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Strategies to Address Policy Barriers to Adult Immunizations in FQHCs

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America's Voice for Community Health Care

The NACHC Mission

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

Agenda

1. What makes FQHCs unique
2. Barriers to Adult Immunization at FQHCs
3. Policy barriers and strategies that are specific to FQHCs
   - Section 330 requirements
   - Federally-funded malpractice insurance (FTCA)
   - Medicaid
   - Medicare
   - Pharmacy
   - 340B
4. Discussion/ Request for input

What Makes FQHCs Unique

FQHCs:

- Target the neediest individuals
  - 49% Medicaid, 23% uninsured, 18% private but cannot meet deductibles and copays
- Offer a broad range of health care and enabling services
  - Medical, dental, preventive, behavioral and enabling care
- Turn no one away due to inability to pay
- Are community-based and governed
  - Have a patient-majority board

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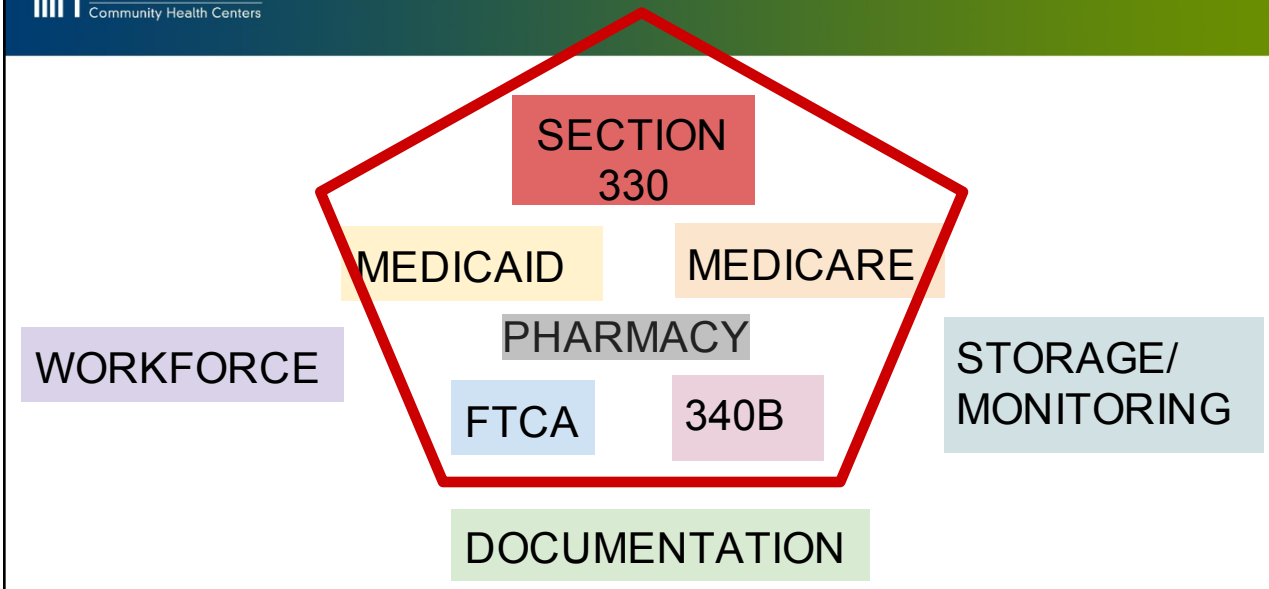
Barriers to Adult Immunizations in FQHCs



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Section 330 - Background

- Section 330 of the Public Health Service Act establishes requirements that apply to all FQHCs
- Section 330 requires all FQHCs to provide immunizations.
- While 80% of FQHCs are required to focus on the general commnity of medically underserved patients ("Community Health Centers")
  - 9% focus on migrant/seasonal farmworkers
  - 9% focus on individuals experiencing homelessness
- HRSA requires FQHCs to report annually on several vaccination measures, through a system called the Uniform Data System (UDS)

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Section 330 – Immunization Measures

Childhood Immunization Measure

	Total Patients with 2nd Birthday (a)	Estimated Number of Patients Immunized (b)	Estimated % patients immunized (c)
Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	384,056	154,557	40.24%

Immunization Measures that include Adults

	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal; diphtheria; tetanus; pertussis (DTaP) (DTP) (DT); mumps; measles; rubella (MMR); poliovirus; varicella; hepatitis B	CPT-4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	4,629,449	3,393,346
Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	4,413,155	4,041,961

Data is for all FQHC grantees, from calendar year 2017.

Section 330: Immunization Measures

- Unlike the childhood immunization, the UDS immunization measures that include adults:
  - Are not commonly-used measures. NCQA does not manage them, and neither Medicare nor Medicaid require them as standard measures.
  - Are not linked to ACIP standards.
  - Are raw numbers as opposed to a percentage of the eligible patient population.

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Section 330: Issues

- HRSA incentivizes performance on the childhood immunization measure, but not the immunization measures that include adults.
  - Performance on this measure is one of the factors used to determine supplemental grant funding, and quality awards.
- FQHCs likely underreport their actual immunization activity
  - Documentation does not "roll up" into aggregate data
  - Immunizations provided to "non-patients" may not be counted

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Section 330 Strategies

1. Encourage HRSA to add a composite measure of adult immunization to the UDS requirements.
2. Encourage HRSA to consider performance on the this adult immunization measure when determining which FQHCs receive supplemental grant funding & quality awards.
3. Encourage outside groups to incentivize FQHCs to focus on adult immunizations by offering funding linked to increases in these rates.
4. Target outreach and supports to FQHCs that focus on specific at-risk populations – e.g., homeless, migrant and seasonal farmworkers.

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FTCA (Federally-Funded Malpractice Insurance)

Background:

- Section 330 grantees receive free medical malpractice insurance through the Federal Torts Claims Act (FTCA.)
- FTCA malpractice coverage applies to community-focused immunization campaigns.
- FTCA malpractice coverage is available for clinicians who volunteer at FQHCs.

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FTCA: Strategies

- Educate FQHCs that FTCA coverage applies to community immunization events, such as flu shot fairs.
  - Is confusion about this, because persons who receive vaccines at community events do not count as "patients."
- Encourage FQHCs to recruit volunteer clinicians to assist with immunization efforts, highlighting the availability of free malpractice coverage.

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Medicaid

- Almost 50% of FQHC patients are covered by Medicaid.
- The most common barrier we heard to increasing adult immunization rates among FQHC patients was the "lack of Medicaid reimbursement."

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Medicaid: Overview

- Technically, Medicaid does pay FQHCs for vaccinations; however, it's done in such an indirect manner that practitioners often do not realize that this payment exists.
- Many suggestions re: how to adjust Medicaid to increase adult immunization rates would be highly complex and difficult to implement, due to either:
  - legal restrictions or
  - because they would entail significant administrative work for the State Medicaid agency, with impacts far beyond adult immunization.

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How Medicaid Pays FQHCs

- Federal law requires that FQHCs and RHCs be paid under a Prospective Payment System (PPS).
- Under the PPS, ***FQHCs and RHCS are paid a flat rate for each "billable visit", regardless of the number or type of services provided during each visit.***

Total Allowable Costs

---------- = PPS Rate (aka average cost per billable visit)

Total "Billable Visits"

The intention behind PPS is to ensure that FQHCs are reimbursed for their reasonable costs to care for Medicaid patients, in order to preserve their Section 330 grant funds to care for the uninsured and underinsured.

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Does Medicaid Pay FQHCs for Immunizations?

- **Practical (FQHC CFO) answer:** Generally not.
  - FQHC gets paid the same amount per visit – their PPS rate -- regardless of whether they provide immunizations.
  - Immunization-only visits with nurses or pharmacists generally don't result in a PPS per-visit payment.
- **Technical (CMS/ Medicaid answer):** Yes.
  - Per Federal law, immunization costs are factored into the calculation of each FQHC's PPS rate.
  - So FQHCs get paid a little bit towards their immunization costs in every PPS payment.

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Immunization Costs are Factored into Medicaid PPS rates

- Federal law requires that immunization costs be included in PPS calculations.
- Medicaid says "FQHCs get paid a little bit towards their immunization costs in every PPS payment."
- FQHCs may think "I don't get paid for giving vaccines."

A Simplistic Example

In its "base year", a FQHC has:

- total costs -- *excluding adult immunization* -- of $1,000
- 10 "billable" visits.

So its PPS (without adult immunization) is $100 per visit ($1000/ 10)

Now assume that in the same year:

- the FQHC's immunization costs were $50,
- bringing total costs to $1,050, across the same 10 billable visits.

Now the PPS rate is $105. ($1050/10)

In other words, ***the FQHC gets an additional $5 for every visit to help cover its overall costs to provide adult immunization - regardless of whether any adult immunizations were provided during a specific visit.***

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Will getting PPS for Immunization-Only Visits Help?

- **Practical (FQHC) answer:** Possibly.
  - If FQHCs felt that they got paid directly for immunization-only visits, they might do more of them.
- **Technical (CMS/ Medicaid answer):** It's a zero-sum game -- and would create a massive amount of work for state Medicaid agencies.
  - If you want more types of billable visits, you need to change the PPS rate – and in the end, total reimbursement wouldn't change.
  - Changing PPS rates opens a Pandora's box.

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Allowing More Billable Visits Is a Zero-Sum Game

- Federal law establishes six types of "billable visits" (face-to-face meetings with MDs, PAs, NPs, etc.)
- States can add more types of billable visits – e.g., nurse-only or pharmacist-only visits.
- But as the number of visits goes up, the per-visit PPS rate goes down.

A Simplistic Example

Consider the same FQHC, which has total costs (including immunization) of $1,050.

If it defines "billable visits" as just the 6 types in statute, it has:
- 10 billable visits
- A PPS rate of $105

If the state counts nurse-only visits as "billable" visits, then the FQHC has:
- 12 billable visits
- A PPS rate of $87.50

But under both scenarios, total reimbursement to the FQHC is the same.
- *$105 x 10 billable visits = $1050*
- *$87.50 x 12 billable visits = $1050*

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How the PPS is like pizza

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What about an Alternative Payment Methodology?

- Federal law allows State Medicaid agencies to create an "Alternative Payment Methodology" (APM) to reimburse FQHCs, in place of the PPS.
- A state could use an APM to remove immunizations from the PPS system.
- But creating an APM is a massive amount of work, and is subject to statutory requirements that:
  - Total reimbursement cannot be less than under PPS.
  - Each FQHC must agree to it.

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One Last Note on Medicaid

- There are no regulations re: Medicaid FQHC PPS.
- Compliance and enforcement are inconsistent.

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Medicare

- Like Medicaid, Medicare:
  - Reimburses FQHCs using a per-visit rate called a PPS.
  - Defines a "billable visit" as a face-to-face interaction with at least one of the six "core" provider types (physicians, PAs, NPs, CNMs, clinical psychologists, and clinical social workers)
- Differently from Medicaid, Medicare:
  - Includes visits with diabetes self-management training (DSMT) and medical nutrition therapy (MNT) providers as "billable visits."
  - Does not include flu and pneumococcal vaccines in the calculation of PPS rates. *(All other vaccines costs are included in PPS.)*

Medicare: Flu & Pneumococcal Vaccines

- Because these vaccines are not reimbursed via PPS, there is no perceived disincentive for immunization-only visits for them.
- FQHCs are reimbursed via a Cost Reporting process.
  - PRO: They receive their full costs, which are greater than fee schedule payment rates.
  - CON: Significant delay between administration of the immunization and receipt of reimbursement

Medicare: Strategies

- FQHCs can leverage Medicare visits for Diabetes Self-Management Therapy (DSMT) and Medical Nutrition Therapy (MNT) to address vaccination.
- FQHCs can maximize nurse-only visits for influenza and pneumococcal vaccines
- CMS could permit FQHCs to bill Medicare Part B for these vaccines at time of service – provided that these payments are reconciled to costs during the Cost Reporting process.

Pharmacy

Background:

- A growing percentage of FQHCs have "in-house" pharmacies, and many of these serve non-FQHC patients
- A growing number of FQHCs are implementing clinical pharmacy programs

Strategy:

- FQHCs could expand the role of in-house pharmacists in recommending and administering adult vaccines.

Section 340B Drug Discount Program

Background:

While the 340B program does not include vaccines, FQHCs can access significant discounts on vaccine purchases through the 340B "Prime Vendor"

Strategy:

Many FQHCs could reduce their costs to purchase vaccines by obtaining them through 340B Prime Vendor program (called Apexus.)

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Discussion & Request for Input

What FQHC-specific policy barrier or strategy was not addressed fully or is missing from the content?

What steps or actions would you recommend be taken from this point?