Introduction
Speaker’s Bio: Steve Weinman

• 1984-2013, employed at large CHC in SW FL
• Began as IT director, produced custom PM System
• Served as CFO, then EVP/COO, oversaw all employees except CEO
• Founding CEO 18 Member HCCN
• CEO of start up health center in Broward County, FL
• Founding Treasurer of Integral Quality Care Managed Care Plan
• Board Treasurer, National Center for Farmworker Health
• HRSA reviewer and consultant
• Principal with FQHC Associates since 2013

FQHC Associates
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Part 1: Concepts & Terminology
Preferred Provider Organization

- No Primary Care Provider assignment required
- No referrals needed
- Providers agree to take discounted fees
- In network utilization encouraged by lower copays
- The dinosaur that won't die
Health Maintenance Organization

- Patients assigned to PCP (Gatekeeper?)
- Referrals required
- In network utilization forced
- Emergency care and OB-Gyn generally exempted
- Originally managed costs only
- Modern versions include quality and outcome measures

Exclusive Provider Organization

- AKA "Narrow Networks"
- No PCP assignment required
- No referrals required
- In network utilization forced
- Emergency care exempted
Accountable Care Organization

- A network of physicians, hospitals, and other health providers that collaborate to improve care and reduce costs for a population of patients
- ACA created shared savings program, providing incentive payments for improving quality and reducing cost
- Pioneer ACO-has experience in coordinating care across settings

Value Based Purchasing

Paying for results instead of volume

Value Based Purchasing Domain Weightings - 2016

- Clinical Processes - 10%
- Patient Experience - 25%
- Outcomes of Care - 40%
- Efficiency - 25%
Triple Aim

1. Improve the individual experience of care
2. Improve the health of populations
3. Reduce the per capita costs of care for populations

Population Health

An effort to measure, manage & improve health outcomes in groups of individuals that share one or more clinical and/or social attributes, such as

- Geography
- Health coverage
- Disease state
- Medical home

Focus includes health outcomes, as well as social, behavioral and environmental determinants of health.
Chronic Care Management

- Services provided to patients with multiple chronic conditions
- Generally refers to Medicare beneficiaries, who are eligible if they have two or more significant chronic conditions
- Can be provided by non-Licensed Independent Practitioners (under direct supervision)

Fee For Service
- Payment dependent on volume and fee schedule
- Billing can be much more complex
- Payors have incentive to pay less or not at all
- Legal issues relating to PPS and Wraparound payments
Capitation
(from Latin “caput”=head)

- Fixed Per Member Per Month provider payment
- CHC is generally responsible for providing primary care services
- Often has gain-share if CHC controls utilization (cost)
- Medicaid generally pays a "wraparound" to the center's PPS rate
- Risk is generally limited to providing care
- Predictable monthly cash flow

Independent Practice Association

- Organized and directed by health care providers
- Jointly negotiates contracts with payors and others
- Provides leverage and negotiating power
- Must take care to avoid anti-trust
Management Services Organization

• Provides services to health care providers, groups of providers or IPAs
• Typically includes functions such as:
  – Membership processing
  – Claims processing
  – Credentialing
  – Referral management
  – QA/QI

Part 2: Changing Landscape
Part 2: Changing Landscape

[Image of diagram]

Part 2: Changing Landscape
Part 2: Changing Landscape

What will happen in the near term?
- People will still need healthcare
- Health center program will survive
- States will be given more flexibility
- Change will accelerate
- Size will matter
- Data will be king
- The prepared will thrive
- As for the rest???
Old Model

Annual UDS Report

Old Model

Annual UDS Report

New Model

Information Tracking in near real time
Old Model
Low Utilizers=$$

New Model
Converting High Utilizers into Low Utilizers=$$

FQHC Associates
Old Model

Hospital Stay = $$

New Model

Re-admit penalties

Old Model

Hospital Stay = $$
Old Model

Insurer bears risk. Costs passed on to employers and government

New Model

Providers & patients bear risk
Part 3: Before You Negotiate

Understand

• Managed Care
• FQHC Benefits
• Your Market
• Organizational Capabilities & Metrics
• Patient Population
• Risk Tolerance
• The Health Plan
• Leverage
• How to negotiate
FQHC Benefits

- PPS (Medicaid/Medicare)
- FTCA
- 340B
- NHSC Loan Repayment
- Grants
- Legal protections (i.e. preferred or essential provider status)

Your Market

- Payer competitive landscape
- Provider competitive landscape
- Utilization and referral patterns
- Prevailing reimbursement schedules
- Managed care penetration and sophistication
Utilization and Referral Patterns

- Will the target population come to your sites?
- Do you have relationships with specialty providers and health systems as needed by your patients?
- Does the health system encourage ER usage by insured patients?
- Will your IT system “speak” to others?
- Is the plan willing and able to contract with the other providers that you need to do your job?

Organizational Capabilities & Metrics

- Provider productivity/capability/capacity
- Facilities/hours
- Information systems
- Relationships within local health care system
- Patient Centeredness: recognition vs. reality
- Management and governance strength and support
- Ancillary services, i.e. case management, pharmacy etc.
- Cultural competence
- Financial strength
- Costs (including grant requirements)
Patient Population

• Social Determinants
• Barriers to success within & outside of control
• Where they live
• How to contact them
• How to motivate them

Risk vs non-risk

• Rewards are often directly related to the risk
• Health Centers are generally very risk averse
• Different flavors:
  – Upside
  – Downside

• **Health Centers must understand their risk tolerance AND all of the types of risk for each potential arrangement**
Risk Examples

• Obvious
  • Investment loss
  • Operating loss
  • Supplemental payment loss

• Less Obvious
  • Market Share loss
  • Administrative overhead

Risk tolerance

• How willing is your board & senior management to take on reasonable amounts of risk?
• Are you financially strong, i.e. cash reserves?
• If your providers fail to perform, can they reasonably be replaced?
Health Plan

• Does the plan have systems in place to help manage the patients care?
• Do they understand FQHCs?
• Are they willing to innovate?
• Are they financially strong?
• Do they pay claims reasonably well?
• Can you get their attention when you need to?
• Is their provider network adequate?
• Do they really buy into health reform?

Leverage

• How much of the primary care market do you control?
• Do you have strong and cooperative relationships with the local provider community?
• Is there a strong PCA, network or IPA in place to support you if necessary?
• How strong are you with state and local “stakeholders”?
• How badly do you need to contract with the payor?
Part 4: Negotiation

Will they even negotiate?
You’re handed a preprinted contract and told that this is the only deal available. What do you do?

• Prepare to differentiate (with data)
• Your team will review
• Legal counsel
• Counteroffer to come. Maybe.
Ask Questions

• What are the payer’s short and long term strategic network goals?
• What are their primary concerns in this market?
• Does the payer understand FQHC issues? Make them explain.
• What quality metrics are most important to them?
• Are they planning any pilot programs that you can participate in?
• Do they seem engaged and excited to be working with you?

Covered Services

• Covered services included in any capitation contract should be **clearly spelled out**
• Additional services (“Bill Aboves”) should have a fee schedule included
Timely Filing and Appeals

• Carefully note how long you have to file claims, and appeal denials
• Make sure that your organization has the ability to abide by these limits

Misc. “Gotchas”

• Can the plan modify contract terms simply by providing notice (i.e. 30 days)?
• Beware vague terms such as “at the plan’s discretion” or “as reasonable”
• If the agreement mentions “affiliates”, make sure that the agreement clearly spells out who they are talking about.
Fee Schedule

• Often expressed as xx% of Medicare
• You should be armed with your most commonly used CPTs and have the actual fees spelled out in writing
• Medicare fee cuts will also cause all contracted fees tied to Medicare to decrease unless explicit contract language prevents this

Withholds vs. Bonus Payments

• Fees withheld from the CAP rate or FFS schedule should be treated as a discount on services
• Quality and other bonus payments are in addition to the regular CAP rate
• Be sure that all conditions that could affect payments are clearly spelled out in writing
Down-coding

- No provision to pay claims at lower than submitted rate without due process and medical record review
- Require explanation for any deviation from CCI
- Spell out any coding edits
- Right to appeal

Over-payment recovery (“offsets”)

- Time limit on how far they can go back
- No fishing or “bounty hunting”
Over-payment recovery ("offsets")

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FQHC Specific example: 340B

- Many plans are utilizing Pharmacy Benefit Management companies to control pharmacy costs
- Often exclude 340B
- A "win-win" strategy should be negotiated
### Why plans hate 340B

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Retail</th>
<th>Plan Pays</th>
<th>Copay</th>
<th>AWP</th>
<th>340B Cost</th>
<th>FQHC Paid</th>
<th>FQHC Profit</th>
<th>Copay Waived</th>
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<td>Percentage</td>
<td>($330) -73%</td>
<td>($220) -73%</td>
<td>($50) -83%</td>
<td>($250) -81%</td>
<td>($85) -68%</td>
<td>($270) -75%</td>
<td>($185) -79%</td>
<td>($135) -77%</td>
</tr>
</tbody>
</table>

**Without 340B**

Substituting for

- Plan spends $80/month instead of $300 😊
- Patient spends $10/month instead of $60 😊
- Pharmacy makes $30/month instead of $50 😞
With 340B

Not Substituting for

• Plan spends $300/month instead of $80 😞
• Patient spends $0/month instead of $10 😊
• FQHC makes $175/month instead of $40 😊

Win-Win 340B Strategy

• FQHC and Plan agree upon a formulary
• Generics are substituted for brands when practical
• When brands make sense, FQHC provides a small discount to the Plan
• End result-Plan saves some money
• FQHC is able to continue to benefit from 340B
Organizational Capabilities & Metrics

- Provider productivity/capability/capacity
- Facilities/hours
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- Relationships within local health care system
- Patient Centeredness: recognition vs. reality
- Management and governance strength and support
- Ancillary services, i.e. case management, pharmacy etc.
- Cultural competence
- Financial strength
- Costs (including grant requirements)
Some Questions

1. Do you use contract pharmacies for 340B?
2. If so, do you run generics as well as brands through 340B?
3. If #1 and #2 are true, did you take those costs into account when negotiating these rates?
4. If not you may wind up losing money on the deal!

Wrap Up & Questions
ABOUT US
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• Stay up to date on the most important news and changes affecting health centers.
• Check out our “FQHC Resources” section for links to funding opportunities, special population information, compliance help, and more.

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We advise and assist our clients in the following areas:
• Development of new FQHCs & Look-Alikes
• Hospital system/FQHC partnerships
• Integrated primary care/behavioral health
• Patient Centered Medical Home recognition
• Medicaid & Medicare optimization
• Compliance with HRSA regulations
• Dental program development & improvement
• 340B pharmacy programs & compliance audits
• Project and grant production management
• HRSA site visit preparation & finding resolution
• Revenue cycle enhancement
• Strategic, fiscal & operational planning
• Board and staff training and facilitation
• Managed care contracting and plan development
• Residencies and university partnerships
• IT (billing, EHR and other system) selection
• Compensation consulting