

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL



Health Center Strong:

Developing and Expressing Health Center Value



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NHCHC National Conference and Policy Symposium

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Capital Link - Overview

- Launched in 1995, nonprofit, HRSA national cooperative partner
 - Offices in CA, CO, MA, ME, MO, SC and WV
 - **Over \$1.1 billion** in financing for **over 225** capital projects
 - **Direct assistance** to health centers and complementary nonprofit organizations in planning for and financing operational growth and capital needs
 - **Industry vision and leadership** in the development of strategies for organizational, facilities, operational and financial improvements
 - **Metrics and analytical services** for measuring health center impact, evaluating financial and operating trends and promoting performance improvement
-

Value Defined?

Noun

1. the regard that something is held to deserve; the importance, worth, or usefulness of something.
2. a person's principles or standards of behavior; one's judgment of what is important in life.

Verb

1. estimate the monetary worth of (something).
2. consider (someone or something) to be important or beneficial; have a high opinion of.

What Will We Be Looking At?

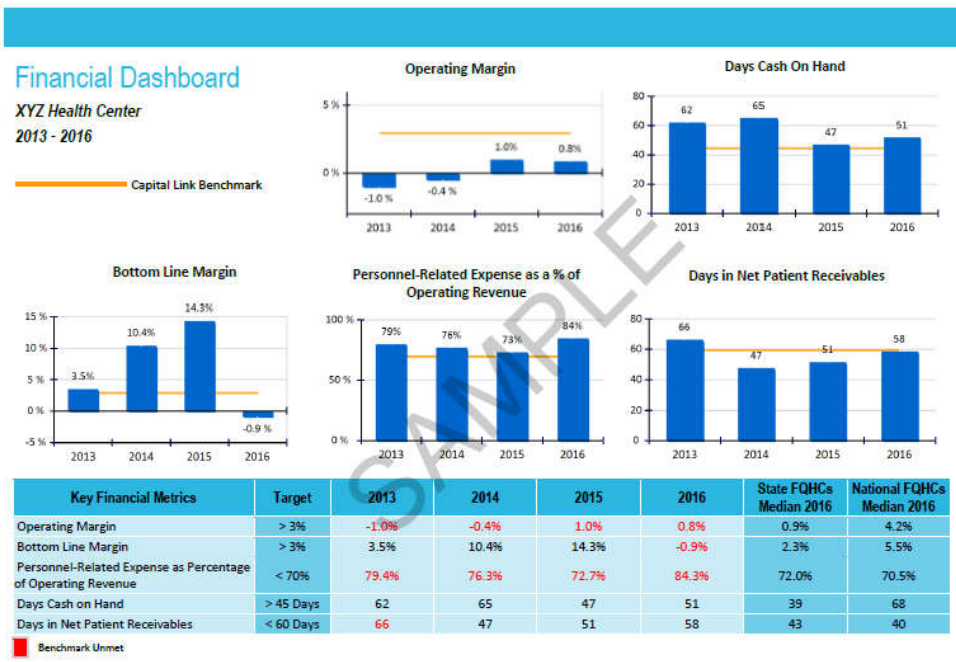
- Data and Benchmarks
- Value and Impact
- Value Based Transition
- Cost of Care
- Forecasting and Scenarios



What Does Success Look Like?



Performance Evaluation Profiles (PEP)



Key Performance Metrics

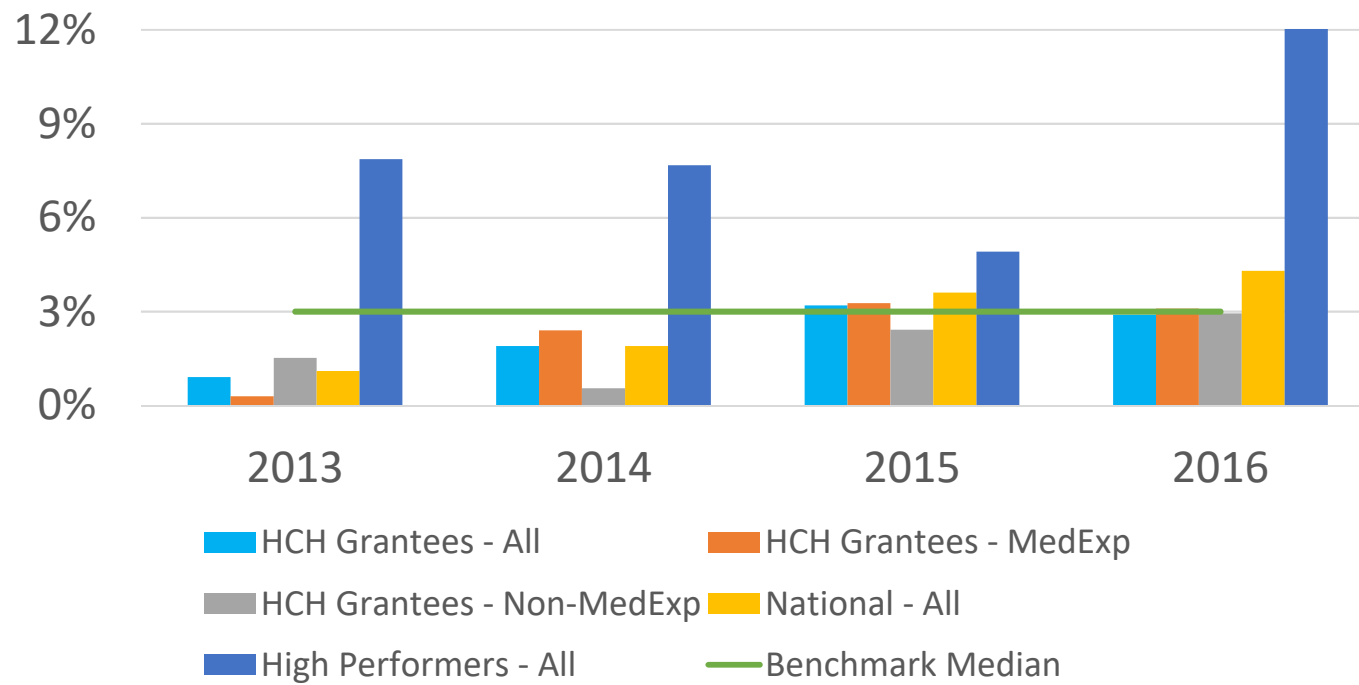
	Metric	Why This Is Important
1	Operating Margin	Measuring stick of your business model; margins typically small but need to be positive
2	Bottom Line Margin	Is performance dependent upon large capital grants and/or other sources of non-operating revenue?
3	Personnel-Related Expense	Consumes 70-75% of budget; key driver of financial performance
4	Days Net Patient A/R	Financial management starts with collecting your money efficiently
5	Days Cash on Hand	Is there enough liquidity to keep operations running smoothly?
6	Physician Productivity (visits)	Productivity is the basis for revenue generation
7	Mid-Level Productivity (visits)	Productivity is the basis for revenue generation
8	Dental Provider Productivity (visits)	Productivity is the basis for revenue generation

*Capital Link Performance Benchmarking Toolkit

Methodology

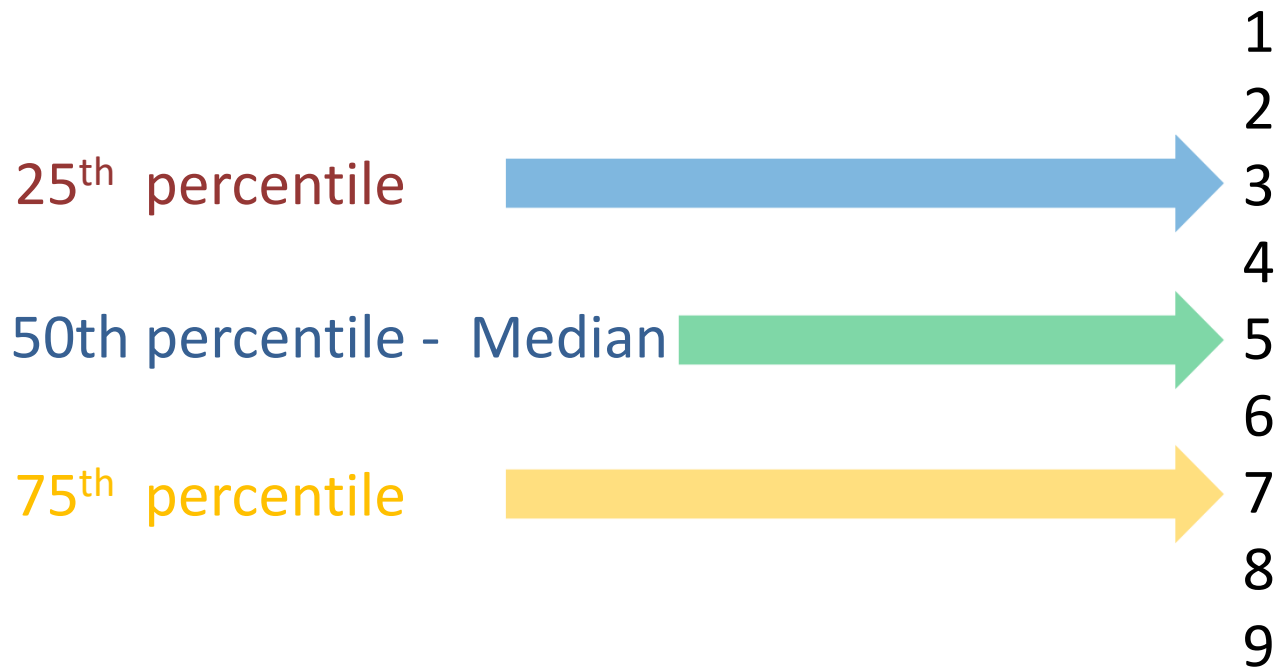
- Capital Link's database contains financial audits and UDS reports for approximately 1,100 health centers
- Medians presented for all categories unless otherwise indicated
- *High Performing* health centers are those that exceed both financial and quality benchmarks
- HCH Grantees are those identified in UDS as receiving 330h funding: ~300 organizations
 - Subgroups of those in/out Medicaid expansion states:
~210/90 split

Operating Margin - Medians

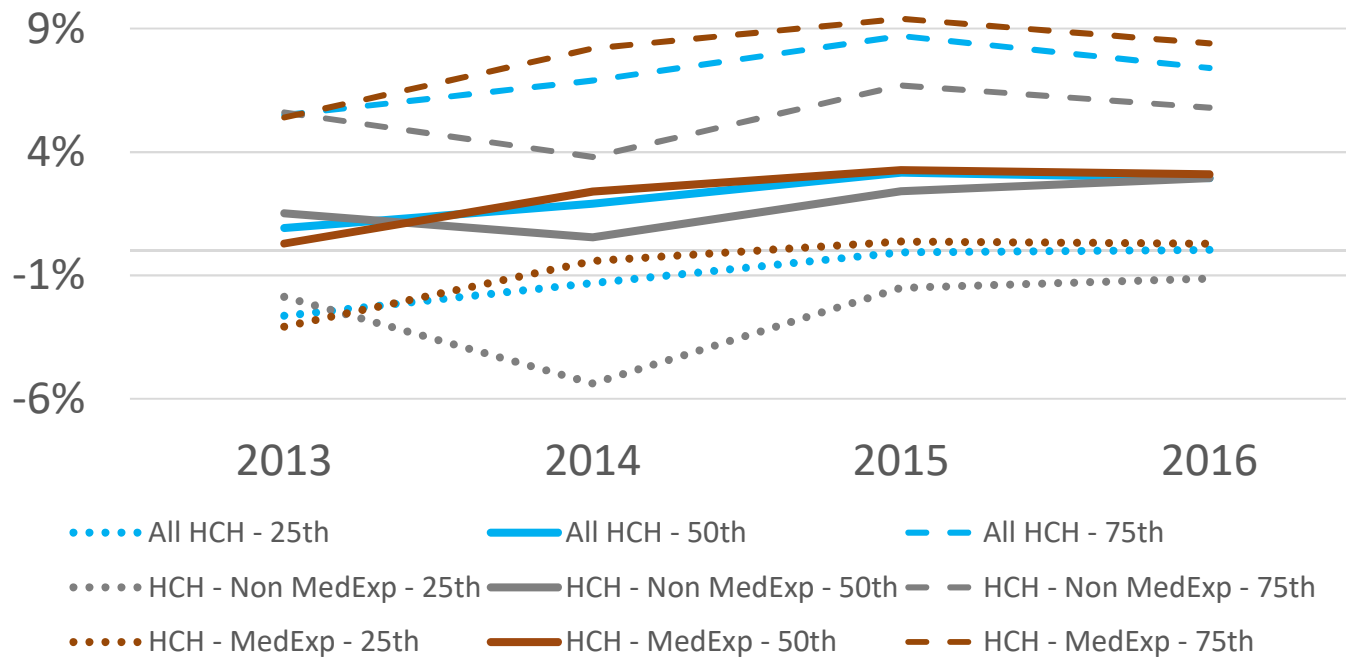


Quartiles

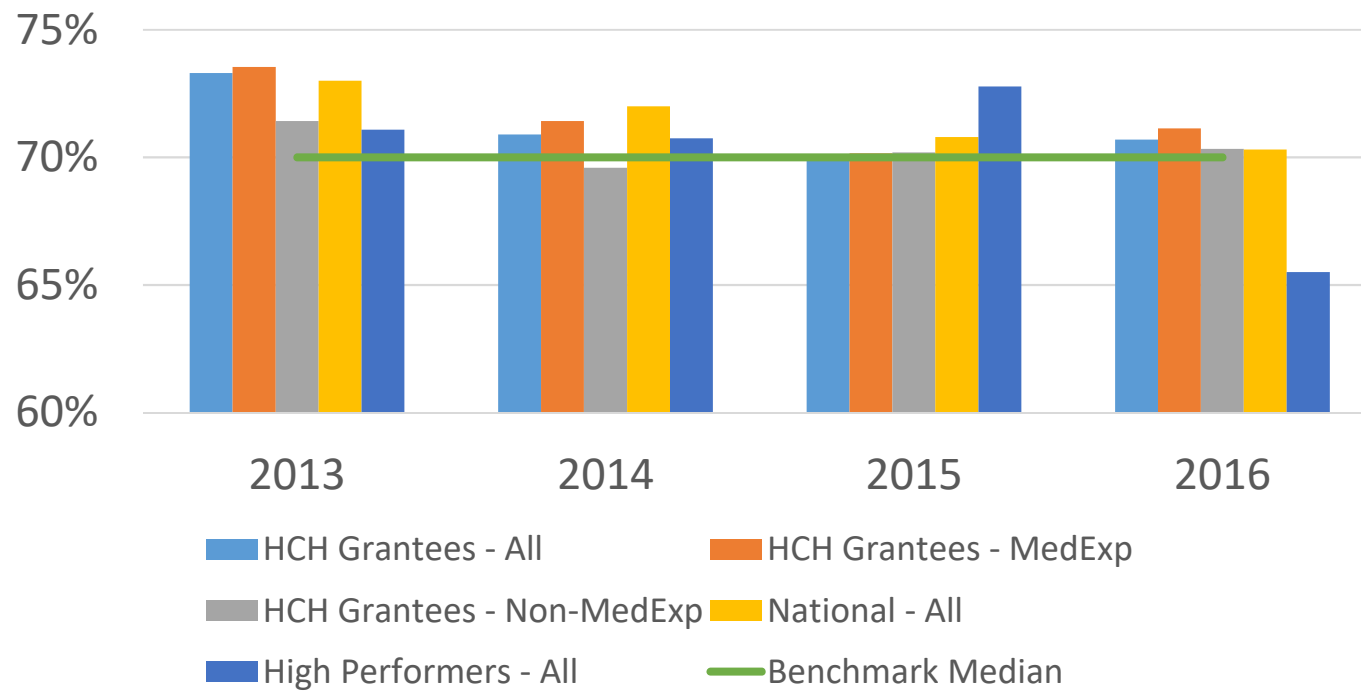
25th Percentile, Median, & 75th Percentile



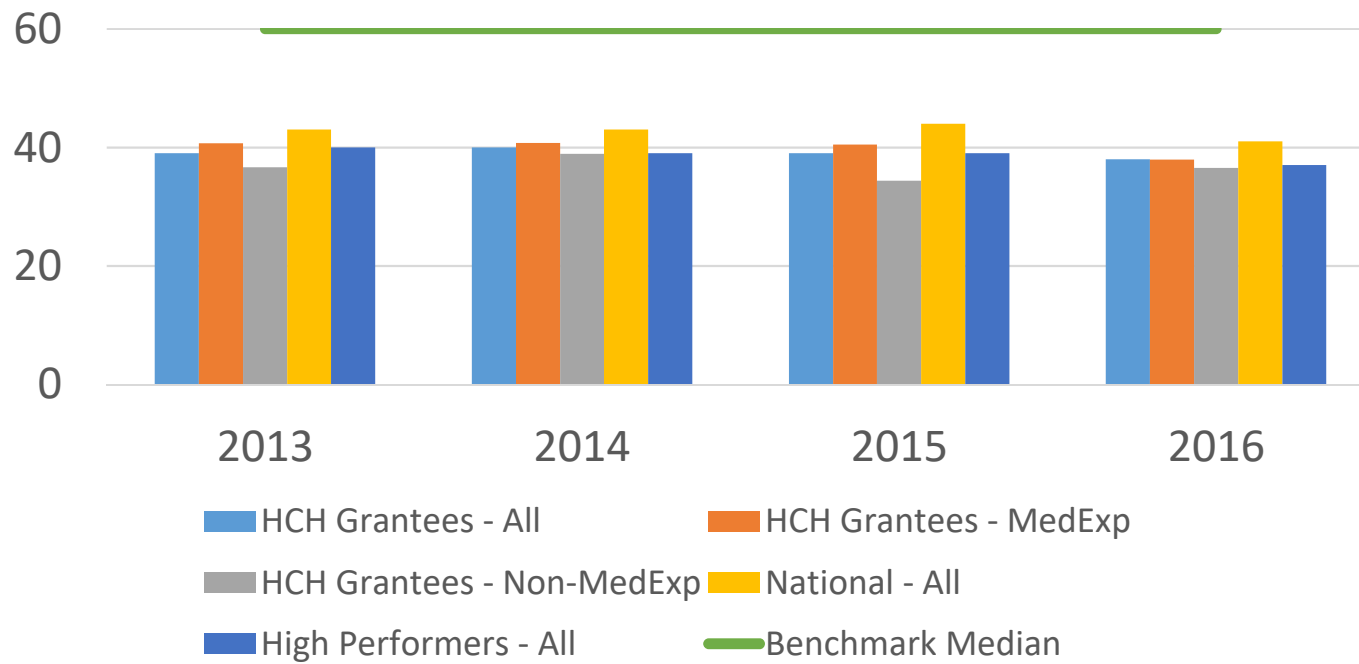
HCH Grantees – Operating Margin Percentiles



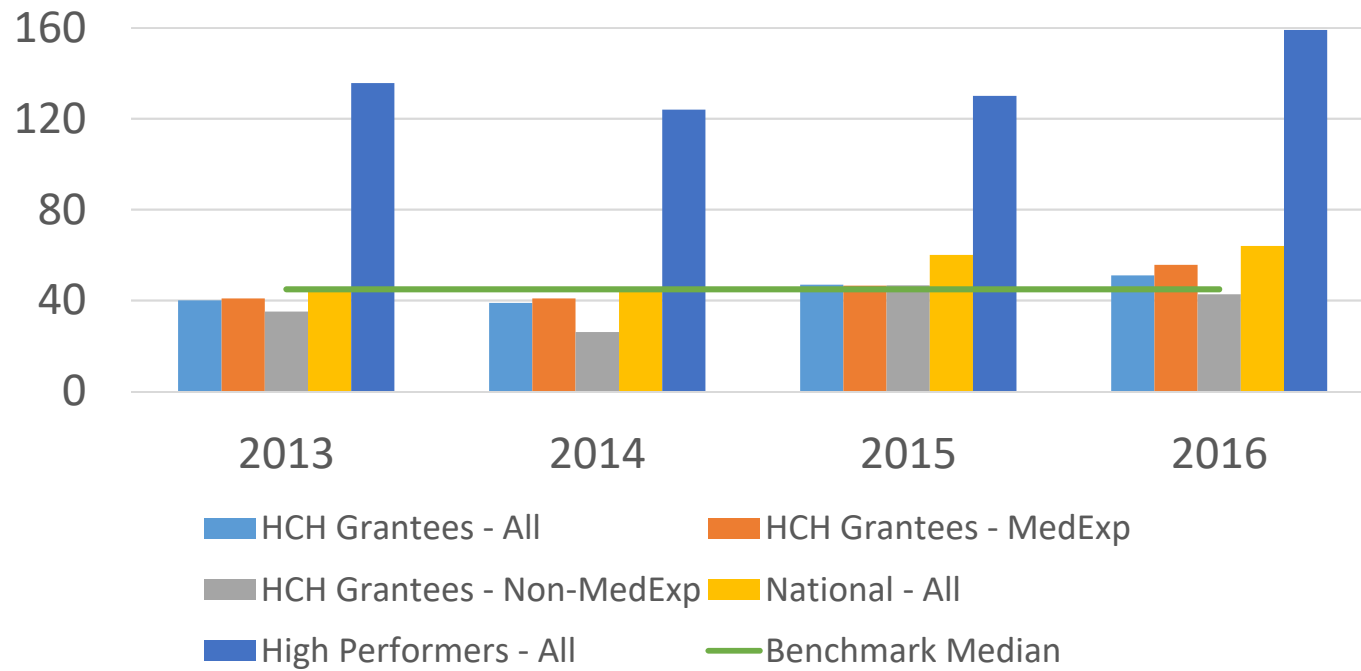
Personnel-Related Expenses As Percent of Operating Revenue - Medians



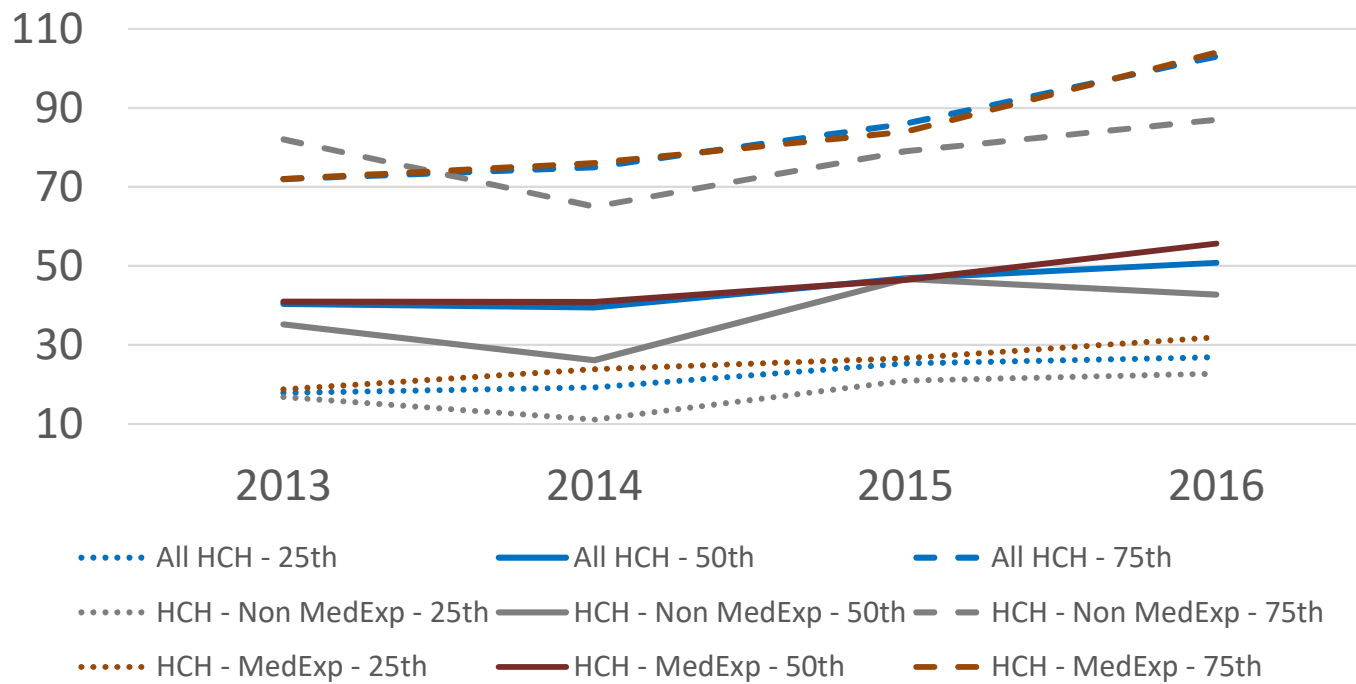
Days in Net Patient Receivables - Medians



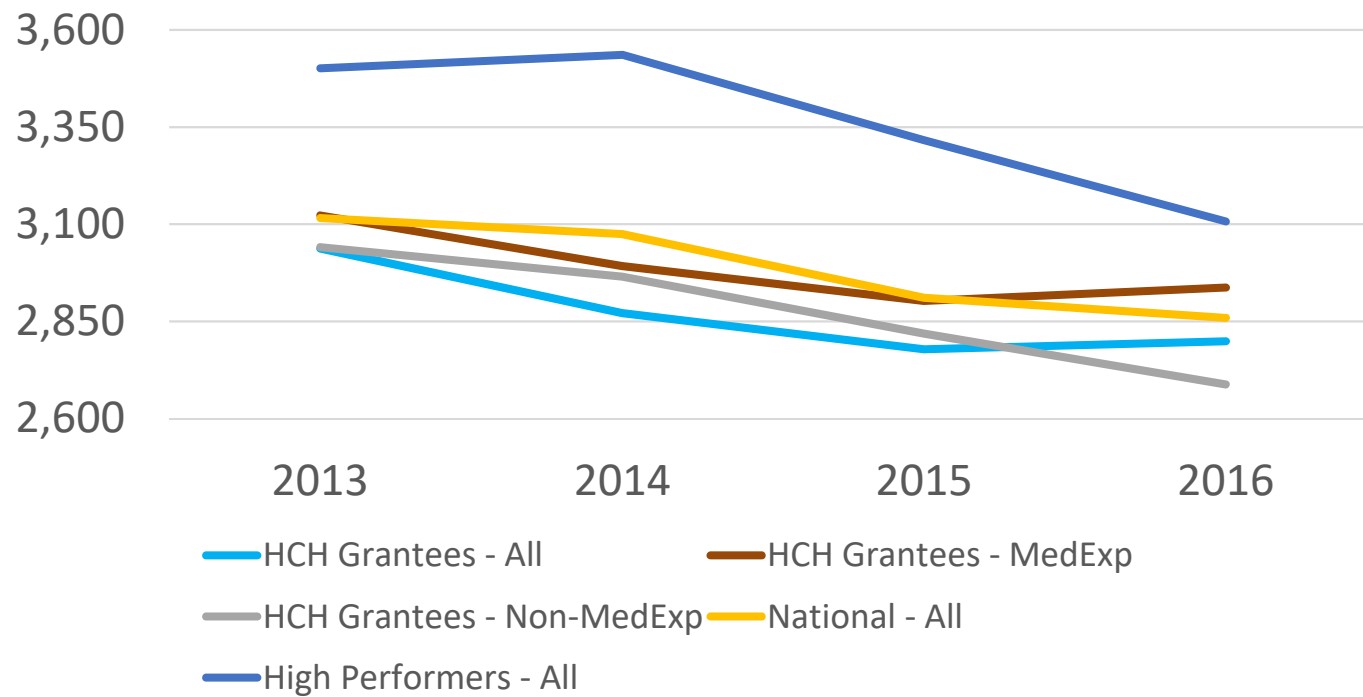
Days Cash on Hand - Medians



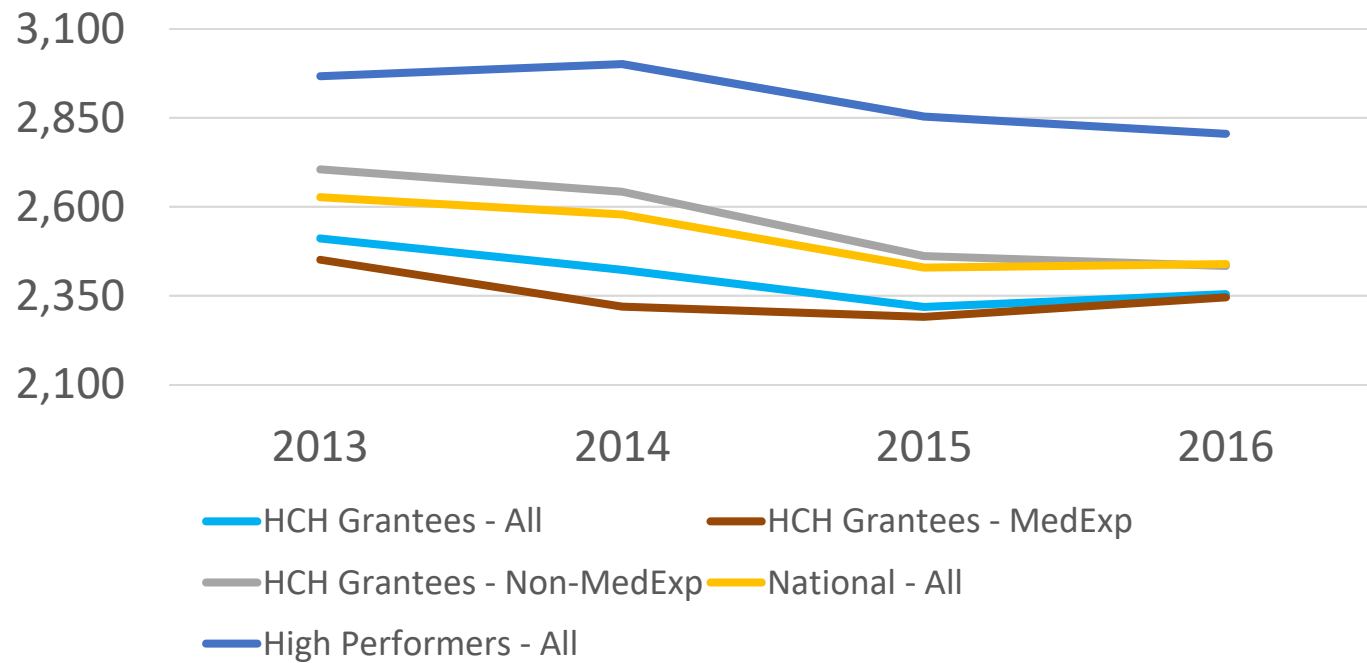
HCH Grantees – Days Cash on Hand Percentiles



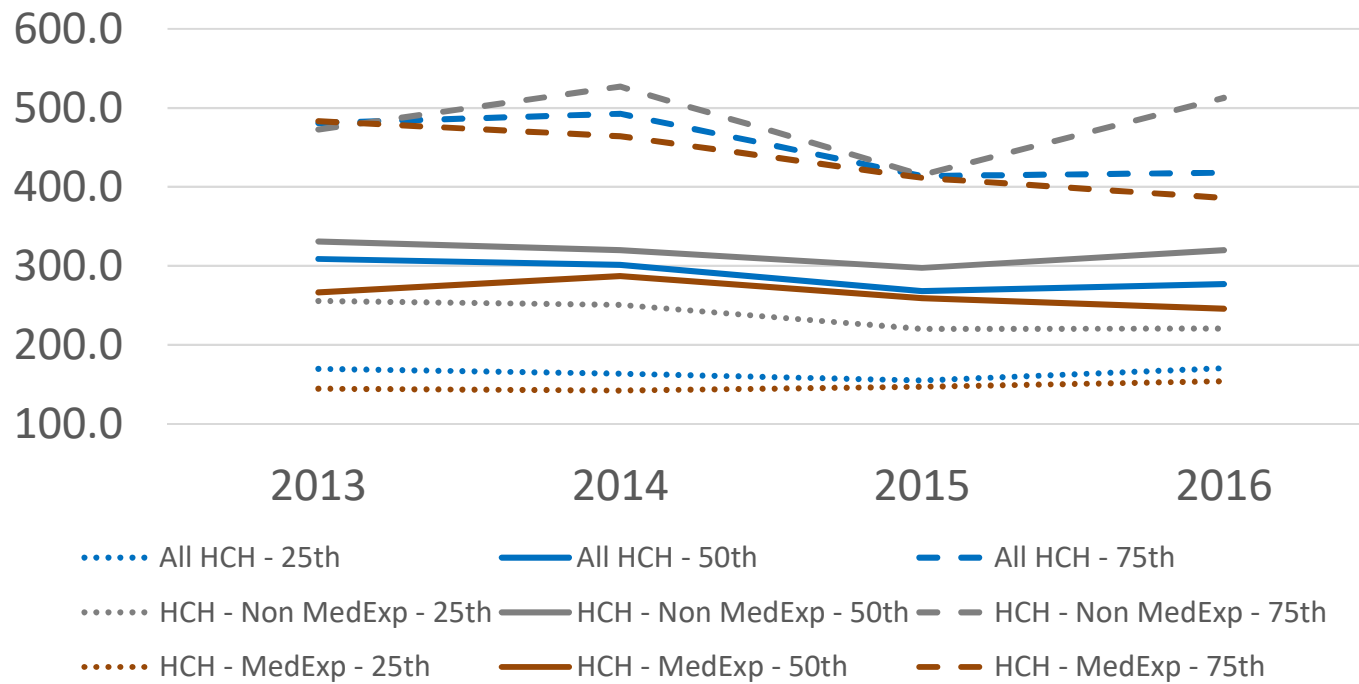
Physician Visits per Physician FTE - Medians



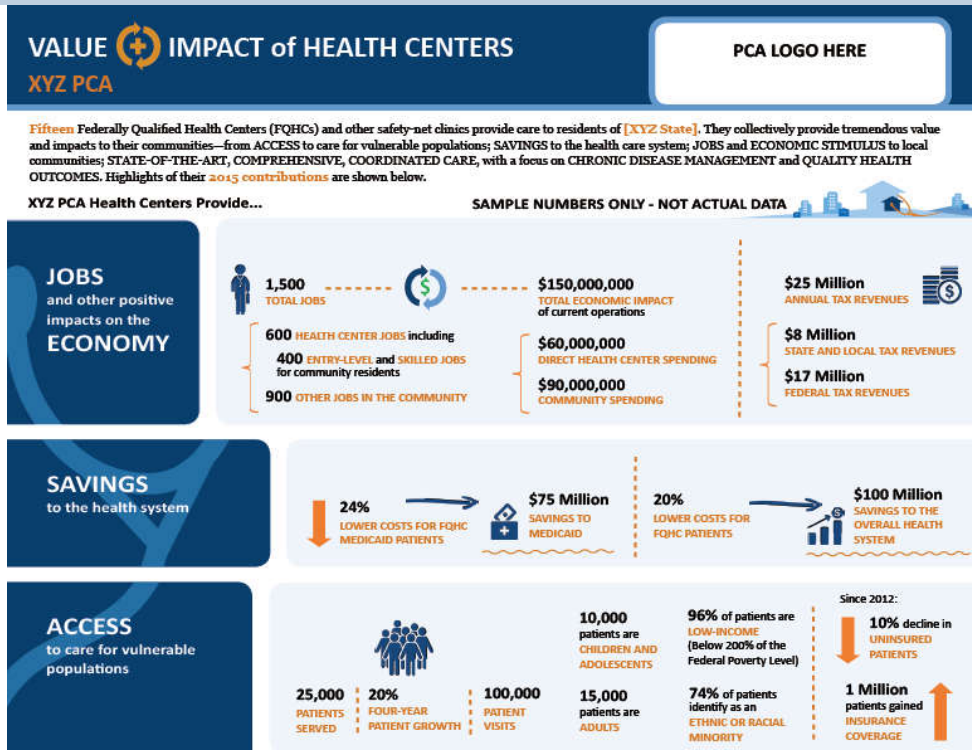
Mid-Level Visits per Mid-Level FTE- Medians



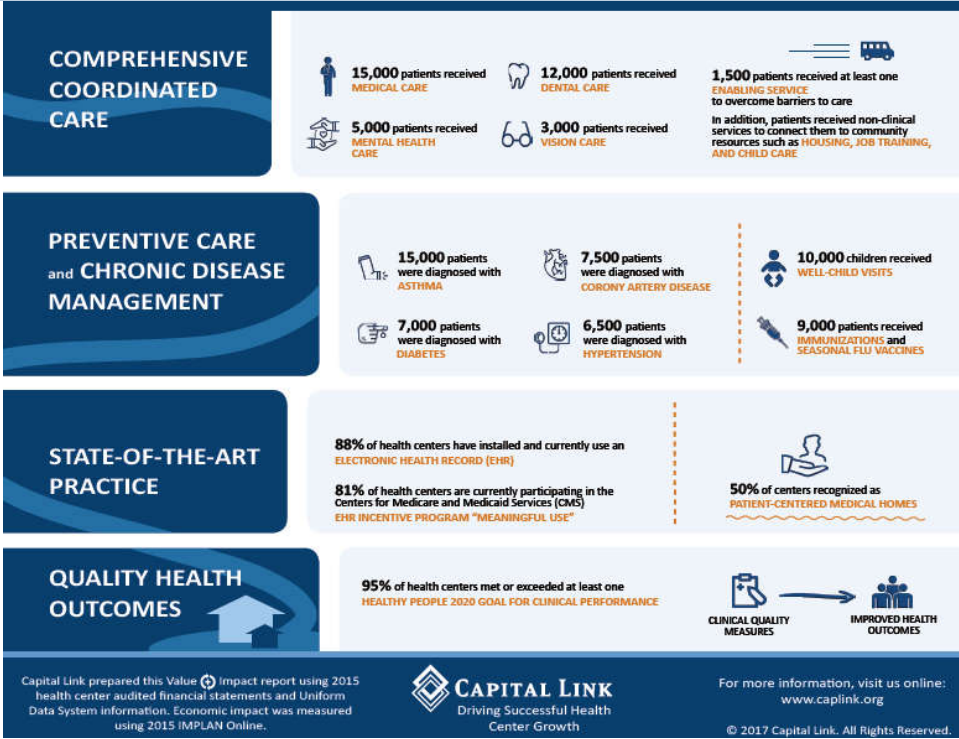
HCH Grantees – Mental Health Patients per Mental Health Provider FTE



Value & Impact



Value & Impact

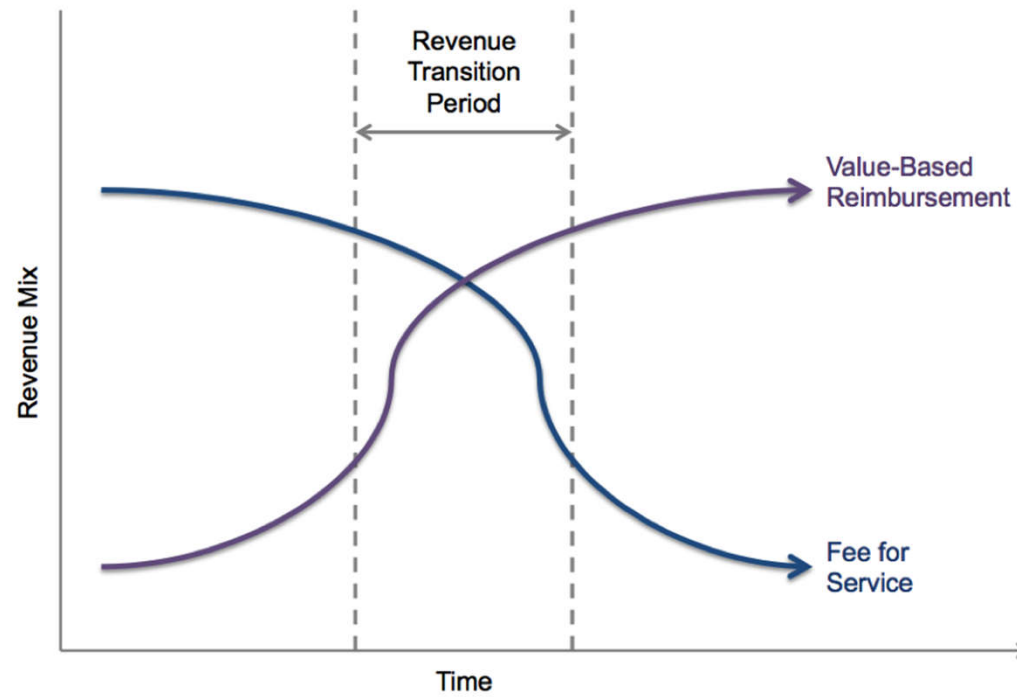


Capital Link prepared this Value Impact report using 2015 health center audited financial statements and Uniform Data System information. Economic impact was measured using 2015 IMPLAN Online.

Transition from FFS to Value-Based Reimbursement



Transition from FFS to Value-Based Reimbursement

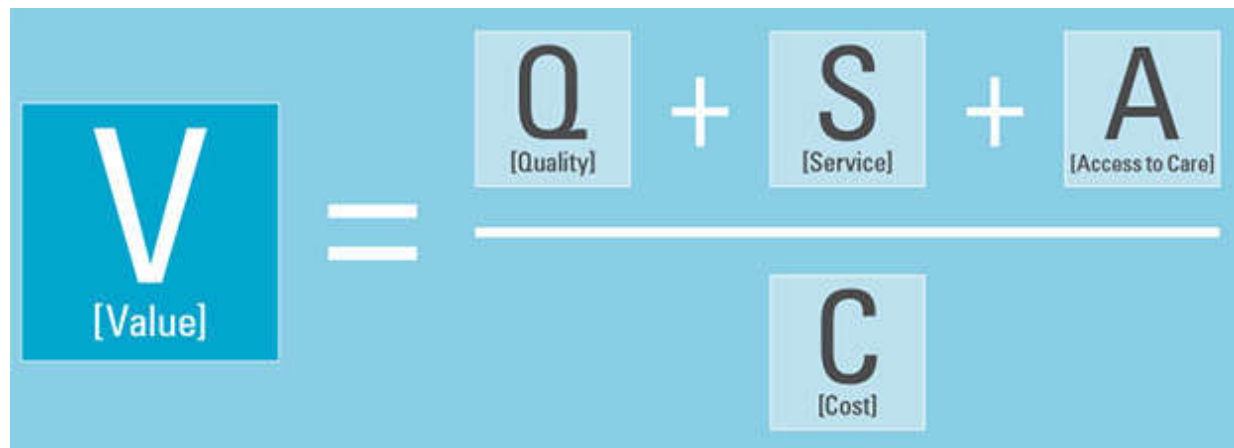


Transition from FFS to Value-Based Healthcare

"Everyone's talking about it,
no one really knows how to do it —
everyone thinks everyone else is doing it,
so we all say we're doing it."

Deb Gage, president and CEO of Medecision

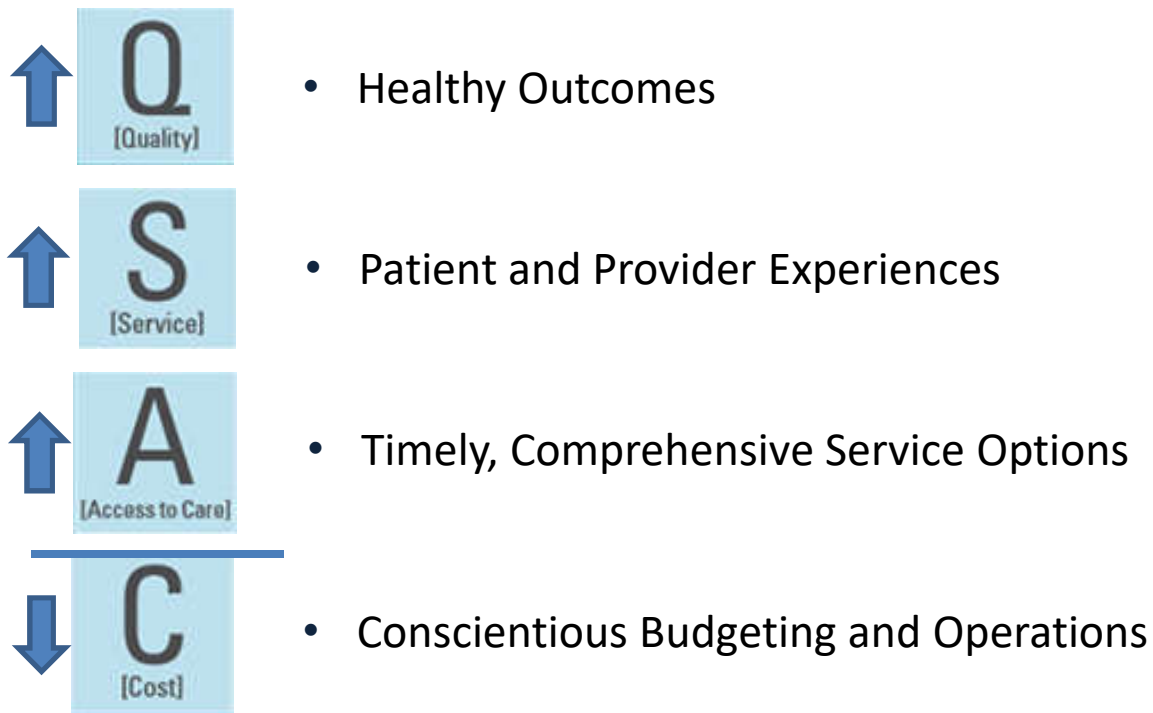
Transition from FFS to Value-Based Reimbursement



What Does Success Look Like?



Transition from FFS to Value-Based Reimbursement



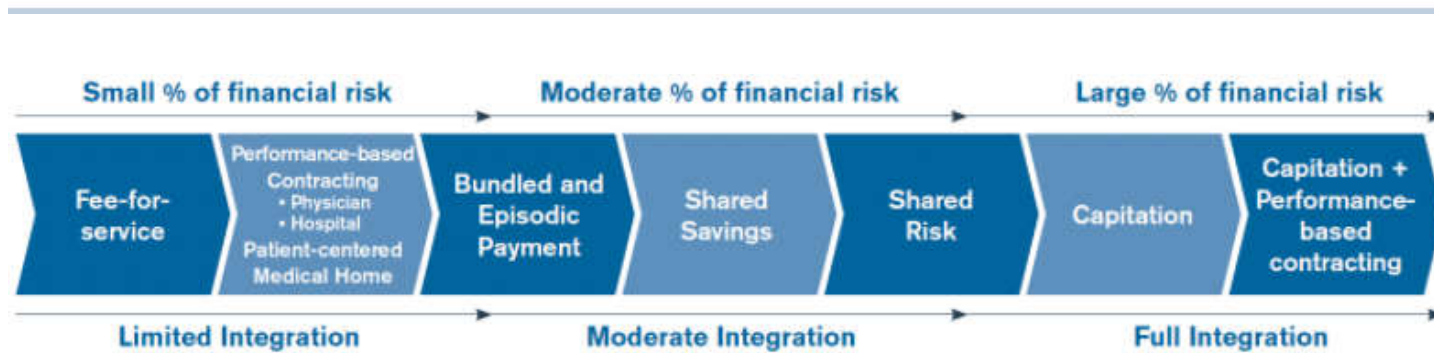
Transition from FFS to Value-Based Reimbursement



Goal 1: Improve Access to Quality Health Care and Services

Objective 1.2: Improve the quality and efficacy of the health care safety net

- Work with safety-net providers, networks, and systems to promote their assessment of and potential participation in **value-based** health care payment systems.



~~Quantity~~ → Quality



Transition from FFS to Value-Based Reimbursement

Fee for Service

- Volume
- Individual health
- Quality is a concern
- Stand-alone systems can thrive
- Little financial risk
- Manage revenues

Value-Based

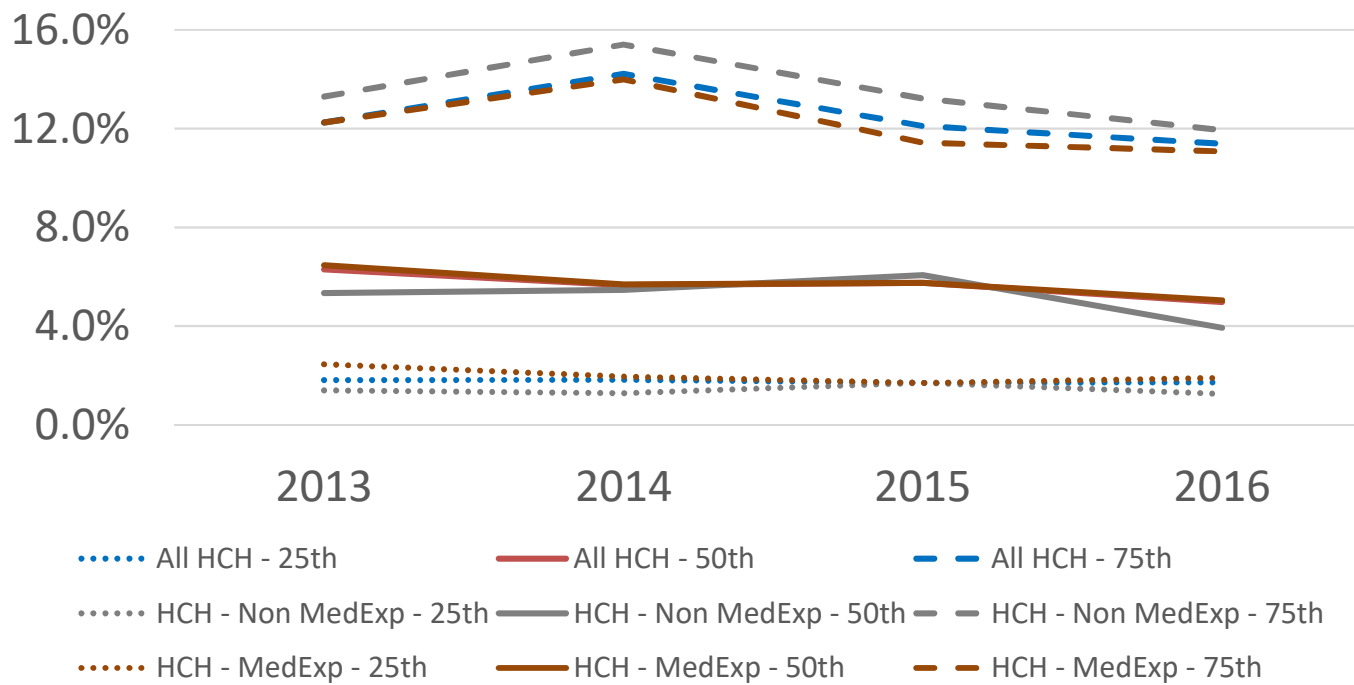
- Outcomes
- Population health
- Quality is financial driver
- Collaboration is essential
- Increased financial risk
- Manage costs

Transition from FFS to Value-Based Reimbursement

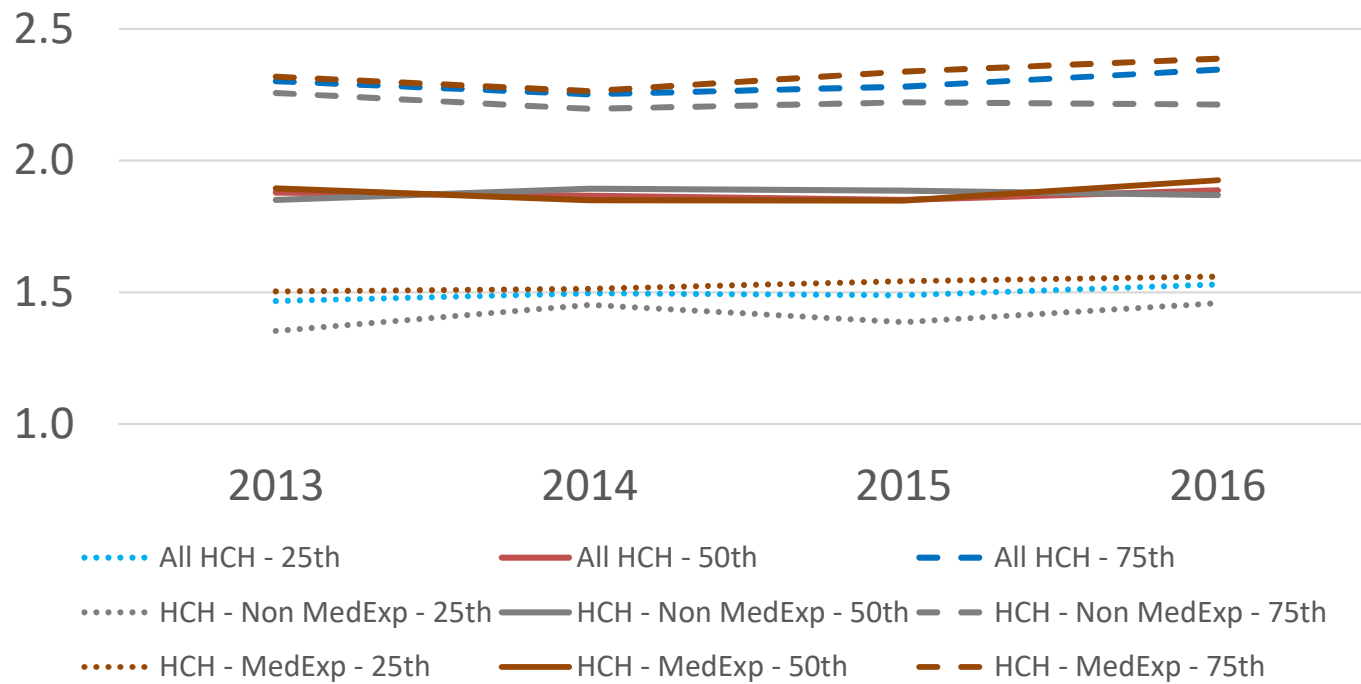
	Metric	Why This Is Important
9	Medical Provider Productivity (patients)	Becomes more important in transition to team-based care
10	Medical Team Productivity	Who are your teams? How do they perform?
11	Cost (Revenue) Per Visit	How are your visit costs changing over time?
12	Cost (Revenue) per Patient	With the move to PCMH, how are patient costs changing?
13	Medical Support Staff Ratio	How strategic is the staffing of the medical teams?
14	Non-Clinical Staff Ratio	Non-clinical employees are not revenue drivers
15	Visit/Patient Growth Rates	Are visits growing faster than patients? Is demand growing?

*Capital Link Performance Benchmarking Toolkit

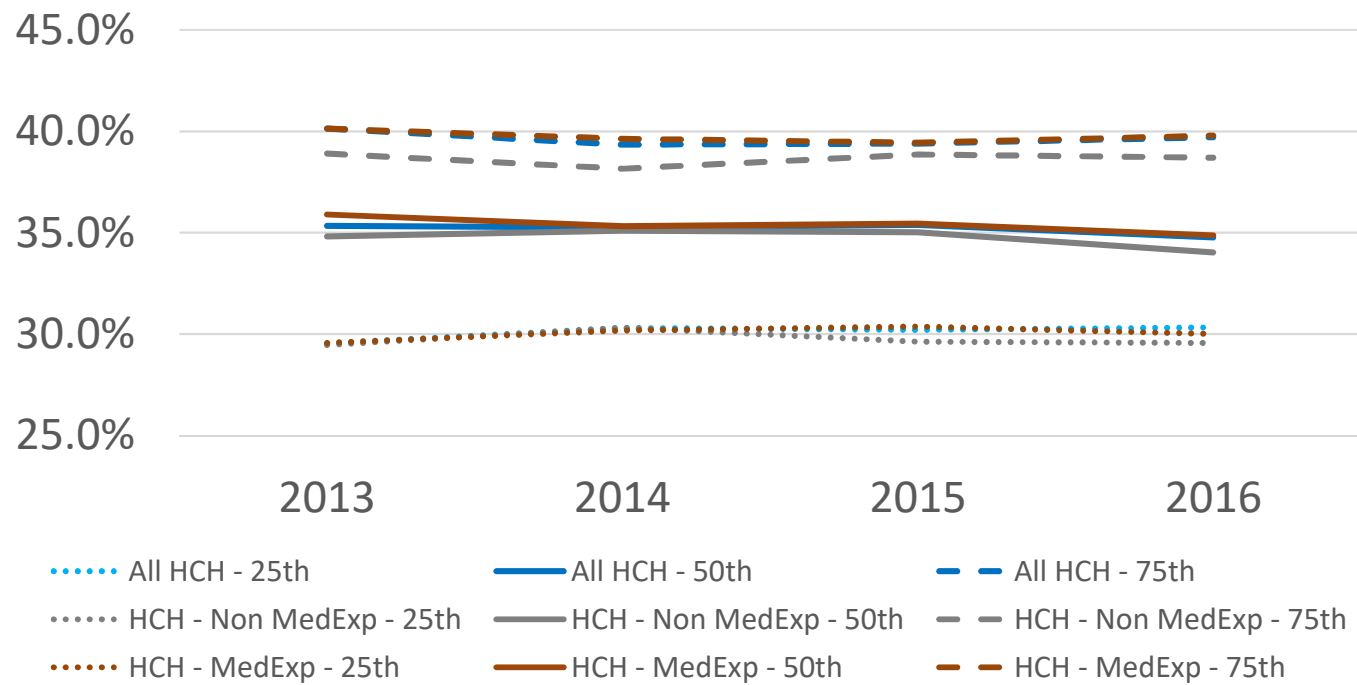
HCH Grantees - Enabling Visits as a Percentage of Total Visits



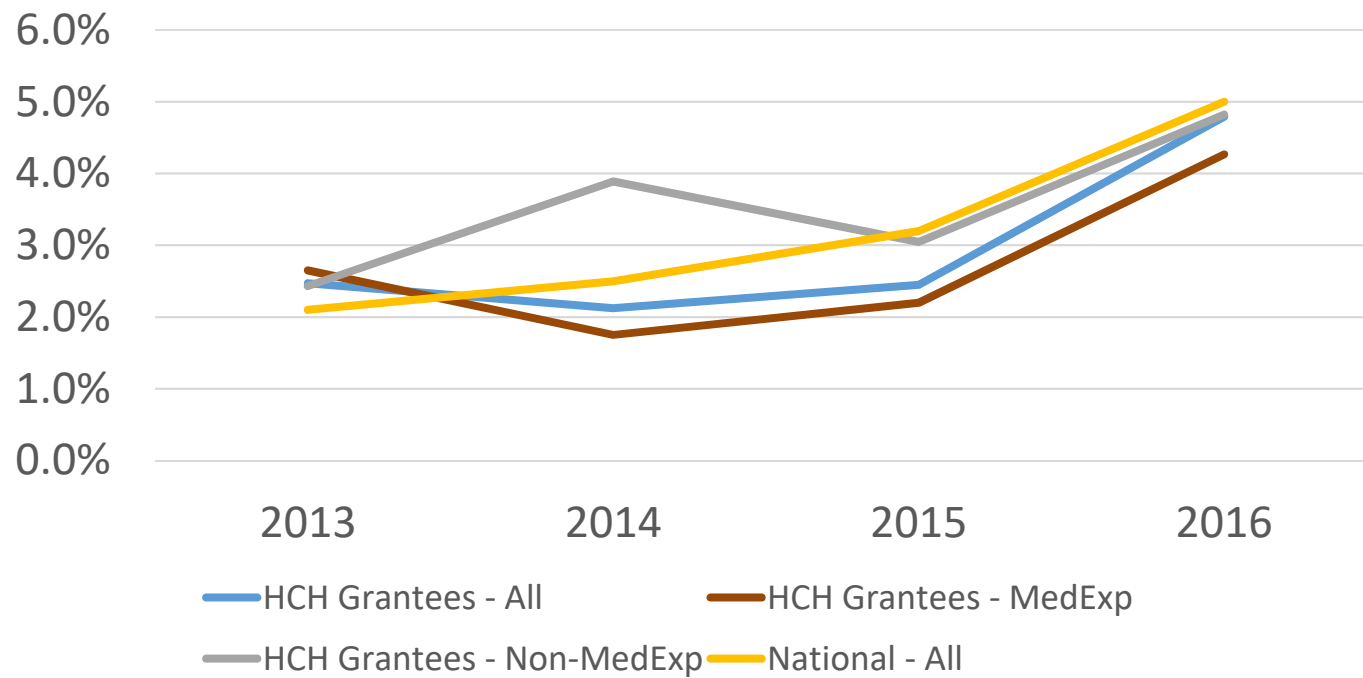
HCH Grantees – Non-Provider Medical Staff per Medical Provider



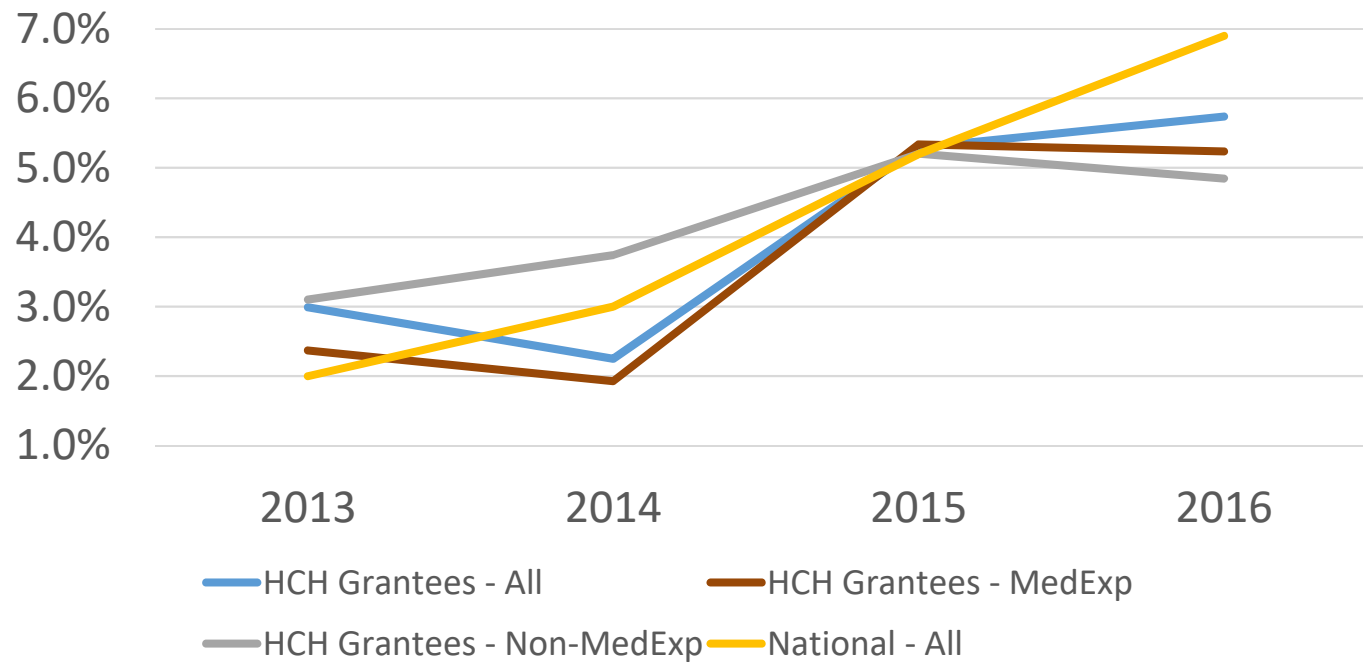
HCH Grantees – Administrative, Facilities, and Patient Support FTEs as Percent of Total FTEs



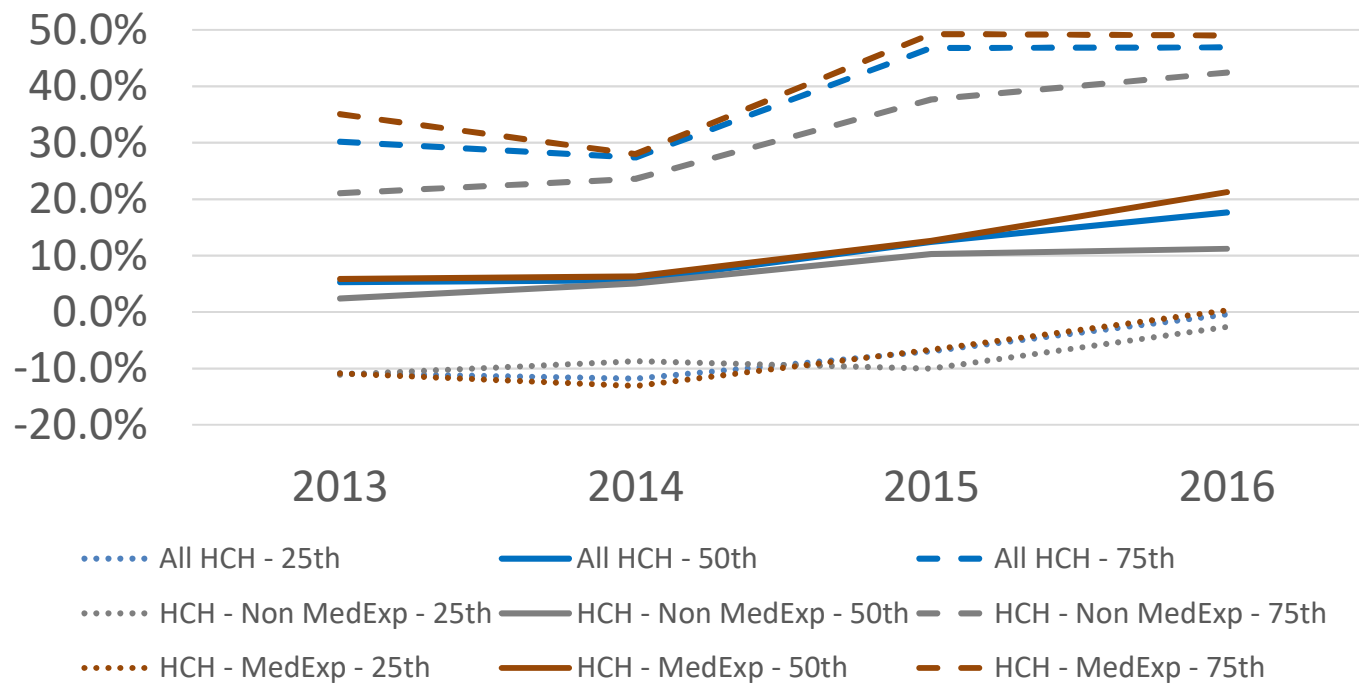
Patient Growth Rates - Medians



Visit Growth Rates - Medians



HCH Grantees - Mental Health Patient Growth Rate





Transition from FFS to Value-Based Reimbursement



California's Capitation Payment Preparedness Program (CP3)

- In 2015, Senate Bill 147 passed.
 - Three-year pilot with a monthly set fee or “capitation” taking the place of per visit payments.
 - Clinics volunteered to be test sites for a pilot of the new payment program authorized by SB 147.
 - improved data systems
 - invested in team-based approach to care, and
 - forecasted of how this new approach would impact clinic finances.
 - Unfortunately, efforts to implement SB 147 have ultimately stalled between the state and CMS.
 - Health clinics are still optimistic that SB 147 will move forward, although the timing of when that will happen remains uncertain.
-

Oregon's Alternative Payment & Advanced Care Model (APCM)



Blue Cross Blue Shield

- Moving away from fee-for-service and linking reimbursement to quality and outcomes
- Partnering with clinicians so they have the individualized data and engaging patients with education and tools
- 37 plans have more than 570 value-based programs
- More than 25 million members are currently accessing care through ACOs, PCMH, Pay-for-Performance programs, and Episode-based Payment programs.
- Those primary care providers that do not meet the requirements of their value-based care payment contracts are left with a 40% lower rate of reimbursement than others

Kaiser Permanente

- Kaiser's take on value-based care has long been imitated with large hospital systems moving into the insurance space as way to take on more financial risk and better control spending
- Three foundational principles for value-based care:
 - Measuring outcomes and costs,
 - Focusing on population segments, and
 - Customizing segment-specific interventions
- “...rebranding the Medicaid program so that it represents a care delivery system of the highest quality, affordable care.”

Kaiser Permanente

- Complex care high-tech centers serve as an option for something between an emergency department visit and a physician appointment. After the introduction of a high-tech center in one region ED visits dropped by 50 percent
- New medical office concept reimagines medical care facilities as more of a community coffee shop, as opposed to “churn(ing) patients through.” Taking cues from multiple industries, including Starbucks, the centers are intended to be places where the community can spend time exercising, eating at a fruit bar or taking wellness classes — maybe not even seeing a doctor

CMS' MACRA

- Medicare Access and CHIP Reauthorization Act
- Desire to achieve truly patient-centered care by improving the relevancy and depth of Medicare's quality-based payments
- Shifts the focus from volume to value. Physicians provide a service and their payment varies based on how well they meet certain quality measures and create value for their patients
- Focus on incentives + care delivery + information sharing

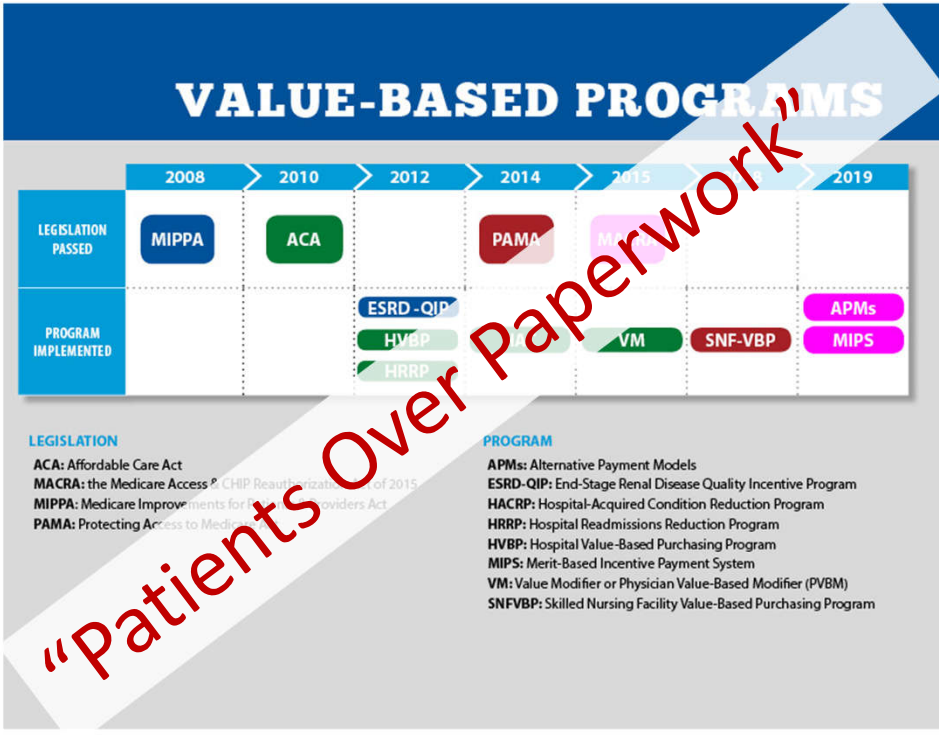


- Better care, smarter spending, and healthier people

CMS' MACRA

- Created the new Quality Payment Program (QPP)
 - The *Merit-Based Incentive Payment System (MIPS)*, which adjusts FFS payments based on quality, resource use, clinical practice improvement activities (CPIA) and advancing care information (ACI, a reformed health IT Meaningful Use program).
 - *Alternative Payment Models (APM)*, which move away from FFS and toward population-based payments.
- FQHCs are exempt from reporting under most conditions
- BUT...

CMS' MACRA



Managed Care on Value-Based Healthcare

- MCOs have focused on identifying and helping high-risk populations and addressing the social determinants of health.
- MCOs are testing value-based payment strategies that link payment with performance and are increasingly focused on engaging patients in their care.
- Leaders report common challenges: setting appropriate payment rates; managing members whose needs differ from traditional Medicaid beneficiaries; ensuring access to specialty care; and effectively implementing payment reform and practice transformation.

Looking Toward the Future

- Fee for Service is still the dominant modality for reimbursement
- Methodologies and issues discussed are still relevant.
- Organizations can and should determine what is driving their costs
- Compare their costs with other service providers various levels

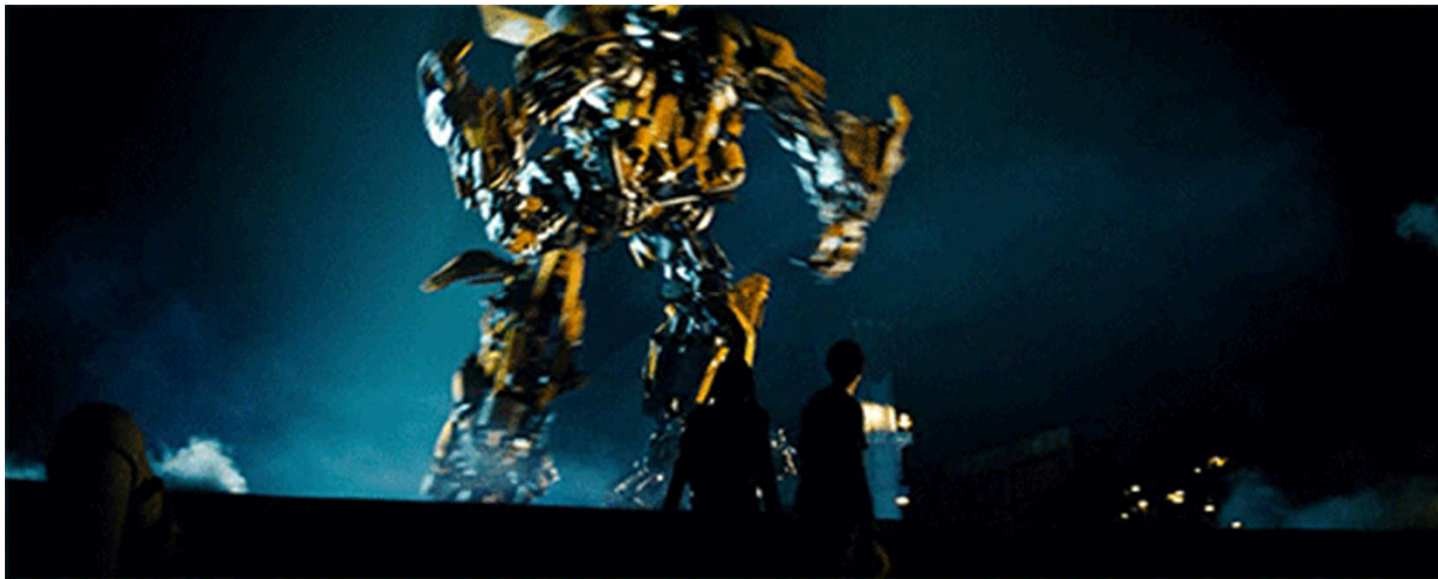
The Future is Likely to Be More Complicated

- Team-based care
- Global or value-based payments
- Integrated care.





Transforming Can Be “Fun”



What Does Success Look Like?

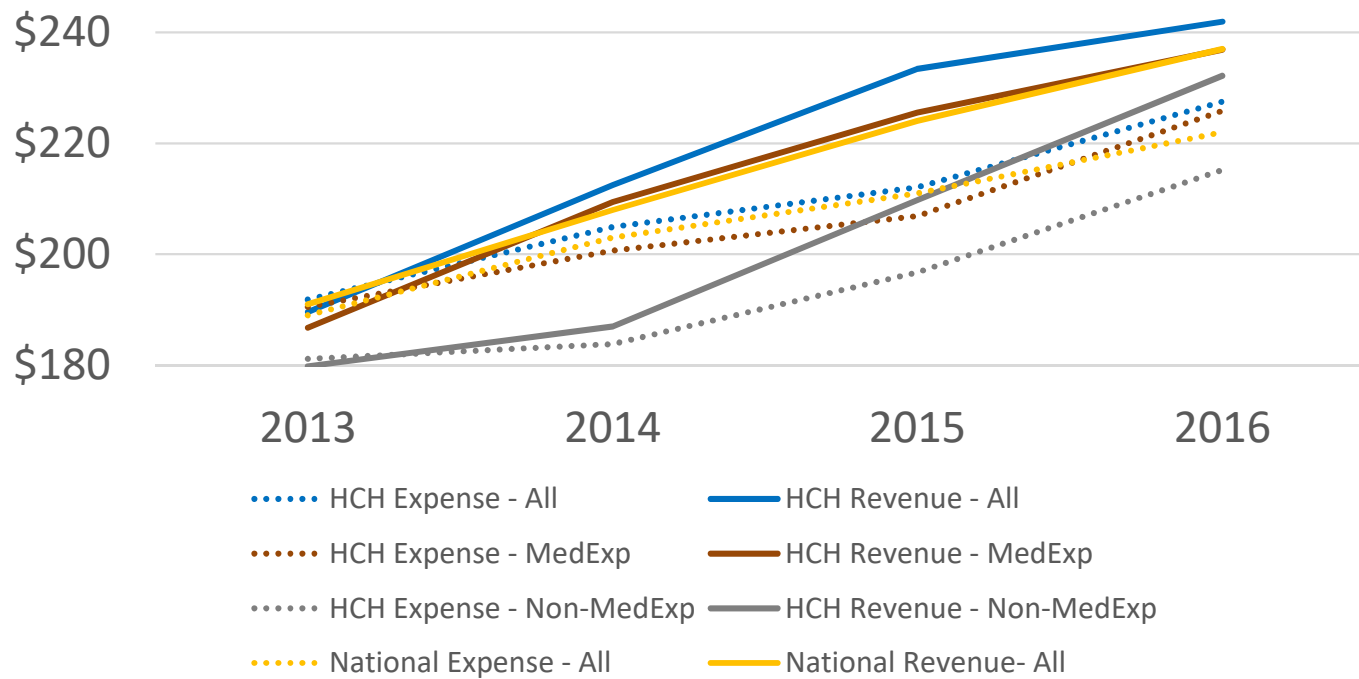


Components of Cost of Care

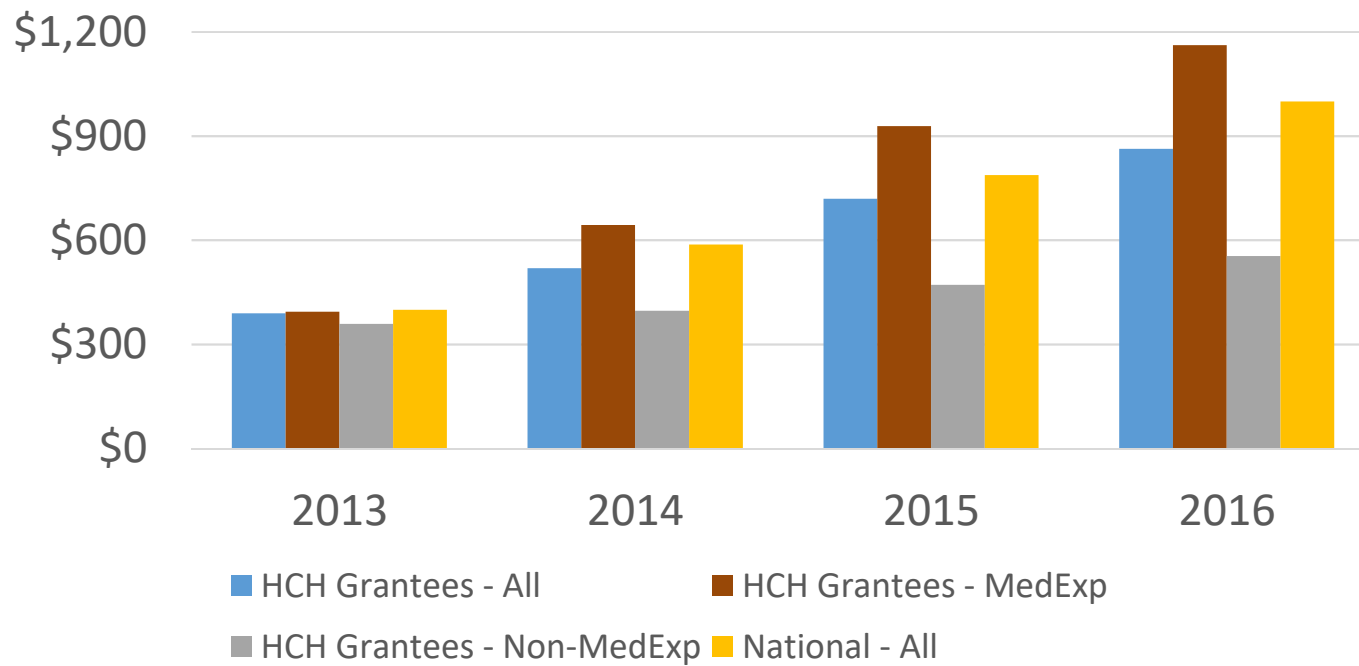
All expenses at the organization can be classified into one of the following categories:

- Provider cost
- Direct support cost
- Direct enabling cost
- Overhead cost
- Ancillary and Other cost

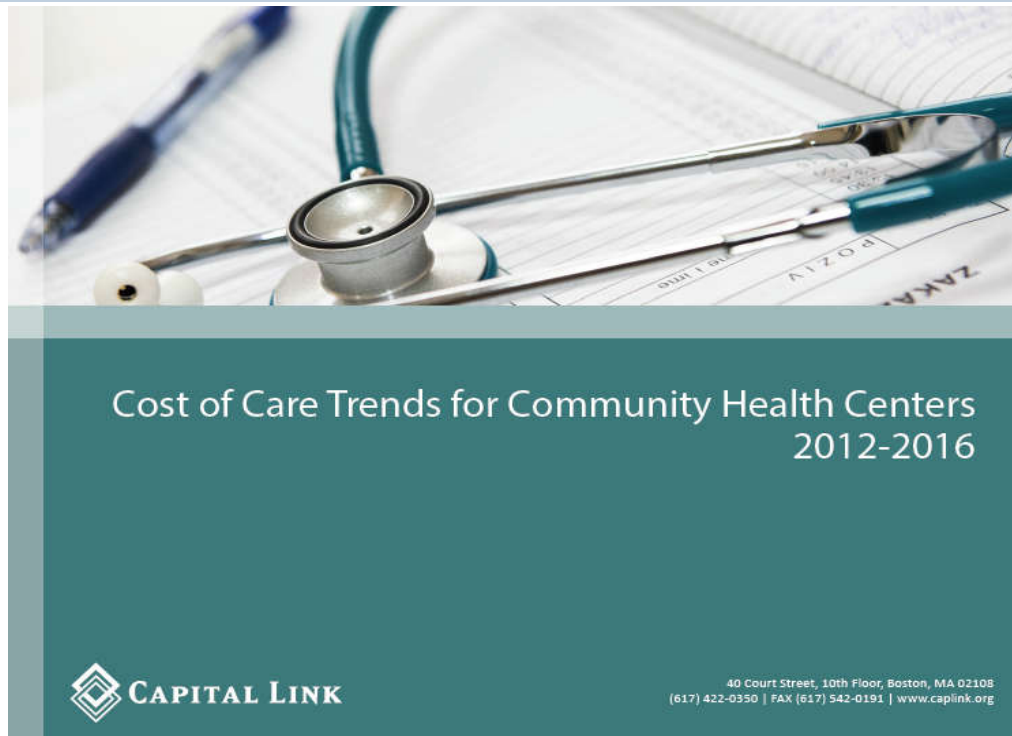
HCH Grantees - Operating Revenue & Expense Per Visit



330 Grant Dollars per Uninsured Patient - Medians



New Resource Coming Soon

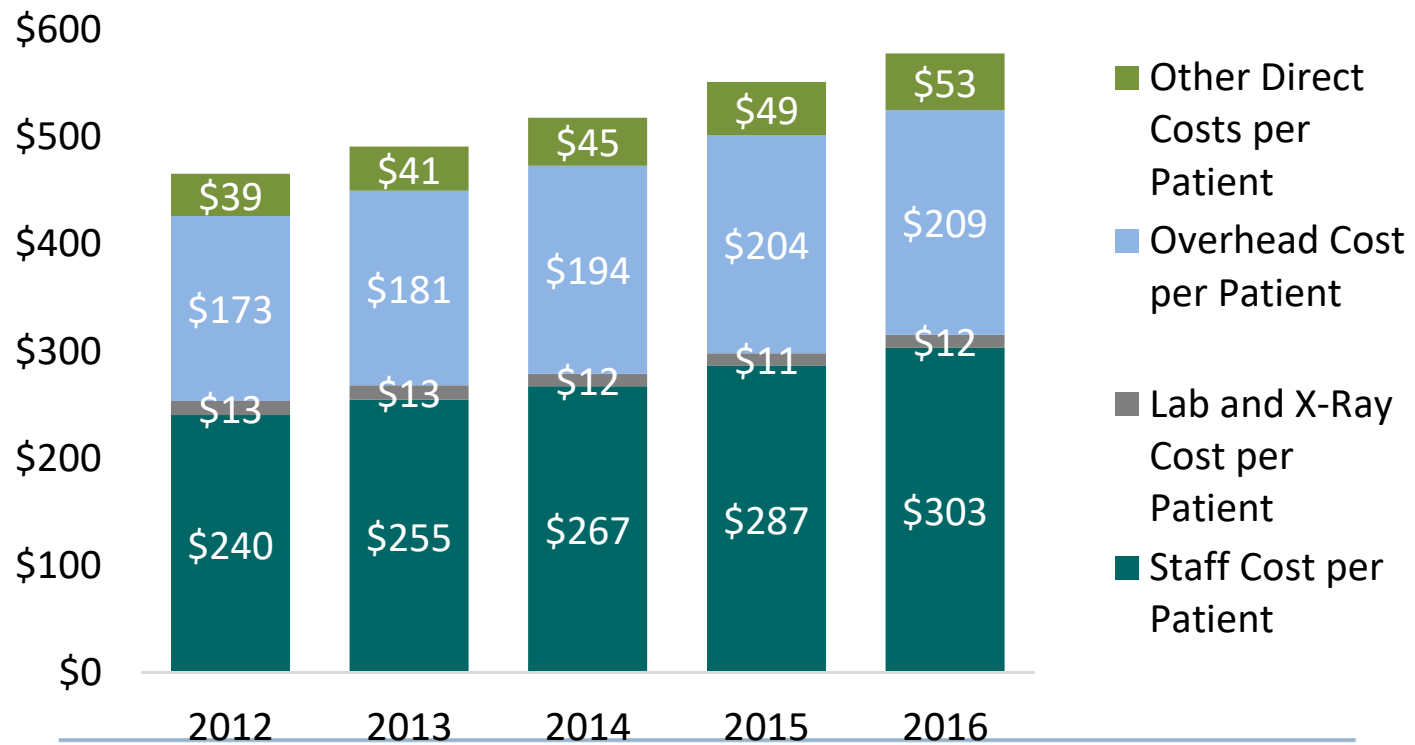


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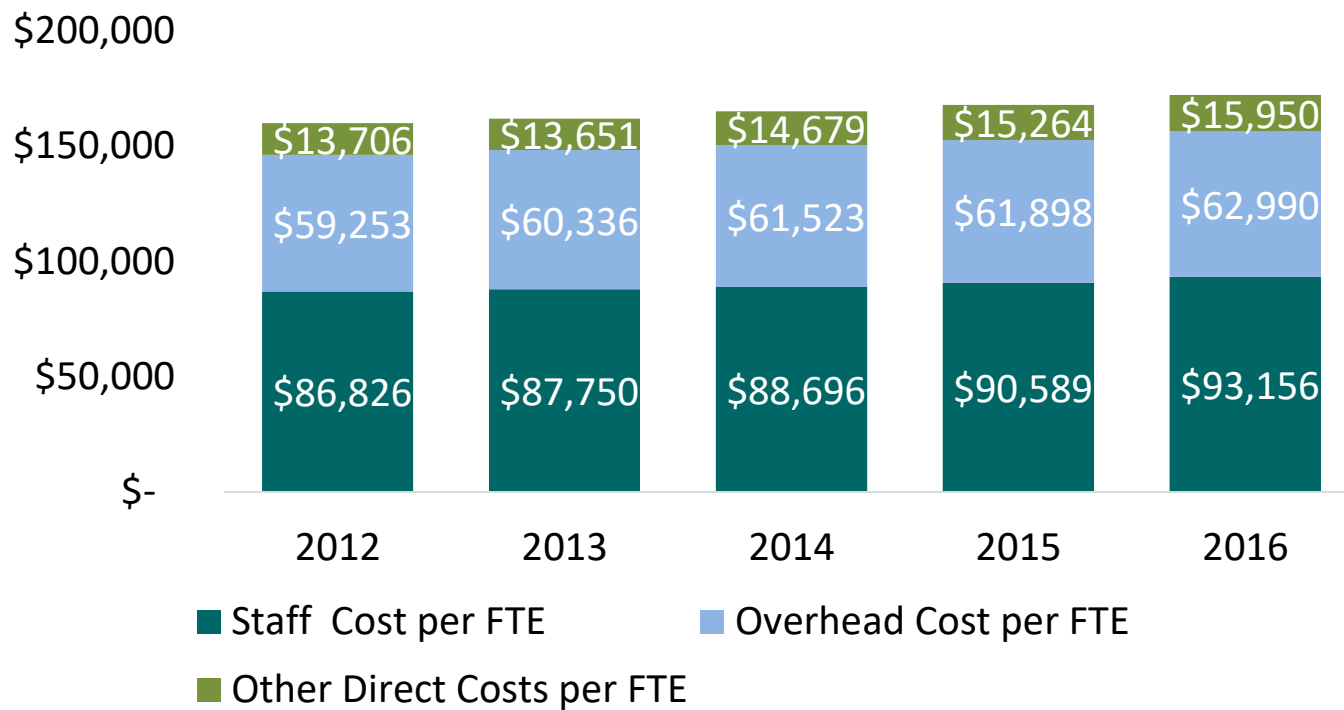
Methodology

- UDS data for all health centers, 2012 – 2016, Tables 5 and 8a
- Median values for each cost component, by patient, visit and FTE associated with each service:
 - Medical
 - Dental
 - Behavioral Health
 - Substance Abuse
 - Vision
 - Enabling Services
 - Other Professional Services
 - Pharmacy Services
 - Pharmaceuticals
- For today's presentation, also providing data for small, medium and large health centers and urban vs rural health centers

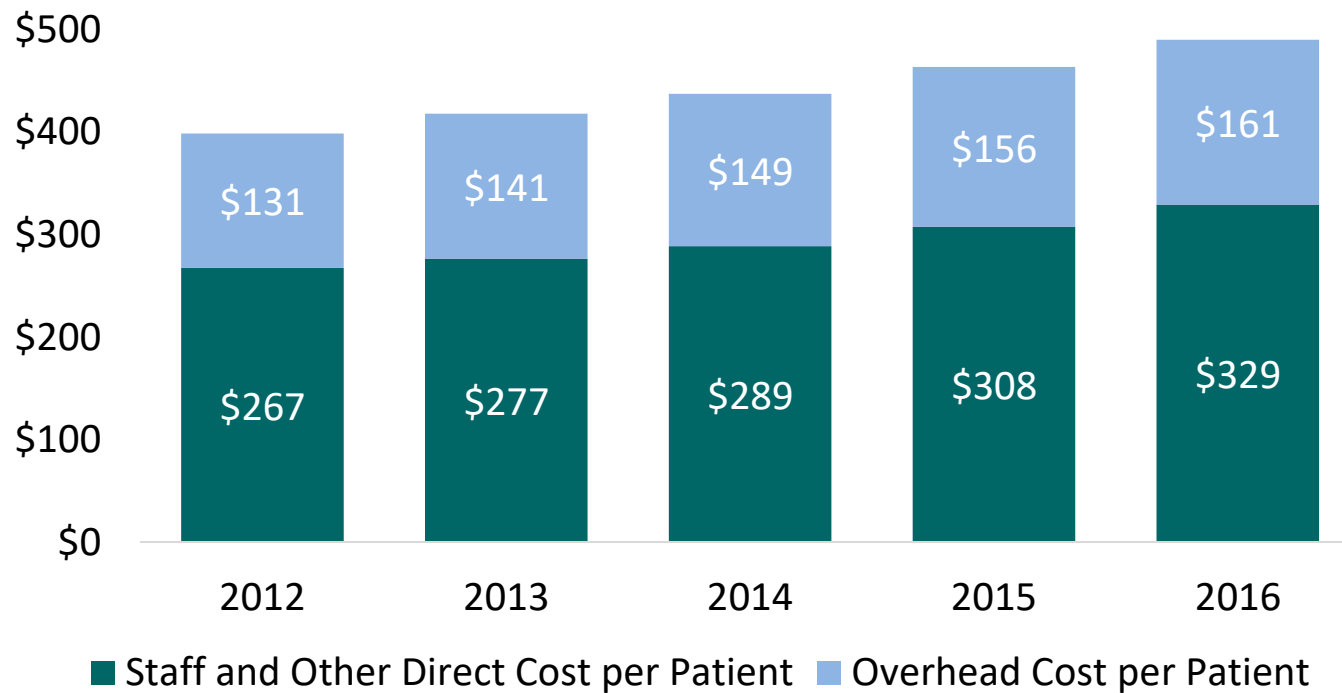
Medical Cost per Patient - National



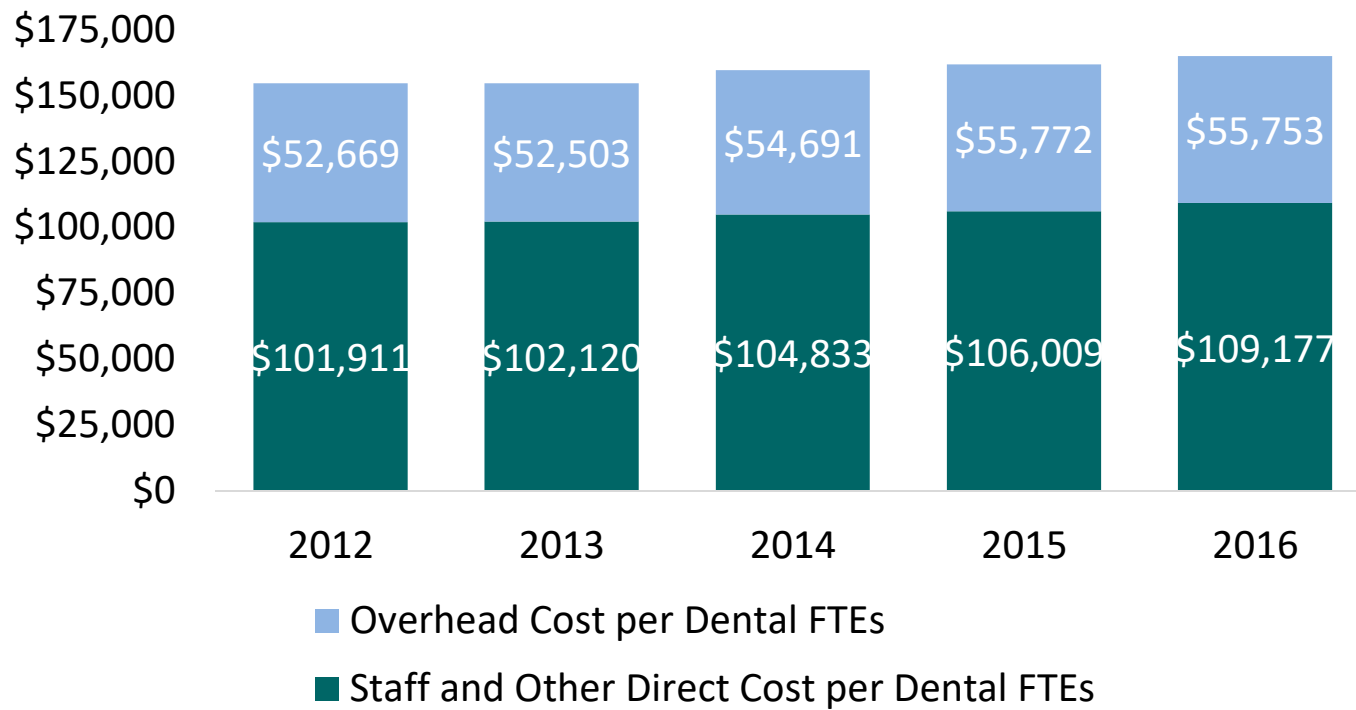
Medical Cost per FTE (Excluding Lab & X-Ray) - National



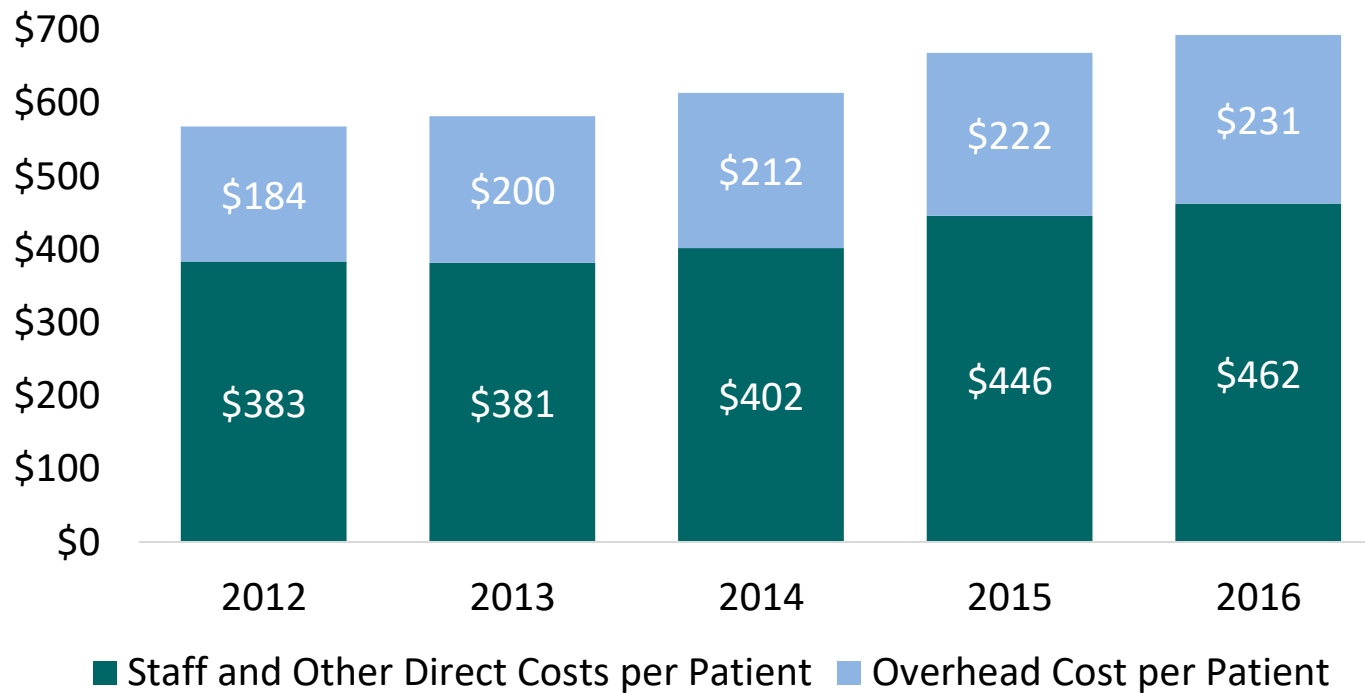
Dental Cost per Patient – National



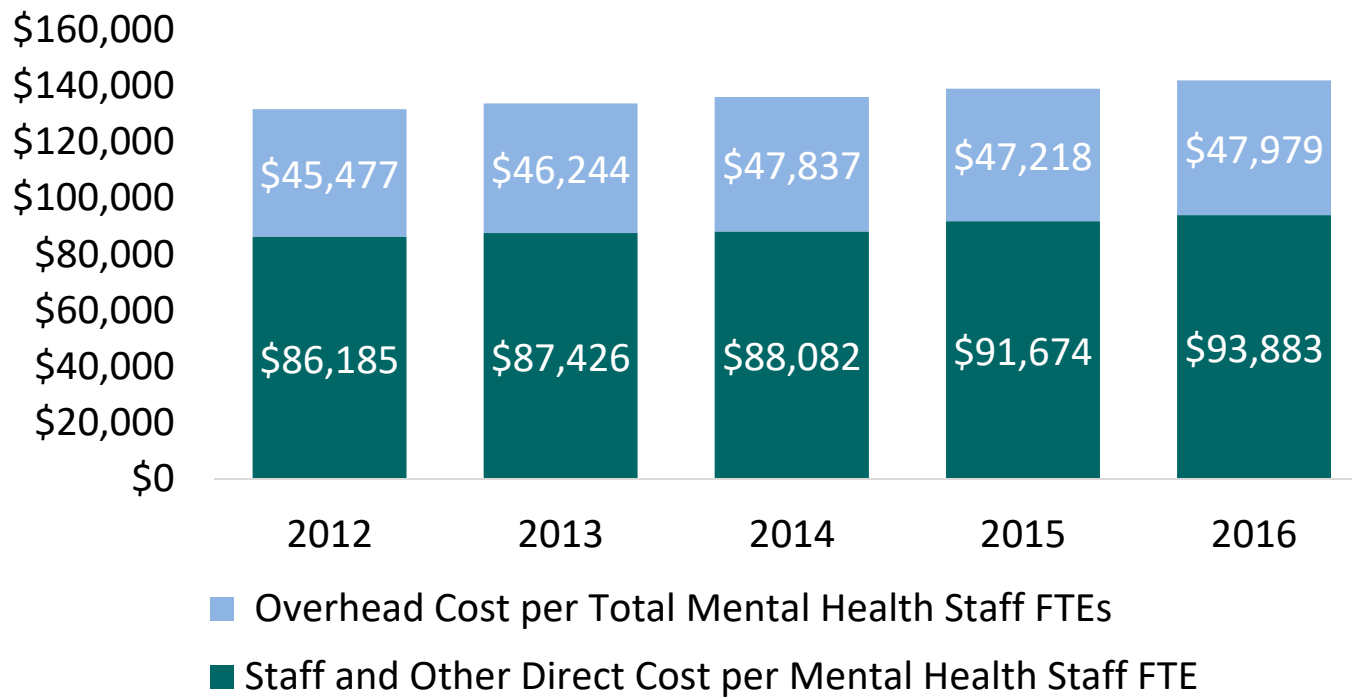
Dental Cost per FTE – National



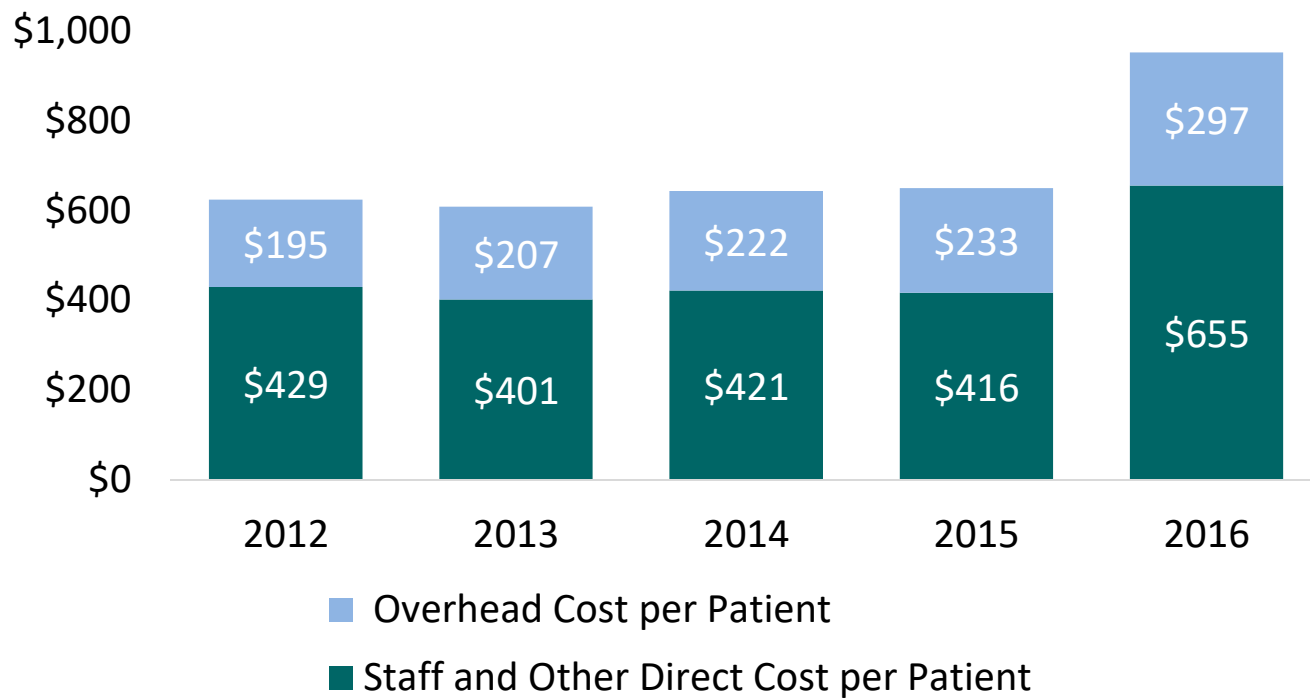
Mental Health Cost per Patient – National



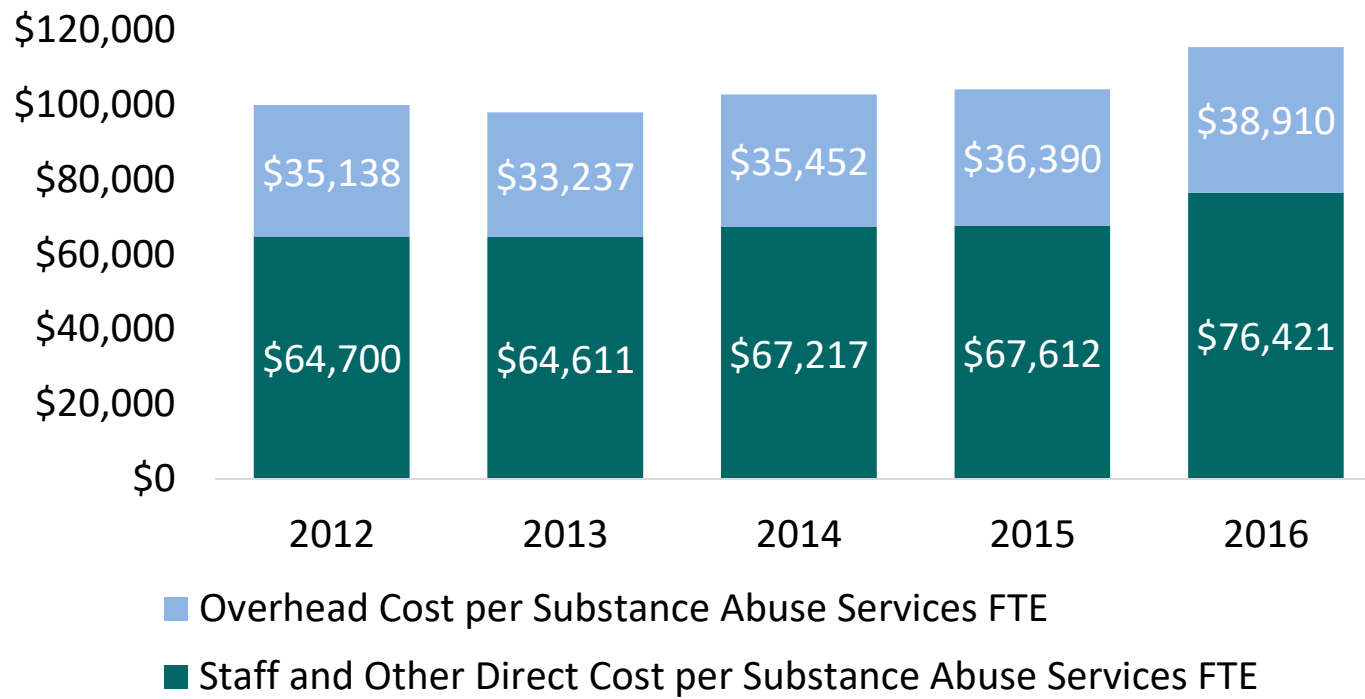
Mental Health Cost per FTE - National



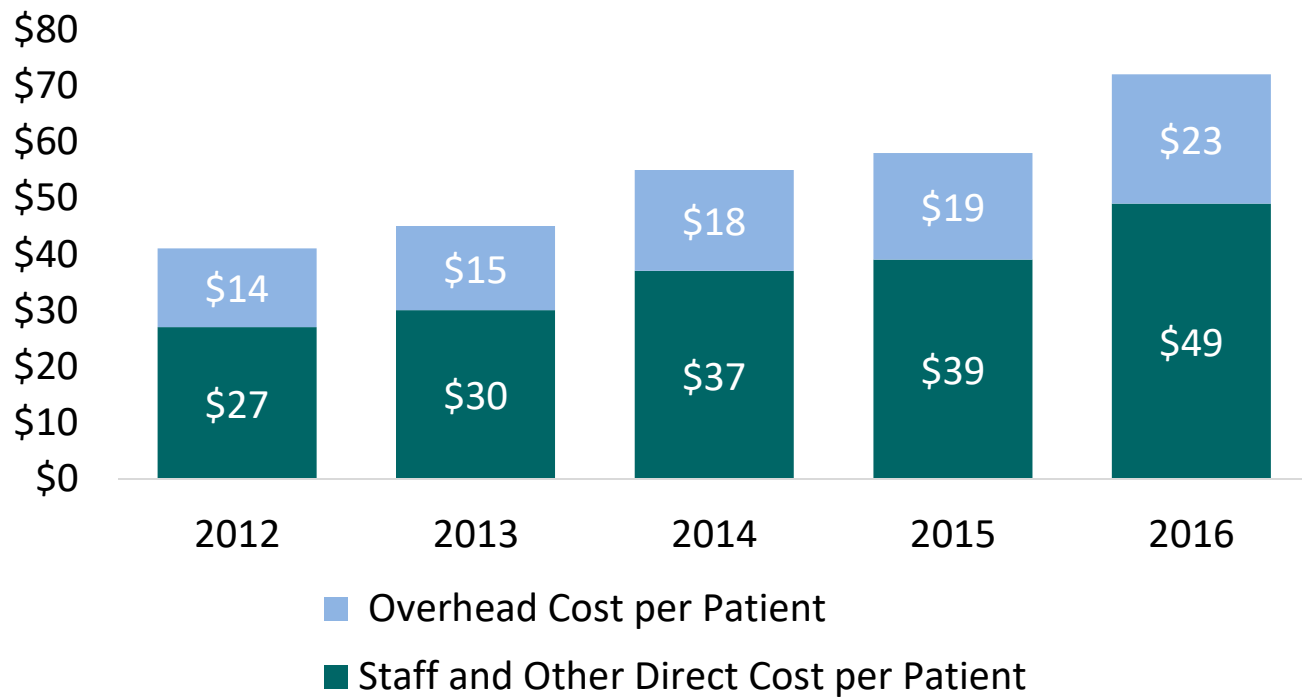
Substance Abuse Cost per Patient – National



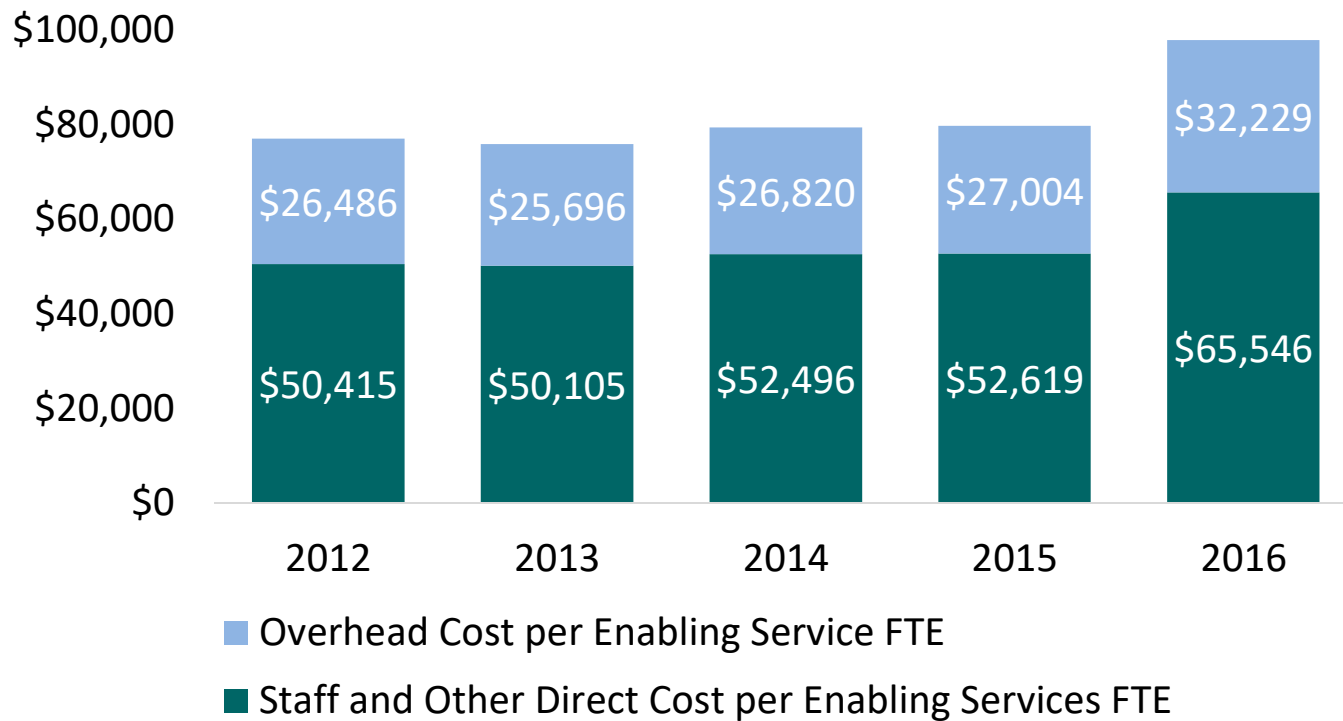
Substance Abuse Cost per FTE – National



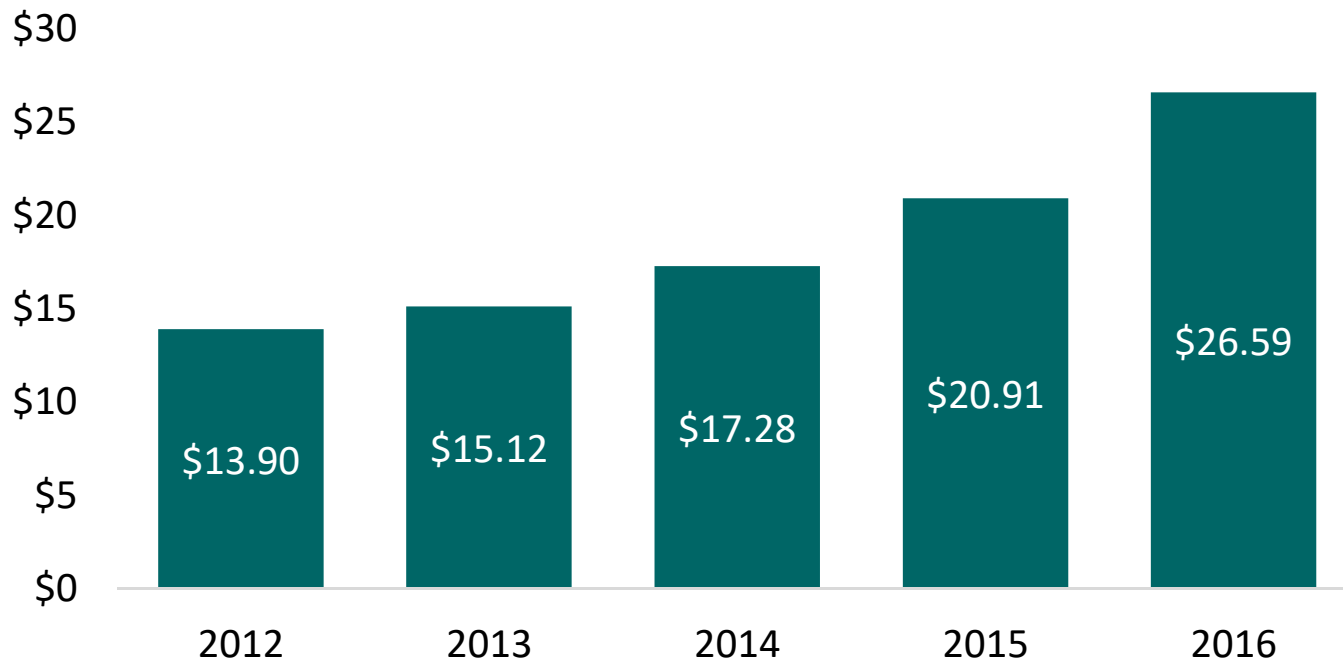
Enabling Services Cost per Patient – National



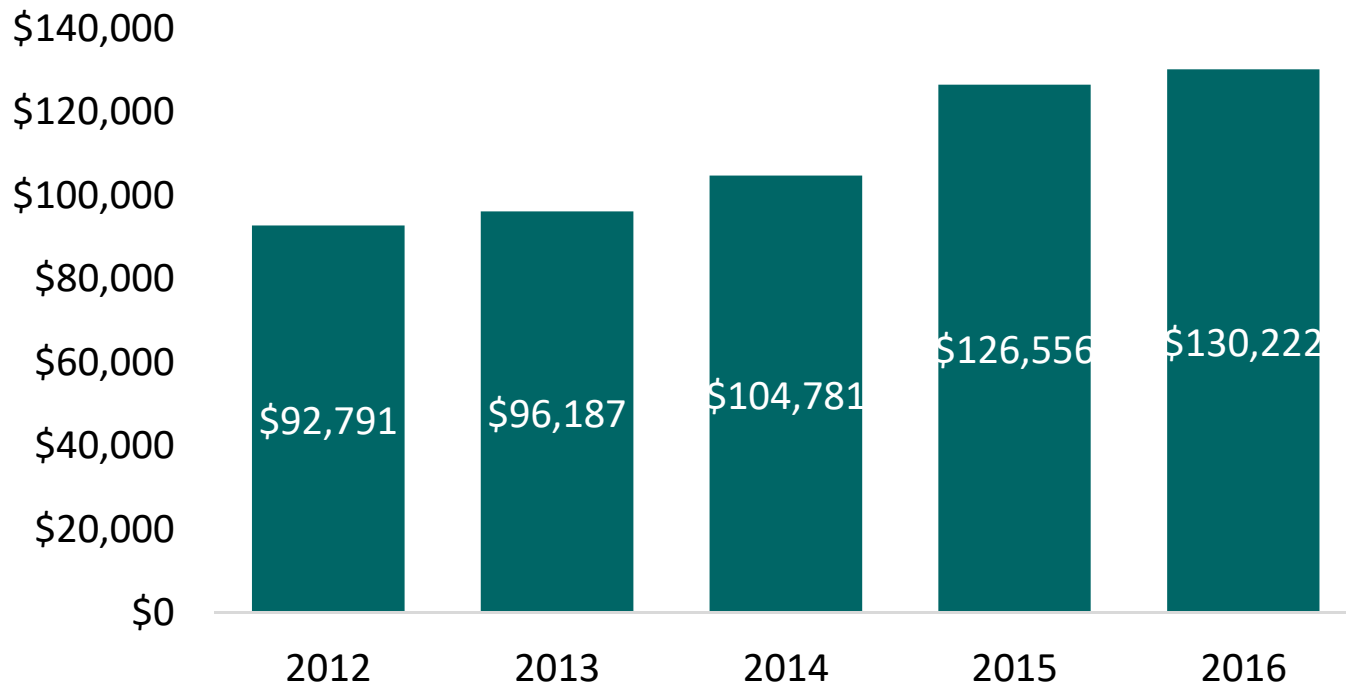
Enabling Services Cost per FTE – National



Pharmaceutical Cost per Patient – National



Pharmaceutical Cost per FTE – National



Trends Summary

- Health center costs across all service lines have been increasing at a relatively rapid pace on a per-patient and per-visit basis
- On an FTE basis, cost increases have been much more modest
- Divergence implies that health centers have been intensifying services for patients without a commensurate increase in per-FTE staffing costs
- Clear economies of scale apparent in the small/median/large health center comparative data, with small health centers having higher costs per-patient, per-visit and per-FTE for most services, with the exception of pharmaceuticals
- Cost differences between rural and urban centers are not as apparent, except for Enabling Services

Understanding Performance Drivers



Fee for Service Context

	Provider 1	Provider 2	Provider 3
Provider Productivity (visits)	2,500	3,000	3,500
Average FFS Revenue per Visit	\$ 162	\$ 162	\$ 162
Total Revenue	\$ 405,000	\$ 486,000	\$ 567,000
Provider Salary	\$ 180,000	\$ 180,000	\$ 180,000
Direct Support Staff	\$ 120,000	\$ 120,000	\$ 120,000
Total Salary Cost	\$ 300,000	\$ 300,000	\$ 300,000
Fringe Benefits (25%)	\$ 75,000	\$ 75,000	\$ 75,000
Total Salary and Benefits	\$ 375,000	\$ 375,000	\$ 375,000
Variable Costs @ \$10/visit (e.g. Supplies)	\$ 25,000	\$ 30,000	\$ 35,000
Total Direct Costs	\$ 400,000	\$ 405,000	\$ 410,000
Overhead (20%)	\$ 80,000	\$ 81,000	\$ 82,000
Total Costs	\$ 480,000	\$ 486,000	\$ 492,000
Surplus/(Loss)	(\$75,000)	\$ -	\$ 75,000

Tracking Performance Drivers: Capitated Model



	Provider 1	Provider 2	Provider 3
Provider visits ("capacity")	2,500	3,000	3,500
Average Visits per Patient	3.5	3.5	3.5
Panel Size (Members)	714	857	1,000
# of Member Months (x12)	8,571	10,286	12,000
Capitation Revenue PMPM	\$47.25	\$47.25	\$47.25
Total Revenue	\$405,000	\$486,000	\$567,000
Total Expenses	480,000	486,000	492,000
Surplus/(Loss)	(\$75,000)	\$0	\$75,000

Capitated Context: Utilization



	Patient A	Patient B	Patient C
PMPM	\$47.25	\$47.25	\$47.25
Annual Revenue	\$567	\$567	\$567
<u>Annual Cost:</u>			
Cost per visit	\$162	\$162	\$162
# of visits per year	2.5	3.5	4.0
Annual Cost	\$405	\$567	\$648
Surplus (Deficit)	\$162	\$0	(\$81)


Financial Sensitivity

- Impact of Medicaid Eligibility & Value-Based Healthcare
- Basic Assumptions
 - Payer Mix
 - Reimbursement
 - Expenses

Financial Sensitivity: Medicaid Eligibility

Medicaid Patient Revenue Modeling Tool			
Current Medicaid Patients:		10,000	
Current Billable Medicaid Visits:		37,000	
Current Medicaid/PPS Rate:		\$150.00	
Percentage Increase (-Decrease) in Medicaid Patients:		0.00%	
		CURRENT PATIENTS	TOTAL REVENUE
Medicare		700	\$300,000.00
Other Public		700	\$300,000.00
Private Insurance		2,100	\$500,000.00
Uninsured/Self Pay		1,510	\$90,000.00
Other Patient Revenue			\$25,000.00

Financial Sensitivity: Medicaid Eligibility

Medicaid Impact Analysis w/	0.00%	Change
Projected Change in Annual Revenue	\$0.00	
Change in Days Cash on Hand	0.0	
	Current	Scenerio
Average Surplus (Deficit) 330 Funding per Uninsured Patient	(\$2.98)	(\$2.98)
Total Surplus (Deficit) 330 Funding for Uninsured Patients	(\$4,497)	(\$4,497)
		


Financial Sensitivity: Medicaid Eligibility

Financial Impact Analysis (Operating Statement)				
CONSOLIDATED INCOME STATEMENT (CURRENT BUDGET)				%
HRSA 330 Grant			\$ 750,000	10%
Patient Revenue				
Medicare	\$ 300,000	5%		
Medicaid	\$ 5,550,000	86%		
Uninsured	\$ 90,000	1%		
Private	\$ 500,000	8%		
Other	\$ 25,000	0%		
Total Patient Revenue		100%	\$ 6,465,000	86%
Other Operating Revenue			\$300,000	4%
Total Revenue			\$ 7,515,000	96%
Operating Expenses			\$ 7,000,000	
Depreciation Expense			\$ 500,000	
Total Expenses			\$ 7,500,000	100%
Operating Surplus/Deficit			\$15,000	0.2%

Financial Sensitivity: Medicaid Eligibility

Medicaid Patient Revenue Modeling Tool			
Current Medicaid Patients:			10,000
Current Billable Medicaid Visits:			37,000
Current Medicaid/PPS Rate:			\$150.00
Percentage Increase (-Decrease) in Medicaid Patients:			-10.00%
		CURRENT PATIENTS	TOTAL REVENUE
Medicare		700	\$300,000.00
Other Public		700	\$300,000.00
Private Insurance		2,100	\$500,000.00
Uninsured/Self Pay		1,510	\$90,000.00
Other Patient Revenue			\$25,000.00

Financial Sensitivity: Medicaid Eligibility

Medicaid Impact Analysis w/	-10.00%	Change
Projected Change in Annual Revenue	(\$495,397.35)	
Change in Days Cash on Hand	(25.5)	
	Current	Scenario
Average Surplus (Deficit) 330 Funding per Uninsured Patient	(\$2.98)	(\$200.86)
Total Surplus (Deficit) 330 Funding for Uninsured Patients	(\$4,497)	(\$504,164)
		

Financial Sensitivity: Medicaid Eligibility

PROJECTED INCOME STATEMENT (SCENARIO)				%
HRSA 330 Grant			\$ 750,000	11%
Patient Revenue				
Medicare	\$ 300,000	5%		
Medicaid	\$ 4,995,000	84%		
Uninsured	\$ 149,603	3%		
Private	\$ 500,000	8%		
Other	\$ 25,000	0%		
Total Patient Revenue		100%	\$ 5,969,603	85%
Other Operating Revenue			\$300,000	4%
Total Revenue			\$ 7,019,603	96%
Operating Expenses			\$ 7,000,000	
Depreciation Expense			\$ 500,000	
Total Expenses			\$ 7,500,000	107%
Operating Surplus/Deficit			(\$480,397)	-7%

Financial Sensitivity: Medicaid Reimbursement

Medi-Cal Patient Revenue Modeling Tool			
Current Medi-Cal Patients:		10,000	
Current Billable Medi-Cal Visits:		37,000	
Current Medi-Cal/PPS Rate:		value-based	
Percentage Increase (-Decrease) in Medi-Cal Patients:		0.00%	
		CURRENT PATIENTS	TOTAL REVENUE
Medicare		700	\$300,000.00
Other Public		700	\$300,000.00
Private Insurance		2,100	\$500,000.00
Uninsured/Self Pay		1,510	\$90,000.00
Other Patient Revenue			\$25,000.00

Financial Sensitivity: Medicaid Reimbursement

Financial Impact Analysis (Operating Statement)				
CONSOLIDATED INCOME STATEMENT (CURRENT BUDGET)				%
HRSA 330 Grant			\$ 750,000	10%
Patient Revenue				
Medicare	\$ 300,000	5%		
Medicaid	\$ 5,550,000	86%		
Uninsured	\$ 90,000	1%		
Private	\$ 500,000	8%		
Other	\$ 25,000	0%		
Total Patient Revenue		100%	\$ 6,465,000	86%
Other Operating Revenue			\$300,000	4%
Total Revenue			\$ 7,515,000	96%
Operating Expenses			\$ 7,000,000	
Depreciation Expense			\$ 500,000	
Total Expenses			\$ 7,500,000	100%
Operating Surplus/Deficit			\$15,000	0.2%

Financial Sensitivity: Medicaid Reimbursement

Initial Budget

Number of Medi-Cal Patients	10,000
Capitation Payment/Annual Per Medi-Cal Patient	\$500
Incentives (PCMH, Outcomes, etc)	\$150,000
Per Member Per Month	\$3.50
TOTAL ANNUAL REIMBURSEMENT	\$5,570,000

Financial Sensitivity: Medicaid Reimbursement

PROJECTED INCOME STATEMENT (SCENARIO)				%
HRSA 330 Grant			\$ 750,000	10%
Patient Revenue				
Medicare	\$ 300,000	5%		
Medi-Cal	\$ 5,570,000	86%		
Uninsured	\$ 90,000	1%		
Private	\$ 500,000	8%		
Other	\$ 25,000	0%		
Total Patient Revenue		100%	\$ 6,485,000	86%
Other Operating Revenue			\$300,000	4%
Total Revenue			\$ 7,535,000	96%
Operating Expenses			\$ 7,000,000	
Depreciation Expense			\$ 500,000	
Total Expenses			\$ 7,500,000	100%
Operating Surplus/Deficit			\$35,000	0%

Financial Sensitivity: Medicaid Reimbursement

Actual Payment

Number of Medi-Cal Patients	10,000				
Capitation Payment/Annual Per Medi-Cal Patient	\$500				
Incentives (PCMH, Outcomes, etc)	\$100,000	DIDN'T GET ALL INCENTIVES			
Per Member Per Month	\$2.75	DIDN'T QUALIFY FOR FULL PMPM			
TOTAL ANNUAL REIMBURSEMENT	\$5,430,000				

Financial Sensitivity: Medicaid Reimbursement

PROJECTED INCOME STATEMENT (SCENARIO)				%
HRSA 330 Grant			\$ 750,000	10%
Patient Revenue				
Medicare	\$ 300,000	5%		
Medi-Cal	\$ 5,430,000	86%		
Uninsured	\$ 90,000	1%		
Private	\$ 500,000	8%		
Other	\$ 25,000	0%		
Total Patient Revenue		100%	\$ 6,345,000	86%
Other Operating Revenue			\$300,000	4%
Total Revenue			\$ 7,395,000	96%
Operating Expenses			\$ 7,000,000	
Depreciation Expense			\$ 500,000	
Total Expenses			\$ 7,500,000	101%
Operating Surplus/Deficit			(\$105,000)	-1%

What Does Success Look Like?



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