Minnesota Association of Community Health Centers
Many Faces of Community Health
How FQHCs Can Thrive Under the Affordable Care Act
Part 2
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Curt Degenfelder
Managing Director
Curtis.degenfelder@mcgladrey.com
http://www.linkedin.com/pub/curtis-degenfelder/1/5b/7a6
The Question for 2010 - 2014

HOW DO CHCS TAKE ADVANTAGE OF, RATHER THAN BECOME A VICTIM OF, THESE CHANGES?
Preparing for 2014

- CHCs must first ensure that their current financial position is strong and their operational performance is positive.

- Health Reform will require CHCs to strengthen internal systems and processes to be successful in this changing world through strategic planning. Planning goals could include:
  - Improve clinical documentation and coding – improve CPT coding and implement ICD-10
  - Improve practice management system reporting – operational reporting such as cycle time; data quality strategy
  - Electronic health record meaningful use and health information exchange
  - Improve customer service to prepare for increased competition for patients
Preparing for 2014 – Strategic Planning Goals

Data
- Improve clinical documentation and coding – improve CPT coding and implement ICD-10
  - New Medicare reporting should be a good test
  - Will impact Medicare reimbursement in 2014
- Improve practice management system reporting – operational reporting such as cycle time and performance on an individual staff level
- Data quality strategy – you can no longer afford GIGO
- Quality –
  1. good start would be to start recording all 12 of the HRSA quality reporting measures – not just those on the UDS
  2. Exceed the 2009 CHC average in all categories by CY 2011
- Electronic health record meaningful use and health information exchange
Preparing for 2014 – Strategic Planning

Goals

Operational

- Develop full patient paneling
- Achieve PCMH certification (at least Level 2).
- Fully integrate medical, behavioral health and dental
- Develop and implement a real corporate compliance program
- Develop and/or strengthen relationships with other “strategic” partners, including ACOs
- Growth strategy (recruit soon-to-be insured uninsured patients in 2013?)
Preparing for 2014 – Strategic Planning

Customer service
- Access – 3rd next available appointment for new & established patients
- Cycle time: total and from entry to exam room
- Phone statistics
- Onboarding for all staff
- Customer service training: how to answer a phone, how to greet a patient, etc
Preparing for 2014 – Strategic Planning

Goals

□ External
   – Develop and/or strengthen relationships with other “strategic” partners, including ACOs
   – Growth strategy (recruit soon-to-be insured uninsured patients in 2013?)
   – Acquisitions (physician practices, hospital clinics) that leverage FQHC rate/NAP/EMC
To be successful, CHCs must manage a “delicate balance” of key cash flow and operating measures –

<table>
<thead>
<tr>
<th>Cash Flow Measures</th>
<th>Operating Measures</th>
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<tbody>
<tr>
<td>Days unrestricted cash on hand</td>
<td>Patient base (patients and visits)</td>
</tr>
<tr>
<td>Days in accounts receivable</td>
<td>Payor mix</td>
</tr>
<tr>
<td>Days in working capital</td>
<td>Reimbursement rates and collection %</td>
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<tr>
<td>Days in reserve</td>
<td>Subsidies for uncompensated care</td>
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<td></td>
<td>Provider productivity</td>
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<td>Cost per visit</td>
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If one of these indicators strays from “the balance”, adverse financial impact may occur if not detected and addressed in a timely manner.

In preparing for Health Reform, CHCs must change their mind-set to “drive-change” while at the same time creating a positive bottom-line and building a reserve!
Preparing for 2014 – The “Delicate Balance”

- The delicate balance is going to be upset by 2014:
  - Payor mix shift – more Medicaid, less uninsured
  - Potential drastic reductions in uncompensated care funding
  - Change in payment methodology: in the future, more visits per patient may not be a good thing
  - Opportunity for growth (or shrinkage)
  - Increased operating costs: EHR, PCMH, more compliance, ACO governance/connectivity
Preparing for 2014 - Financial

- Hopefully at this point the CHC has built some level of reserves
- Building infrastructure may require investments that eat into reserves
- Health centers can more confidently invest reserves when:
  - The organization is profitable
  - The organization’s operations are cash flow positive
  - Not all organizational net assets are tied up in the building
- ACOs may also require insurance reserves
Preparing for 2014 – Financial

Revenue enhancement opportunities

– Are we monitoring trends in our patient base, ensuring that patients are seen when required? What’s the relationship between provider productivity, no-show rates, and third next available appointment?

– Are changes in payor mix being monitored, and internal systems reviewed to ensure that patients are being properly registered?

– Are we effectively managing the components of patient services revenue by payor: are we billing and collecting appropriately, and is revenue real?

– Are we aware of the level of uncompensated care we are providing to the community and do we have the resources to subsidize this cost?

– Do we have a sense of how many of our uninsured patients will become insured in 2014?

– Do we have an opportunity to increase our Medicaid rate through a change of scope (does our state even allow it?)?
Preparing for 2014 - Financial

Cost containment opportunities

- Are we monitoring provider productivity and staffing ratios versus patient demand?
- Do we have a facilities plan, so that valuable capital can be spent on improving operations, so that we are not stuck in inefficient buildings?
- Do we have a cost-based charge structure and are we comparing it to rates negotiated with insurers or rates included in global payment rate structures?
- Are we preparing departmental profit and loss statements, and evaluating performance versus the mission of the CHC?
- Is your CHC considering the implementation of incentive compensation programs? For providers and/or staff? (may want to consider re-aligning your compensation program with that of a global payment system’s success factors.)
- *Cost containment and utilization management on a “per unit of service” basis will be the wave of the future.*
The all-inclusive FQHC visit rate has not been good for patient access:

- It encourages churning (having more visits than necessary) of patients
- The focus on billable providers has caused health centers to overlook other potential points of patient entry/contact

The patient centered medical home looks for staff to perform at the “top of their practice”

Thus access is increased by having a greater number of “providers” seeing patients, and for more appropriate services
Practice Restructuring – PCMH – How Do We Pay For It?

- Basic systems envision an add-on to current per visit rates
- More advanced systems envision paying for additional cost through capitation
- To get appropriately compensated, may need to record services of all staff (especially for patients who receive service from a non-billable provider)
- Potentially use RVU system
- Health center may be assigned management of a population (either in an ACO or PCMH model)