Facing the Challenges of Health Reform and ACO Development: Strengthening the Financial Infrastructure of Health Centers

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Director of Research and Policy at JSI and CEO of Capital Link
Massachusetts League of Community Health Centers
Community Health Institute and Exhibit Fair
May 5th, 2016
Summary of Presentation

• Recent Financial and Operational Trends of MA CHCs (with national comparisons)

• Current Status of Payment and Delivery Reform
  - JSI findings
    • Current status of implementation of APMs and delivery system transformations
    • Barriers and facilitators to participation
    • Implications for next steps for health centers
  - Barriers to Payment and Delivery System Reform
    • JSI Findings
    • Capital Link Observations
  - Health Center Perspectives on State Policy Options
Recent Financial and Operational Trends of MA CHCs (with national comparisons)
Total Patients – By Quartile

Massachusetts Total Patients Served

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile

- 2011: 14,416
- 2012: 14,942
- 2013: 16,439
- 2014: 15,338
MA CHCs are larger than their national counterparts

Patient Visits

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Operating Revenue

Total Operating Revenue
(Millions)

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Proportionally Lower Grant Support and Higher NPSR

Revenue Mix

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<tr>
<td>Grants and Contract Revenue</td>
<td>27%</td>
<td>33%</td>
<td>27%</td>
<td>31%</td>
<td>27%</td>
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<tr>
<td>Net Patient Service Revenue</td>
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<td>59%</td>
<td>70%</td>
<td>60%</td>
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<td>3%</td>
<td>4%</td>
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Legend:
- Grants and Contract Revenue
- Net Patient Service Revenue
- Other Operating Revenue
Grant Composition

Section 330 Grants As Percent of Total Grants
Federal Capital Grants As Percent of Total Grants
All Other Federal Grants as Percent of Total Grants
State and Local Government Grants as Percent of Total Grants
Foundation and Private Grants as Percent of Total Grants
Other Non-Patient Related Revenue as Percent of Total Grants
## Payer Mix – More Favorable in MA

<table>
<thead>
<tr>
<th>Payer Mix (Patients)</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<td><strong>MA</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medicaid Patients</td>
<td>41%</td>
<td>45%</td>
<td>40%</td>
<td>50%</td>
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<td>Medicare Patients</td>
<td>17%</td>
<td>17%</td>
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<tr>
<td>Other Publicly Insured</td>
<td>10%</td>
<td>9%</td>
<td>9%</td>
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<tr>
<td>Privately Insured</td>
<td>8%</td>
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<tr>
<td>Self-Pay</td>
<td>16%</td>
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<tr>
<td><strong>National</strong></td>
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<td>33%</td>
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<td>Medicare Patients</td>
<td>17%</td>
<td>36%</td>
<td>18%</td>
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<tr>
<td>Other Publicly Insured</td>
<td>7%</td>
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<td>Self-Pay</td>
<td>36%</td>
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</table>

- **Medicaid Patients as % of Total Patients**
- **Medicare Patients as % of Total Patients**
- **Other Publicly Insured Patients as % of Total Patients**
- **Privately Insured Patients as % of Total Patients**
- **Self-Pay Patients as % of Total Patients**
MA CHCs are Weaker Financially than National Counterparts

Operating Margin

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
MA Health Centers Have Less Cash

Days Cash on Hand

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Personnel costs are higher, but downward trend
Service Mix – More diverse and variable in MA

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<tr>
<td>Enabling Visits</td>
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</table>

- Dental Visits as a Percentage of Total Visits
- Enabling Visits as a Percentage of Total Visits
- Medical Visits as a Percentage of Total Visits
- Other Visits per Total Visits
MA CHCs Have Higher Total Visits per Patient

Total Visits Per Patient

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Staffing Mix

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<tr>
<td>Mid-Level FTEs</td>
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<td>10%</td>
<td>8%</td>
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<tr>
<td>Other FTEs</td>
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Quality of Care

- Percentage of Children Immunized: 189%
- Percent of Patients with Asthma Given an Asthma Treatment Plan: 190%
- Percentage of Patients Screened for Colorectal Cancer: 191%
- Percent of Patients Age Screened for Cervical Cancer: 201%
- Percent of Children Assessed for Excess Weight: 202%
- Percent of Adults with Risk Assessed for Excess Weight: 203%
- Percent of Coronary Artery Disease Patients on Lipid Therapy: 205%
- Percent of Ischemic Vascular Disease Patients on Antithrombotic Therapy: 206%

2014 Massachusetts
2014 National
Operating Revenue per Visit

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Operating Expense per Visit

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile
Working Capital

Working Capital to Monthly Expense Ratio

- Massachusetts 25th Percentile
- Massachusetts 50th Percentile
- Massachusetts 75th Percentile
- National 25th Percentile
- National 50th Percentile
- National 75th Percentile

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Current Status of Payment Reform: JSI Findings
Introduction and Purpose of Study

• In 2012, Chapter 224 mandated movement to Alternative Payment Methodologies (APMs)

• Despite delays, Governor Baker’s administration is proposing to accelerate movement toward accountable care organizations in both the public and private sectors

Purpose of this study is to document:

• The current status of MA health centers in implementing key components of payment and delivery system reforms

• Barriers to implementation of these reform efforts

• Health center perspectives on reforms moving forward
Methods

• Initial meeting with the Mass League to identify initial list of interviewees
• Added additional CHCs based on analysis of UDS data to ensure diversity in populations served, geography, and size
• 42 interviews conducted to date
  - 36 interviews at 14 health centers
  - 2 health plans
  - 3 hospital-led ACOs
  - MassHealth
## Current Participation in APMs

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<th>PCPRI</th>
<th>BCBS AQC</th>
<th>Medicaid MCO</th>
<th>PACE</th>
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*Not taking risk yet*
Number of Health Centers Participating in APMs

N=14

- Not participating: 2
- Participating in 1: 5
- Participating in 2: 3
- Participating in 3 or more: 4
Scope of Participation in APMs

Health Center 1
(Total Patients = 25,000)

- NHP: 4,400 (17%)
- PCPRI: 4,400 (18%)
- Network Health: 4,200 (17%)
- Other: 12,000 (48%)

Health Center 2
(Total Patients = 27,000)

- BCBS AQC: 2,354 (9%)
- NHP: 2,000 (7%)
- PCPRI: 450 (2%)
- Other: 22,196 (82%)

Source: Interviews, UDS data
CHC Participation in APMs

• Overwhelming sense that FFS system is broken, that APMs are “way of the future”
• CHCs share a common view on the important components of APMs
  - Generally desire primary care capitation
    • Supplemental payments for behavioral health
  - Interested in shared savings
• CHCs desire to build financial, clinical, and data infrastructure to participate in APMs
CHC Participation in APMs

• However, lack of participation comes from sense that the terms currently offered for APMs were unfavorable
  - Adverse to downside risk
  - Not enough upside to overcome skepticism

• Concern that high-quality, efficient health centers are penalized with shared savings arrangements that are based on baseline costs (which are lower)
  - Cements pre-existing payment inequities in the system between health centers and mainstream providers

• Frustration over existence of different programs for different patients (PCPRI vs. MCO programs)
  - Administrative burden
  - Creates difficulties for doctors in providing equitable care for their patients
Current Participation in Delivery System Transformations

• Across the board, CHCs are implementing delivery system transformations due to a sense of alignment with their mission as CHCs
  - Efforts build on strategies for care delivery that CHCs have practiced for years prior to payment reform
  - High degree of variation in implementation
  - EHRs necessary but not sufficient; support needed
  - Few are measuring ROI

• Despite participation in APMs, these remain funded through grants or other revenue streams. APMs are not offsetting cost of delivery system reforms
  - “In general, far too many CHCs are on the fringe of financial ruin. The only CHCs in a financial position to take on risk have the backing of hospital funds, have large PACE programs, or have other large revenue streams from pharmacy, etc.” – Health Center CFO
Delivery System Transformation Participation

Number of Health Centers Participating in Delivery System Transformations

- PCMH: 14
- Integrated PC/BH: 11
- Dental: 11
- Integrated Pharmacy: 10
- Care Management: 8
- CHWs: 7

Number of Health Centers Implementing Delivery System Transformations

- Implementing 1 to 3: 6
- Implementing 4 to 5: 1
- Implementing all 6: 6
CHC Strategies for Enhancing Value

- **Value defined as:** *improving health while controlling costs*

- **Common strategies**
  - Readmission reduction programs
  - ED diversion programs
  - High-cost care management

- **Getting providers to work at top of license**
  - NP-based care delivery model
  - Others – social workers, CHWs
  - Home visiting, home care
Population Health

- Range of population health efforts
  - Community-wide HTN, diabetes management, asthma, blood pressure management programs
  - Community grocery stores and nutrition programs
  - Community-wide coalition building and needs assessments
  - Prevention Wellness Trust Fund (PWTF) grant participation
  - Partnerships with housing projects
  - Plans for developing community-wide master plan to address social determinants of health

- Inconsistency in how population health is understood – as patient panel or community-wide
Barriers to Payment and Delivery System Reform
Barriers: JSI Findings

• When health centers participate in delivery system transformations that lower total cost of care per patient, they are not typically rewarded

• APMs currently do not offset costs of delivery system transformations or population health, leading to concerns about sustainability

• Problems with the collection, analysis and reporting of quality data

• Size can be a major barrier to participation to payment and delivery system reforms
Barriers: Capital Link Observations

- MA health centers are forging ahead with payment reform without the revenue to support it

- Primary care needs a “living wage”
  - Based on 2014 data, to achieve a 4% operating margin:
    - 25th percentile (increase margin by 6%) + $53/patient/year
    - 50th percentile (increase margin by 4%) + $59/patient/year
    - 75th percentile (increase margin by 2%) + $23/patient/year

  - An increase of $2 - $5 per patient per month just stabilizes the base!
    - Additional “transformation” needs additional investment
Health Center Perspectives on MassHealth Priorities
(1) How do we ensure there is adequate investment in infrastructure developments?

- **What we heard:** Care management reduces utilization and total cost of care; however, “reward” payments come after the investment. Health centers do not have enough cash on hand to float those up-front costs.

- **Opportunities:**
  - 2703 SPA: 90% federal matching for chronic care health home
    - Potential source of matching dollars: tax on highest-cost providers in the system
  - 1115 DSRIP: source for large scale investment to catalyze delivery system transformation
  - The State is pursuing both of these opportunities listed above
(2) How to ensure primary care receives a fair share of the health care expenditures?

- **What we heard:** There is increasing recognition of primary care in payment and delivery system form, but primary care still only accounts for a small portion of total medical expenditure (TME)

- **Opportunities:**
  - Run capitated payments through primary care
  - Encourage health centers to form a primary care provider-led ACO, rather than hospital-led ACOs
  - Delegate care management from health plans to PCPs
  - Create rewards for efficient providers on basis of TME
(3) How to pay for ongoing care management?

• **What we heard:** Care management achieves the state’s priority of reducing inpatient utilization, which reduces total cost of care. However, lack of reimbursement for care management functions makes it financially unsustainable.

• **Opportunities:**
  - Delegate care management function and payments from health plans to health centers
  - Align reimbursement policy with strategies for encouraging providers to work at the top of their licenses (e.g., subcap)
  - Reduce barriers to BH care coordination in primary care by providing supplemental PMPM payments
(4) How to incorporate population health into APMs?

- **What we heard:** Health centers are participating in APMs, but those contracts have not yet covered the cost of population health initiatives

- **Opportunities:**
  - Include population health metrics in future MassHealth procurements
  - Include funds for population health as part of ACO contracts
  - Include population health goals as key requirements for Massachusetts ACO certification
MassHealth Strategies for Accountable Care and Delivery System Reform (April 2016)

<table>
<thead>
<tr>
<th>Strategy:</th>
<th>Primary Care Component:</th>
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| Form Accountable Care Organizations (ACOs) | • At minimum, an ACO must include primary care providers  
• Encouraging ACO attribution through PCP selection |
| Integrate community based partners | • DSRIP funding designed explicitly for social determinants i.e. "flexible services"  
• Services not traditionally reimbursed but likely to improve health outcomes  
• Encouraging enrollment in Senior Care Options, One Care and PACE programs |
| Partner with MCOs to support ACOs | • The State expects MCOs to work with ACO providers  
• MCOs help determine which care management functions are best performed at the provider vs. at the MCO level  
• MCOs support providers in making shift to accountable care (including analytics for population management) |
| Invest to help transition the system into integrated, ACO models | • DSRIP funding for targeted technical assistance specifically for CHCs to prepare for payment reform  
• Grant program targeted at helping “less-sophisticated” providers join ACO models  
• Direct funding available to community partners under a performance accountability framework |

Source: MassHealth Delivery System Restructuring: Overview and Additional Details (April 14, 2016)