New Mexico's Federally Qualified Health Centers

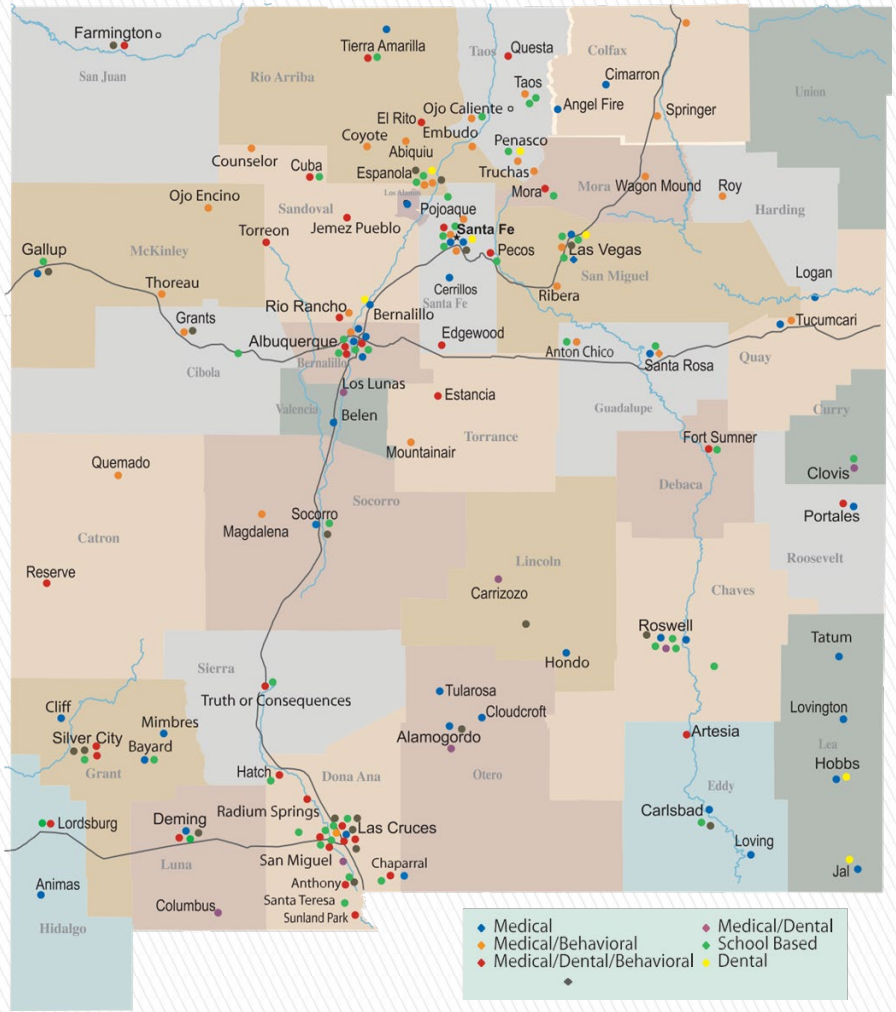
Prepared for the Legislative Health & Human Services Committee

By Yvette Ramirez Ammerman, CEO
New Mexico Primary Care Association July 3, 2024

New Mexico PRIMARY CARE ASSOCIATION

FQHC/LAs in NM

- 16 Private Non-Profit FQHC organizations
- 4 Private Non-Profit FQHC Look-Alike organizations
- Over 200 locations
- Serving 32 of 33 Counties
- Cared for over 331,000 New Mexicans in 2023



80 % of the Clinic sites are in Rural or Frontier Areas

- Number of Sites Delivering
- Medical Services 112
- Dental Services 61
- Behavioral Health Services 101
- School-based Health Clinics 80

Note: Over 200 Physical Locations – Many Dental & Beh. Health services are co-located with Medical

New Mexico PRIMARY CARE ASSOCIATION

FQHC/LAs in NM

- Unique within Healthcare Delivery system
  - Physical, Mental, Dental Health (often co-located)
  - Pharmaceutical Services
  - Screenings
  - Immunizations
  - Well Child Services
  - Case Management
  - Health Education
  - Eligibility Assistance (Medicaid enrollment)
  - Outreach
  - Transportation
  - Translation

What's Behind the Name

- Federally Qualified Health Centers go by many names:
  - FQHCs/ LAs
  - FQs
  - Community Health Centers
  - Primary Care Clinics
  - Community Primary Care Clinics
  - Primary Care

Becoming an FQHC/LA

FQHC/LA is a federal designation that requires an application process with ongoing reporting and monitoring

An organization must:

Be located in, or serve a high need community

Be governed by a community board that is at least 51% health center patients

Provide comprehensive care on a sliding fee scale based on ability to pay

Have a quality assurance program that promotes ongoing quality improvements

In 2023 FQHCs/ LAs Served Almost 1 in 6 New Mexicans

- 66,200 Uninsured
- 142,330 Medicaid Patients
- 56,500 Medicare Patients
  (14,000 are dually eligible)
- 76, 900 Private Insurance

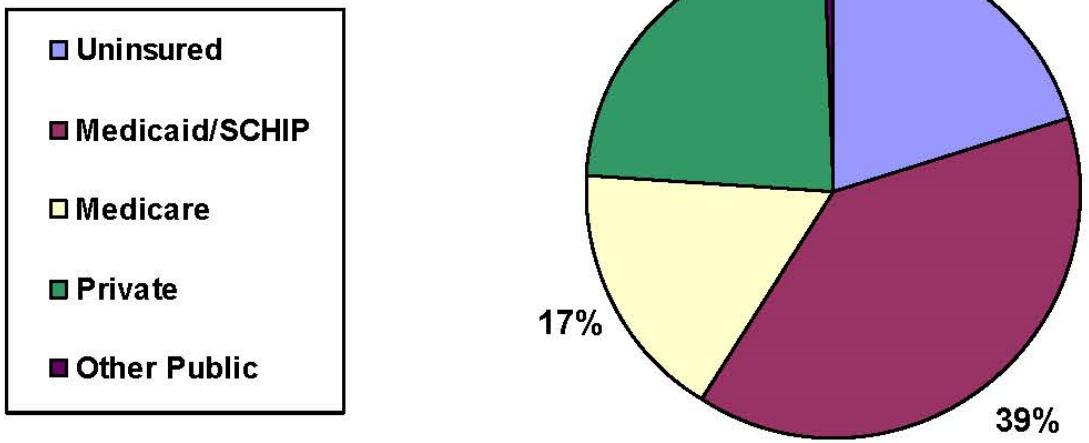
In 2023 Primary Care Clinics Provided 1.55 million Visits

•	20,000 migrant/seasonal farmworkers	• Dental Visits	218,046
•	17,000 homeless patients	• Mental Health &	
•	19,000 school-based patients	Substance Abuse Visits	400,163
•	6,500 veteran patients	• Health Ed./Case Mgmt.	101,897
•	2,367 prenatal care patients	• Vision & Other Visits	14,112
Total Visits			1,549,706

Patients by Insurance Status

Data Year: 2023

Patients: 331,000



Capacity and Workforce – 4,000 FTEs

Physicians	119
Nurse Practitioners	176
Physicians Assistants	36
Certified Nurse Midwives	6
Dentists/Hygienists/Therapists	317
Mental Health/Substance Use	462
Nurses	136

Capacity and Workforce – 4,000 FTEs

Other Medical	850
Pharmacy Personnel	100
Enabling Service Staff	328
Program Staff	69
Quality Improvement	39
Patient Support Personnel	607
All other Support Staff	766

FQHCs/ LAs Serve New Mexico's Most Vulnerable

2023 Patient Poverty Status

- 63% Below 100 % Federal Poverty
  ($31,200 for family of 4)
- 81% Below 150 % Federal Poverty
  ($46,800 for family of 4)
- 90% Below 200 % Federal Poverty
  ($62,400 for family of 4)

Primary Care Clinics Serve almost 60% of all New Mexicans living below 100% of the FPL

The Pandemic provided opportunities and challenges for FQHCs

- With Federal Assistance and DOH support and coordination, FQHCs provided testing and treatment to over 200,000 New Mexicans.
- Clinics continue to provide hundreds of thousands of free self tests and care to patients
- This has been particularly critical in rural areas, where patients, non-patients, local governments, and school district personnel have received screening close to home.

Federal And State Assistance has been Key in Insuring FQHC Stability

Federal Funding helped FQHCs:

- Offset revenue losses from early pandemic declines in productivity.
- Develop facility infrastructure to promote social distancing.
- Provide supplies and Personal Protective Equipment (PPE) to protect staff and patients.
- Upgrade technology and training which helped FQHCs deliver over 1.65 million virtual visits since the start of the pandemic.

Federal And State Assistance has been Key in Insuring FQHC Stability

Additional Federal Funding also helped FQHCs:

- Support significant non-revenue producing activities including testing, outreach, and patient contacts.
- **Maintain** critical medical, dental, and behavioral health clinician and support staff, despite inflationary pressure caused by workforce shortages.

Federal Reporting and Monitoring

- FQHC/LAs collect data and submit annually (UDS report)
  - Patient Demographics
  - Staffing and Utilization
  - Services Rendered
  - Quality Care Indicators (immunizations, screening for: weight, tobacco use, heart disease, breast and cervical cancer, colorectal cancer, HIV, depression)
  - Health Outcomes and Disparities (birth weights, controlled high blood pressure and diabetes)
  - Financials- costs, revenue

Federal Reporting and Monitoring

- Operational Site Visit (once per funding period- every 3 years)
  - Needs assessment- to ensure appropriateness of services and availability / access (hours of operation, scheduling)
  - Provide all required primary, preventive, and enabling services and other services as appropriate
  - Patients are provided interpretation, translation services
  - Referral system for specialty care
  - Staff are appropriately licensed, credentialed, and privileged

Federal Reporting and Monitoring

- Operational Site Visit (once per funding period- 3 year)
  - Provisions for patient medical emergencies/ after hours care
  - Maintain relationship with one or more hospitals with admitting privileges and procedures to ensure follow-up care
  - Sliding fee discount (patients under 100% offered full discount or nominal fee)
  - Quality Improvement/ Assurance program

Federal Reporting and Monitoring

- Operational Site Visit (once per funding period- 3 year)
  - Review Key Management
  - Review of Contracts and Subawards Management
  - Conflict of Interest policies
  - Collaborative Relationship (hospitals, other health centers, private providers, community stakeholders)
  - Financial Management and Accounting Systems (including annual audit)
  - Billing and Collections- review of policies and practice

Federal Reporting and Monitoring

- Operational Site Visit (once per funding period- 3 year)
  - Budget- projected costs supported by Federal award and other non-federal revenue
  - Program Monitoring and Data Reporting
  - Board Authority and Composition
  - FTCA Deeming (annual application)

FQHC/ LAs Income by Source

Income Data			Collections Data	
Total Income	$455,827,940		Total Collections	$269,752,561
% Income from Patient Service:	59.2%		% Medicaid:	48.7%
% Income from BPHC:	22.2%		% Medicare:	23.7%
% Income from other sources:	18.6%		% Other Public:	1.1%
			% Private Insurance:	21.5%
			% Self Pay:	5.0%
			% Retroactive Payments:	2.2%

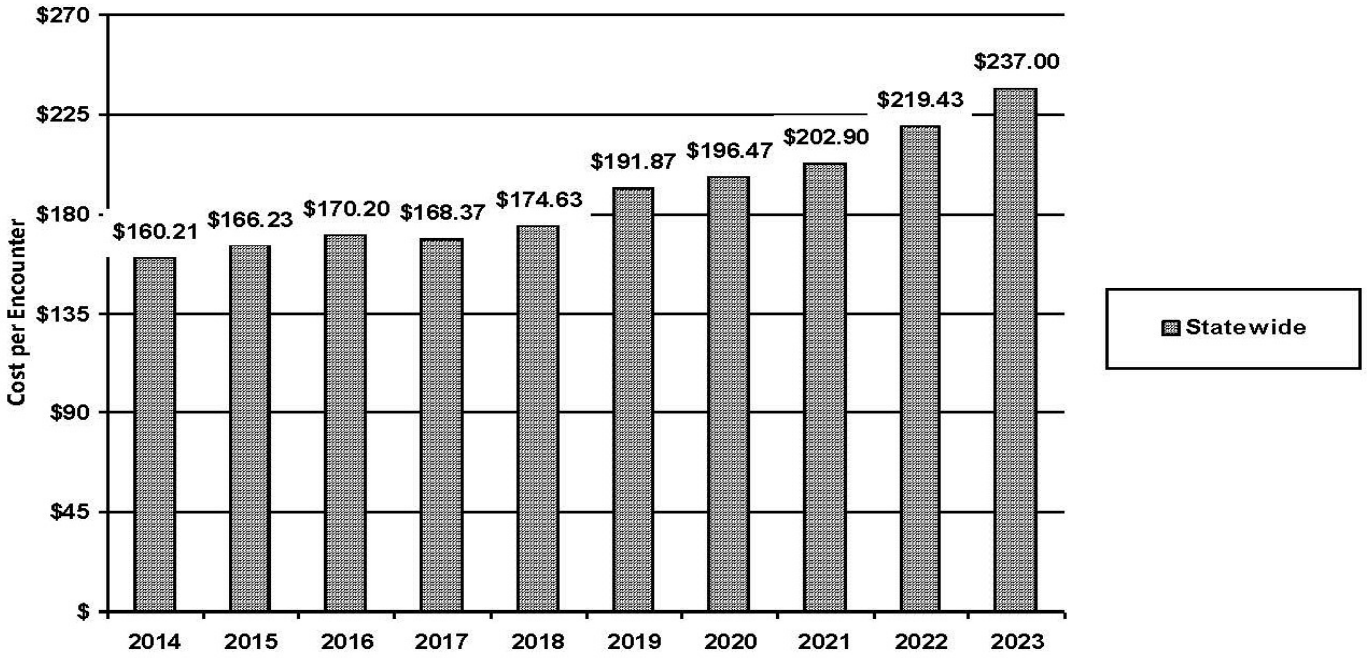
Challenge: Wage and General Inflation

- The cost of nearly everything has gone up since the onset of the Pandemic. There have been dramatic increases in supply costs and wages. FQHCs/ LAs expend **70%** on wages and benefits. Using 2023 data, a 5% wage increase would require an additional $16 million.
- All healthcare providers (including FQHCs) face the daunting and potentially de-stabilizing challenge of absorbing both labor and supply cost increases, if revenues do not increase proportionally.

Increasing Costs

Cost Per Encounter - Medical

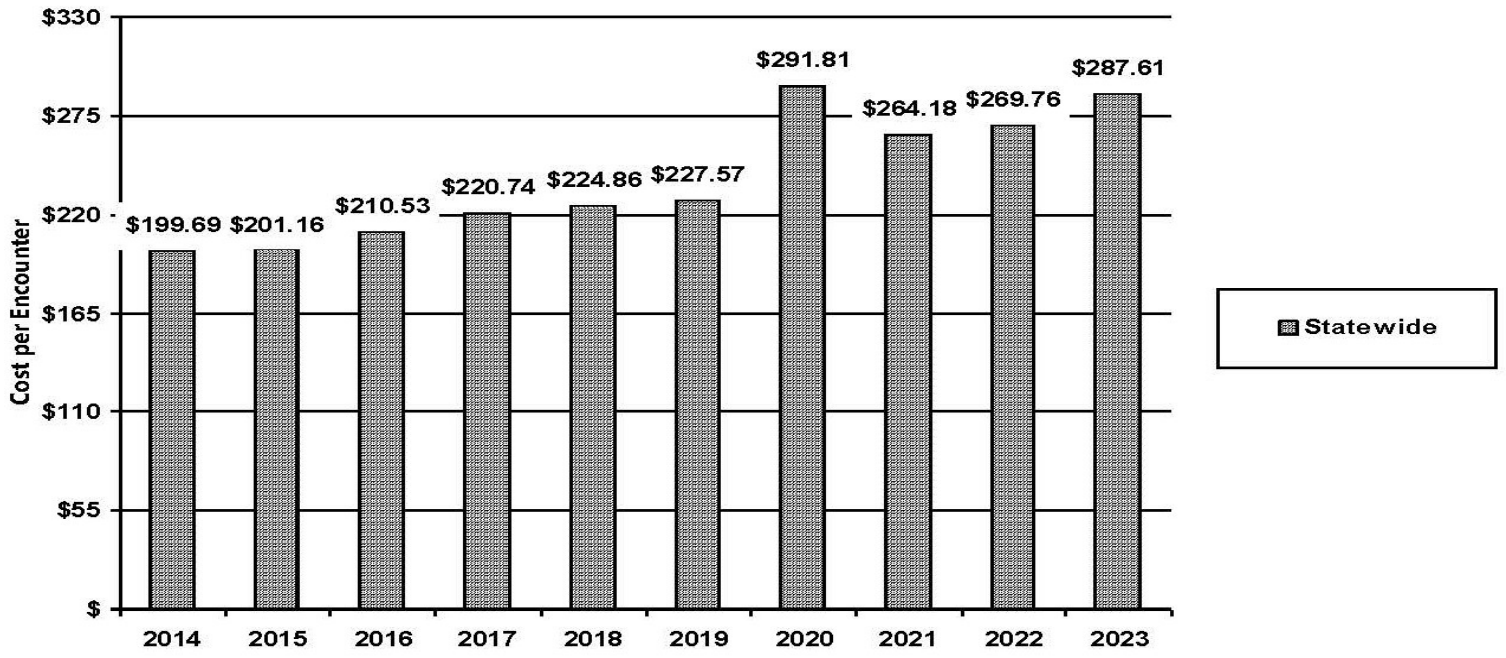
State (All States) - 10 year trend (2014 - 2023)



Increasing Costs

Cost Per Encounter - Dental

State (NM) - 10 year trend (2014 - 2023)



Decline in Health Center Financial Stability:

Members noted a decline in health center financial stability, resulting from multiple factors:

Revenue stagnation/loss: participants noted multiple revenue issues, including flat health center grant funding, an end of COVID-19 related supplemental funding support, and declines in their Medicaid patient population.

The **unwinding** of the COVID-19 pandemic's emergency Medicaid eligibility has led to the loss of Medicaid coverage for many health center patients. While some former Medicaid patients have secured private coverage on the health insurance exchange, many more have become uninsured, reducing health center revenues.

The private insurance policies secured by some patients formerly covered by Medicaid typically pay less than Medicaid, adding to health center revenue declines. Additionally, health care provider shortages reduce health center ability to generate revenue through service to paying patients.

Increase in medical care costs: The financial instability caused by revenue declines is compounded by significant increase in medical care costs. These cost increases have, in part, from widespread inflationary pressures in the economy.

Increased Workforce Problems

Workforce supply shortage: Increased workforce shortages due to retirements and inadequate training pipelines. Shortage issues cover all categories of staff including clinical practitioners, nursing staff and support staff.

Declining worker interest in health centers: The lack of newly-graduated healthcare worker interest in working in rural or underserved. The lack of interest is due to perceived inadequacies of available housing, education options and/or activities for family members. These same factors have a similar negative impact on long-term health professional retention.

Changing worker expectations and values: Significant changes in workforce expectations and values. Changes include a strong and growing preference for remote work/telehealth positions, flexible hours, and higher compensation. There is also less worker importance attributed to *mission* and *meaningful work*.

These factors can increase conflict between patient needs and health center staff work requirements. Participants noted that health center competitors are better resourced and are more able to attract professionals and support staff while catering to patient interests.

New graduate requirements: participants noted that newly-graduating health professionals require greater mentoring and increased support during the early years of their employment. These requirements place strains on an already stretched health center staff.

Challenge: Health sector technology and cybersecurity issues

- Problems with high-speed internet accessibility and reliability, particularly in rural areas
- Increasing cost of maintaining secure health center billing and information systems and the uncertainty surrounding how Artificial Intelligence will be incorporated into health center operations.

Challenge: Changes in patient expectations

- Patients have increasing questions related to traditional health care. Disinformation related to health care – for example, related to the value/risks of immunization – is readily available and some patients have increasing distrust of health care. This distrust can lead to a lack of patient treatment compliance as well as outright conflict with health center staff. NMPCA members have noted that a result of distrust is increasing patient reliance on alternative health care services.