Partnerships for Care

HIV TAC TEAM

Adapting Health Care Financing in Changing Revenue Landscapes

Presenter: **Marissa Tonelli**

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Adapting Health Care Financing in Changing Revenue Landscapes

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Learning Objectives

- Discuss the financial impact of the Affordable Care Act, Medicaid expansion, and the changing payer mix on health centers
- Describe federal and state-level policy implications affecting health center financial sustainability
- Identify opportunities for health centers to leverage payment reform changes for HIV prevention, care, and treatment services

Healthcare System Changes

- Reduction in federal and state funding for public health services
- Healthcare reform implementation
- Focus on a quality, collaborative, and/or accountable care models
- Value-based payment shifts the health care system towards paying providers based on value

Healthcare Reform

ACA impacts the systems that serve patients we work with, not limited to the following:

- Health Resources and Services Administration Ryan White HIV/AIDS Program (HRSA HAB)
- Centers for Disease Control and Prevention (CDC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Centers For Medicaid and Medicare Services (CMS)
- Federally-Qualified Health Centers (FQHCs) and Look-Alikes

Healthcare Reform

- The Patient Protection and Affordable Care Act (ACA) (March 23, 2010)
  - Enhances patient rights and protections
  - Mandates essential health benefits and mandates states to establish state health insurance marketplaces
  - Provides new ways to hold insurance companies accountable
  - 20 million Americans gained health coverage as of March 2016
  - Medicaid expanded to cover those up to 133% of the federal poverty level
  - Others above 133% FPL may receive subsidies if they cannot afford insurance in the private market

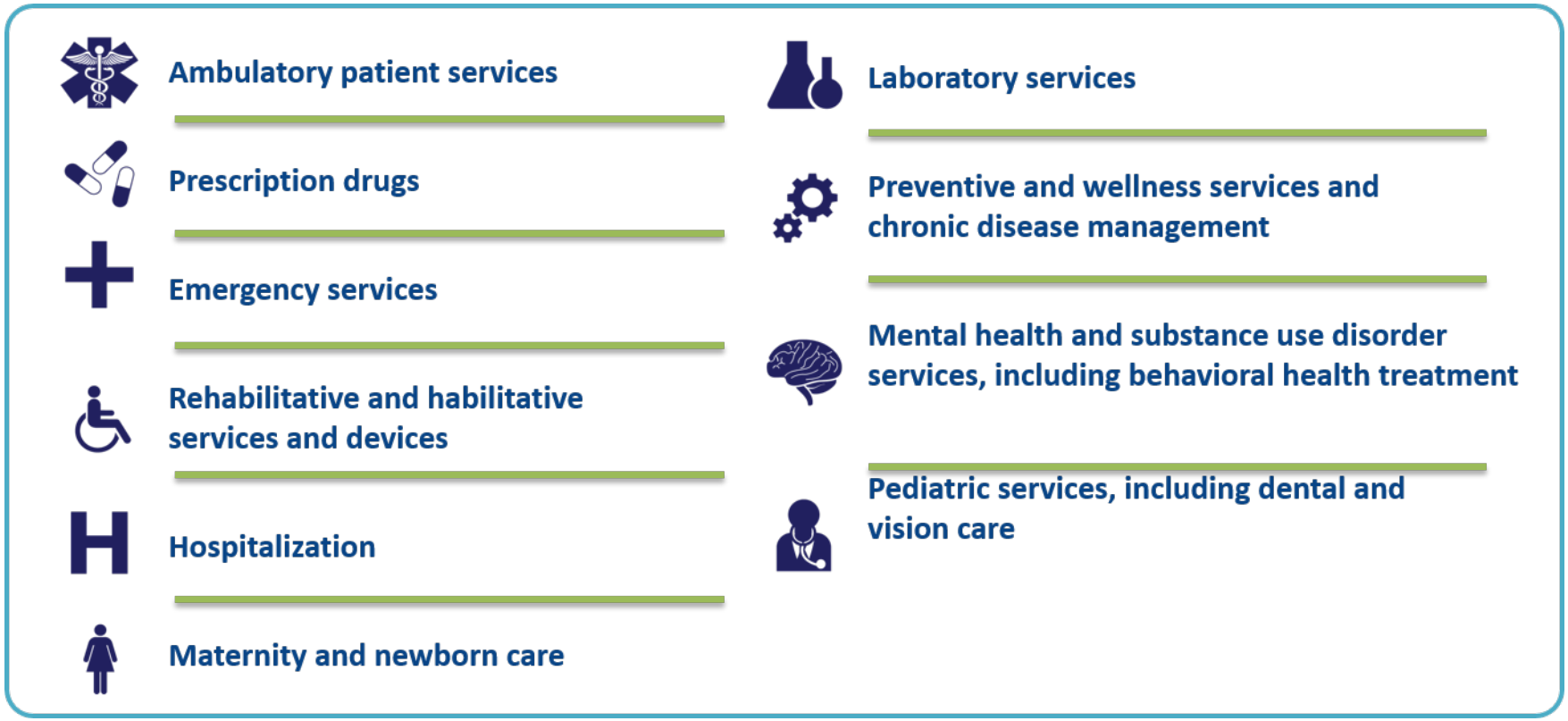
US Preventive Services Task Force

- Requirement that private insurance plans cover recommended preventive services without any patient cost-sharing
- Insurers now must cover evidence-based services for adults that have a rating of “A” or “B”
- STI screening (including HIV), HCV, diabetes, obesity
- Counseling (STIs, tobacco use, health/diet)
- Linkage and retention in care (health navigation and care coordination services)

Health Reform & Expansion of Access

- Federal subsidies for people with income within the range: 138% FPL < income < 400%
- Plans have to contract with "Essential Community Providers," including FQHCs, health centers, and Ryan White providers serving high-risk, special needs, and underserved individuals
  - States have additional ECPs included in marketplaces in addition to CMS categories
- Plans must include Essential Health Benefits

What Does the Coverage Look Like?



§§1302(a)-(b) of ACA; CMS-9980-F: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, February 20, 2013

Health Reform & Expansion of Access

- Improved access to insurance
  - Guaranteed issue and renewability
  - Young adults allowed to remain on parent's insurance to age 26 in private plans
  - Employer-sponsored insurance requirements
- No lifetime or annual benefit limits
- Reduction in financial burden
  - Ability to purchase insurance with subsidies / tax credits
  - Out of pocket maximums
  - Coverage of preventive health services without cost-sharing
  - Prohibitions on discriminatory premium rates, i.e., gender and health status

Health Reform & Expansion of Access

- Quality coverage
  - More information and services
  - Preventative care and coordinated care, including HIV/STI testing and counseling without deductibles or copays
- Increasing opportunities for health and well-being
  - Investments in prevention, wellness and public health activities
  - Expansion of initiatives that strengthen cultural competency
  - Increased funding for health centers

Health Reform & Expansion of Access

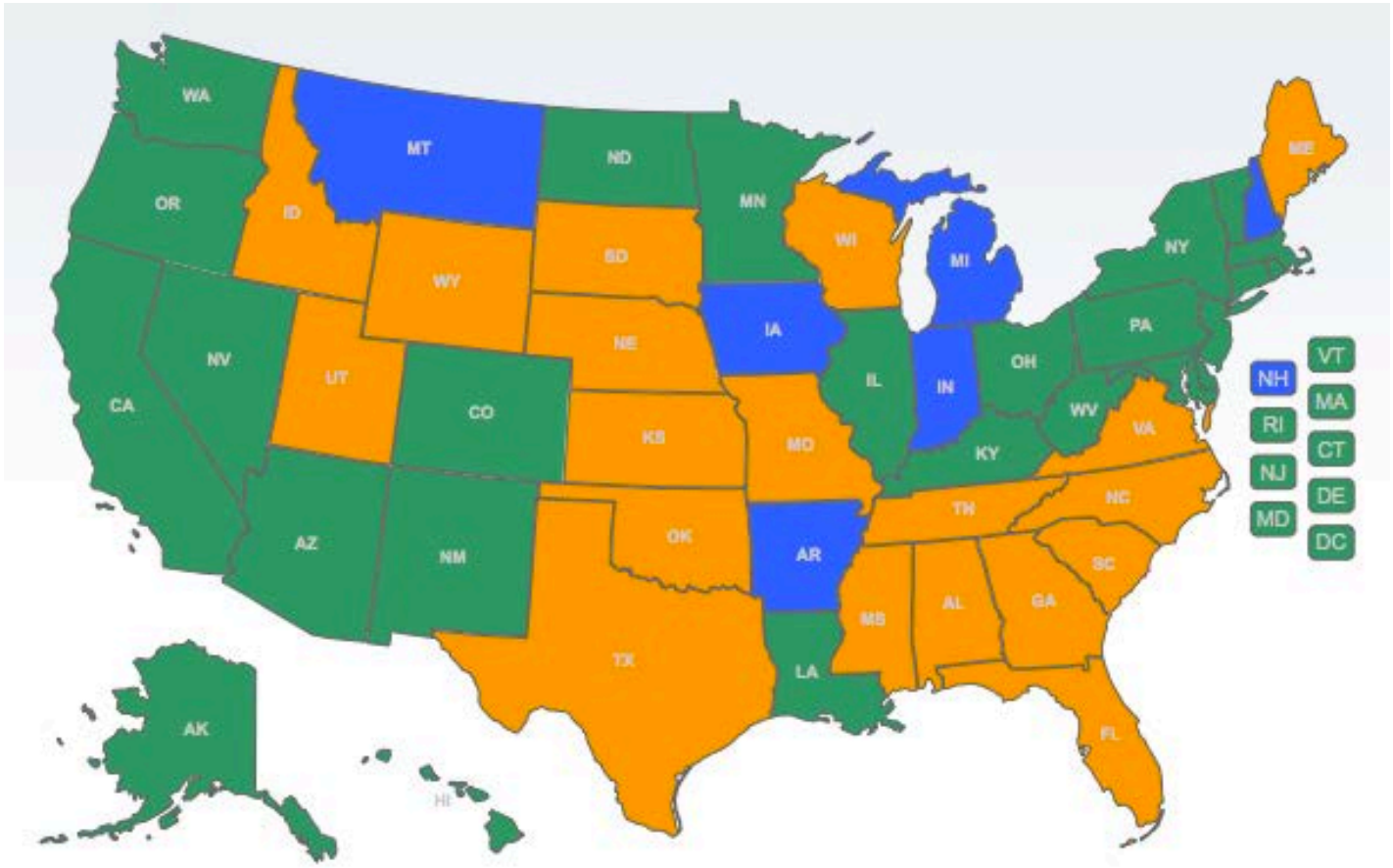
- Medicare changes (elderly & under-65 disabled)
  - End to Medicare Part D drug benefit coverage gap ("doughnut hole")
  - Improved coverage of prevention benefits - beginning in 2011, no coinsurance or deductibles will be charged in traditional Medicare for preventive services that are rated A or B by USPSTF
  - Allows ADAP payments to count toward true out-of-pocket (TrOOP) threshold used to determine eligibility for catastrophic coverage under Part D

Source: Kaiser Family Foundation

Challenges For Providers and Patients

- Assisting patients in identifying plans
  - Provider/ pharmacy in network
  - Locate formularies
  - Compare options
- Checking formulary coverage
  - Treatment regimen coverage for chronic disease (HIV, viral hepatitis)
  - Coverage of preferred regimens
  - Cost-sharing burden (co-pays, co-insurance, reaching out-of-pocket limit early in calendar year)
- Contracting with plans
  - Providers ensuring continuity of care
  - In Qualified Health Plan in Marketplaces

Medicaid Expansion



Produced by:
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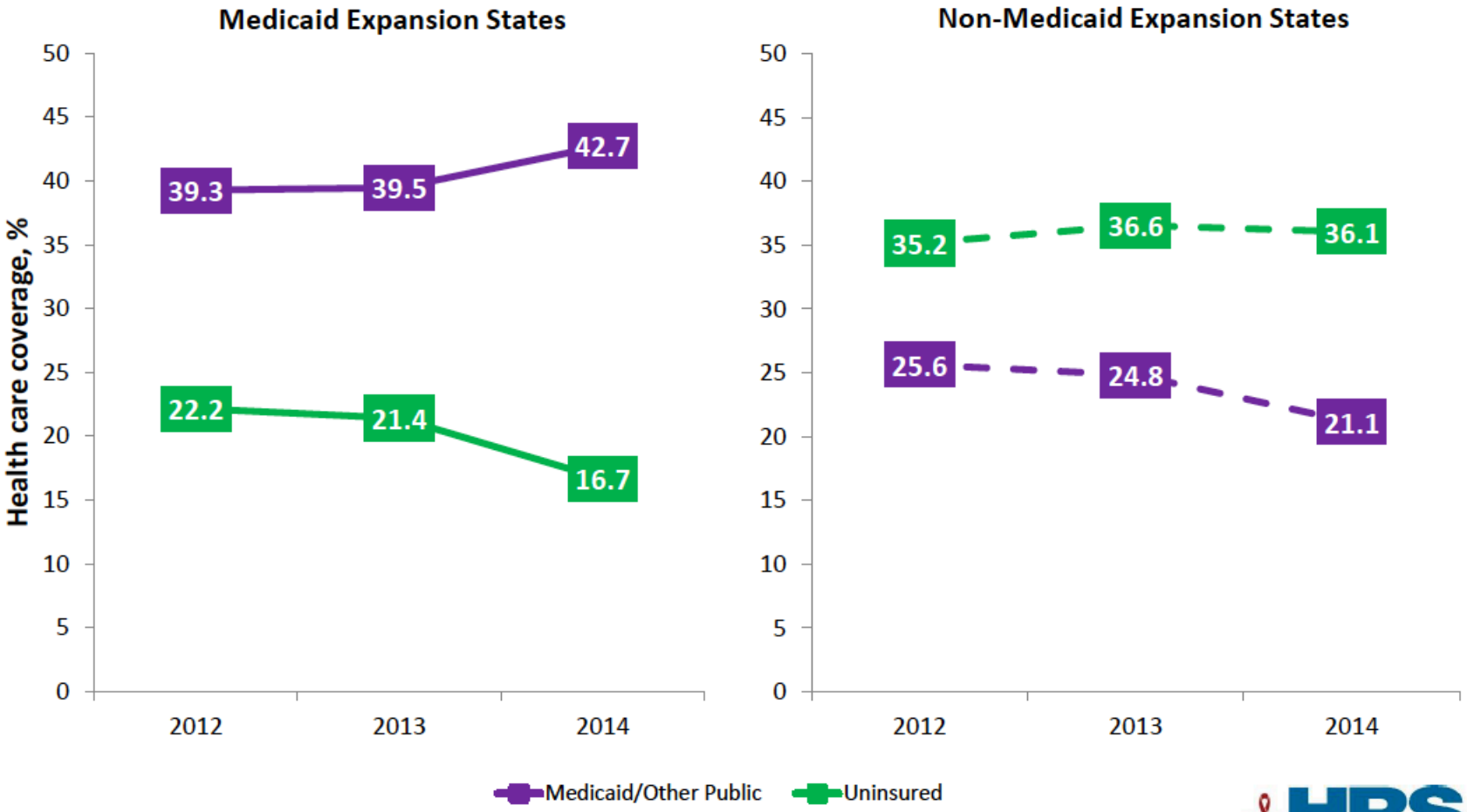
Key:

- 19 states are not expanding Medicaid
- 26 states (count includes the District of Columbia) are expanding Medicaid
- 6 states are expanding Medicaid, but using an alternative to traditional expansion

Expansion vs. Non-expansion & the Impact on HIV care

ACA is changing insurance landscape for many but not evenly across the country



ACA Implementation

Potential Challenges

- Reduced funding/ re-distribution of funding
- Changes to reimbursements and payer mixes
- New rules for medical billing claims (potential for more errors – costly)
- More billing expertise needed
- Tremendous uncertainty – entire healthcare system is changing/transforming

Potential Opportunities

- More people will have insurance, hence access to services
- Third party reimbursement for HIV prevention services
- Enhanced care coordination
- Medicaid payment reform to focus on value-based strategies

The continuing role of RWHAP

RWHAP continues to play a crucial role in access to insurance, medication, and care for PLWH.

- **AIDS Drugs Assistance Program (ADAP)**: All 50 state (and territory) health departments provide free medications or assist with co-pays, insurance premiums or deductibles for low-income PLWH.
- RWHAP comprehensive services for uninsured (ineligible) PLWH.

Ongoing Needs:

- Improve insurance and coverage literacy (ACE TA Center)
- Continue to collect data to inform policy

Taken from Kaiser Family Foundation presentation *"The ACA and People with HIV: Observations from Focus Groups in Five States"*

NATIONAL HEALTHCARE FUNDING IMPLICATIONS

Reduction in Public Health Funding

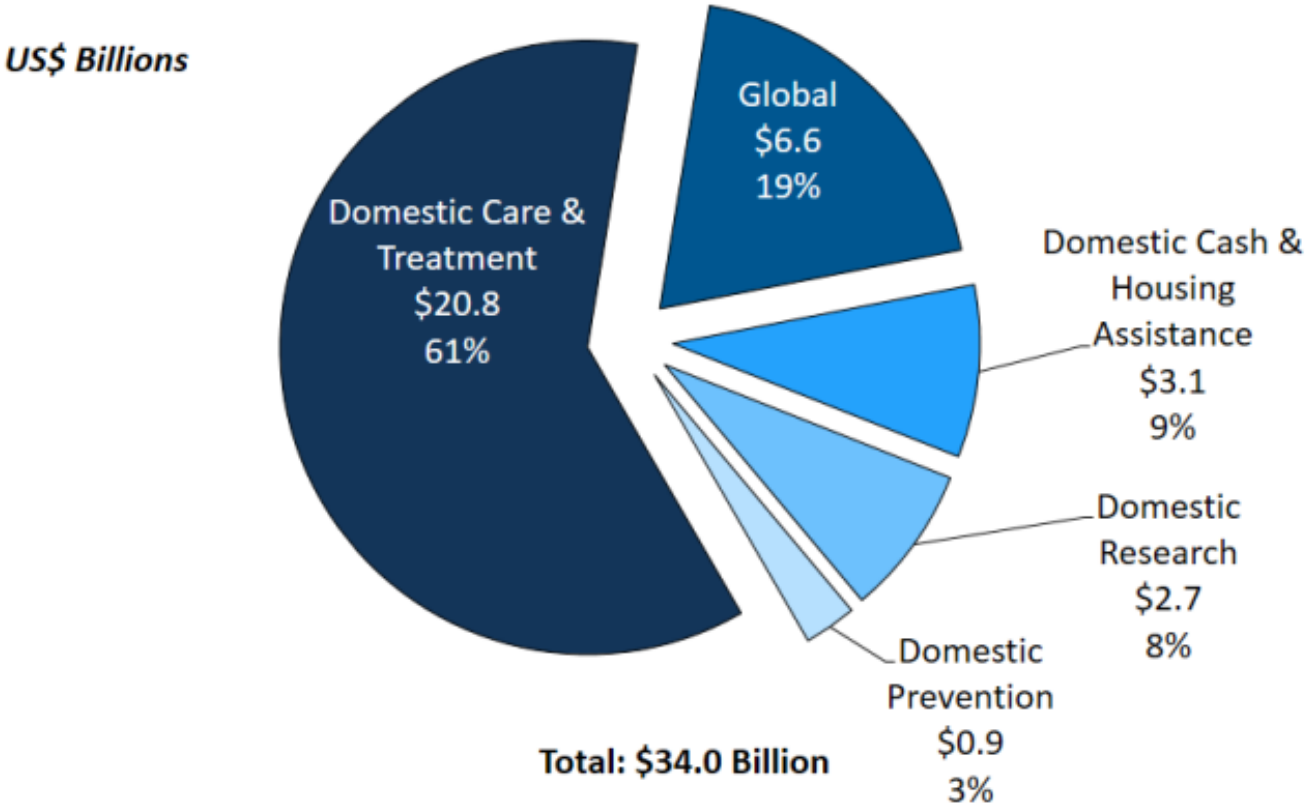
- Discretionary government money is changing at all levels for STD/HIV prevention programs and others
- 48 state and territorial health agencies report budget cuts starting in 2008
- Federal funding for public health declined from $31.4 billion to $28.9 billion from 2010 to 2012
- More cuts have occurred since then and are expected to continue!

Source: CAI Global, STD Technical Assistance Center

Current Public Funding for HIV Services

Figure 1

U.S. Federal Funding for HIV/AIDS, by Category, FY 2017 Request



NOTE: Categories may include funding across multiple agencies/programs; global category includes international HIV research at NIH.
SOURCE: KFF analysis of data from FY2017 President's Budget, Congressional Budget Justifications, White House Office of Management and Budget personal communication.

THE HENRY J. KAISER FAMILY FOUNDATION

Federal Funding for HIV/AIDS (FY2011 – FY2017)

Program/Account (US$ Millions)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017 Request	Change FY16-FY17	Change FY16-FY17
Ryan White Program	$2,336.70	$2,392.20	$2,248.60	$2,313.00	$2,318.80	$2,322.80	$2,331.80	$9.00	0.40%
ADAP (non-add)	$885.00	$933.30	$886.30	$900.30	$900.30	$900.30	$900.30	$0.00	0.00%
CDC Domestic Prevention (& Reasearch)	$800.40	$822.60	$768.60	$786.70	$786.70	$788.70	$788.70	$0.00	0.00%
National Institutes of Health (domestic)	$2,683.50	$2,681.60	$2,508.70	$2,524.00	$2,566.20	$2,569.00	$2,568.10	($0.90)	0.00%
SAMSHA	$178.10	$177.40	$173.10	$180.30	$180.50	$181.80	$197.90	$16.10	8.90%
Department of Veterans Affairs (VA)	$852.00	$956.00	$987.00	$1,047.00	$1,093.00	$1,117.00	$1,174.00	$57.00	5.10%
HOPWA	$334.30	$332.00	$315.00	$330.00	$330.00	$335.00	$335.00	$0.00	0.00%
Other domestic discretionary	$316.90	$318.50	$355.40	$373.60	$381.60	$392.90	$381.80	($11.10)	-2.80%
Subtotal Discrentionary	$7,501.90	$7,680.30	$7,356.40	$7,554.60	$7,656.80	$7,707.20	$7,777.30	$70.10	0.90%
Medicaid	$4,370.00	$3,960.00	$4,190.00	$4,780.00	$5,570.00	$5,860.00	$6,060.00	$200.00	3.40%
Medicare	$7,420.00	$7,810.00	$8,260.00	$8,780.00	$9,420.00	$9,950.00	$10,680.00	$730.00	7.30%
Social Security Disability Insurance (SSDI)	$1,806.00	$1,893.00	$1,963.20	$2,031.40	$2,083.00	$2,070.00	$2,127.00	$57.00	2.80%
Supplemental Security Income (SSI)	$590.00	$525.00	$580.00	$600.00	$605.00	$635.00	$610.00	($25.00)	-3.90%
Federal Employees Health Benefit (FEHB)	$150.00	$161.00	$169.00	$175.00	$183.00	$200.00	$211.00	$11.00	5.50%
Subtotal Mandatory	$14,336.00	$14,349.00	$15,162.20	$16,366.40	$17,861.00	$18,715.00	$19,688.00	$973.00	5.20%
Total Domestic	**$21,837.90**	**$22,029.30**	**$22,518.60**	**$23,921.00**	**$25,517.80**	**$26,422.20**	**$27,465.30**	**$1,043.10**	**3.90%**

Source: Kaiser Family Foundation

Changing Payer Mix

- In Medicaid expansion states, health centers have higher revenue per patient and Medicaid revenue is a larger share of total revenue

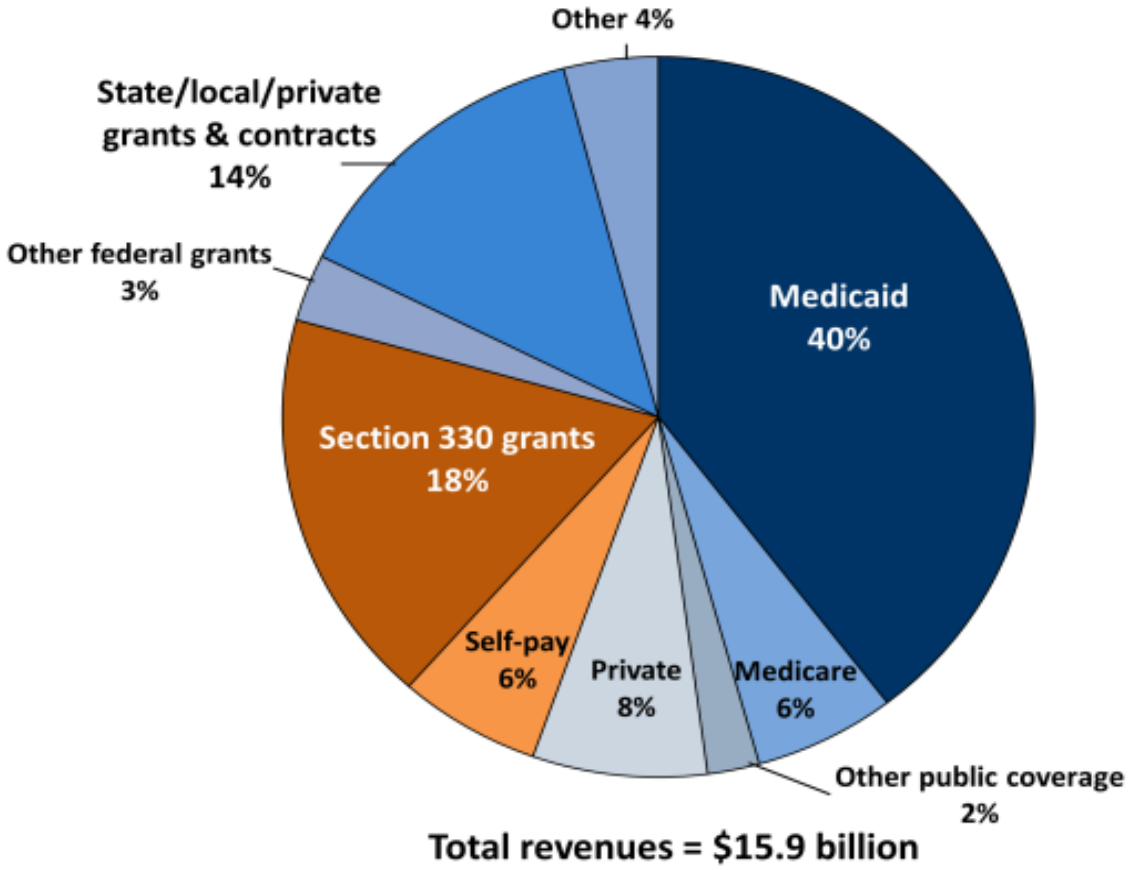
- Still expect many uncompensated care costs-- low-income patients may not be able to pay for services not covered by insurance (may not disclose insurance status)

Sources: HRSA, Health Center Fact Sheet

Health Center Revenue

Figure 7

Health Center Revenues, by Source, 2013

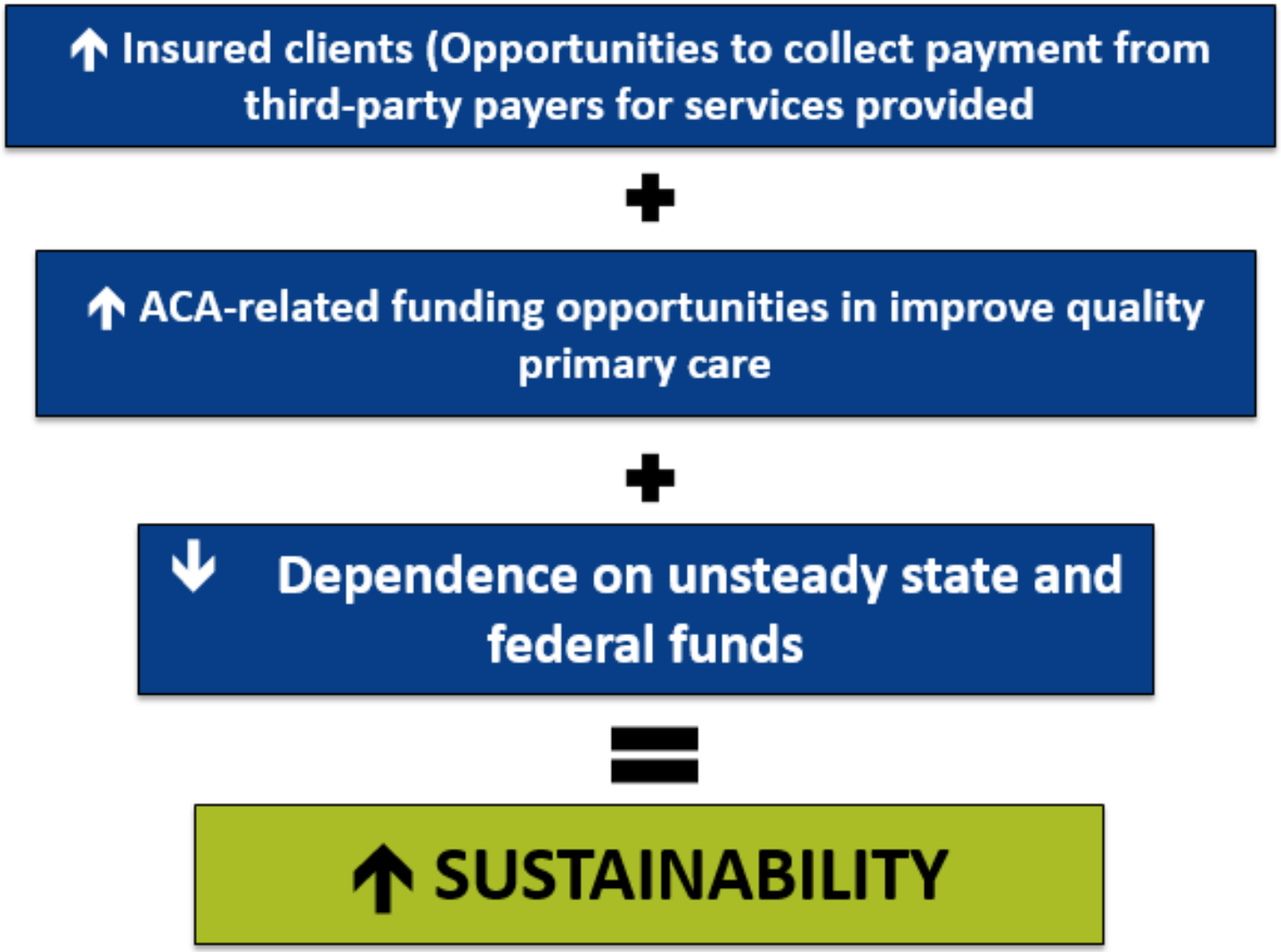


SOURCE: GWU analysis of 2013 UDS data on federally funded health centers.

Health Center Financing

- Health centers earn approximately two-thirds (69%) of their operating revenues through direct charges for patient services
- Non-patient revenue is made up from Federal Revenue (45%), local grants/ contracts (19%), and state grant/contracts (3%)

Seize the Opportunities from ACA



THRIVING IN AN UNCERTAIN FUTURE

Health Center Revenue Opportunities from ACA

- Increasing federal grants for health centers/ primary care
- Incentive-based quality improvement and service delivery reforms
- Expanding coverage through the insurance Exchanges and expanded Medicaid*
- Increasing Medicaid revenues
- Raising the Medicare payment rates

Federal Grant Opportunities

- *"HHS announces an additional $169 million in ACA funding to 266 community health centers" (2015)*
- **"***HHS Awards over $260 Million to Health Centers Nationwide to Build and Renovate Facilities to Serve More Patients"(2015)*
- *"CMS Announces $32 Million to Increase Number of Children with Quality, Affordable Health Coverage" (2016)*
- *"HHS awards $156 million to health centers to expand oral health services"(2016)*

- **Open opportunities:**
  - HRSA-17-050 & 17-051: Health Center Program's Service Area Competition (SAC) – due 8/16 and 8/29

Incentive-based Reform Opportunities

- Patient Centered Medical Homes (60% or more of health centers)
- Federally Qualified Health Centers (FQHCs)
- Medicaid health homes (Section 2703)
- State Primary Care Association health home initiatives
- HRSA Supplemental Funding for Quality Improvement in Health Centers
- Payment/ service delivery models via CMS Innovation Center
  - State Innovation Models (reforms)
  - Demonstration grants (i.e. FQHC Advanced Primary Care Demonstration)
  - Delivery System Reform Incentive Payment (DSRIP)

ACA-Related Prevention Expansions

- Preventive services covered by private health plans
- Incentives for patients to receive preventive care (FQHC Medicare payment rate)
- Primary Care Extension Center
- Community-Based Collaborative Care Networks (Section 10333)
- Community health worker/ allied health professional reimbursement (state-based)
  - Medicaid reimbursement for preventive services staffed by a broad array of health professionals, including those that may fall outside of a state's clinical licensure system

Funding -- Think Outside the Box!

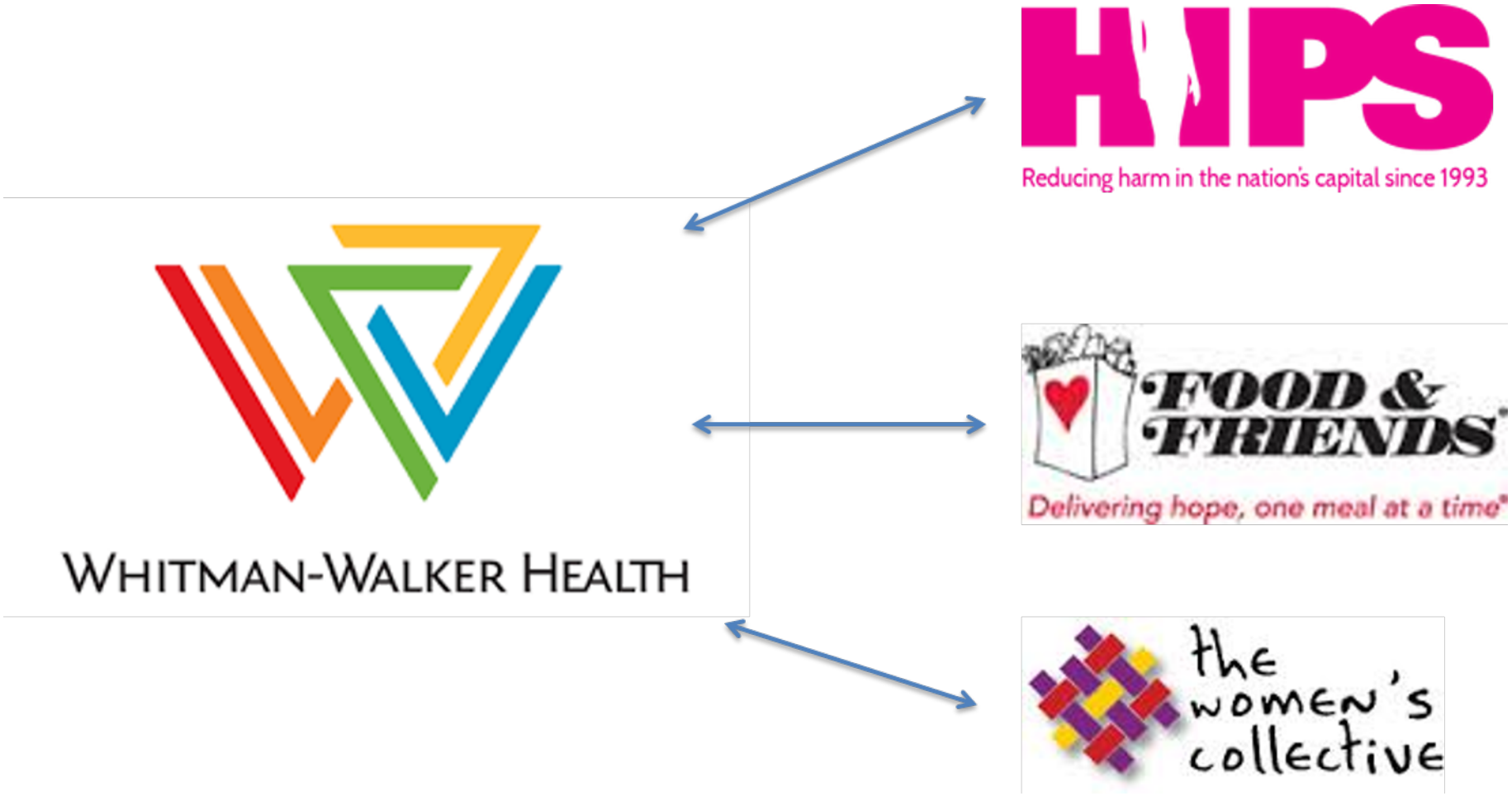
- Rural Economic Development Loan and Grant Program (REDLG) is designed to promote rural economic development and job creation projects
  - Ex. Facilities and equipment for medical care to rural residents
- SBA 7a Loans provide funds to small businesses and are a good option for small healthcare practitioners
  - Ex. Purchase equipment or real estate, construct a new building or renovate an existing building, establish a new business, or refinance existing business debt
- Private foundations (Hearst, Pfizer, and others)

CASE STUDIES: PARTNERSHIPS FOR COORDINATED CARE

Partnerships for Coordinated Care

- Increase access to services for our clients
- Access to new clients (i.e. enter new geographies, serve new focus populations)
- Grow agency's knowledge, capabilities, and skills
  - Quality improvements in existing services
  - Improved efficiency in existing services/referrals
- Increased funding/resources
- Achieve shared outcomes (i.e. community health outcomes)

Community-Wide Medical Home



Coordinated Care Network

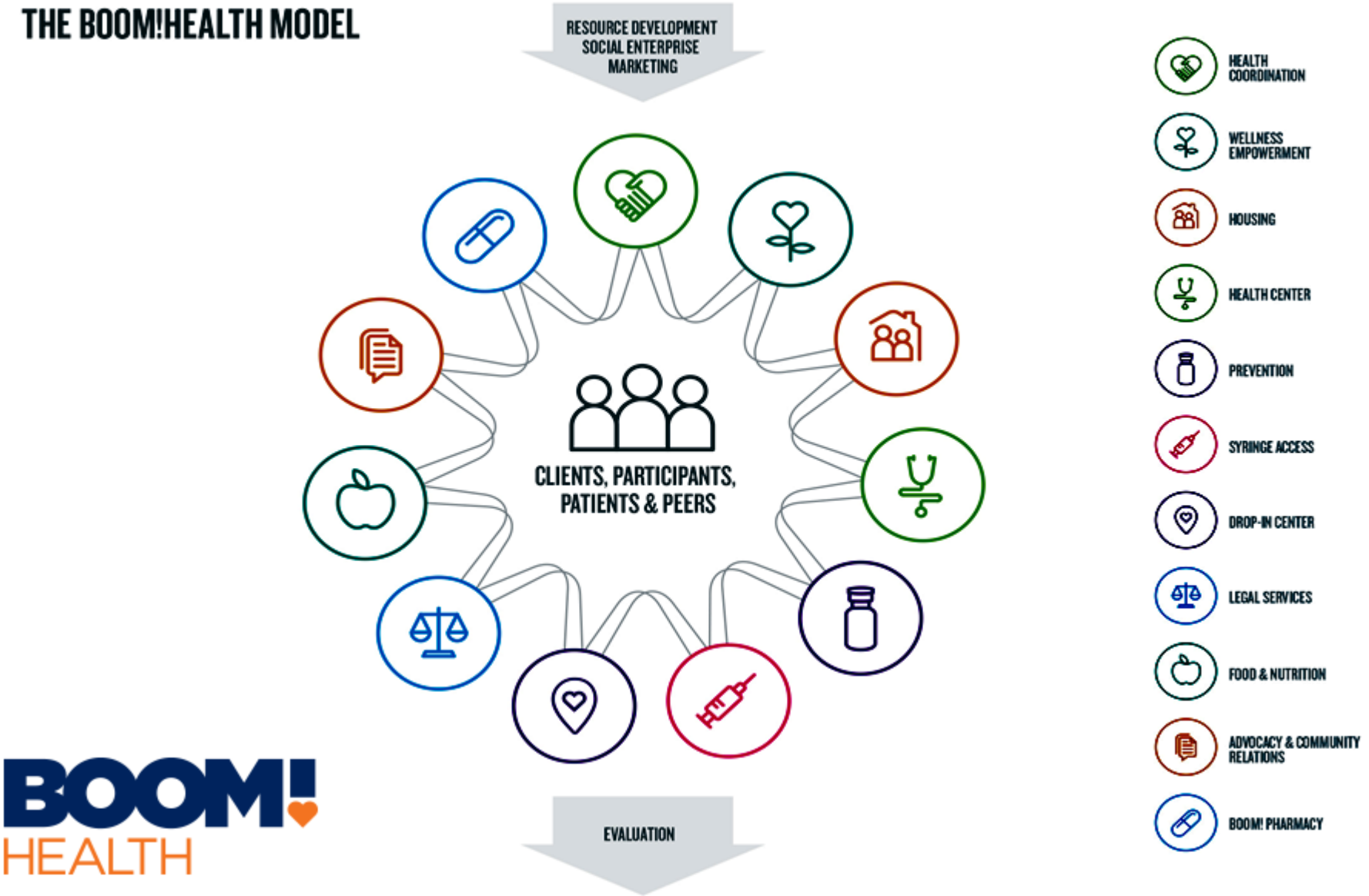
Christie's Place is a leading nonprofit social service organization in San Diego County whose mission is to empower clients to take charge of their health and well-being.

In 2010, Christie's Place started the Coordinated HIV Assistance and Navigation for Growth and Empowerment (CHANGE) for Women program (C4W). C4W is designed to directly address individual and systemic barriers that prevent HIV+ women of color (WOC) from successfully engaging in medical care.

Agencies and clinics that once worked independently to form a system of care have now transformed into a united operating "network of care." The C4W partnership has allowed agencies to stop "competing for clients" and instead provide services in conjunction with the other agencies to wrap-around each client and assist them to get into and stay in medical care.

http://www.christiesplace.org

Mergers & Acquisitions



BOOM! HEALTH

CASE STUDY: THIRD PARTY BILLING FOR (HIV) PREVENTION

State Example: Massachusetts

- First state to implement health reform (2007)
- Almost 100% rate of insured residents
- Transitioned away from public funding for HIV/STD services in clinics (despite community backlash)

Clinic Implementation

- MA healthcare reform implemented, clinic contracted with multiple insurance providers
- Staff trained on how to discuss payment with clients and how to process claims
- Visits billed to public and private insurance increased from 9% to 40%
- Visits declined to 175- 190 visits per month, **but clinic remains open and financially viable**
- Able to withstand deep budget cuts in 2010

Source: CAI Global, STD Technical Assistance Center

Billing commercial and public insurance for services can:

1. Help close budget gaps and offset the cost of providing free services to patients without health insurance

2. Mean the difference between a clinic closing its doors or achieving long-term sustainability

CASE STUDY: PRIMARY CARE QUALITY IMPROVEMENT INCENTIVES

State Example: MA

- $245M has been awarded to MA to improve primary care, offer longer hours, increase professional capacity, and provide more clinical sites
  - $4.4M of the $245M has been awarded to health centers to help enroll residents in the state's health insurance marketplace
  - These funds supported over 700,000 people from 2013 through 2015 enrolling in healthcare coverage

State Example: MA

- Health centers partnering with the state's Office of Health and Human Services to improve primary care services (10 health centers)
  - Coordinates partnerships between health sectors and considers cultural competence in its approach to payment reform
  - Prioritizes needs of health centers who do not receive incentive-based payment reform opportunities
- *Supporting Integrated Systems of Care for Hospitals*: Incentive payments to Medicaid safety net hospitals to fundamentally change the delivery of care to Medicaid members
- *Invest in infrastructure to transition government health care programs to alternative payment methods*: Payments to ACOs that demonstrate increased care coordination and integration across care settings and to support the development of innovative payment strategies
- *Build on the Success of the Primary Care Medical Homes Initiative:* Assist primary care practices to transition into certified medical homes

CASE STUDY: MEDICAID HEALTH HOMES

State Example: New York

- *NYS Care Coordination Models*
- *Health Home Model for Service Delivery*: Focus on linkages to community and social support services
- *New York State Medicaid Medical Home Program*: Incentivizes primary care providers who meet national medical home standards

CASE STUDY: CMS HEALTH CARE INNOVATION

Florida Health Care Innovation

- The University of Miami, in partnership with Medicaid health plans, the University of Florida College of Dentistry, the Center for Haitian Studies, the Larkin Residency program, and Overtown Youth Center, received an award to improve care and access to care for children in four communities in the Miami-Dade County area who have health problems that include asthma, obesity, type II diabetes, and STDs.
  - Expansion of services and utility of school-based health clinics
  - Increased collaboration with other care providers, services, and school-health stakeholders, and
  - Enhanced usage and sharing of health information technology.

What now?

- Time to adapt, acclimate, and secure funding to sustain programs!
  - Reexamine strategies and role as safety net provider.
  - Leverage new opportunities and mitigate challenges.
  - Develop a new vision, if needed.
  - Integrate a nimble business model.

Strategic Responses to Consider

1. Invest in capital improvements for expansions that can demonstrate quality to become "provider of choice" in the community
2. Re-organization of workforce to improve efficiencies (increase care management staff)
3. Maximizing revenue through enhanced medical documentation and coding

Strategic Responses to Consider

4. Expansion of services for billing:
   - Hiring and using "billable" providers, i.e. clinical pharmacists, nutritionists, certified diabetes educators (new revenue and improve clinical outcomes)
   - Programs for seniors (annual wellness visits)
   - Negotiate with MCOs for value-based reimbursement
5. Partnership expansion (CBOs or hospital networks)

Questions?

HealthHIV's Resources

- "Health Insurance Contracting for HIV Prevention Services: From Barriers to Billing" (webinar and guide)
- "Maximizing Third Party Reimbursement through Enhanced Medical Documentation and Coding Series"
  - Four-part webinar series on enhancement of third party billing systems to maximize revenues
  - Desk-reference guide
- Additional fiscal resources on HealthHIV's *Fiscal Vault: Unlocking Resources to Fiscal Sustainability*

Links to resources can be found at:
http://www.healthhiv.org/resources/webinars/

Other Resources

- ACE TA Center Outreach and Enrollment tools/resources
  - https://careacttarget.org/ace/tools-and-resources

- ADAP contacts in your state (@ www.NASTAD.org):
  - FL: Jimmy Llaque, (850) 245-4477, jimmy.llaque@flhealth.gov
  - MA: Annette Rockwell, (617) 624-5762, annette.rockwell@state.ma.us
  - MD: Mary Bahr, (410) 767-5678, mary.bahr@maryland.gov
  - NY: Christine Rivera, (518) 459-1641, christine.rivera@health.ny.gov

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Partnerships for Care

HIV TAC TEAM

WE NEED YOU!

Participate as Health Center co-presenter.

Contact:

Victor Ramirez,
P4C HIV TAC Collaborative Training Coordinator
vramirez@mayatech.com

Thank you for participating in this Webinar.
We hope that you are able to find the information provided useful as you continue your P4C project.
We ask that you take a few moments to complete the feedback survey you will receive when you close out of this webinar.

Partnerships for Care

HIV TAC TEAM

Thank you for participating in today's webinar

If you have any additional questions, please email us:
P4CHIVTAC@mayatech.com

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