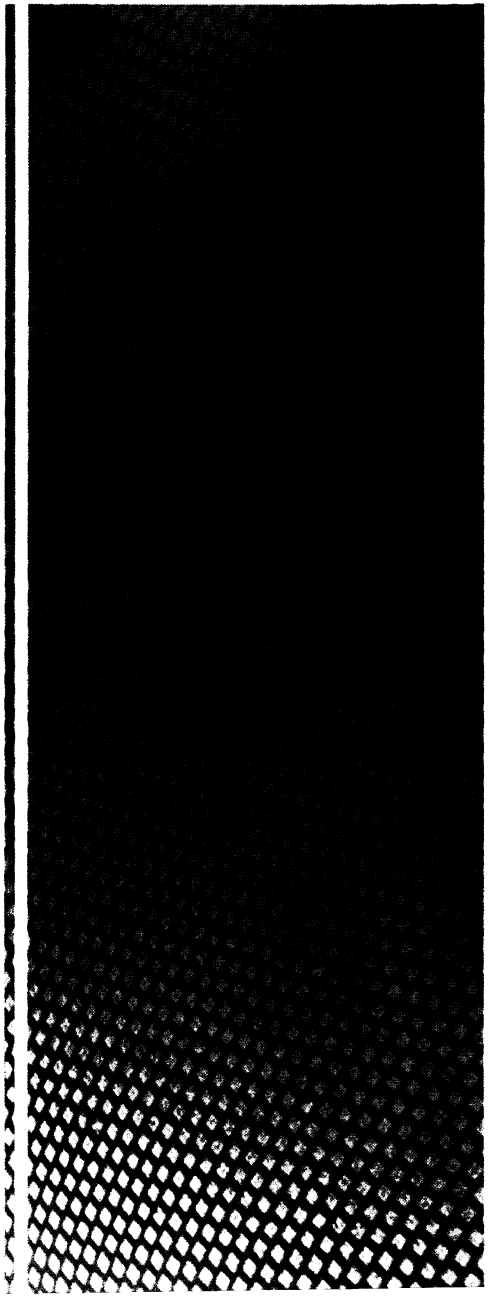
Montana's Community Health Centers



Montana Primary Care Association, Inc.

CHILDREN & FAMILIES INTERIM COMMITTEE
March 19-20, 2012
March 19, Exhibit 1

We are community-directed, nonprofit, patient-governed providers of comprehensive primary and preventive healthcare (medical, dental, behavioral) and support services;

To vulnerable and underserved populations in high need areas;

Regardless of the ability to pay;

Held accountable to rigorous standards of continuous clinical and financial quality improvement.

"What is a community health center?"

By the Numbers	
Total # of MT CHCs	15
# of MT CHC patients	100,000
% of these patients <200% Federal Poverty Level	89%
% of all MT CHC patients who are uninsured	50%
% of all MT Medicaid enrollees seen by CHCs	12%
% MT Medicaid expenditure to CHCs	1.2%
# of CHCs with a dental clinic	10
Total # of CHC dental patients	28,000
% total CHC visits that are dental visits	16%
% of CHC dental patients enrolled in MT Medicaid	20%
Ratio of MT CHC Medicaid patients to CHC dentists	207:1
Average # of dental visits per MT Medicaid CHC patient	2.35
% of MT Medicaid enrollees who did not have a dental visit in 2010	66%

A "by the numbers" overview of Montana's Community Health Centers

Third party and commercial health insurance plans.

Patient payments.

Medicare.

Medicaid.

Community health centers must provide healthcare services to anyone, regardless of their ability to pay.

"How are community health centers paid?"

Community Health Centers operate under PPS as a distinct prospective payment structure supporting care of vulnerable populations.

The PPS was established by Congress with the intent of ensuring appropriate payment for Medicaid-covered individuals so that health centers would not cross-subsidize Medicaid-related costs with federal grant funds.

"What Is the Prospective Payment System (PPS) and why do community health centers receive it?"

"What is PPS?"

PPS is a bundled payment that includes the cost of primary, oral, and behavioral healthcare, of care management, and of enabling services, and is paid on an encounter basis.

PPS is an improvement upon the traditional fee-for-service payment with rates that are set prospectively factoring in growth limits and uniquely set on each health center's costs and scope.

PPS is effectively risk-based. If a health center patient needs more care, it is furnished but at no additional cost.

PPS serves as a quality and accountability-based reimbursement insofar as community health centers must annually comply with stringent federal reporting and performance requirements as a condition of retaining federal grant funds.

"What is PPS?"

The general formula for establishing a PPS rate is to take the average of the total reasonable costs for 1999/2000 and divide by the average of the total visits for those years (*i.e.*, total costs / total visits = PPS rate).

A State Medicaid plan must pay for covered services provided by community health centers.

These covered services include "Federally-qualified health center services" and "any other ambulatory services offered by a federally qualified health center and which are otherwise included in the [State] plan."

"How is PPS calculated?"

Enabling services include child care, eligibility assistance, health education, interpretation and translation, outreach, transportation, and supportive counseling services.

Enabling services address the non-clinical, psychosocial issues that are critical barriers to health among health center populations.

Health centers are required to provide or to arrange for the provision of enabling services as a condition of their federal grant funds.

"What are *enabling services* and why are these included in the PPS rate?"

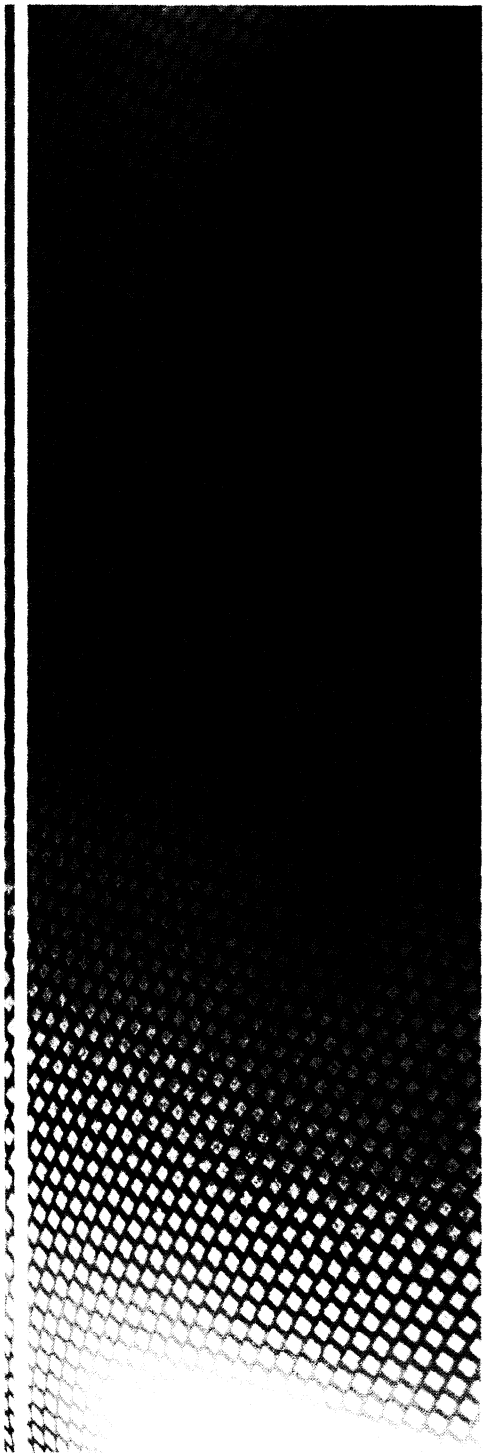
Community health centers compete for federal grant funds known as Section 330 grants.

These grant funds are used exclusively to offset the costs of uncompensated care by means of a sliding fee schedule of discounts.

Patients must prove that they are uninsured or underinsured and that their individual or family income is below 200% of the Federal Poverty Level to be eligible for the sliding fee schedule of discounts.

"What other sources of funding do community health centers have?"

Considerations for Payment Reform in Montana



Perverse incentives?

Currently, most providers are paid on a fee-for-service basis; receiving additional payments as more "care" is delivered, regardless of its value to the patient.

Conversely, insufficient payments to providers may inadvertently create perverse incentives for providers to stint on providing appropriate care or to limit access to needed care, especially to the most vulnerable patient populations.

Paying for the *Triple Aim*

New payment methodologies are needed to encourage providers of all types to focus on delivering high-quality, efficient care.

To accomplish this, payment levels must be carefully calibrated to ensure providers' financial viability while providing incentives to reduce costs, safeguards to ensure high quality, and inducements to increase access to vulnerable populations.

If appropriately designed, bundled payments could support the goals of health reform by encouraging providers to consider not only the services they deliver but the overall efficiency, effectiveness, and coordination of care patients receive across providers and settings.

This broader notion of health care delivery could lead to improved quality and the reduced cost growth necessary to enhance the long-term sustainability of Montana's health system.

From volume to value

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