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Finance: A Guide to Safety Net Provider Reimbursement

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Table of Contents

- Safety Net Provider Reimbursement: Current and Future** _____ 2
 - FQHC Reimbursement – Current Requirements and Methodologies _____ 2
 - Medicare _____ 2
 - Medicaid _____ 3
 - Private Insurance _____ 4
 - Self-Pay/Uninsured _____ 4
- Specialty Physician Reimbursement – Current Requirements and Methodologies _____ 5
 - Medicare _____ 5
 - Medicaid _____ 6
 - Uninsured/Self-Pay _____ 6
- Hospital Reimbursement – Current Requirements and Methodologies _____ 7
 - Inpatient Reimbursement _____ 7
 - Outpatient Reimbursement _____ 8
 - Supplemental payments _____ 8
 - Hospital Reimbursement: Outlook _____ 8
- Long Term Services and Supports (LTSS) – Current Requirements and Methodologies _____ 9
 - Skilled Nursing Facilities _____ 9
 - Waiver Providers _____ 10
- Payment Principles: Moving Toward an Integrated Model of Healthcare Delivery _____ 10
 - FQHCs _____ 13
 - Specialty Care _____ 15
 - Hospitals _____ 15
- Long term services and supports _____ 16
- Integrated Care Models _____ 17
- Conclusion _____ 18

Safety Net Provider Reimbursement: Current and Future

The prevailing healthcare fee-for-service reimbursement system in the United States does not provide sufficient incentives for providers to improve quality and contain costs. Instead, it tends to reward them for providing a high volume of patient visits, which adds to costs. The system is also deficient because it promotes siloed care—with each provider acting independently—rather than rewarding a team-based approach, where providers with different competencies and specialties work in an integrated system to improve the health status of the whole population. The problems are magnified in the safety net because reimbursement rates are often so low that providers have strong incentives to provide higher volumes of services to maintain a reasonable level of income. Because of the deficiencies of the current system, there is increasing recognition of the need to move to integrated care and reimbursement systems that reward providers on the basis of value provided, measured by quality and cost effectiveness.

The purpose of this paper is to explore the implications of such changes for safety net providers. We begin by discussing the current reimbursement systems and their effects, and then we explore the options for redesign that promise better performance. Understanding the current payment system will help in the transition to realigned incentives and the protection of essential services. Specifically, we will review Federally Qualified Health Centers (FQHCs), specialty care, hospitals, skilled nursing facilities and, briefly, home and community-based waiver providers.

FQHC Reimbursement – Current Requirements and Methodologies

One of the primary benefits of FQHC designation is enhanced reimbursement under Medicare and Medicaid. The original intent behind cost-based reimbursement was two-fold:

- to ensure that federal grant funds that support care for the uninsured do not have to subsidize publicly funded patients; and
- to ensure that FQHCs are reimbursed for the enabling services – including case management, patient education and transportation – they are required to provide under federal law.

The sections that follow outline the current reimbursement methodologies utilized by the major FQHC payers.

Medicare

Nationally, approximately 8% of FQHC patients have Medicare coverage as their primary insurance.¹ Medicare reimburses FQHCs for services on a reasonable-cost basis per encounter up to a cap (currently \$126.98 for urban FQHCs and \$109.90 for rural FQHCs). The cap is adjusted each year by the Medicare Economic Index (MEI), which has risen between 0.5% and 2.0% annually. Costs are adjusted based on a productivity standard of 4,200 visits per year per full-time physician and 2,100 visits per year per full-time mid-level. Certain services, including labs, are excluded from the

¹ UDS National Roll-up 2011.

encounter rate and reimbursed separately through Medicare Part B. According to an analysis by the National Association of Community Health Centers (NACHC), the majority (approximately 75%) of health centers have actual costs that exceed the current Medicare cap. Under the Affordable Care Act (ACA), however, Medicare will move to a prospective payment system (PPS) similar to Medicaid (see discussion below) and eliminate the current payment cap.

As for most Part B services, Medicare pays 80% of the rate for each visit, and the beneficiary is responsible for 20% of the cost-based rate. FQHC services, however, are exempt from the Part B deductible (i.e., the beneficiary receives “first dollar” coverage for FQHC services). Services provided to Medicare Advantage enrollees are reimbursed at the same cost-based rate via a “wrap-around” payment. The Medicare Advantage plan must reimburse the FQHC at a rate comparable to what the plan would pay for the same service in other provider settings; the federal government pays the FQHC the difference between the cost-based rate and the Medicare Advantage payment.

Medicaid

Approximately 40% of FQHC patients nationally are covered by Medicaid, making it the single most important source of patient services revenue in most FQHCs.² Pursuant to the Benefits Improvement and Protection Act (BIPA) of 2000,³ State Medicaid programs have the option of implementing a cost-based PPS, an alternative methodology, or a combination of both. Under the PPS methodology, each FQHC establishes its base encounter rate based on its average total reasonable cost per visit from 1999 and 2000. For FQHCs formed after 2000, the base PPS rate is typically determined based on the average PPS rates from FQHCs in the same geographic region offering a similar scope of services. The base PPS rate for each health center is adjusted each year by the MEI. Many states that have implemented the PPS have put in place various “limiters” designed to limit costs to levels deemed reasonable. These limiters include overall rate caps (e.g., rates capped at the 60th percentile of statewide median costs), overhead caps (e.g., overhead capped at 35%), or productivity screens.

States electing to use an alternative payment methodology (APM) 1) must ensure that the alternative payment rate is at least as high as the PPS rate and 2) FQHCs must agree to be reimbursed under the APM. Examples of APMs include maintenance of a pure cost reimbursement methodology (e.g., Kansas) and a methodology that utilizes the Medicare maximum rate with an add-on to account for additional Medicaid FQHC services (e.g., Michigan).

States must also have a process in place to allow FQHCs to adjust their rates because of a change (increase or decrease) in the scope of services provided. FQHCs are eligible for “wrap-around” payments for their Medicaid managed care patients (as with Medicare); these payments make up the difference between the payment received from the plan and what the FQHC would have received

² Ibid

³ P.L. 106-554, Section 702.

under the prospective payment system.⁴ In addition, some Medicaid managed care plans have attempted to augment fee-for-service reimbursement through pay-for-performance and/or shared savings incentives. Others have begun to move beyond fee-for-service reimbursement to capitated models that range from primary care-only capitation to capitation that transfers risk to the FQHC for downstream services such as diagnostics, specialty care, and in some cases, inpatient care.

Private Insurance

Nationally, approximately 14% of FQHC patients are privately insured, though this figure varies widely by geography and health center.⁵ As they do with other providers, private insurers negotiate individual payment rates with FQHCs. While there has not been a comprehensive study of the adequacy of private insurance rates for FQHCs, at least one study of rates per patient encounter paid by New York insurers found rates to be approximately \$38 less than Medicaid rates, on average.⁶ Rates from private insurers tend to mirror those paid to physician offices, which generally do not cover enabling services (e.g., case management, transportation).⁷ As a result, many FQHCs are reimbursed by private insurance at rates that are not reflective of the comprehensive array of services they provide. As with Medicaid managed care plans, some commercial plans have also begun to develop and test new reimbursement models that move away from pure fee-for-service and toward value-based reimbursement. These models range from shared savings approaches to models that transfer substantial segments of downstream risk to the FQHC.

Self-Pay/Uninsured

Currently self-pay patients comprise approximately 36% of FQHC patients nationally,⁸ but this figure is projected to drop precipitously beginning in 2014 as states implement their Medicaid expansions and health insurance exchange programs under ACA.⁹ Pursuant to federal law, FQHCs are required to see all patients in their service area who present for care regardless of ability to pay. For individuals who do not have a payer source, FQHCs are required to have an established schedule of charges and a corresponding discount schedule based on the patient's income. Individuals with incomes below 100% of the federal poverty level (FPL) cannot be charged more than a "nominal

⁴ Pursuant to Section 1903(m)(2)(A)(ix) of the Social Security Act, Medicaid managed care organizations must "provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic." This provision prevents the MCO from shifting costs to the state and federal government through a larger wrap-around payment. A parallel provision for Medicare Advantage plans may be found at 1857(e)(3)(A).

⁵ UDS National Roll-up 2011.

⁶ "Improving Commercial Reimbursement for Community Health Centers: Case Studies and Recommendations for New York." Manatt Health Solutions, New York, Fall 2007.

⁷ Primary Care Development Corporation and RSM McGladrey, *New York's Primary Care Reimbursement System: A Roadmap to Better Outcomes*. 2008

⁸ UDS National Roll-up 2011.

⁹ The National Association of Community Health Centers projected that, by 2015, 22% of FQHC patients nationally would be uninsured. However, this projection preceded the Supreme Court decision in June 2012, which effectively made the Medicaid expansion under ACA optional for states.

fee” for services. Individuals with incomes above 200% FPL must be assessed full charges for their visit. Individuals between 100% and 200% FPL are charged based on a sliding fee schedule.

FQHCs receive federal grant funds to offset the cost of caring for the uninsured. While these funds were historically very large, in recent years grant amounts have been fixed at \$650,000 annually per FQHC. Grant awards are not linked to the payer mix of the individual FQHC; therefore, in FQHCs that have a relatively high number of uninsured patients, federal grant funds typically cover only a fraction of actual uninsured costs.

Specialty Physician Reimbursement – Current Requirements and Methodologies

Medicare

The traditional Medicare fee-for-service program reimburses specialists under the physician fee schedule, which sets payment amounts for approximately 7,000 services and procedures utilizing a resource-based relative value scale (RBRVS) weighting system. When the RBRVS relative value unit (RVU) weight is multiplied by a conversion factor (CF), the product is Medicare’s payment for the service. The fee is modified up or down by a geographic adjustment factor that accounts for cost differences across areas.

The sustainable growth rate (SGR) was designed to control spending on Medicare physician services, including specialty care. Created under the Balanced Budget Act of 1997, the SGR is used in calculating the update to the CF from one year to the next. The update to the CF can be positive or negative and depends on the relationship between a spending target and actual spending for a prior year. Four factors determine the spending target:

- the change in the number of fee-for-service Medicare beneficiaries;
- the increase in the cost of operating a medical practice, as measured by the Medicare economic index (MEI);
- the increase in the ten-year moving average of real gross domestic product (GDP) per capita in the United States; and
- the projected change in spending associated with changes in law or regulation.

If the target is exactly met by actual spending in that year, the CF is increased by the MEI. If actual spending is less than the target, fees are increased by more than the MEI. If actual spending exceeds the target, fees are increased less than the MEI, or even reduced.

The SGR has been the subject of much debate in recent years, as critics argue that its unpredictability and inability to keep up with actual costs could have a significant negative effect on access. As a result, Congress has implemented a number of temporary adjustments to prevent actual reimbursement cuts from taking effect. The budgetary cost of completely repealing the SGR

and replacing it with a guaranteed positive update has been estimated at more than \$300 billion over a ten-year period.¹⁰

Medicaid

States have substantial flexibility in establishing payment rates for specialty care under Medicaid. Methodologies and payment levels must comply with the broad federal requirement stating that they are “consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population in the geographic area.”

Under fee-for-service arrangements, states pay providers directly for services. States may develop their payment rates based on:

- the costs of providing the service;
- a review of what commercial payers pay in the private market; and
- a percentage of what Medicare pays for equivalent services.

Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. Under managed care arrangements, states contract with organizations to deliver care through networks and pay providers.

As states have faced budget pressures, many have reduced physician rates for both primary care and specialty care. There is growing evidence that low payment rates are contributing to access issues for specialty care. For example, a recent GAO report found that physicians have a much more difficult time finding specialty care for children covered by Medicaid and CHIP than they do for privately insured children: 84% of participating physicians experienced difficulties in referring children in Medicaid or CHIP to specialty care, while the comparable number for privately insured children was 26% – a ratio of more than 3 to 1. For all children, physicians most frequently cited difficulty with specialty referrals for mental health, dermatology, and neurology.¹¹

Uninsured/Self-Pay

While the uninsured can access primary care through federally qualified health centers, access to specialty care is extremely limited because of the lack of funding sources. Hospital services for the uninsured are partially subsidized through Medicare and Medicaid disproportionate share hospital (DSH) payments. Primary care services for the uninsured in FQHCs are partially subsidized by federal grants. In contrast, specialty care lacks such a funding source and is often supported by local tax dollars within public healthcare systems, private grants, or voluntary programs such as “access” projects that match uninsured patients with private specialists who agree to see a fixed number of uninsured individuals.

¹⁰ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2012.

¹¹ United States Government Accountability Office, *Most Physicians Served Covered Children But Have Difficulty Referring Them for Specialty Care*, June 2011 (GAO-11-624).

In recent years, the Health Resources and Services Administration (HRSA), the agency responsible for oversight of FQHCs, has implemented policy guidance that allows FQHCs to incorporate some specialty care into their scope of services, allowing cost-based Medicare and Medicaid reimbursement as well as federal grant dollars to support specialty care.

Hospital Reimbursement – Current Requirements and Methodologies

Combined, Medicare and Medicaid often comprise 50% to 80% of a hospital's business; therefore, the payment structures utilized by these payers are critical to a hospital's financial success. This dependence will only increase as more people gain Medicaid coverage under the Affordable Care Act.

Medicare is entirely federally funded and utilizes uniform hospital payment policies nationally. The payment designs differ by type of care such as acute, rehabilitation, or psychiatric, while the rates vary depending on geographical differences. Background on Medicare payment policies can be found at http://www.medpac.gov/payment_basics.cfm.

Medicaid is jointly financed by the state and federal governments; the proportion of the cost paid by each varies by state, with the federal share depending primarily on state per capita income. Each state, while adhering to some core federal requirements and principles, can design its program as it sees fit. As a result, Medicaid payment structures are more diverse than Medicare's. However, reimbursement rates are almost always below Medicare rates, as states must pay a portion of these expenses using general revenue fund dollars, which are often severely constrained (e.g., in periods of economic downturns) at the very time that the demand for Medicaid services increases.

There are three traditional components of hospital reimbursement: inpatient payments, outpatient payments, and supplemental payments.

Inpatient Reimbursement

Three base payment methodologies are commonly utilized to reimburse hospitals for inpatient care: cost, per diem, and per case reimbursement. A brief overview of each structure is highlighted below.

- *Cost reimbursement:* A prospective cost-based rate is paid per day or per case based on historical costs with a cost settlement occurring after the fiscal year end. Once a very popular reimbursement structure, it is now less commonly used, as it does not incentivize providers to control costs. Now it is generally reserved for special situations to preserve access, either geographically (e.g., rural) or by service (e.g., behavioral health).
- *Per diem reimbursement:* Hospitals receive a payment for each day the patient is hospitalized. The rate is prospectively determined typically based on the average resources per service consumed by a specific provider or class of providers. This methodology is most commonly utilized to reimburse psychiatric, rehabilitation, or long term acute care services. Per diem rates are also being utilized less frequently as they lack any incentive to control length of stay and, thus, costs.

- *Per case (or per admission) reimbursement:* This structure utilizes diagnosis related groups (DRGs) that base payments on the acuity of illness and resources typically consumed when treating particular illnesses. The predetermined fixed payment encourages providers to be cost conscious and achieve efficiencies. It fails, however, to promote reduction of potentially avoidable admissions and readmissions.

In addition to the base methodologies described above, inpatient reimbursement frequently has adjustments related to capital, medical education, and outliers (cases that are more expensive by a margin set by the state), among other factors.

Outpatient Reimbursement

Whereas inpatient reimbursement systems are relatively uniform, hospital outpatient structures are much more varied. Medicare utilizes a DRG-like structure called ambulatory payment groups (APGs), which establishes a bundled payment for each outpatient encounter based on diagnosis. Depending on the state, Medicaid may employ a variety of structures, including cost, APGs, fee schedules, and bundling.

Supplemental payments

Public payers frequently utilize targeted payments to address access issues or recognize a provider's unique role in the delivery system. Within Medicaid, for instance, access to obstetrical care or trauma care is deemed critical, and as a result, special payments have been created based on a provider's level of care (e.g., Level III perinatal center), volume of care (more than X discharges), or based on hospital location (e.g., rural). Additionally, hospitals with a disproportionate share of Medicaid business typically have large volumes of uninsured/unreimbursed care, and supplemental payments are utilized to preserve access. The magnitude and variety of supplemental programs has rapidly increased over the last decade as Federal law began to permit providers to self-finance these payments through the use of federally matched provider taxes.

There are two broad categories of supplemental hospital payments:

- Disproportionate Share Hospital (DSH) payments, which some hospitals receive based on a payer mix that is heavily Medicaid or uninsured; and
- Upper Payment Limit (UPL) payments. As noted above, Medicaid payment rates are almost always below Medicare rates, creating the opportunity for supplemental payments to fill this gap. States are prohibited, however, from paying rates that exceed what Medicare would have paid the hospital for the same or similar services, an amount known as the "upper payment limit."

Hospital Reimbursement: Outlook

The implementation of the Affordable Care Act presents both significant opportunity and risk for hospitals. For states pursuing a Medicaid coverage expansion, much of the care previously defined as charity or self-pay will be reimbursed under Medicaid (with the federal government paying at

least 90% of the cost). Some of it will also be covered under the state Health Insurance Exchanges,¹² which should create significant financial benefit for hospitals. However, to help finance the expansion, the hospital industry will be subject to Medicare payment reductions exceeding \$150 billion over 10 years. For safety net hospitals there is also substantial risk, as Medicare Disproportionate Share (DSH) payments will be reduced by \$22 billion, and Medicaid DSH payments will be reduced by \$14 billion over the next 10 years. Individual hospitals can only estimate the resulting balance in overall payment changes. What is even less clear is the financial impact that increased use of care management and other delivery system redesign will have on reducing inpatient care.

Long Term Services and Supports (LTSS) – Current Requirements and Methodologies

Skilled Nursing Facilities

Historically, skilled nursing facilities (SNFs) have been reimbursed based on per diems. In recent decades many state Medicaid programs have adopted payment methodologies that vary based on patient needs. Medicare payments significantly exceed Medicaid payments in most markets, but only apply to “rehabilitative stays” for a limited number of days after a hospitalization. Medicaid pays for the vast majority of SNF days, with private pay and commercial insurance making up a relatively small percentage, particularly within the safety net. Many states have implemented assessment fees paid by nursing facilities as a source of revenue to raise rates for these facilities, but very little of this is tied to quality outcomes. These fees serve as the state share of Medicaid payments and are matched by the Federal government. Even dollars directed toward rewarding quality are based on internal nursing facility metrics, not reducing readmission rates, or moving individuals to less costly home and community-based settings, as allowed under federal waivers. Some states do create penalties for failing to serve individuals with lower needs in a community-based setting, but few provide actual incentives to move people to these settings. It should also be noted that federal investment in “meaningful use”¹³ of electronic health records (EHR) technology does not extend to SNFs. Consequently, most of them do not share information electronically with physician and hospital partners.

The impact of this reimbursement system is reflected anecdotally in two discussions with industry leaders in one state. They acknowledged that currently 10% to 12% of their patients could be served in less costly settings, but they did not feel these services were available. Additionally, they indicated between 65% and 80% of all of their hospital admissions occurred on Saturdays and Sundays. This disproportionate number of admissions is reflective of facility staffing and availability of physician services. There are currently no incentives for the nursing facility to increase the

¹² While there will be an exchange in every state, States have the option of establishing their own exchange, utilizing a hybrid “federal-state partnership exchange,” or defaulting to a federally facilitated exchange.

¹³ Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.

expenditure of resources on weekends to reduce readmissions. These situations could be rectified with careful redesign of the reimbursement system to facilitate that change. Instead, perverse incentives create an opportunity for the SNF to restart the higher Medicare payment cycle after a readmission.

Waiver Providers

Waiver providers are paid on a fee-for-service basis in nearly all cases for the services they provide, which can include a wide range of services designed to help individuals live at home or in another non-institutional setting (e.g., personal care, adult day care, respite care). States have started experimenting with managed care, but these experiments are limited and relatively new. Even in states that have pervasive managed care, waiver services are often exempted. It is also true that in many cases providers of waiver services have responsibility for the health and safety of these patients but do not have financial incentives to ensure that the medical care these individuals receive is high quality and cost effective. Most waiver services are concentrated on efforts to keep these individuals in non-institutional settings, although providers are not always considered part of the traditional medical community. In many cases these providers frequently accompany clients to hospital emergency rooms with little recognition of the essential role they play in care management.

A home and community-based services waiver is considered successful if it is less expensive than the institutional setting it replaces. Only infrequently is there a formal mechanism for measuring quality in the two settings. In addition, the payment arrangements for the alternative providers typically do not include appropriate incentives to promote quality and efficiency, even though these providers care for some of the most complex patients. Furthermore, the incentives do not encourage regular communication with other providers who are part of the care team. For example, these providers are not included in any “meaningful use” incentives even though they care for some of the most complex patients and should be regularly communicating with other providers who are part of the care team. To understand the scale, a single waiver in a Midwestern state covers about 10,000 developmentally disabled individuals at a cost of nearly \$500 million annually, with more than 80% of that spent on residential habitation type services.

Payment Principles: Moving Toward an Integrated Model of Healthcare Delivery

Historically, payers designed provider reimbursement systems that had the unintended consequence of making difficult the transition to payment systems that would promote greater provider efficiency and accountability. For example, when Medicare and later Medicaid rolled out their DRG hospital inpatient payment system, they were careful to continue to pay physicians on a piecemeal, fee-for-service basis. The fear was that physicians and hospitals would rush to discharge patients before they were clinically stable. Commercial insurers filed antitrust suits against hospital systems that attempted to negotiate partial or global capitated payments on behalf of themselves and their medical staffs with whom they had formed physician hospital organizations (PHOs). Payers and other healthcare policy experts have more recently come to realize that, with the proper

patient protections, provider collaborations that incorporate incentives that reward efficiency and quality can be in the best interest of the patient, provider, and payer.

Healthcare payment arrangements that reward the provision of cost-effective care are not new to the healthcare system; in fact, they were included in some of the transiently successful payment reform attempts of Health Maintenance Organizations (HMOs) in the 1980s. Experience with health care cost containment efforts has produced the following lessons:

- Financial reward must do more than reward right-time and right-place service provision. Incentives must promote improved outcomes and enhanced member satisfaction. There must be a clear link between payment and service value.
 - There should not be any inducement to restrict necessary care or the full discussion of care options with the patient.
 - Quality measures should be both process and outcomes-based, with a preference for the latter when feasible. They should include parameters that evaluate proper chronic disease management, provision of preventive services for the full member panel, and patient experience of care. They should induce both short-term and long-term value improvements.
 - Pay-for-performance programs and other payment arrangements that allow providers to share in savings must be designed to ensure that providers do not stint in providing care. To encourage all providers to participate, these programs should offer rewards based on evidence of improvements and reaching set targets.
- There must be a gradual progression of provider accountability from the organization level down to the practice level that encourages innovative approaches to care. The rate at which changes are incorporated must be commensurate with a provider's ability to handle that responsibility.
 - If accountability is held at the organizational level alone, practice patterns are slow to adapt and innovation is suppressed.
 - If providers are given financial accountability without the experience or financial reserves to manage that responsibility, they are being set up to fail. Providers need to assume accountability at both vertical (the amount of downside risk as well as upside potential) and horizontal (the breadth of clinical services for which a provider assumes responsibility) levels. Such accountability should be introduced in a gradual fashion, and only as providers demonstrate their ability to handle current responsibilities.
 - Long-term success of the model will depend on how well budgets and bonuses are set; providers need time to implement changes. Capitation is the only payment reform model that truly makes a complete break from a volume-based system.
 - Payment reform must be a phased-in process that accompanies delivery system redesign; neither can get too far out in front of the other. Delivery system modification progresses much more slowly than contractual modifications because of the continual process of piloting, evaluating, and modifying.

- Provider groups should be incentivized to allocate resources to improve quality and patient satisfaction, but should be restricted to budgets that grow more slowly each year.
 - Savings should largely be reinvested to create even higher value care and generate additional savings.
 - Payers must not be so eager to reap a large share of short-term savings that they choke the process from reaching its full potential.
- A multi-payer approach that applies to as much of a provider’s practice as possible is best.
 - Providers must be able to apply a uniform model of care across their practice. It is not feasible or desirable to apply an approach to providing a higher value of care to only a subset of patients. As practices are modified to respond to new incentives, the entire patient panel will benefit from these new methods of service delivery. In some healthcare sectors (e.g., primary care), this is more resource-intensive but results in overall total savings. Cost must be distributed over as much of the member panel as possible to keep it reasonably affordable.
 - Payers should be discouraged from “free-loading” on the system by keeping the benefits of higher-value care for themselves.
 - Payers should come to a general agreement on the value metrics, with the bounds of federal antitrust law, so providers have clear goals for practice transformation; data aggregation across multiple payers facilitates statistically significant analysis and benchmarking.
 - As members change payers, if the members remain within the same system of care, providers will still reap long-term benefits from the improved value of care they provide.
- There are start-up costs associated with the transition to accountable care, including establishing governance and administrative systems, paying for new staff to administer the new approaches, e.g., Patient Centered Medical Homes (PCMHs), and building the information technology to collect and analyze member data as well as facilitate communication among disparate providers.
 - Safety net providers often do not have capital resources to make such investments.
 - Some states are effectively allowing providers to access projected savings up front and use them to fund needed infrastructure; however, this “borrowing” is ill-advised as these savings should ideally be used to reinvest into further system improvements.
 - Thus, payers will need to fund the transformations.
- The distribution of savings within integrated provider groups must take into consideration not only who is responsible for generating those savings, but also who is willingly sacrificing traditional revenue in order to create savings.
 - Maximum value can be achieved only when disparate providers work in partnership to achieve similar measurable goals; thus, all providers must have the opportunity to share in the distribution of savings.

- Distribution of rewards from savings must avoid creating big winners and big losers. At the same time savings need to be directed where they produce the most valuable results. This means that providers with fixed overhead expenses may need to be paid on an increased per unit basis to partially compensate for lower volume.
- There must be a reevaluation of reimbursement disparity between primary care providers and specialists that is reflective of value-based considerations.
- Governance of integrated provider organizations must create a more even balance of power than has been the case traditionally.
 - Although hospitals may consume a disproportionate share of healthcare budgets or have deep financial reserves, the currency for reformed payment is attributed lives (i.e., lives assigned to the integrated provider organization). Governance needs to recognize this change in balance and respond accordingly.
 - Providers that spend much of their effort fighting for control divert attention from the more important task of delivery system redesign; the latter requires an open and balanced exchange of ideas from representatives of the various healthcare sectors.

These principles have informed many of the payment reform initiatives and demonstrations under the Affordable Care Act, which are designed to test ways to “bend the cost curve.” These initiatives include the Medicare-Medicaid Alignment Initiative for dually eligible beneficiaries, the Medicare Shared Savings and Pioneer ACO programs, the Medicare Global Payments demonstration, and the State Innovations Model program, which is designed to support states in a collaborative planning process to develop payment and delivery system reform models. These principles also set the stage for the following sections that describe what reformed payment looks like for each provider group.

FQHCs

FQHCs are given special payment consideration in recognition of the fact that they care for patients with complex social and health care needs. A high proportion of them are uninsured; thus, their needs are great, and they require enabling services not typically provided by most PCPs. The PPS (prospective payment system) was instituted to allow community health centers to spend their Section 330 block grant funding on the uninsured population rather than to offset financial losses from caring for the Medicaid or even Medicare population. In retrospect, however, PPS provided perverse incentives: the higher the per-unit cost of providing care and the more face-to-face patient encounters, the higher the total revenue. More recently, PPS rates have often been capped, with increases tied to medical inflationary trends; but the disparity of reimbursement between FQHCs and other private PCPs caring for the Medicaid population will leave FQHCs non-competitive if these structural supports are eliminated in the future. State budgetary constraints are leading to discussions of how best to move away from these structural supports without jeopardizing access, especially since the number of uninsured individuals seen by many FQHCs will significantly decrease in 2014 as a result the Affordable Care Act.

In the meantime, many FQHCs are in the process of implementing Patient Centered Medical Homes, a more resource-intensive primary care delivery model that has higher value since it enhances

coordination, especially during transitions of care, and reduces medical errors, duplication of services, and non-evidenced based care. Although some FQHCs are paid under primary care capitation, almost all receive a PPS-based fee-for-service wrap-around payment that dwarfs capitation in magnitude and leaves the FQHC responding to volume-based incentives. Some are able to supplement their revenue with additional payments from pay-for-performance programs, shared savings or, rarely, partial capitation, none of which affect wrap-around payments.

Under an integrated delivery system with reformed payment, FQHCs are freed from strict reimbursement for face-to-face patient care services. Under this model the highest value comes from managing their populations, not just responding to patients who appear at their front doors. Enhanced patient access results from virtual visits by phone and email, not just by extended hours.

Value is measured by the appropriateness of the care the FQHC delivers and its ability to provide or direct services to the most cost-effective setting. This often translates into more intensive primary care services that result in evidence-based referrals to specialists, but only after appropriate pre-visit diagnostic testing. For example:

- FQHC access is measured by reduced emergency department visits for ambulatory care sensitive conditions.¹⁴
- Quality management of chronic illness results in reduced hospitalizations.
- Fewer re-hospitalizations occur as transitions of care are actively managed.

As an alternative, reimbursement could move to risk-adjusted, primary care capitation that covers FQHC basic services, including integrated behavioral health when applicable. As a transitional strategy, PPS wrap-around payments could still be made to compensate for a more complex and sicker population, as well as for enabling services such as patient transportation, interpretive services, community health workers, social workers, and patient education. These wrap-around services could also be paid on a per-member-per-month (PMPM) basis that is comparable for FQHCs serving similar populations, not disproportionately higher for historically inefficient providers. An additional PMPM fee could be paid for care management of the most complex and highest-cost members. Pay-for-performance incentives that are clinically and financially significant could be added; the rewards should be great enough to induce FQHCs to change their model of care to specifically pursue them. Initially, FQHCs could be rewarded for achieving savings without being exposed to downside risk for exceeding the targeted budget. As the integrated system improves its ability to manage a population in an accountable fashion and has the required financial reserves, a two-sided model—one that includes both an enhanced upside potential and downside risk—could be instituted. Eventually, there could be a transition to a partial or global capitation reimbursement structure in which FQHCs share in savings generated by the entire integrated system. Funding may be required to initiate this transformational process.

¹⁴ Ambulatory care sensitive conditions are conditions, such as asthma and diabetes, where appropriate ambulatory care can prevent or reduce the need for admission to the hospital.

The measure of FQHC's success will be their ability to provide lower-cost primary care that improves population health and patient satisfaction. FQHCs will increasingly be in direct competition with non-FQHC PCPs for their patients. The sooner they recognize this and begin the long process of service redesign, the more likely they are to remain independent and grow.

Specialty Care

With rare exceptions, specialists continue to be paid on a fee-for-service basis. There are isolated examples of specialists who have organized themselves to accept sub-capitation, but even within those groups, individual providers are often paid based on volume. Increasingly, integrated systems are able to capture bundled cost of care for certain specialties, particularly those that are procedure-oriented. Payers are experimenting with hospital-physician bundled payments for episodes of care that meet the following criteria:

- high volume of cases across the system;
- relative predictability through low to moderate variation in the cost of the bundle;
- concentration of services and costs within the integrated system so that the system costs are controllable;
- engaged and willing group of specialists; and
- readily identified opportunity for care standardization and improvement.

Integrated providers are also beginning to collect data to profile specialists by their rates of complications and total cost of care. This information is made available to both patients and PCPs who, in turn, are given financial incentives to choose the specialist of highest value.

However, a truly integrated system will eventually move to capitated payment for specialists; they will be paid a risk-adjusted actuarially determined amount. The best model will be to create pools of funding for specialists based on risk-adjusted actuarially defined capitation rates. The specialist and primary care physicians, including those in FQHCs, will share in the surplus or losses in these pools. This integrates their incentives for appropriate care.

Hospitals

Whether reimbursement is fee-for-service (FFS) or value-based, hospitals can be expected to try to garner as much of the local market share of the health care business as possible, particularly for that segment of the population for whom the margin between payment and cost of services is the greatest. To maintain and grow market share and increase profits or surplus, hospitals work to create physician loyalty, reduce network leakage, establish leverage with payers to negotiate higher rates, and reduce costs of providing service. For many safety net hospitals, these tasks are more difficult because of the mixed market signals they receive. For example, safety net hospitals have come to depend on supplemental payments that were historically linked to the cost and amount of care provided, thereby facing little incentive to reduce costs. Enhanced care management and technology advances have already reduced inpatient volume. Payment reform places inpatient stays in the crosshairs for further utilization reduction.

Under fee-for-service reimbursement, hospitals are financially rewarded for:

- Attracting patients with lucrative insurance coverage even though the higher reimbursement is not directly related to the clinical value of the service provided.
- Providing specialized services otherwise unavailable in the market.
- Maximizing the volume of high-margin procedures.
- Controlling DRG/case rate-related expenses through cost-effective care and decreased length of stay.
- Minimizing hospital acquired infections and never events.

Under value-based payment, hospitals are incentivized to:

- Improve accessibility for members with lucrative insurance coverage, but at the right time (preferably before clinical deterioration occurs) and in the most cost-effective setting.
- Minimize utilization of high-cost acute care, procedures, and Emergency Department (ED) services including reducing ambulatory care sensitive admissions and preventable complications.
- Control expenses across the continuum by improving PCP access and continuity of care, as well as measuring and benchmarking providers for utilization of the ED, specialists, expensive diagnostics, preferred medications and similar areas where there is poor correlation of utilization and clinical outcomes.
- Manage comprehensive outcomes/standards as basis for payment.

Long term services and supports

Long term services and supports include both institutions and home and community-based waiver services. These providers have a tremendous impact on hospital admissions and readmissions as well as unnecessary emergency department visits. By creating incentives for these nursing facilities to reduce unnecessary admissions and emergency department visits and to increase employment of vulnerable populations, integrated delivery systems can significantly reduce costs, particularly in the case of dual eligibles. Further, incentivizing institutions to move appropriate individuals back into the community can also save money. It is important to note that, at this time, there are few incentives for LTSS providers to participate meaningfully in the larger health system. Moreover, managed care traditionally has not shared savings with these providers, nor did the federal government include them in meaningful use funding for improving electronic medical records implementation and connectivity to other health entities.

There is a major opportunity to improve the management of care transitions by:

- identifying individual members at risk for unplanned transitions;
- educating members or responsible parties about transitions and how to prevent unplanned transitions by recognizing early warnings;
- managing planned transitions by forwarding care plans, communicating with care givers, and notifying the PCP;
- supporting the member through transitions; and

- analyzing member admissions to facilities and ED visits to identify improvement opportunities.

It is important to include LTSS providers in the integrated delivery system and incentivize them to make the system better since they can have a significant impact on overall cost and quality. Outcomes-based payment should reward them for timely access, quality of care, and appropriate utilization.

Integrated Care Models

The transition from FFS to value-based payment requires a fundamental change from managing just patients to managing populations. It requires new contractual payer arrangements and delivery of care redesign. Advantages of moving toward value-based payment include jettisoning the perverse incentives of fee-for-service payment, attracting physician partners who seek to align themselves with hospital systems ready to accept risk, securing appealing purchaser contracts, and alignment of financial incentives with the mission of improved population health. Risks include the possibility of heavy financial losses resulting from inadequate care management and payers' refusal to adopt value-based reimbursement structures or share data. Improvements in quality and reductions in cost are likely to appear only sometime after the initial redesign, so organizations must have the institutional willpower to persevere.

Delivery system redesign to move from patient to population management includes:

- implementing evidenced-based practice guidelines;
- standardizing care processes and devices;
- identifying care gaps;
- eliminating unnecessary utilization;
- creating disease registries to identify gaps in care;
- risk stratifying patients and prioritizing interventions;
- care managing complex, high-risk patients to improve chronic disease management and optimize transitions of care;
- providing information technology tools that facilitate proactive care delivery;
- attention to palliative and end-of-life care; and
- evaluating the efficiency and quality of network performance.

Hospital systems are seeking to create clinically integrated organizations that maximize physician alignment with health system goals and have a culture of transparency, performance improvement, and collaboration.

Accountable Care Organizations (ACOs) are a relatively new approach to integration and are still in the experimental stage. Although the Centers for Medicare and Medicaid Services (CMS) has a strict definition of ACOs as they apply to the Medicare Shared Savings Program, there are various models being developed at local levels for other payers. They come in three basic types:

1. Hospital-driven ACOs in which physicians are employees or contractors who are attracted by the stability of a salary. A word of caution about this model: physicians do not do well as disempowered employees and need to be active participants in delivery system design. In addition, hospitals without other counter balancing groups often do not completely escape the desire/need for admissions and visits.
2. Physician-driven ACOs in which a physician group is the ACO and the hospital(s) is relegated to a vendor relationship; this limits the extent that incentives can be aligned.
3. Joint Management ACOs in which physician entities and the hospital(s) jointly develop and manage the ACO; this requires a common vision, sense of purpose, shared responsibility, transparency, and trust.

To complicate matters, the market is responding by forming new collaborations, partnerships, and consolidations. Medical groups, hospital systems, health plans, and technology firms are forming such aggregations among themselves as well as with each other. Economic pressures create strong incentives to reduce costs, and combining to achieve economies of scale is part of the effort to achieve savings. However, scale in health care has not always reduced cost. Having sufficient size is critical to managing risk, but large scale does not always produce lower costs. High-cost services benefit from consolidation, while lower-cost, high-volume services tend to benefit from flatter organizations that can still provide appropriate quality review.

Conclusion

Safety net providers serve an essential role in caring for a significant portion of the most frail and vulnerable of our society. Over the past several decades government has employed special reimbursement strategies to recognize the unique challenges inherent in this task. These special arrangements, however, have been largely cost-based and inconsistent with cost-effective, outcomes-based payment. They have also reinforced siloed care and not created sufficient incentives to better manage transitions between levels of care or assigned clear responsibility for doing so. Alternative payment methodologies that promote innovative delivery system reform and incentivize effective care delivery must be embraced. These include:

- strategies that move from reimbursing for volume to incentivizing value;
- management of population health rather than focusing on reactive care;
- delivery system restructuring to assure continuity and avoid duplication;
- participation in multi-provider integrated systems;
- responsiveness to patient experience of care concerns; and
- inclusion of commercially insured members, particularly those newly insured through the new federally required Insurance Exchanges.

Safety net providers must not lose sight of their mission to serve the remaining uninsurable population, which will increasingly depend on the ability of the provider to efficiently care for an insured population in a manner that is competitive with other health care providers. Providers must move beyond their four walls and partner with other organizations to effectively serve the population.

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Douglas Elwell is a managing principal with Health Management Associates specializing in health finance, community partnerships and hospital operations.

Prior to joining HMA, Mr. Elwell was president of Health and Hospital Corporation (HHC) of Marion County, a municipal corporation operating the largest public hospital and public health department in the state of Indiana. In this role, he significantly increased healthcare-related federal revenues from various sources to HHC and the State of Indiana. While serving as president, he also chaired the community access project that was awarded a federal Community Access Program grant.

Prior to joining HHC, Mr. Elwell held various positions with private hospitals and health systems including chief financial officer and chief executive officer. During this time he developed expertise in managed care and hospital operations and finance. He also held a Nursing Home Administrators license as part of his duties. He started his career in public accounting, auditing both health care entities and publicly held companies.

Mr. Elwell has been a member of the executive committee of the National Association of Public Hospitals and served as treasurer of that organization's board. He holds a bachelor's degree in Accounting from the University of Wisconsin and a Masters of Science and Administration from the University of Notre Dame.

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Dr. Jones has more than twenty five years of experience as a founding physician and CEO at a large urban community health center. Dr. Jones completed his internal medicine residency, chief residency and cardiology fellowship and now holds a position as Clinical Associate at the University of Chicago. He has lived in the impoverished community that he has served since 1980. He worked for four years as a part time medical director for a managed care organization focused on the Medicaid population. The health center has been at the forefront of delivering care under a near global capitation payment system for more than twenty years and now covers approximately 15,000 lives. It is has earned top ratings among community health centers

nationally for its financial performance under managed care and has reinvested those margins into caring for the uninsured as well as innovative efforts of improving health. Its fitness center visits equal its number of medical visits. It is redesigning its delivery model to take advantage of its EMR and using care coordinators to enhance its medical home capabilities in unique fashions.

Dr. Jones is a pioneer in the Accountable Care Organization (ACO) movement and works part time as the Chief Medical Officer for Medical Home Network. MHN is a foundation-funded demonstration project to improve health status of Southside and Southwest side Chicago area residents by taking a population health approach to organizing healthcare providers to enhance quality, improve access, reduce costs and reinforce the medical home.

Dr. Jones focuses his work at HMA on Medicaid ACO development and helping FQHCs make the transition to the rapidly changing environment being prompted by health care reform. He explores new delivery models made possible by the change from strict reimbursement only for face to face medical provider encounters to one that also rewards for successful population management.

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Gaylee Morgan joined HMA in March 2002, and has 15 years of experience in Medicaid policy and financing, and provider reimbursement. At HMA, Ms. Morgan has worked with numerous providers to assess the feasibility of becoming federally qualified health centers (FQHCs). She has also helped develop financing strategies for FQHCs, hospitals and health systems, and has worked with numerous providers and other organizations to develop innovative strategies to increase access to care for the indigent.

Prior to joining HMA, Ms. Morgan was a financial policy consultant for a major academic medical center where her responsibilities included developing financial models and analyzing the effects of changes in Medicare and Medicaid payment policies on hospital revenue. From 1998 to 2001, Ms. Morgan was a health financing analyst with the U.S. Office of Management and Budget (OMB). At OMB, Ms. Morgan worked with states and the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) on the development of Medicaid 1115 and 1915(b) waivers and analyzed the policy and budget implications of statutory, regulatory and administrative changes in the Medicaid program.

Ms. Morgan has a master's degree in public policy from The University of Chicago.

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Backed by 15 years of hospital association and seven years of national health care consulting experience, Steve Perlin has demonstrated expertise in health finance, policy development and legislative advocacy. His specialties include innovative financing and policy solutions that facilitate health care delivery system transformation and enhance access to care for Medicaid and other vulnerable populations.

Steve has extensive Medicaid reimbursement and financing experience including redesigning Medicaid inpatient and outpatient reimbursement systems and developing provider tax and intergovernmental financing structures.

Prior to joining HMA, Steve served as vice president of finance for the Illinois Hospital Association. Steve conceived and developed a plan for a \$500 million intergovernmental transfer which funded an expansion of Medicaid payments and facilitated the elimination of the Illinois hospital tax. He contributed to the design, development and implementation of a resource based Medicaid outpatient reimbursement system, resulting in a gain of more than \$100 million to Illinois hospitals. Steve spearheaded an initiative to exempt hospitals from the Medicaid provider tax, generating nearly \$10 million in savings for member hospitals. He also championed a Medicaid DRG inpatient reimbursement system that increased hospital revenue by \$250 million annually.

His breadth of work ranges from providing strategic guidance, developing financial models, crafting legislation to securing federal CMS approval of state plan amendments. Steve works with a broad range of clients from hospitals, health systems and hospital associations to local and state units of government, foundations and other not-for-profit organizations.

Steve received his MBA from The George Washington University and his bachelor's degree from the University of Wisconsin-Madison.

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Health Management Associates (HMA) has amassed a wealth of on-the-ground experience that is important to share more widely as the nation undergoes the dramatic changes anticipated over the next several years. To that end, it is forming the Accountable Care Institute (ACI). The ACI will:

- provide a venue in which to share experiences and best practices from across the country related to the development of community-specific integrated delivery systems, new financial strategies to incentivize value, and innovative partnerships between providers and payers to ensure effective care for the unique populations they are both trying to serve;
- develop and offer resources to others to help spread lessons learned in the development of these new approaches to the delivery of accountable care;
- facilitate the training of new leaders in health system change; and
- translate delivery system lessons learned on the ground into policy and policy into change at the delivery system level, whether financial, legal, clinical or organizational.

Over the past decade, HMA has been assembling a growing practice of senior health care clinicians and administrators, finance experts, behavioral health professionals, managed care leaders, long term care innovators and others committed to developing new approaches to delivering health care services, particularly to populations and communities that have traditionally been underserved. HMA has worked for large health systems, consortia of providers, individual hospitals and ambulatory providers, states and counties, foundations and managed care plans to assess current delivery of care, plan new approaches and assist in implementation. This work has been growing in volume as the country has started to seriously grapple with how to assure access and quality—and the improvement of health status—while rolling back the cost trajectory which is universally agreed to be unsustainable. Expertise in integrated and accountable care as it applies to the delivery of care to those funded by public dollars is in demand; it is anticipated that the ACI will provide a vehicle for meeting that demand.