Engaging Federally Qualified Health Centers (FQHCs) in Payment Reform Initiatives

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West Side Community Health Services

Is the largest Federally Qualified Health Center (FQHC) in Minnesota and includes:

- 17 primary care sites in the Twin Cities metro east including large ambulatory care facilities, dental facilities, school based clinics, and services in public housing and homeless settings.
- @ 37,000 unduplicated patients served last year with 40% uninsured and 45% Medicaid covered
- @ 98% at or below 200% of Federal Poverty Level

![Graph showing language proficiency and race/ethnicity](image)
Service Integration
Meeting Patient Need

Primary medical care with embedded:
- Integrated mental health and substance use services
- Oral health services
- Clinical and dispensing pharmacy
- Integrative Medicine and Complementary Care
- Care Coordination and patient engagement/activation staff
- Vision services including optometry ramping up

Why Engage FQHCs in Payment Reform Initiatives

- Fragmented care from patchwork of providers willing to accept Medicaid reimbursement
- Disparate systems challenge care coordination/management - separate funding streams and eligibility criteria for people/services combos
- FQHCs have the necessary primary care, care coordination, and patient activation experience
- Primary Care Focused: Removes internal pressures
Motivators for FQHCs to Engage in Payment Reform

**EXTRINSIC**
- Increased competition – default provider to provider of choice
- Increasingly irritated payers - Relatively weak clinical outcomes compared to costs/spending = Unsustainable cost growth
  - Demographics
  - Disease burden

**INTRINSIC**
- Desire to stay relevant in dynamically changing market plan
- Care Transformation
- Address health inequity while reducing health disparities
- Opportunity to leverage needed resources for populations served

**BOTH: EXTRINSIC AND INTRINSIC**
- Better access to clinical information and related insights
  - EMR adoption and Health Information Exchange
  - More information is better
- Financial Constraints/Pressures
- Service Delivery Constraints/Pressures

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The Path from Volume to Value

Market experience demonstrates that a solid start along this journey requires 3+ years of thinking/planning and that many FQHCs are not even contemplating this change.

**Fee for service**
- No incentive to implement preventive care strategies, prevent hospitalization or take any other cost-saving measures

**Pay for Performance**
- Compensated for meeting certain metrics for quality and efficiency
- Quality benchmark metrics tie physician reimbursement directly to the quality of care they provide

**Bundled* payments**
- Encourages efficiency and quality of care because there is only a set amount of money to pay for the entire episode of care
  - Facility-based episodes of care
  - Disease-based episodes of care
  - Disease-based for sub pops

**Shared Savings**
- Incentives for providers with respect to specific patient populations

**Shared Risk**
- A percentage of any net savings realized is given to the provider

**Global capitation**
- A fixed total dollar amount paid annually for all care delivered
- Global cap includes a quality component

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Other Payment Reform Paths for FQHCs

- Collaboration
  - Risk managed by provider
  - Medical home
  - Bundled payment
  - ACO shared savings, global payment
  - Hospital-physician Gain-sharing
  - Payment for coordination
  - Physician and hospital P4P
  - Payment adjustment for hospital-acquired conditions, readmissions
  - Payment for shared decision making
  - Fee for service

- Optimize for volume
- Optimize for outcome

Size of circle = ability to bend the medical cost trend curve

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FQHC Barriers to Engaging

- Concerns that this is about shifting risk to providers from MCOs without associated resources
- Duplicative efforts and conflict about where/how to deploy resources. For example, where should care management resources reside?
- Effectiveness of patient activation and care coordination? Will value based initiatives “compensate” innovation and modeling that generates long term savings.
- Lack of long term view and emphasis on population health ... Is cost containment the prime motivator driving “accountable care”.
- Lack of analytic resources. Do we have to build it ourselves?
- Lack of alignment between payers about attribution, quality measurement, etc.
- Wide variation in clinical processes – standardization not historically emphasized
- High entry barriers - $ to invest in critical infrastructure (people, process, technology, policy)
- No guarantee that it will work
- Fear of the unknown and business uncertainly if FQHC PPS were compromised without sufficient replacement

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Navigating the Path from Volume to Value: A Tricky Proposition for FQHCs

Value-driven, coordinated, and comprehensive care

Volume-driven, fragmented care

Operating model

Transition

Future

Critical metric to monitor:
What % of business comes from attributed lives in shared savings/capitation arrangements vs. from fee-for-service revenue?

Care delivery

Payment

FQHC PPS

Episode payment

Shared savings models

Partial capitation

Global payment

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FQHC Engagement in Accountable Care – FUHN: A Success Story

- FUHN = Federally Qualified Health Center Urban Health Network
- Nine FQHCs and one FQHC Look-Alike located in Minnesota’s Twin Cities – 7 in Minneapolis and 3 in Saint Paul serving approximately 125,000 Minnesotans across 40 sites.
- FUHN Hypothesis: Carefully targeted increases in funding for primary care, care coordination and supportive services for an identified set of patients will produce an overall decrease in the total cost of care, whilst improving clinical outcomes for these patients.

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FUHN Program Goals and Elements

**Triple Aim + 2:**
1. Reduced total cost of care
2. Improved clinical quality
3. Improved patient and family satisfaction
4. Emphasis on primary care services and relationship
5. Enhanced Care Coordination and patient activation

**Key Program Components:**
1. Population health management infrastructure and robust data analytics
2. Performance improvement & clinical transformation that is provider and quality focused and led
3. Care coordination across care settings including care transition and ED follow-up
4. Executive commitment and program governance that allows equal input from all organizations

**FUHN Attribution:**
Population is Growing

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Clinical Practice Transformation
FUHN Initiatives

Clinical Practice Transformation
• Use of e-health technologies and data analytics
• Design effective clinical interventions
• Emergency Department utilization target efforts
• Re-invigorate care coordination
  — Motivational interviewing
  — LEAN process improvement
  — Change management
  — Utilization of population health analytics
  — Team-based care

Engagement Barriers
Confronting FQHCs

1. Perception that only large Integrated Care Systems can deliver cost savings
2. Upfront investments are steep – both operational and time. For FUHN
   ❖ State upfront Investment/Contribution = $0
   ❖ Fortunately, leveraged strategic partnership with
3. High Level of collaboration and commitment amongst ACO participating organization is a must.
   ❖ FUHN FQHCs went from “extreme competitors, to extreme collaborators”
4. Sharing / determining best practices is a must and specifically clinical practices that improve care/services through strong clinical and quality improvement.
Engagement Barriers
Confronting FQHCs

5) Data informing clinical care initiatives must be actionable and timely. Must also prevent “tsunami” of data.
   ◆ Dependent on analytic capabilities to identify at-risk/soon-to-be at-risk patients
   ◆ Dependent on interoperability with external (non-FQHC) providers

6) Culture and process change takes time – people like innovation, but they don’t like change.

7) Resources for care coordination is a must. FUHN’s experience demonstrates that care coordination is critically important to success – both in terms of financial and clinical outcomes. Unfortunately, it is also the area that is most underfunded.

FUHN’s Motto: Triple Aim Plus Two – emphasis on Primary Care and Care Coordination

FUHN Success
TCOC Reduced and ED Use Reduced

FUHN Trends – Baseline through Year End 2015

Success To Date:
◆ TCOC reduced by 3.1% in Year 1, 4.2% in Year 2, and 4.9% in Year 3.
◆ Quality outcomes improved every year
◆ Increased patient activation every year

$16,607,540

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On-going Challenge for All FQHCs Under Payment Reform

- Shifting sands of the environment where FQHCs are and need to be ...
- Balancing act between FFS and payment reform ... many unknowns and financial planning is challenging.

Play Checkers — Maintain mission to serving underserved

Play 3D Chess — Participate in evolving marketplace.

Payment Reform
FQHC Parameters for Success

Leadership
- Measurable goals
- Cohesive clinical model

Governance and operational partnership
- Legal and data sharing agreements
- Board and committee structures to set and manage to standards
- Participation standards for all partners
- Payer contracting support — Financial modeling/analysis — Performance tracking/reporting

Clinical/Practice transformation
- Opportunity analysis and prioritization
- Process improvement method(s) for disciplined reduction of variation
- Workforce planning and development
- Practice improvement advisory and coaching

Care management
- High needs — patient identification
- Coordination — cross care setting management
- ED/P encounter reduction
- Gaps in care reduction
- Service quality improvement — better REDI results
- System of care design/management

Analytics infrastructure
- Multi-source data harmonization
- Population health improvement analytics — big data
- Patient care improvement information — little data
- Data sharing across system of care — patient, practice, provider and population level information
What’s really needed:
- Shared, longitudinal patient-centric record enables optimal care support
- Actionable, role-based information delivered securely at the point of care
- Automated analytics and related actions that use data and business rules grounded in clinical model to improve staff productivity

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Are FQHC-Led Medicaid Payment Reform Initiatives Realistic?

- Absolutely!
- FUHN is a direct outcome of the environment it “resides” in and the boldness of the FQHCs around the table ....... be under the bus, on the bus, or drive the bus.
- FUHN’s success is both repeatable and scalable, and states are uniquely positioned to encourage and support FQHC innovation.
- Are FQHCs strategic partners, absolutely if:
  - Primary care capacity is shrinking.
  - Medicaid expansion is putting more pressure on safety net providers.
  - Beneficiary/Enrollee complexity demands better coordination.
  - Health Disparity / Inequity continues to persist.
  - Health outcomes are a consequence of a patient/community/population’s available resources and understanding in addition to health care received.

FQHCs are ideally situated to succeed under payment reform with modest investment. Enhanced community based primary care is key to achieving the goals of accountable care.

Final Thoughts ... Better with FQHCs In?

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