HEALTH MANAGEMENT ASSOCIATES

How FQHCs Can Deliver Innovative Care Under Existing and Value-based Payment Models

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Art Jones, MD
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OUR SPEAKERS

Margaret Kirkegaard, MD, MPH, Principal (Chicago)

- **Dr. Kirkegaard is Board Certified in Family Medicine with expertise in integration of public health and healthcare delivery systems and population-based health care delivery for vulnerable and underserved groups. She has worked with multiple clinical providers to expand innovative models of care.**

Art Jones, MD, Principal (Chicago)

- **Dr. Jones has 27 years of experience as a primary care physician and chief executive officer (CEO) at a Chicago area community health center. He was the architect for the first capitated Federally Qualified Health Center (FQHC) alternative payment methodology in the country in 2001. He is a sought-after national expert in creating FQHC APMs. He has consulted with several other primary care associations, other FQHC integrated delivery systems and individual FQHCs nationally to negotiate alternative payment methodologies including shared savings and to improve performance on those value-based payment arrangements.**

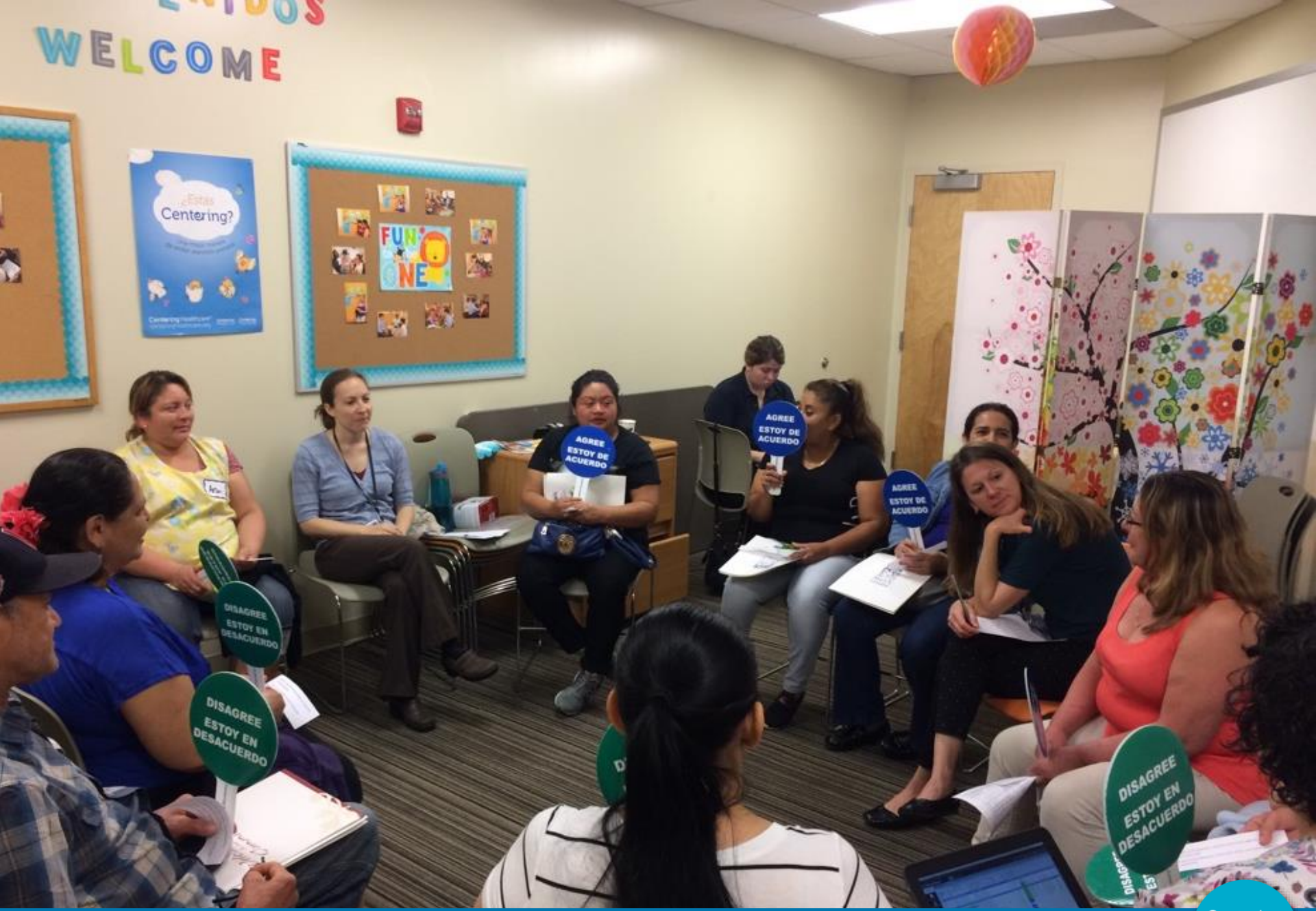
OBJECTIVES

1. Understand the strengths and weakness of the Prospective Payment System.
2. Learn how to enhance reimbursements for specialized services.
3. Identify opportunities and barriers among alternative payment models.
4. Find out how to succeed in a value-based care environment.

Question #1

What type of organization do you represent?

- ❑ FQHC
- ❑ Healthcare provider but not FQHC
- ❑ Health plan
- ❑ Community-based organization
- ❑ Medicaid or other state agency
- ❑ Other



CASE STUDY: CENTERING PREGNANCY

Centering® Healthcare Institute

What is Centering?

- An **evidence-based, patient-centered framework** for providing healthcare in a **group** format
- Clinical intervention **implemented by healthcare providers** that uses the healthcare visit as the touchpoint for **engaging** patients in their own care and **connecting** them to other patients and support services
- **Replaces individual appointments** with group appointments , however individual appointments can always be used to supplement group appointments
- Defined by a standard set of guiding principles referred to as the **Essential Elements** of Centering and adheres to quality and practice standards established by **Centering Healthcare Institute**

PTB risk reduction

- 33%

Matched cohort study
Ickovics, et al 2007

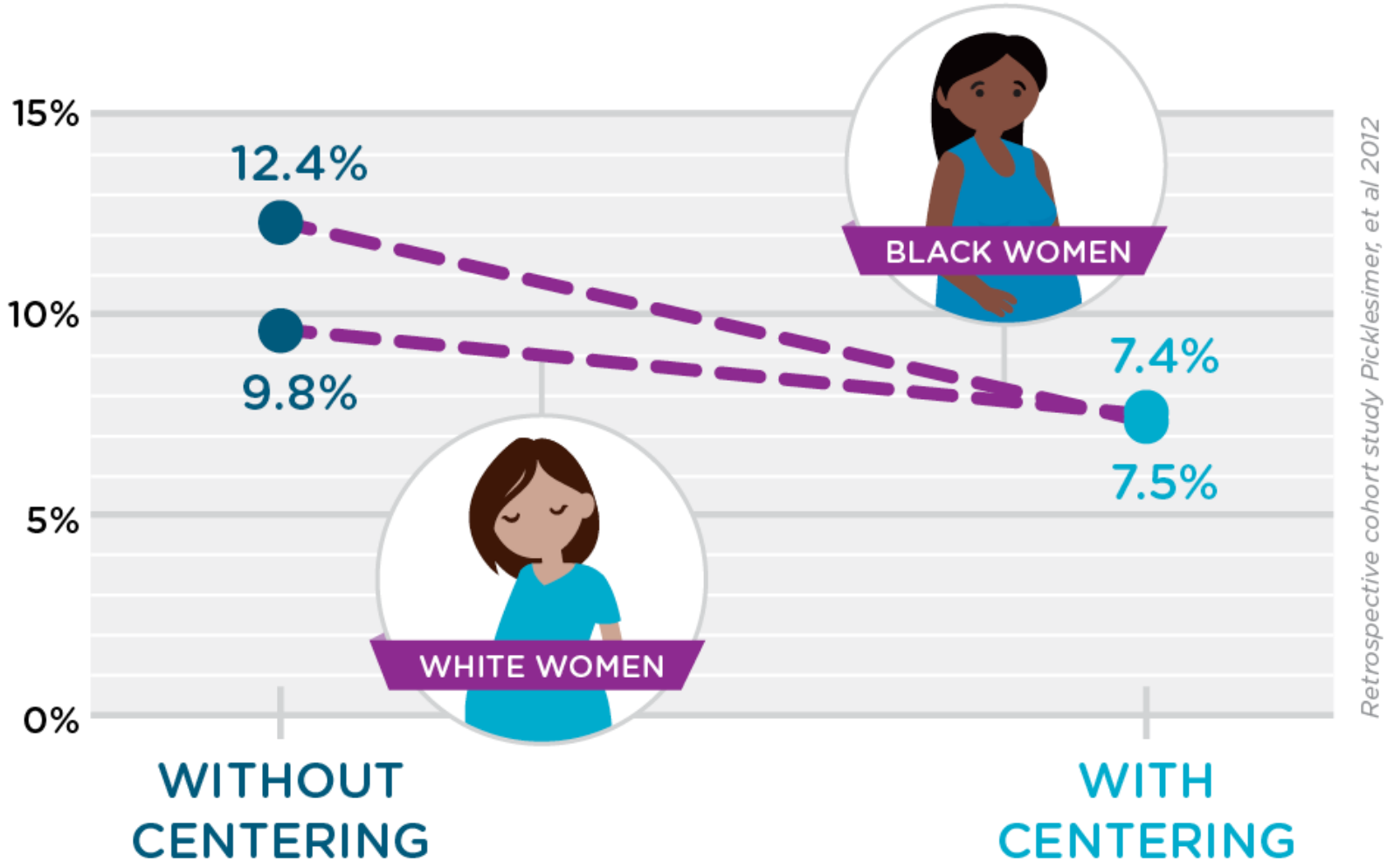
A multi-site randomized control study of 1,047 women found a 33% reduction in risk of preterm births in Centering patients compared to those receiving only individualized prenatal care. The reduction among African Americans was even higher at 41%.

- 47%

Retrospective cohort study
Picklesimer, et al 2012

A 2012 retrospective cohort study compared 316 women in Centering to 3767 in traditional care and found a 47% reduction in risk of preterm birth in Centering patients compared to those receiving only individualized care.

Preterm Birth <37 Weeks By Race



USING VALUE-BASED PAYMENT MODELS TO SUPPORT INNOVATIVE CARE

- Many FQHCs provide Centering model of care
- Generally receive PPS payment only although administration of program can require additional resources
- FQHCs report desire for more flexibility in payment to support more flexibility in clinical care

FQHC GENERAL OVERVIEW

- "Federally Qualified Health Center" is a federal designation for community health centers; must apply through a competitive "New Access Point" application
- There 1368 FQHCs with approximately 14,200 sites that served 29.8 million people and 72 FQHC Look-Alikes serving 595,000 people in 26 states
  - 91% below 200% of poverty
  - 68% below 100% of poverty
  - 22% Black, 37% Hispanic/Latino
  - 17.3% residents of public housing
  - 23% medically uninsured
  - 1.5 million homeless individuals
  - 1.0 agricultural workers or dependents

FQHC & FQHC LOOK-ALIKE BENEFITS

FQHC Grantees	FQHC Look-Alikes
Receive annual grant to offset the cost of caring for the uninsured	No
Eligible for other HRSA grant opportunities (e.g., capital, expansion)	No
Eligible for free tort protection under the Federal Tort Claims Act	No
Eligible for reimbursement under a Prospective Payment System from Medicaid and the State Child Health Insurance Program (SCHIP) with "wrap-around" payments for individuals enrolled in managed care plans	Yes
Eligible for Prospective Payment System from Medicare, with "wrap-around" payments for individuals enrolled in Medicare Advantage plans	Yes
Access to discounted drug prices through the federal 340(b) program	Yes
Access to out-stationed Medicaid eligibility workers	Yes
"First-dollar" Medicare coverage (i.e., Medicare deductible is waived for FQHC services)	Yes
Access to the federal Vaccines for Children (VFC) program	Yes
Access to National Health Service Corps providers and resources	Yes

PROSPECTIVE PAYMENT SYSTEM (PPS)

- Before 2000: Medicaid cost reimbursement
  - Allowable costs for Medicaid services/Total face-to-face encounters
- Medicare and Medicaid Benefits Improvement and Protection Act (BIPA) of 2000 replaced reasonable cost reimbursement with Prospective Payment System (PPS)
- Ensure adequate reimbursement for the wide range of services FQHCs are required to provide
- Ensure that Section 330 grant dollars, which are intended to offset uninsured patient care costs, aren't needed to subsidize below-cost payments from Medicaid and Medicare.
- Provide some mechanism (i.e., Medicare Economic Index, no cost reconciliation) for containing cost growth

PROSPECTIVE PAYMENT SYSTEM (PPS)

- *Base Rate*: States required to pay current FQHCs 100% of the average of their reasonable and allowable costs during FY1999 and FY2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during FY2001 by the FQHC
- *Reasonable costs*:
  - States can apply "tests of reasonableness" as the Secretary prescribes in Medicare regulations
  - Productivity standards
  - Overall caps (e.g., new health centers capped at 60th %tile) or administrative caps
  - Some tests of reasonableness have been successfully challenged by FQHCs

PROSPECTIVE PAYMENT SYSTEM (PPS)

- *Allowable costs*
  - FQHC Services, as defined in Medicaid Statute: 42 USC §§ 1396a(a)(10)(A) and 1396d(a)(2)(C) and 1396d(l)(2)
  - FQHC services (Medicare rural health clinic services) and any other ambulatory services in the State Medicaid plan provided by the FQHC
  - Gray area = enabling services
- Significant variation across states in "allowable costs"
  - Partially attributable to "any other ambulatory service" provision
  - Some states carve out required services (prenatal, lab, radiology)
  - **Enabling services also treated inconsistently across states.**
  - **Enabling services are required of FQHCs per 42 U.S. Code § 254b, but PPS payment provisions do not specifically reference this section**

PROSPECTIVE PAYMENT SYSTEM (PPS)

- *Encounter* – The PPS rate is an all-inclusive "encounter rate," which includes a face-to-face visit with a billable provider and any services provided incidental to that visit (e.g., lab)
  - **Non-provider visits (e.g., nurse-only, case management only) are not billable, but costs may be included in PPS rate**
- *New FQHCs* -- For FQHCs designated after FY 2000, the State plan shall provide for payment in an amount (calculated on per visit basis) that is equal to 100% of the costs based on:
  - The rates established for other centers or clinics located in the same or adjacent area with a similar case load or
  - In the absence of such a center, in accordance with Medicare FQHC cost principles
  - In some states, this rate becomes permanent; in other states, it is an interim rate until the FHQC establishes its own cost-based rate.

PROSPECTIVE PAYMENT SYSTEM (PPS)

- *One rate versus multiple* – States have a single PPS rate for each health center that covers all services (e.g., medical, dental, behavioral health); other states establish service-specific rates or varying rates for each of a health center's sites
- *Trend rate* – After the base rate is set, the FQHC's PPS rate is adjusted each year by the change in the Medicare Economic Index (MEI) for primary care services
- *Carve-outs* -- May be excluded from rate; billed separately
  - Pharmacy (optional)
  - Off-site services ("four walls" requirement)

PROSPECTIVE PAYMENT SYSTEM (PPS)

- *Change in Scope* – States must have processes in place to adjust PPS rates based on an increase (or decrease) in the scope of services provided by the FQHC
  - Two-step process: HRSA approval of scope change followed by appeal to state for rate adjustment
  - Examples: Adding a new service (including non-billable services), changes in intensity of services
- *Managed Care* - States required to make "wrap around" payments (at least 4x/year) to FQHCs that contract with Managed Care Entities
  - Payment = difference between the payment received by the FQHC for treating the MCE enrollee and the payment to which the FQHC is entitled under the PPS

FQHC CHANGE IN SCOPE

- A change in the type, intensity, duration and/or amount of services.
- Each state has different policies concerning scope changes detailed in the Medicaid State plan.
  - May impose a minimum change in cost threshold (for example, an event must cause at least a 3% net increase in the FQHC's average cost per visit).
  - May recognize scope changes associated only with the addition of new services.
  - My refuse to recognize the full cost impact associated with a change in the scope of services.
  - Some states have never fully implemented a change in scope policy, or do not implement it continuously.

STRENGTHS OF PROSPECTIVE PAYMENT SYSTEM (PPS)

- Has largely fulfilled the goal of ensuring that Section 330 grant funds are not used to subsidize Medicaid
- Relative to traditional fee schedules, which often are not updated for years at a time, PPS has done a better job keeping up with costs
- Depending on details of state PPS methodology, creates financial incentives for providers to invest in enabling services that can improve outcomes and reduce downstream costs
- Provides a mechanism (albeit imperfect) for FQHCs to have changes in the type or intensity of services to be reflected in their rate

WEAKNESSES OF PROSPECTIVE PAYMENT SYSTEM (PPS)

- Medicare Economic Index (MEI) has generally not kept pace with costs, causing some FQHCs to struggle financially

Year	2010	2011	2012	2013	2014
MEI	1.2%	0.4%	0.6%	0.8%	0.8%
Year	2015	2016	2017	2018	2019
MEI	0.8%	1.1%			1.5%

- Lack of concrete guidance has led to wide variations across states in how PPS is implemented
  - Some states allow separate PPS payments for visits to a medical provider and a behavioral health provider on the same day and some do not
- Adding innovative models of care do not usually trigger change in scope

Question #2
How familiar is your organization with APMs?

- ❑ We understand what APMs are but do not have any experience working with them
- ❑ We are beginning to develop capacity to develop and/or implement APMs
- ❑ We have some experience with developing and/or implementing APMs
- ❑ We are very experienced with developing and/or implementing APMs
- ❑ We have successfully developed and/or implemented APMs that have been shown to improve value of care

ALTERNATIVE PAYMENT METHODOLOGIES

- BIPA allows states to either a PPS utilizing the methodology prescribed in statute or
- An Alternative Payment Methodology (APM), which must:
  - Pay participating health centers at least what they would have been paid under the PPS; and
  - Be agreed to by the health center(s) receiving the APM
  - Not all health centers in the state must participate
  - Health centers may opt-in and opt-out of the APM
- APM option gives states and FQHCs some (albeit limited) flexibility to adapt to state needs/preferences
- Some states have both PPS and APMs in place
- Several types of APMs exist

ALTERNATIVE PAYMENT METHODOLOGIES

- Eight Categories of FQHC APMs (some states have a combination)
  - PPS inflated above MEI (Texas)
  - Cost reconciliation (MO)
  - Rebased rate (DE)
  - Enhanced rate above PPS for some services (MI)
  - Full FQHC PPS plus a quality or utilization incentive (DC)
  - Per member per month bundled wrap payment (OR)
  - Per member per month bundled wrap payment with a quality component (WA)
  - FQHC wrap revenue included in the MCO premium (IL)

THE ATTRACTION OF A CAPITATED FQHC APM

- Improve predictability of revenue stream and cash flow
- Movement away from strict reliance on face-to-face visits as payment
- Support practice transformation including use of a broader “non-billable” workforce
- Improve member-centric access to primary care
- Facilitate care for a larger population via larger PCP panel sizes without increasing that PCP’s visit volumes
- Reward for outcomes
- Align with any opportunity for shares savings and/or shared risk for the cost of health care services beyond primary care

CAPITATED FQHC APM

(PPS derived revenue in the Baseline Year)

# of empaneled Medicaid Member Months in Baseline Year

= PER MEMBER PER MONTH APM RATE*

*Rate is inflated annually by current trend rates; broken into State and MCO portions

ASSUMPTIONS FOR ILLUSTRATION PURPOSES

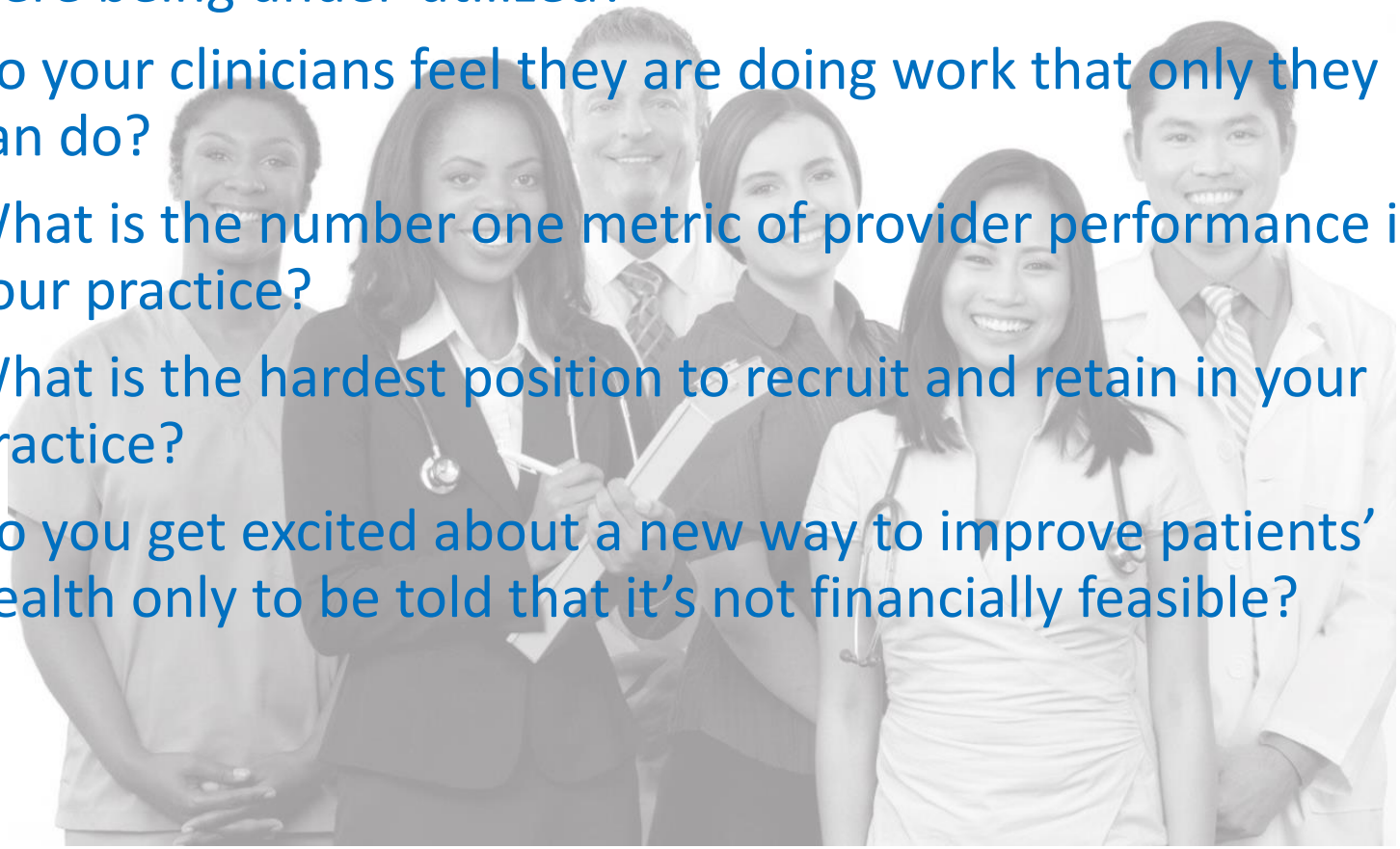
- PPS $135/visit
- PCP productivity 3500 visits/yr.
- PCP panel size 946
- % Medicaid 57%
- Medicaid panel size 539
- Total PCP visits 3.7—3.5—3.3
- Demand for PCPs willing to serve Medicaid recipients allows panel expansion to fill resultant capacity at same payer mix

- PPS FFS equivalent revenue $269,325
- ($135/visit X 3.7 average annual visits X 539 Medicaid member panel size)

EXAMPLE: NON-PREVENTIVE PCP VISITS PROGRESSIVELY DECREASE

Per FTE PCP	Baseline Year	Year One	Year Two
PCP Visits PMPY	3.7	3.5	3.3
PCP Panel Size	946	1000	1061
% Medicaid	57%	57%	57%
PCP Medicaid Panel Size	539	570	605
Medicaid Payment Equivalent PMPM	$ 41.63	$ 39.38 PPS $ 41.63 APM	$ 37.13 PPS $ 41.63 APM
PCP Panel Medicaid Revenue per FTE	$269,325	$269,325 PPS $284,715 APM	$269,325 PPS $301,970 APM
Increase PCP Panel Revenue per FTE		$ 0 current $15,390 APM	$ 0 current $32,645 APM

PRIMARY CARE CAPITATION AND USE OF THE FULL CARE TEAM



+ Have you lost team members because they felt their talents were being under-utilized?
+ Do your clinicians feel they are doing work that only they can do?
+ What is the number one metric of provider performance in your practice?
+ What is the hardest position to recruit and retain in your practice?
+ Do you get excited about a new way to improve patients' health only to be told that it's not financially feasible?

OTHER VALUE-BASED PAYMENTS OPPORTUNITIES

Preserving Revenue

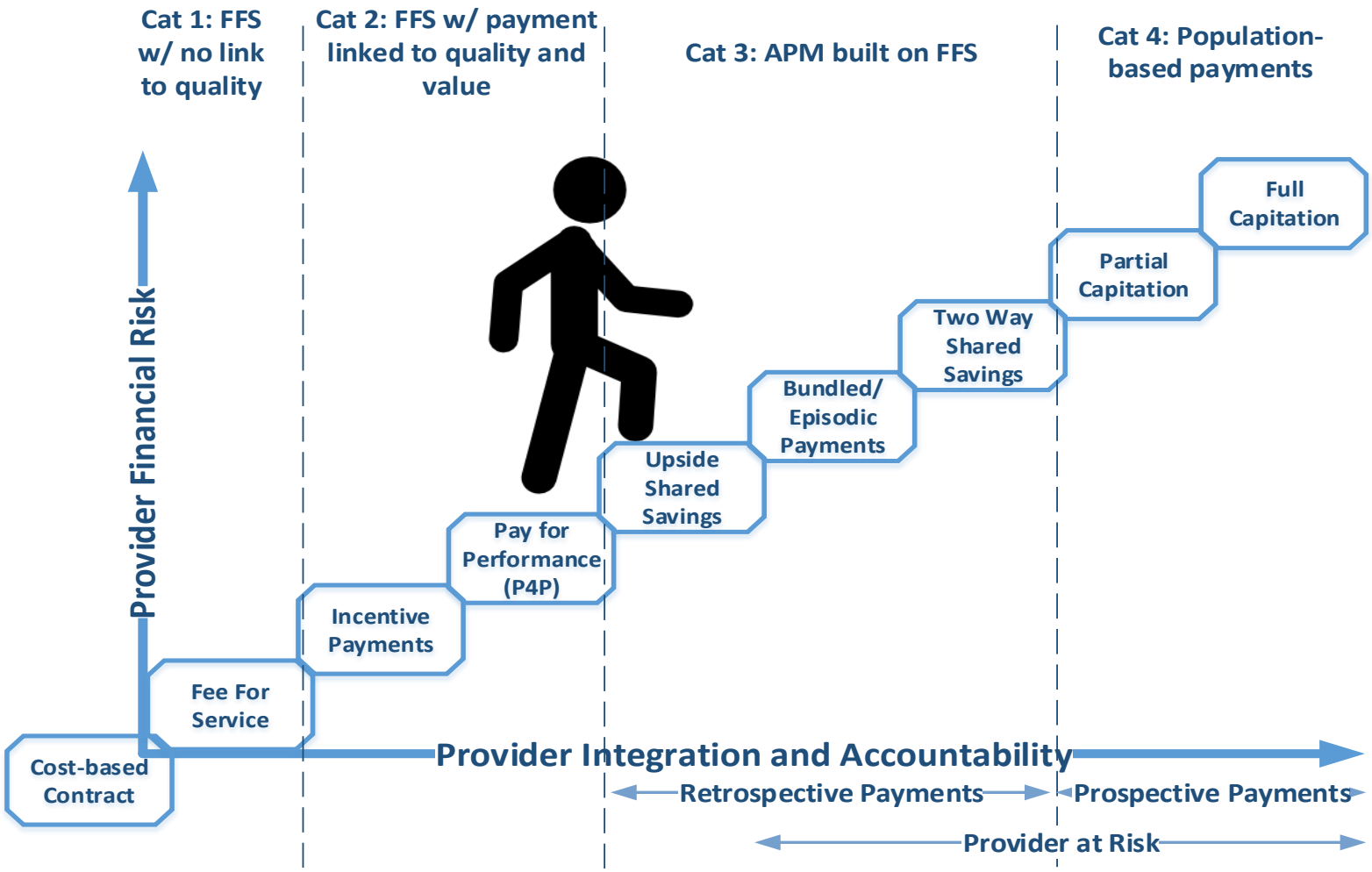
- **Fee-for-service PPS or Capitated APM**

A Bigger Piece of the Cake (Market Share)

Icing on the Cake

- **CC fee**
- **CM fee**
- **PCMH**
- **P4P**
- **Shared savings**
- **Shared risk**
- **Partial capitation for non-PCP services**
- **Global capitation**
- **Bundled payment for maternity services**

FQHCS VARYING PROGRESS IN PURSUIT OF VALUE-BASED PAYMENT



QUESTIONS/DISCUSSION

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