ Thus, the critical question is whether health IT investments are considered a change in scope of services.

Limited federal guidance has been given defining a change in scope of services, leaving it largely to the states to interpret. The result has been a patchwork of state policies, many lacking detail on the standards and procedures for pursuing a rate adjustment due to a change in scope of services. However, CMS has published a series of questions and answers relating to the PPS system, which provide some guidance: "A change in the 'scope of services' is defined as a change in the type, intensity, duration and/or amount of services."¹⁹ Among the states that have defined a change in the scope of services in state plan amendments, at least four – Arkansas, California, New Jersey and Texas – include a change in technologies as meeting the definition.²⁰ Because they are included in

state plan amendments, these definitions have been directly approved by the federal government.

When taken together, the limited guidance and statutory language indicate that in order to trigger a change in an FQHC's PPS rate, the health IT investments must have an impact on the clinical services or service delivery provided by the FQHC. Thus, Medicaid reimbursement rules not only provide a legal basis for reimbursing health IT investments in FQHCs, but also they appear to condition such reimbursement on the ability to demonstrate an impact on patient care and services.

Medicare reimbursement to FQHCs is based on an all-inclusive per visit rate that is calculated using FQHCs' reasonable costs.²¹ Federal regulations mandate that "[a]ll necessary and proper expenses . . . are recognized."²² "Necessary and proper costs" are defined as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." Health IT costs fall well within the scope of these rules. However, because FQHCs' Medicare payments are subject to a reimbursement rate cap impacting 75 percent of FQHCs nationally, these rules currently have limited practical application in supporting health IT in FQHCs.²³ New policy could be created, however, that would allow an exemption to the Medicare cap for health IT investments that impact patient care, as discussed below.

¹⁴ National Association of Community Health Centers, "Economic Impact of Health Care Regulation: The Impact of the Medicare Payment Cap on Federally Qualified Community Health Centers," (2006), http://www.nachc.com/advocacy/Files/CMS%20Public%20Comment%20Economic%20Impact%20FINAL2006_02_09.pdf.

¹⁵ 42 U.S.C. § 1396a(bb). Currently, approximately half of all states utilize an alternative payment methodology (APM), either in combination with the PPS or alone, see National Association of Community Health Centers, "Update on the Status of the Medicaid Prospective Payment System in the States," (September 2006), http://iweb.nachc.com/downloads/products/spr_9_06.pdf.

¹⁶ 42 U.S.C. § 1396a(bb)(2).

¹⁷ 42 U.S.C. § 1396a(bb)(3).

¹⁸ 42 U.S.C. § 1396a(bb)(2), (3)(B).

¹⁹ CMS Q&A, "Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics," question 20.

²⁰ Arkansas State Plan Amendment, Transmittal No. 2001-004 (approved June 25, 2001), p. 1bb; California State Plan Amendment, Transmittal No. 03-011 (approved March 8, 2004), p. 6-M; New Jersey State Plan Amendment No. 04-13-MA (approved November 19, 2004), p. 9(c)7; Texas State Plan Amendment, Transmittal No. 01-004 (approved 11/13/01), p. 24d.

²¹ 42 U.S.C. § 1395l(a)(3)(A).

²² 42 C.F.R. § 413.5(a).

²³ The Medicare cap for CY 2007 for urban FQHCs is \$115.33 and for rural FQHCs is \$99.17. See "Announcement of Medicare Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases," CMS Transmittal 1126 (December 8, 2006).

DISCUSSION

In order to prepare FQHCs to participate in a rapidly evolving landscape in which better access to information will enable continuous quality improvement, support for health IT adoption under existing revenue streams is critical. While a strong legal and policy basis exists for such reimbursement under Medicaid and Medicare, further action is needed by federal and state officials, and by FQHCs, to both encourage FQHCs to utilize such resources, and to develop criteria by which cost-based reimbursement is appropriate.

Federal officials should encourage state officials to ensure that state rules define health IT investments that impact the clinical delivery of care as a change in scope under federal law, thereby warranting an adjustment in Medicaid reimbursement. Further, while the merits of the existing cap on Medicare reimbursement for FQHCs continues to be the subject of considerable debate, it is clear that the application of this cap in the context of health IT is inconsistent with federal goals related to health IT adoption, movement toward value-based purchasing and interoperability through the creation of a nationwide health information network. Indeed, when the existing cap on reimbursement for FQHCs under Medicare was developed in 1992, EHRs were not in operation, and therefore their costs were not considered in developing the cap. Federal officials should issue guidance that, at the very least, creates an exemption to the Medicare cap for health IT investments by FQHCs, such as interoperable EHRs and costs related to participation in health information exchanges that support the federal agenda for health IT.

State Medicaid programs also have a key role to play and a significant stake in ensuring FQHCs invest strategically in health IT and are able to transition to quality-based reimbursement. Historically, little federal guidance has been given regarding how to apply reimbursement standards

under Medicaid, including how to define a “change in scope of services,” leaving it to states to determine both the process and standards for such determinations. However, a strong legal, policy and factual basis exists for interpreting health IT investments that directly impact the delivery of health care services as constituting a change in the scope of services warranting an adjustment in reimbursement.

States should take advantage of this opportunity to support health IT investment goals by acknowledging that health IT investments directly related to the provision and monitoring of clinical care constitute a change in scope of services under the law. In addition, such guidance should encourage FQHCs to make investments in certified, interoperable EHRs by creating a presumptive finding that such investments constitute a change in scope. States also should educate FQHCs about the benefits of implementing EHRs through a network model and should support FQHC efforts to participate in community health information exchanges.

Finally, FQHCs themselves should approach health IT as a tool to improve patient care and as a means for furthering their core mission and purpose. As such, FQHCs should work together with state officials to promote reimbursement for health IT investments that improve patient care and pave the way for quality-based reimbursement. In states that are engaged in quality improvement and affordability initiatives enabled by health IT, FQHCs should align their health IT strategies accordingly to support the case for affirmative rulings with respect to change in scope of services fueled by health IT. A coordinated health IT strategy that aligns public policy and marketplace actions, including those of FQHCs, is the best approach for ensuring the impact of health IT on service delivery, clinical value and quality-based reimbursement reform.

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