CLINICALLY INTEGRATED NETWORKS:

BUILD, BUY OR STAY ON THE SIDELINES

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AGENDA

I. Headwinds facing federally qualified health centers(FQHCs)

II. The decision to pursue advanced alternative payment models (APMs)

III. Assessing readiness to succeed

Learning Objectives

1. Prompt health center leadership team to discuss and make a strategic decision about active pursuit of more advanced alternative payment models.

2. Draw from a knowledge of FQHC experience with value-based payment in other states for guiding that discussion.

3. Encourage FQHC colleagues to attend the next two webinars to learn more about FQHC capitated APMs and how to accelerate DC Connected Care Network's participation in shared savings programs.

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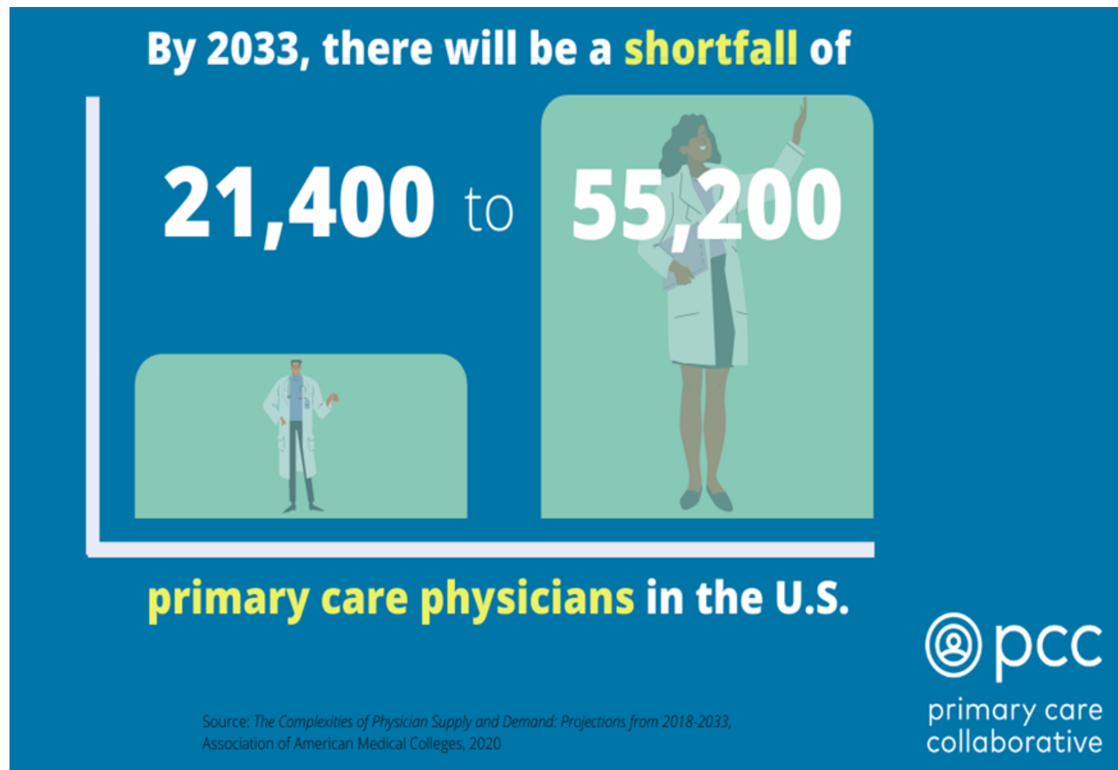
HEADWINDS FACING FQHCS IN 2023

HEADWINDS FACING FQHCS IN 2023: WORKFORCE SHORTAGE

Billable Clinicians



Other Care Team Members

- Care team members are looking for better work/life balance offered by working at least part of the time from home.
- They want more fulfilling work in which they assume greater responsibility for improving the health of their patients.
- The current fee-for-service payment system is a barrier to using the full care team to help patients self-manage and optimize their health.

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HEADWINDS FACING FQHCS IN 2023: GAP BETWEEN CONSUMER PRICE INDEX (CPI) AND MEDICARE ECONOMIC INDEX (MEI)

Inflated workforce and other operating costs are more reflective of CPI than MEI during periods of high inflation and a major contributor to weakening financial position.

From	To	U.S Annual Inflation Rate*	MEI	MEI vs. CPI
2022	**2023**	**6.5%**	**3.8%**	**-2.7%**
2021	**2022**	**7.86%**	**2.1%**	**-5.8%**
2020	**2021**	**4.70%**	**1.7%**	**-3.0%**
2019	2020	1.23%	1.9%	0.7%
2018	2019	1.81%	1.5%	-0.3%
2017	2018	2.44%	1.2%	-1.2%
2016	2017	2.13%	1.4%	-0.7%
2015	2016	1.26%	1.1%	-0.2%
2014	2015	0.12%	0.8%	0.7%
2013	2014	1.62%	0.8%	-0.8%
2012	2013	1.46%	0.8%	-0.7%
2011	2012	2.07%	0.6%	-1.5%
2010	2011	3.16%	0.4%	-2.8%
2009	2010	1.64%	1.2%	-0.4%

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HEADWINDS FACING FQHCS IN 2023: MEDICAID REDETERMINATION

3.8 Million

More than 3,816,000 people in 39 states and DC have been disenrolled from Medicaid since April 1, 2023.

As of July 28, 2023

As many as 24 million people could lose Medicaid coverage in the end.

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Source: Kaiser Family Foundation kff.org

HEADWINDS FACING FQHCS IN 2023: THREAT TO 340B REVENUE

- 340B program offers discounted drugs to certain safety net providers who serve vulnerable or underserved populations
- Duplicate Discount Prohibition - In order to better oversee the program and prevent duplicate discounts, states may make decisions to allow 340B covered entities to carve in or out of the Medicaid program
- *June 15, 2022:* The Supreme Court of the United States ruled unanimously in favor of the AHA and others, reversing a 2020 court of appeals decision upholding the authority of the Department of Health and Human Services to significantly cut payments to certain hospitals that participate in the 340B Drug Pricing Program
    - Concerns that 340B discounts have become so numerous and large that they are driving up the costs of 340B drugs in private markets
- **Some state Medicaid agencies have eliminated or plan to eliminate 340B opportunities for covered entities**

Source: https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/340b-drug-pricing-program/index.html

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HEADWINDS FACING FQHCS IN 2023: CHANGING PATIENT EXPECTATIONS

Source: iStock

Source: Adobe Stock

The use of telehealth services for Medicare-insured individuals rose tenfold: 53 million telehealth visits in Apr.-Dec. 2020 vs. 5 million during the same period in 2019.

Patients want more convenient and timely access to care.

Source: U.S. Government Accountability Office https://www.gao.gov/products/gao-22-104454

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HEADWINDS FACING FQHCS IN 2023: INCREASED MARKET COMPETITION

one medical

CITYBLOCK HEALTH

Oak St. Health

Walgreens

VillageMD

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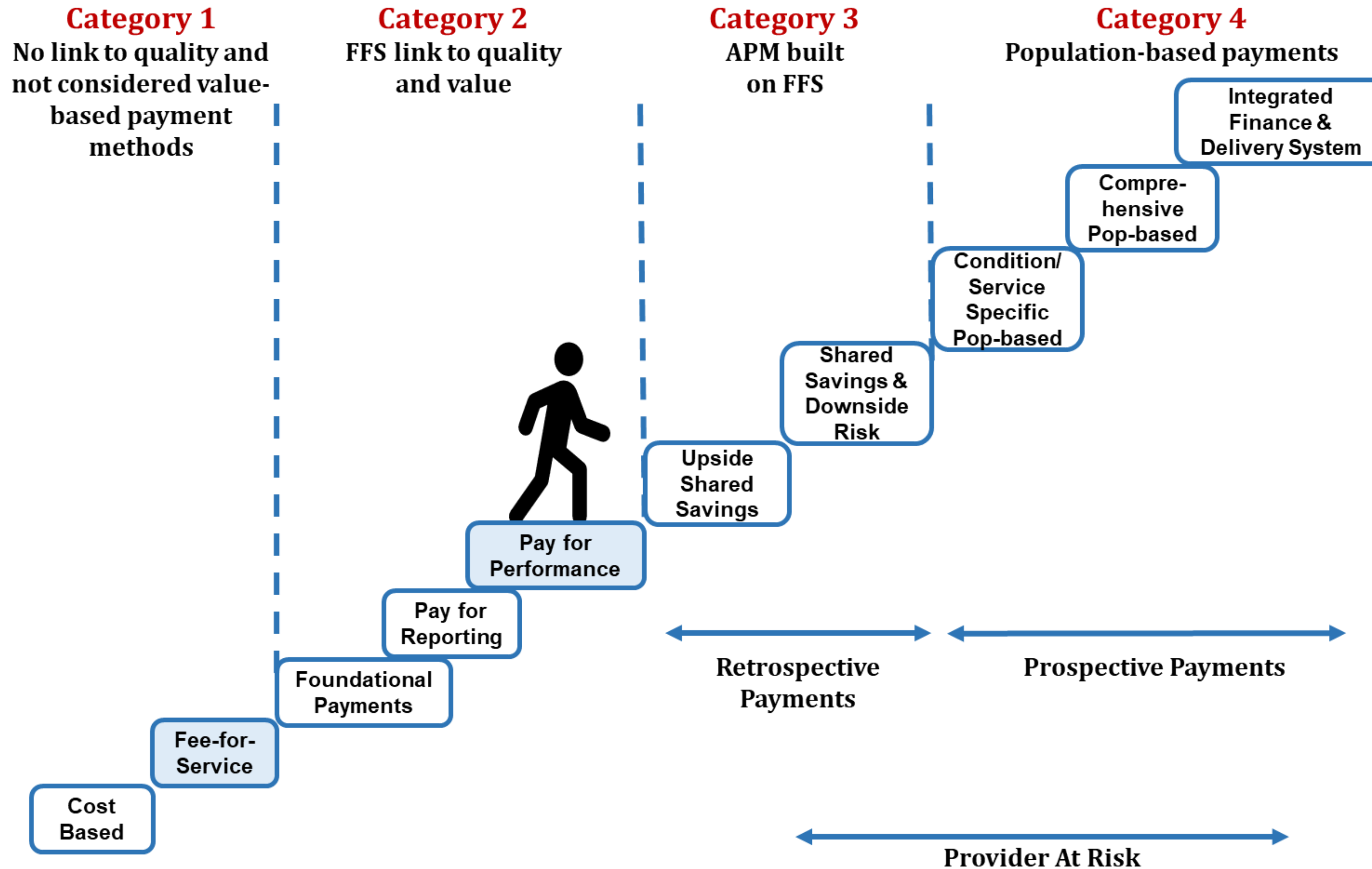
THE DECISION TO PURSUE ADVANCED APMS

THE SEARCH FOR NEW REVENUE STREAMS: ADVANCED APMS



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SHOULD I PURSUE, AND IF SO, HOW SHOULD I PURSUE ADVANCED APMS?

- Can't I just keep living on the first floor (or go back to the basement)?
- Can I wait for the elevator?
- How badly can I get hurt if I fall climbing the stairs?
- Is this the only set of stairs and if so, can I skip some steps?
- Do I really have to make it to the top?
- Does the railing go to the top?
- Should I hold someone's hand on the way up and if so, who's?

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OPTIONS FOR FQHCS TO PURSUE SHARED SAVINGS/RISK

1. Alone
2. Partner with other providers in a clinically integrated network (CIN)
3. Contract as a participating provider
4. Wait and watch

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ASSESSING READINESS TO SUCCEED

READINESS ASSESSMENT TO SUCCEED IN AN ADVANCED APM: 4 DOMAINS

- Leadership
- Information technology, data analytics and reporting
- Care delivery
- Finance

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QUESTIONS WHEN EVALUATING A POSSIBLE CIN PARTNER: LEADERSHIP

1. What is the clinically integrated network's (CIN) organizational structure? Is it a non-profit or limited liability corporation?
2. What are the organization's mission and values and those of its board of directors and major participating providers? Are they compatible with those of the FQHC?
3. What is the decision-making process? What, if any, entities have controlling interest? What decisions need a supermajority approval? Are there reserved powers, and if so, who holds them?
4. Can participating providers choose which contracts to join, or will they be required to participate in every value-based contract?
5. Are the CIN's participating providers willing to be accountable to one another for performance? Do they understand and comply with their fiduciary responsibility to the CIN?
6. Do any provider participants also serve as the operating entity(s) and if so, how are potential conflicts of interest guarded against?

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QUESTIONS FOR AN EXTERNAL LEAD ENTITY: INFORMATION TECHNOLOGY, DATA ANALYTICS AND REPORTING

1. Is the CIN participating in a health information exchange (HIE)? Is it importing admission, discharge, and transfer (ADT) feeds from the HIE or directly from regional hospitals?
2. Does the CIN have a data warehouse that imports and analyzes member eligibility files, claims files, ADT alerts, and electronic health records data?
3. What is the ability to share timely and actionable information across the provider network that inform decisions at the individual patient and the population levels? Is the CIN meeting user and payer reporting needs?
4. Is there a performance dashboard that is risk-adjusted, includes appropriate benchmarks, and transparently reports performance at the CIN and participating provider levels?
5. Are participating providers using that information to improve outcomes?
6. Is there a data governance committee charged with setting information technology-related policies, monitoring performance and prioritizing work orders?
7. Are there policies and an audit procedure to mitigate privacy and security risks?

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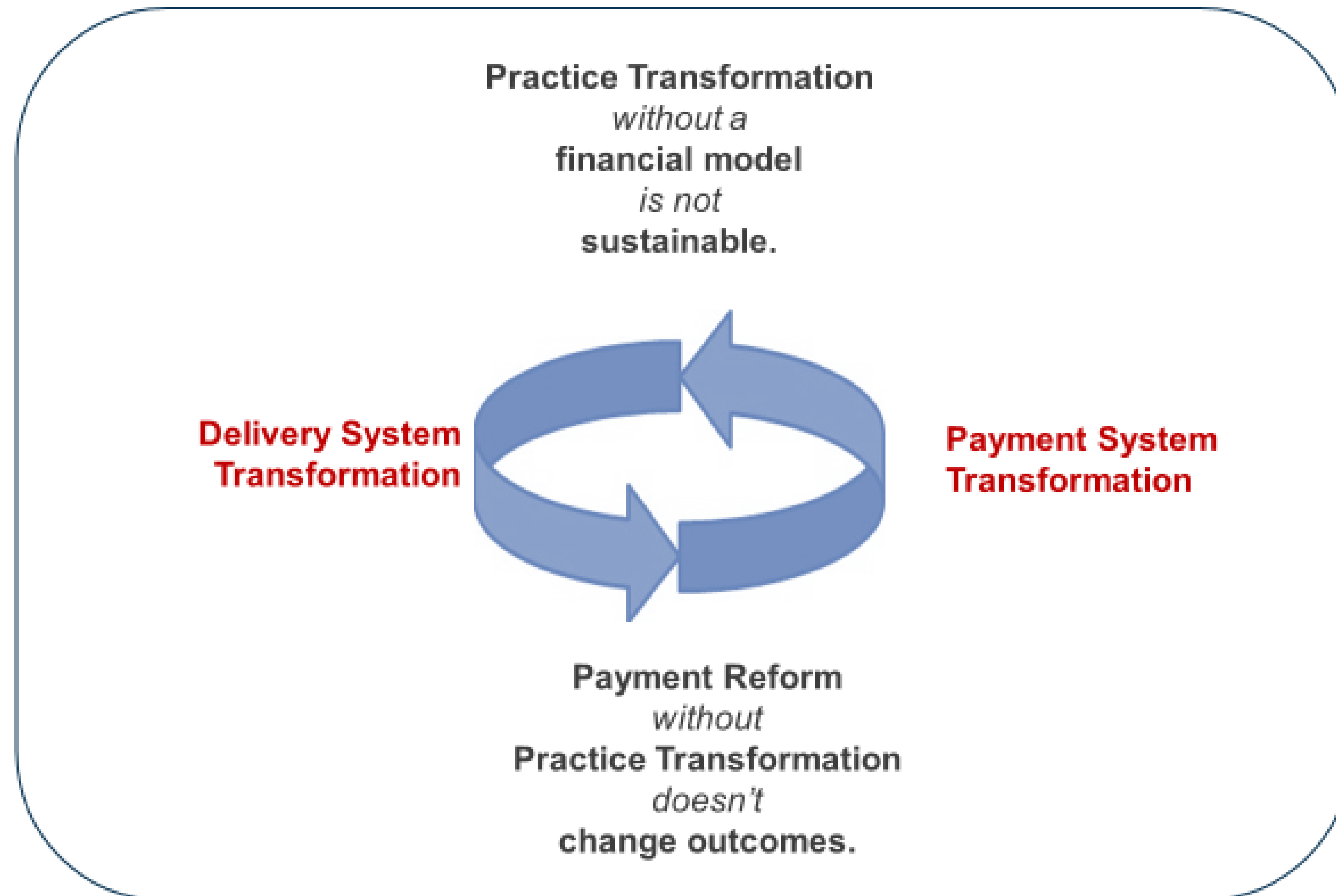
INTERDEPENDENCE OF PAYMENT REFORM AND PRACTICE REDESIGN



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QUESTIONS FOR AN EXTERNAL LEAD ENTITY: CARE DELIVERY

1. Is there a clinical committee and workgroup structure to identify opportunities to improve member outcomes, reduce cost and design models of care to address those opportunities?
2. Are the care models proposed by the clinical committee treated as best practices with voluntary adoption by providers, or do they become standards of care expected to be followed?
3. Is there a uniform and effective approach to care coordination?
4. Do members of the clinical committee champion adoption of those models of care at practice sites?
5. Does the quality improvement plan align with the metrics that have financial implications in the value-based contracts?
6. Does the quality improvement plan address managed care members who are assigned but not yet seen by the assigned primary care provider (PCP)?
7. Do primary care providers preferentially make referrals to specialists based on an objective assessment of them as high-value providers?
8. Are there models of care to address high-cost, special-needs populations?

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QUESTIONS FOR AN EXTERNAL LEAD ENTITY: FINANCE

1. Does the CIN contract with the payer for payment of network providers' direct services as well as value-based incentive payments? If so, do the terms comply with federal PPS equivalent payment rules?
2. What is the CIN's current performance in its value-based payment arrangements?
3. What is the strategic plan to pursue more advanced alternative payment models?
4. What is the maximum risk exposure for participating providers?
5. What capital reserves exist, and will providers be expected to make capital contributions?
6. What leverage does the CIN have to secure more lucrative arrangement with payers than its individual participating providers?
7. What is the distribution methodology for incentive funds?
8. What is the CIN's operational cost compared to historic and anticipated value-based payments?

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NATIONAL FQHC EXPERIENCE IN ADVANCED APMS: GO ALONE EXAMPLES

I. Very few FQHCs have the size, resources, managed care experience, and operate in markets amenable to assume global risk or even shared risk for the general Medicaid population.

II. A few FQHCs are assuming global risk in PACE programs.

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NATIONAL FQHC EXPERIENCE IN ADVANCED APMS: FQHC-LED CIN EXAMPLES

I. State Primary Care Association-led and Health Center Controlled Network-facilitated CINs (for example Idaho, Iowa, Louisiana, Michigan, Missouri, North Carolina, and Wisconsin) are in shared savings arrangements and some have advanced to shared risk arrangements.

II. Independent but FQHC-led CINs in some states (for example Florida, Massachusetts, New York, and Virginia) are in advanced alternative payment models for total cost of care.

III. Some FQHCs have partnered or contracted with hospitals in CINs.

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NATIONAL FQHC EXPERIENCE IN ADVANCED APMS: FQHC AND NON-PROVIDER ENTITY EXAMPLES

I. A few FQHCs partner with PACE program operators.

II. Equity-backed provider aggregators have targeted FQHCs for Medicare shared savings programs, ACO REACH and increasingly, the Medicaid population.

III. Some health plans are partnering with FQHCs in CINs that contract with other payers for advanced alternative payment models.

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NATIONAL FQHC EXPERIENCE IN ADVANCED APMS: WAITING ON THE SIDELINES

I. Many FQHCs continue to contract for pay-for-quality incentive payments but have not progressed to even shared savings.

II. What strategy should you pursue?

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WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

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UPCOMING SESSIONS & MORE INFORMATION

Upcoming Cohort Sessions:

- **Value-based Payment: Is it disrupting health care for the better? Role of a Capitated Alternative Payment Model**
  (Aug. 23, 12 – 1 pm ET)
- **Value-based Payment: Is it disrupting health care for the better? Role of a Clinically Integrated Network**
  (Sept. 13, 12 – 1 pm ET)

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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