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SUPPORTING MICHIGAN HEALTH CENTERS

Medicaid Alternative Payment Methodology for Federally Qualified Health Centers

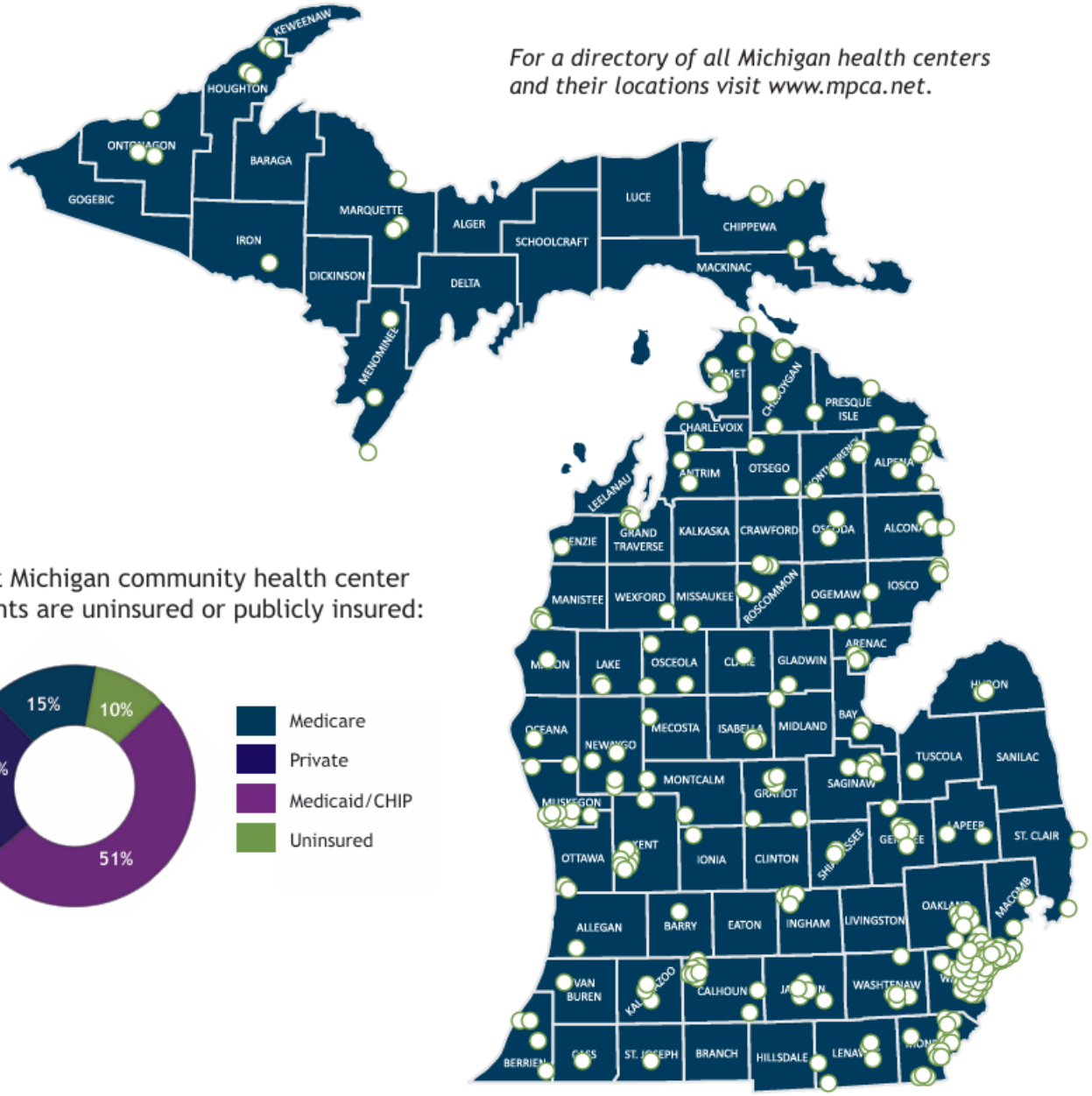
House Appropriations Subcommittee on Medicaid and Behavioral Health

June 24, 2025

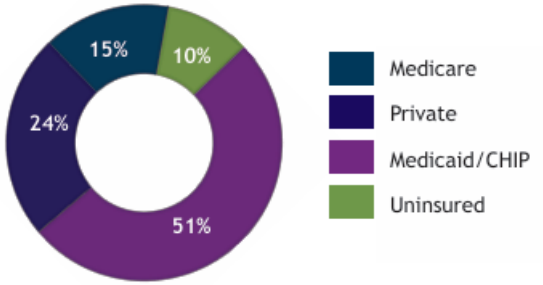
Michigan's Health Centers

- MPCA's 48 member health centers including Federally Qualified Health Centers, Tribal Health Centers, an Urban Indian Health Program, and other community-based healthcare organizations who provide healthcare through over 420 locations across the state and serve over one in 15 Michigan residents

For a directory of all Michigan health centers and their locations visit www.mpca.net.



Most Michigan community health center patients are uninsured or publicly insured:



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Health Centers Deliver Access to Care Cost-Effectively in the Medicaid Program

HEALTHY PEOPLE SPELL A HEALTHY ECONOMY

Michigan health centers don't just put people back to work, they also CREATE JOBS and generate cost savings.

6,485

Michigan health centers employ 6,485 people of all skill and education levels.

$612

Michigan Health Centers **save Michigan's Medicaid program** $612 per beneficiary per year.

$171 million

Estimated savings Michigan Health Centers generate annually to Michigan's Medicaid program.

$2.5 million

In 2024, staff at Michigan Health Centers provided more than **2.5 million patient visits**, both in clinic and virtual.

$51

Services provided by Michigan Health Centers to adult Medicaid beneficiaries cost **$51 per member per month less** than those provided by other providers.

History of the Current Medicaid Reimbursement Approach for Health Centers

- The Benefits Improvement and Protection Act of 2000 created the Prospective Payment System (PPS) for Medicaid FQHC reimbursement (prior to the PPS, FQHCs were paid based on their actual costs of delivering healthcare services)
- Per-visit payments generally cover most qualified services provided during a visit (a fixed, predetermined "bundled" rate), unlike a visit in a private physician's office in which each service is billed individually
- Per-visit payments are made when a patient is served by a healthcare provider exercising independent judgment such as a physician or nurse practitioner, dentist or dental hygienist, and psychiatrist or clinical social worker
- In Michigan's Medicaid program, for Medicaid beneficiaries enrolled in a Medicaid health plan, a health center is paid a portion of their per-visit payment by a health plan and a portion through a reconciliation process conducted by MDHHS

A Longstanding Reimbursement Approach with Positives and Challenges

- While there are a variety of rate sufficiency and other challenges associated with the current PPS, the APM is focused on achieving structural improvements in how health centers are reimbursed (vs. the amount they are reimbursed)
- The structure of PPS hasn't easily adapted to team-based care or other evolutions in healthcare practice because it limits reimbursement to services rendered by more traditional types of healthcare providers
- In team-based care models, a variety of types of care team members play a role in a patient's care depending on the patient's health needs and goals, and services that can improve health outcomes don't always fit the mold of the current PPS
- In addition, current PPS reconciliation and related reimbursement processes are complex, time-intensive, and costly for all parties involved- an APM can improve upon some of the administrative burden present in the current PPS

Legislative Authorization for Michigan's APM

- In the FY 24 budget, the Michigan Legislature authorized the design and implementation of a population-based APM for FQHCs and provided $6 million in one-time resources to support initial implementation

  - Sec. 1963. (1) … The alternative payment methodology must be a population-based payment system that is based on a per-patient reimbursement for each Medicaid recipient assigned to each federally qualified health center. Funds appropriated in this section shall be used both to support alternative payment methodology implementation costs incurred by the department and to provide funding to support the preparation and success of FQHCs participating in the alternative payment methodology.

Goals for the Alternative Payment Methodology

- Develop a reimbursement structure for team-based care delivery that embraces population health
- Maintain or improve measurable quality and patient satisfaction indicators
- Improve provider/care team satisfaction & retention
- Reduce the administrative burden associated with reimbursement processes for health centers and MDHHS
- Stabilize and create greater predictability in reimbursement resources

Basic Design on the APM

Patient Visit 1 $150	Patient Visit 2 $150
Patient Visit 3 $150	Patient Visit 4 $150

The APM will delink payment from the traditional per-visit payment model and convert existing PPS rates to a more flexible per patient per month reimbursement. The approach will allow health centers greater flexibility (with guardrails) in maximizing their care teams and pursuing different models of care to meet patients' needs.

Monthly Payment 1 $50	Monthly Payment 1 $50
Monthly Payment 1 $50	Monthly Payment 1 $50
Monthly Payment 1 $50	Monthly Payment 1 $50
Monthly Payment 1 $50	Monthly Payment 1 $50
Monthly Payment 1 $50	Monthly Payment 1 $50
Monthly Payment 1 $50	Monthly Payment 1 $50

Timeline and Implementation Approach

- MPCA and MDHHS began working collaboratively on Michigan's APM design following legislative authorization to prepare for implementation in 2026
- The APM is moving forward in a phased approach to ensure health centers are fully prepared to participate successfully and systems supporting the APM are well constructed
- Approximately 5 health centers will implement the APM in 2026, and approximately another 5 will in 2027
- $2 million of the previously appropriated one-time resources are supporting implementation costs within MDHHS; $4 million will support transition and implementation needs among the first approximately 10 participating health centers, along with a set of learning and support resources

FY 26 Appropriations Request

- MPCA recommends $18 million in additional one-time funding to support more health centers in making the transition to the APM over the course of several years, with the overall goal of supporting 75% of Michigan health centers adopting the APM
- Like the first one-time investment, this funding will support upfront, specialized training for care team members, redesigning patient care workflows to provide better access and coordination, setting up new policies/processes that each center will need, updating patient care technologies including electronic health records and population health management systems, and ensuring state infrastructure, processes, and technology needed for the APM are in place and functioning well
- Appropriations Requests for Legislatively Directed Spending Item (Rep. Longjohn)

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Exploring APM Options and Learning from Other Implementations

- APM approaches have been explored in Michigan for almost 10 years and have been implemented in several other states, with more states pursuing similar ideas today

1. **Full FQHC PPS via Managed Care:** As previously discussed, some states are using APMs specifically in the managed care context, to obtain CMS approval to require MCOs to pay the full PPS rate.

2. **Rebased Per-Visit Bundled Payment:** Some states have used APMs to "rebase" the FQHC per-visit rate—i.e., update the rate so that it is based on a more recent year's average costs per visit. Because federal law requires the PPS rate to be based on FY1999-FY2000 costs, this type of update is considered an alternative methodology. Rebasing the rate through an APM can help ensure that the per-visit rate bears a reasonable relation to health center costs. Because the MEI is an austere inflationary measure and because many states have not maintained effective scope change rate adjustment policies for FQHCs, annual increases in the PPS rates in some states have not kept pace with FQHCs' cost experience.

3. **Reasonable Cost Per-Visit Bundled Payment:** The third commonly used type of APM represents a continuation of the retrospective cost-based payment methodology that was used in Medicaid before the PPS was implemented in 2001. Some states (five, as of 2015) use an APM to carry out retrospective cost-based payment in lieu of the PPS.[13] Under this methodology, FQHCs prepare an annual Medicaid cost report. FQHCs receive an interim per-visit payment based on average costs per visit in a prior year, and payments for each year are subject to reconciliation following the settlement of the cost report.

4. **Per Member Per Month Bundled Payment:** Under a fourth common type of APM, gaining in popularity in recent years, states are seeking CMS permission to delink payment from the face-to-face visit, converting the existing FQHC PPS/APM to a capitated per member per month (PMPM) payment. Oregon[14] and Washington[15] have implemented such models, meaning that participating FQHCs in those states receive fixed monthly payments for attributed patients based on historical patient utilization. Health centers receiving payment under this methodology report that it allows for a more transformative use of the medical home, enabling them to maximize use of the care team and further meet the needs of their patients.

5. **Bundled Payment with Quality Indicators:** While the majority are still under development, the fifth common type of FQHC APM provides incentives for meeting identified quality indicators while still ensuring total payments are not less than what health centers would have received under their FQHC PPS. APMs in Colorado[16] and Washington[17] represent two such models in which a portion of the payment is conditioned on the FQ HC's performance on quality indicators. Washington's model is a capitated methodology that incorporates quality indicators, while Colorado's is a per-visit rate. Further work is needed to determine how best to incentivize addressing social risk as well as how to reward it.