WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Adapting Healthcare Financing in Changing Revenue Landscapes

Speaker: Marissa Tonelli

21 July 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh and I'd like to welcome you to the Adapting Healthcare Financing in Changing Revenue Landscapes webinar. This webinar is brought to you by the Partnerships for Care HIV Training, Technical Assistance and Collaboration Center, HIV TAC.

The Partnerships for Care project is a 3-year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand provision of HIV testing prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center HIV TAC.

Our speaker today is Marissa Tonelli. Ms. Tonelli is the Senior Capacity Building Manager for Health HIV's National Center for health care capacity building. She is responsible for managing HIV prevention, care, and treatment capacity building programs for health departments, community-based organizations, AIDS service organizations, and health care organizations. Marissa leads capacity building assistance that focuses on organizational sustainability and fiscal health in the era of health care reform, which includes funding diversification, third party billing and reimbursement, and business model development.

She also serves as a Senior Capacity Building Manager of the Health HCV initiative, an advocacy and education initiative of Health HIV. Marissa has been providing capacity building assistance with Health HIV since June 2012. Prior to joining Health HIV, Marissa was a CVC fellow with a field assignment at the DC Department of Health's HIV/AIDS, Hepatitis, TB and STI administration, where she provided technical assistance on tuberculosis and viral hepatitis prevention to community based organizations.

Marissa received a Bachelor's of Science in Public Health from the George Washington University School of Public Health and Health Services. Please join me in welcoming Ms. Tonelli.

MARISSA TONELLI: Thank you so much, Steve. I think that was one of my longest bios. I didn't realize I had done so much in four years at Health HIV, but it's fun to recap. And as you

mentioned, over the past two years I've done significant work with nonprofit health care organizations, HIV organizations, health departments, community-based organizations, and AIDS service organizations, primarily related to how public funding is shifting. And ensuring fiscal diversification and sustainability, including third party reimbursement in this era of changing revenue. So thank you again.

And thank you to MayaTech for inviting me to present. I'm very happy to be here today. And I hope, for all the health vendors on the line, that I can share something new with you today to help you ensure sustainability of your HIV programs and public health programs moving forward. So I'll get started. Great!

So our learning objectives today are one to discuss the financial impact of the Affordable Care Act, Medicaid expansion and the changing payer mix on health centers, to describe federal and state level policy implications affecting health center financial sustainability, and also to identify some opportunities and best practices, lessons learned, for health centers to leverage payment reform changes to ensure sustainability of your HIV prevention, care, and treatment services.

So we know the health care system has changed significantly, especially as health care reform implementation has come to play. We're seeing a reduction in federal and state funding for public health services. A renewed focus on quality collaborative and accountable care models, and also a value-based payment shift in the health care system. So moving towards paying providers for value, quality, and collaboration versus services.

Health care reform or the Affordable Care Act has been one of the biggest impact on the health care system today. And we know it also impacts other programs and systems that we work with and as health centers, as nonprofits, including HRSA-- [? CNO ?] P4C is funded through HRSA Bureau of Primary Health Care. We're also seeing health care reform impact the Centers for Disease Control and Prevention funding and how they are implementing their programming, substance abuse and Mental Health Services Administration, SAMHSA, centers for Medicaid and Medicare, services about CMS there, and also how Federally Qualified Health Centers, FQHCs, which many of you may be in lookalike's are operating right now.

So I wanted to point out just a couple of things and we all, having been in the health care sector since the Affordable Care Act was implemented in March of 2010, we know that has enhanced our patient rights and protections. We know it's mandating essential health benefits, and mandated states to establish state health insurance marketplaces. And as an account of that we see almost 20 million new Americans have gained health coverage as of March 2016, which is huge.

So these are potentially new clients that health centers, ASOs, CBOs-- that we are seeing. And it's allowing us to leverage third party billing as a new opportunity to increase funding diversification through new clients that have access to health insurance and the reimbursement system.

I also wanted to point out that at the same time we have, through the ACA, required that private insurance plans cover the recommended US Preventive Services Task Force, USPSTF. Preventive services, those that are evidence based services for adults that have a rating A or B from USPSTF. And that includes STI screening, HIV, hepatitis C screening, diabetes, obesity counseling and testing to also STI counseling, tobacco use, health, diet, nutritional counseling, as well as linkage to care and retention care services. So health navigation and care coordination services. So this is really important, because these are services that are available to clients and that are reimbursed without any cost sharing for the patients.

And additionally wanted to point out, we know that plans also are required to contract with essential community providers and this is under the Affordable Care Act legislation as well. So that includes Federally Qualified Health centers, health centers, other Ryan White providers, particularly those serving high risk special needs and underserved individuals. And other states have also had additional essential community providers included in their marketplaces in addition to the CMS required categories that date they laid for us. And also the essential health benefits must be included by all plans.

So what does this look like? I particularly wanted to point out the preventive and wellness services and chronic disease management as we know we're working in preventing HIV and also caring for individuals living with HIV. Mental health and substance abuse disorder treatments also must be covered, including behavioral health treatment. Many of which, the people living with HIV that we're serving, are also dealing with mental health or substance abuse comorbidities. And also prescription drug coverage, which is very important for individuals that are living with HIV, not only to cover their HIV medications but also any other co infections that they may be living with such as hepatitis C or other chronic conditions that they're living with.

And how has it impacted the client? So we know that they have improved access to insurance, no lifetime or annual benefits, and a reduction in financial burden. So for many, there's a new ability to purchase insurance with subsidies or tax credits, there are out of pocket maximums, that coverage of preventive health services as I mentioned before without cost sharing, and also this prohibition on discriminatory premium rates based on gender, health status, HIV status, et cetera.

We also know that there's additional quality coverage. So again, preventive care has been promoted more than it had in the past, as well as coordinated quality care. And there's also an increased transparency and should be more as well, providing individuals with more information and services about their care.

And we also have an increasing opportunity for health and well being through new funding, new initiatives, new investments in prevention, wellness and focus on public health itself. All as a result of this health care reform implementation.

On the Medicare side I just wanted to point out one piece in particular, which is this improved coverage of prevention benefits that began in 2011 without coinsurance or deductibles. And so

I wanted to point, that's again, looking at the USPSTF preventive services. This is important as well because again, the access to HIV testing which is rated an A and so individuals that-- adults, ages 18, I think, must have at least one HIV test in their lifetime and it's even higher for those that are at risk.

So we know that the coverage for HIV testing has increased. As I mentioned before, STI, hepatitis C, and then counseling, which is really important. So again, in the Medicare side for the elderly or disabled, this is another important kind of an action that came from the Affordable Care Act.

And also with this come some challenges. So there are new challenges both for the providers and the patients. So assisting patients and identifying the right plan for them having the provider and pharmacy that's in their network, understanding the formularies and being able to compare options, that's been a challenge both on the patient and the provider side. And as I mentioned, formulary coverage, so insuring it's coverage for all of your HIV, hepatitis or other chronic disease treatment regimens without cost sharing or with limited cost sharing is important.

And then lastly, on the provider side, this renewed urgency to contract with these health plans and providers, if organizations have not been doing so already. So ensuring that you're contracting with all of the Qualified health plans in marketplaces that are serving your client population or covering your client population.

Medicaid expansion has been a huge political issue as we've been looking at this over the last five, six years. We know that currently-- and this is as of June of this year, so last month-- 19 states have elected not to expand Medicaid. I know out of the P4C-- four states, that would only include Florida, so the other Maryland, Massachusetts, and New York as you know, have chosen to expand. And then there's also six states that have expanded Medicaid but are using an alternative to the traditional expansion model and you can see those states in blue there.

And I wanted to point this out as certainly something we've been looking at as an advocacy organization as well, which is that the ACA has changed this insurance landscape but the expansion versus the non expansion states have really made it an uneven playing ground across the country.

This is actually some information shared by HRSA and it shows that you can see on the left, the Medicaid expansion states in 2014, there is still a lack of coverage for individuals although uninsured rates have gone down. And they've gone down significantly in the Medicaid expansion states, they seem to be pretty steady on the uninsured, the green bars on the non Medicaid expansion states holding steady at about 36%. So you can see 20% more of uninsured individual's in the non expansion state, so that's pretty significant.

And another couple pieces to point out with the Affordable Care Act implementation is, again as I mentioned, we'll go into this a little bit, the reduced funding and redistribution of funding

based on the Affordable Care Act implementation. So for redirection of funds often towards clinical care and away from some preventive services. There's changing reimbursements and payer mixes, new rules for medical billing, which not only could lead to more errors and could be more costly but also requires more billing expertise on the part of the health care organizations.

And there's still this tremendous uncertainty and I'll talk about Ryan White in a second. But so this uncertainty around what will happen with some of our government programs and government safety nets that have really been kind of the cornerstone, especially in HIV, of providing comprehensive quality care to individuals for many, many years.

And then there's, on the other side, many opportunities. So with more people having access to insurance, access to services, that's a potential for more reimbursement for the health care organizations as well. Enhanced care coordination being improved is another benefit both for patients and the providers. And Medicaid payment reform, as I mentioned, focusing on value and quality.

And there's this continuing role of the Ryan White HIV/AIDS program, as I mentioned. It continues to play a crucial role for access to insurance, medication, and care for people living with HIV. And I particularly wanted to point out one of the programs, which is called the AIDS Drug Assistance Program known as ADAP. And I know every state-- all of you may be familiar with your state ADAP or may not be familiar with your state ADAP. But it is a state administered program. It is authorized under part B of the Ryan White HIV/AIDS program. And it provides medications and also assists with co-pays insurance premiums and deductibles for low income people living with HIV, who have limited or no coverage through private insurance, Medicaid or Medicare.

So this is a really great service, I wanted to point out that a great resource for the P4C projects to link to-- link your eligible people living with HIV or working with to this resource if they are unable to purchase insurance and unable to pay for their medications. And it provides a comprehensive services for uninsured or ineligible people living with HIV as well. So not just the drug assistance program, but beyond that, the Ryan White HIV/AID program provides a variety of comprehensive services.

So actually at the end of this slide deck, I have a link to and some contact information to your four ADAP leads, ADAP coordinators in the four states, in New York, Maryland, Massachusetts, and Florida. And also I believe Steve pointed out in the handout section there's the ADAP member directory available, so feel free to pull that up and download. You can find information to contact your ADAP program coordinator.

Lastly, just wanted to mention there's still ongoing needs as we move forward in the HIV realm and others, which is improving insurance coverage and literacy. And so there are other HRSA funded programs that are available that are doing really great work and that's including the ACE TA center. And I've added their contact information as well at the end of this slide deck.

So I'm going to talk for minute about some of the national health care funding implications and public health funding. And wanted to point out specifically on the slide, federal funding for public health which has declined over time. And so there is a couple set of numbers here, so $31.4 billion to $28.9-- about $2.5 billion between years there's 2010 and 2012. And that's changed, of course, we're in 2016 now and we continue to see some of that decline over time.

We know the discretionary government money is changing and we know there's uncertainty, especially with the political environment and it being an election year. So there's concern in all state and territorial health agencies and federal health agencies around budget cuts that could be coming down the pike and are expected to continue.

Particularly wanted to point out, this is a 2017 request for funding for HIV services. It's about $30 billion for domestic HIV services. So you can see the pie chart, how it breaks down from care and treatment, which would be the Ryan White HIV/AIDS program, prevention, CDC, research primarily in the NIH, and then housing assistance, again. And that can be Housing and Urban Development, or the HOPWA program, housing opportunities for people living with HIV, which is funded through the Ryan White program.

And here you can see how even though it has increased over time, and you can see that in the total domestic line at the bottom of this chart here, we know that it's being redirected away from public health services and especially from prevention services and focusing on care. So we know we need to start thinking as health care organizations and as nonprofits how to better fund and cover prevention services, whether it's through third party billing, increasing other funding opportunities and diversifying funding, or leveraging existing funding from Ryan White and other programs to really ensure that we're still not only providing comprehensive care but preventing HIV disease in the US.

So the change in payer mix is another big concern of organizations as we're looking at how to diversify our fiscal revenue. We know that in Medicaid expansion states health centers have a higher revenue per patient and there's a larger share of the revenue. But we know that as well, there's still many uncompensated care costs.

So individuals who are not covered by insurance, not able to pay for services also is a huge issue. Again, why it's important, if you have insured individual's living with HIV, the ADAP program and the Ryan White program are really important access points for individuals to have free or low cost care. Especially if they're still not insured, especially those in the Medicaid non expansion states like Florida.

And you may have similar pie charts for your organization individually, but we know as a whole on average, and this is 2013 data, as you can see, health center revenues primarily came from Medicaid followed by grant funding. And so you can see Medicaid private insurance is only about 8%, 6% self pay, 6% Medicare, 2% public coverage, and then the rest of the combination of section 3330 grants, state, local, private grants and contracts and other federal contracts.

So on the next slide, I'll point out that data also shows 2/3 or 69%, so a bit more than 2/3 of health centers operating revenues are through direct charges. So as I mentioned, Medicaid, private, self pay, et cetera. And then the non patient revenue is about 45%, and I listed those before.

So knowing that this funding is shifting, knowing that already there is maybe not a 50% depending on the health center, but at least 45% of health center revenue and financing is made up of local grants and contracts, state grant and contract, and general public health funding, we know that's important to seize these opportunities from the Affordable Care Act as newly insured clients are coming into services there's opportunities to collect payment. We know there's ACA related funding opportunities to improve quality in primary care and incentivize value and quality in primary care.

And this ultimately will decrease our dependence on this unsteady or uncertain state and federal funding and increase sustainability. So I just wanted to summarize that that way.

Right now there's some opportunities, as I mentioned, for health centers to increase their revenue and to diversify their revenue, more importantly. And I highlighted a couple of the others-- 5 kind of pieces that I put out here.

One is the increasing federal grants for health centers and primary care providers to incentivize-based quality improvement and service delivery reforms, which would increase reimbursement rates, expanding coverage through insurance exchanges, and expanded Medicaid. So again, more individuals accessing insurance and thus being able to build their insurers and having reimbursement from those clients, new clients or existing clients that weren't insured previously. And increasing Medicaid revenues in general and raising the Medicare payment rates are all kind of five ACA related revenue opportunities for health centers that I wanted to point out.

I pulled a couple of headlines for the last-- or press releases, I think, from HHS for the last two years. Just a few of them to point out that there has been a pretty significant additional funding specifically to health centers over the last couple of years as it relates to the Affordable Care Act. And the P4C program is just one of them that has come through from HRSA.

So there are a lot of opportunities. There was funding of community health centers-- in 2015, a couple of funding opportunities. 2016, for different types of programs. And currently I wanted to point out two open opportunities which some of you may or may not be aware of, the Health Center Program's Service Area Competition, which are due mid-August and the end of August. There's two different announcements that I saw there. And that's just an opportunity to ensure continued access to comprehensive culturally competent in quality primary care services for communities in vulnerable populations served by health centers.

And so I didn't look specifically at the eligibility requirements, but just wanted to point out that there are grant opportunities, there probably will continue to be grant opportunities that are

new and different and might require you to expand some of your services or expand your mission and some of the work you do and improve the quality of your programs. But you should keep that in mind and constantly be aware, sign up for the list to get those grant notifications and be aware that new funding opportunities are continually coming out from HHS and other federal partners.

And then I also mentioned the incentive-based reform opportunity. So many of you may be patient centered medical homes. I'm not sure exactly how that breaks down, but we know on average about 60% or more of health centers are PCMH recognized. Federally Qualified Health centers also received incentive-based payments. Medicaid health homes, State Primary Care associations also have health home initiatives. So there's a state based health home initiative. HRSA's funding for quality improvement in health centers. And also a variety of different payment and service delivery models that have come out and been implemented by the CMS Innovation Center.

I know in terms of the state innovation models, both Massachusetts, m and New York all have state innovation models. And there's also demonstration grants and delivery system reform incentive payments as well. So these are all opportunities that should be researched, looked into. Some states might have access to these incentivized payment opportunities and you should certainly consider it as a health center to maximize your revenue and increase payments as well.

And on the prevention side, as I had mentioned before, we now have more preventive services that are required to be covered by all private health plans. There's also incentives for patients receive preventive care and also several different models, [INAUDIBLE] networks being developed since the implementation of the Affordable Care Act.

So the primary care extension center models, I know New York and Maryland have both partnered with lead states to implement some initiatives under that particular program that was authorized under the Affordable Care Act. The community based collaborative care network-- so integrating care and collaborating, developing care networks as well has been another kind of mode for organizations to leverage resources and also maximize reimbursement for the services that they're providing.

And lastly, wanted to point out kind of this new understanding of how community health workers or allied health professionals outside of the prescribers and the traditional Provider types can now also reimburse for their services. So some this is very state based, we know that Medicaid did put out some language in 2013 that they would reimburse for preventive services from health professionals that are outside of a clinical licensure system.

And again, the states have kind of taken this on. Every state Medicaid to really look into it and determine how to move that forward. So some examples of services that non licensed providers could potentially reimburse for and are currently covered in Medicaid managed care or other plans are care coordination, educational counseling. So again, in the HIV realm that's

very important. Home visit, group health education, and some other opportunities and also one-on-one interaction with counselors as well.

So it's important to be paying attention to some of the new policies, especially those that are coming out from the Health and Human Department of Health and Human Services, Centers for Medicaid and Medicare, Services. All opportunities for you to leverage your existing staff, your existing resources at your health center to maximize reimbursement and have access to expanded services and provide additional services to your clients as well.

I also wanted to point out that it's important, and I've heard this before so-- from other health centers to really think outside the box. So I have a couple examples. I have another example I wanted to share as well that's just kind of one that I've heard before, but-- the Rural Economic Development Loan and Grant program. I know, I was trying to figure out how many health centers in the P4C program were rural health centers and there may only be one or two.

However, it's an opportunity that folks might not think about, to look at programs that are coming out of this type of a funding opportunity for economic development and loan and grant program. And for example, they're funding things such as facilities and equipment, payments for medical care to rural residents, startup venture costs, community development assistance, and other kind of business expansion opportunities as well.

And also the SPA 7a loans as well, provides small businesses. So for small health care practitioners or small health centers, helping you purchase equipment or real estate to expand your business, establish a new business or also train your staff is another opportunity as well.

And some other foundations Hearst, Pfizer, others, also important to look at. I wanted to point out one kind of fun example from an organization that I've worked with called Iris House. So for any New York City based organization's, you may be familiar with their Executive Director who were close with-- her name is Ingrid Floyd.

But she, for example, was looking at how she could get funding from her representatives in her state and also any kind of legislation in the state where they can really advocate for their organization. And they did this by really tracking how many of their clients were coming in were from different zip code, so had different representatives within their state and advocating on behalf of their clients. So being able to say we have x number of clients that are in your jurisdiction, they will be voting this year, it is an election year. So using that kind of as an advocacy piece to help kind of move funding in the direction of public health.

And so I thought that was interesting because that was really thinking outside the box to advocate for why increased funding would be needed and thinking about who are your constituents and where can you really be able to speak on behalf of your constituents and make those advocacy points for increased public health and health center and HIV funding within your organization and within your jurisdiction, a metric, which is happening on a state based level.

I wanted to point out a couple of case studies. And this is based on at the end of this slide deck I have a few strategic responses that I'd like you to consider, and this is just one of them. So partnership development is a piece that I think is a really important consideration in this time and place. It can not only increase your access to new clients, so by partnering with an organization you have the potential to enter new geographies, reach a new focus population or reach new clients, and also develop your agency's knowledge, capabilities, services, and ultimately increase funding. So partnering on funding opportunities, sharing or subcontracting on funding opportunities-- it's grant funding, et cetera.

And I wanted to point out one specific community-wide medical home model that really highlights the key aspects of what a coordinated care network might look like, so a health center that was partnering with community-based organizations. This is Whitman-Walker Health and they partnered with three organizations. They implemented formal contractual partnerships that included financing dollar amounts with these three organizations.

And what they were noticing as a health center overall is that they were losing a lot of their clients who were either coming in for testing and not coming back afterwards to be provided care, they had patients that were coming in for one appointment and not returning afterwards. And so they reached out to their community partners because they knew that re engaging these clients would eventually improve not only health outcomes, improve the quality of care they were delivering, but also would improve [? net ?] rates as they'd be able to provide more services for these clients.

So they decided to partner with HIPS that worked with transgender individuals, primarily in sex workers, Food and Friends, delivering-- that's a food delivery service. So partnering with an organization that did food delivery, again, to improve the quality of the care that they're delivering to all their clients. And then the Women's Collective, which was reaching primarily black African American women in the DC region. So all ways for them to improve this coordinated care effort and ultimately expand their services, expand their reach to clients, and improve the coordinated effort in the community which was Washington DC. So that's one example.

I want to give the next example, which is Christy's Place, another nonprofit service organization. This is in San Diego. And I apologize for not picking any Massachusetts, Maryland or Florida sites. But I do have a New York example next.

And Christy's Place did a similar thing, which is really working with wrap around providers to help get their clients back into care and stay in medical care. So again, another possible model to look at here in San-- based in San Diego.

And mergers and acquisitions, another kind of form of a partnership. In a way that is also something to consider. So we do know so Boom! Health was the merger of Citywide Harm Reduction and Bronx Aid Services. And prior to that, one of the organizations was doing Medicaid billing. But it allowed both to now do Medicaid and private insurance billing and have

onsite health care services. And also have onsite syringe access services, prevention services, housing and a variety of food and nutrition, legal services.

So again improving kind of this medical home for their clients and increasing reach to new clients, which brought in more revenue for the health centers and also improve the sustainability of the non-profit which was Citywide Harm Reduction. And so this happened a few years ago in New York City, a great example of a really effective merger that happened.

Another piece, kind of strategy to consider, is thinking about third party billing especially for prevention services, especially for HIV prevention. As we know, as I mentioned, public funding for many of these services in clinics, in clinical settings, is going to likely transition over the next few years. And we're hearing that across the board, whether it's health departments, community based nonprofits, and health centers as well.

I wanted to point out that Massachusetts, again, one of the first states to implement health care reform, which is great, I'm actually from Massachusetts. I'm very proud of that fact. And they've almost reached 100% rate of insured residents, which is great.

Now, looking at transitioning away from public funding as health care reform is being implemented, the health department and their community partners encourage clinics to move away from public funding, move away from city funded test kits, city funded testing programs, grant funded testing programs, and move towards the reimbursement model.

And so the clinics contracted with insurance provider's, they were trained how to talk to their clients about HIV testing and why it was being reimbursed and how it would be processed. And their visits billed to public and private insurance increased about 31%, which is great.

And I did want to point out-- it's important to point out that they had visits decline mainly because of clients concern about confidentiality and the ability to access quote free HIV testing elsewhere from other community based clinics. But ultimately as we move forward and with the budget cuts that are going to be happening down the road, and this is just an example from 2010, as big budget cuts to the state of Massachusetts and their health department, these clinics were able to remain open and financially viable because their transition to a billing model.

And so we know that billing commercial and public insurance for services can really help close budget gaps and offset the cost of providing free services, which many organizations do to patients without insurance and could be the difference between a clinic closing its doors or achieving long term sustainability. So really important to think about, many especially emergency rooms, health centers that have just relied on state or city funded test kits, it's probably not going to be the way of the world in the next few years.

And so we really need to consider how we can leverage some of these new opportunities from the Affordable Care Act for counseling, for testing. We know it's probably not going to be

reimbursed at the rate that a grant program would be. But with the-- making the assumptions and thinking ahead and forecasting and understanding that those grant programs may not be around forever, it's important-- a very important piece to think about is starting to bill for these preventive health services in HIV and otherwise.

I also wanted to, again, talk about another strategy so the primary care quality improvement incentives. And I have a Massachusetts example on the next slide. We know that Massachusetts have been awarded about $245 million to improve primary care. And health centers offer longer hours, many states also had some of these primary care quality improvement models being implemented starting from the federal level.

And they funded and supported individuals to get enrolled in health coverage and also have access, as I mentioned, to health centers that improved primary care services, longer hours, cultural competency, et cetera.

And here are just some of the examples of these types of programs. So health centers were partnering with the state's Office of Health and Human Services. There was 10 that were developing these coordinated partnerships between health sectors and considered cultural competence as one of the most important parts of payment reform as well. And it was prioritizing the needs of health centers that had not received some of the other incentive-based payment reform opportunities. And those that were not SQHCs or PCMHs as well, PCMH recognized that were receiving higher reimbursement rates.

And there was also a couple-- I just highlighted a couple of other kind of primary care quality improvement initiatives. There's one that's investing in infrastructure, building the success of primary care medical homes such as assisting primary care practice to transition into certified medical homes.

So again, a lot of these programs trickling down from the federal level, as I mentioned earlier, trickling down to the state level and bringing significant amount of funding, new funding, into states. Upwards of $250 million into states to increase their quality primary care programs and health center operations.

And then I also wanted mention Medicaid health homes. And so we know, kind of in New York, New York's care coordination models, they have a health home model as well that's focusing on linkages and community and social support services. And then the Medicaid medical home program again, similar, incentivizes primary care providers who meet national medical home standards.

So a lot of the federal initiatives trickling down into the states and becoming a health home, providing more incentives to providers for quality care and value based care, and also kind of improving the care system overall. So not only opportunities to improve your organization's operations, but also to improve reimbursement and increase that funding diversification.

I didn't want to leave Florida out. I did find that Florida has implemented one of the CMS's Health Care Innovation models. And it's led by the University of Miami in partnership with Medicaid plans, the University of Florida, and a few other organizations. And so this was an award to improve care and access for children in Miami-Dade area that had asthma, obesity, type 2 diabetes, and STDs.

And so again, this was looking at improving services and expanding services in school-based health clinics. However, this focus on working within health clinics within health centers to improve quality care and incentivize quality care was really important. And again, that was a CMS Innovation model, so these federal programs trickling down to states and allowing new funding opportunities and incentive-based payment opportunities for health centers.

So, what now? I just have a couple of slides left. So I just wanted to kind of close some of my comments with mentioning that really now, if not two years ago really, is the time to adapt to acclimate, to secure funding, to sustain your programs, particularly in the HIV realm as we-- there's uncertainty around HIV funding, uncertainty around public health funding in general, and particularly on the prevention side as I mentioned several times as well.

So it's important to reexamine strategies and your role as a safety net provider, to leverage new opportunities and mitigate challenges, possibly develop a new vision if that's needed, and integrate a nimble flexible dynamic business model as well. So I wanted to, on the next two slides, talk about some-- summarize some of the strategic responses that could be considered.

We know that health centers are competing more and more with hospitals, which is a challenge. But investing in some capital improvements, whether it's in health IT or any sort of kind of programming and new equipment that may or may not help to bring in more clients is really essential. You want to become the provider of choice in your community so that you have access to insuring clients that are coming through your doors and increasing your revenue as well.

So how can you demonstrate whether it's quality, expanding your programs to become this provider of choice. And really compete more and more with many of these hospital organizations.

It's important to also consider reorganizing some of your workforce to improve efficiency. So we know there's a focus on care management and care coordination. We know that increasing in ensuring that your clients, especially people living with HIV, are engaged in care, retained in care are important, not only for health outcomes but again, also for reimbursement and billing.

And so these are some opportunities to think about how will you reorganize to really improve these efficiencies, how will you leverage new opportunities to utilize allied health care professionals such as community health workers to provide some of these services that are now available to Medicaid without a licensed clinical practitioner. So all things to consider kind of in this reorganization of your workforce.

And then also how can you maximize your revenue through enhanced medical documentation and coding. And I didn't mention this previously in our conversations but did want to mention it now, that this is also an important piece as organizations have transitioned to ICD-10 coding and understanding that medical documentation is essential to maximizing revenue as you submit claims to insurance providers. And so understanding kind of the coding and medical documentation lingo and procedures and making sure you are doing that to the best of your ability and chasing down every dollar is going to be important as well. And I can share some resources for that at the end of this.

And I also wanted to mention expansion of services for billing. So again, hiring using the billable providers. Also considering the community health workers as a billable provider depending on your state legislation and how they move health worker certifications forward et cetera. Thinking about expanding programs for seniors, so if you are not serving seniors think about expanding programs for seniors.

So we know the annual wellness visits in Medicare are reimbursed at a high rate. How can you expand your services, your programs, and your reach to other new potential clients that could bring in a lot of revenue for your organization. And then also there are these opportunities to negotiate with the managed care organizations for value based reimbursement. So the higher quality care, the higher reimbursement you'll recoup for your organization.

And lastly, wanted to mention partnerships. So considering partnerships with community based organizations that can help you to increase the retention and engagement rates of your clients. And also where can you partner with hospital networks and do you want to partner with hospital networks, who may or may not be the biggest competitor for you right now.

So those are just five-- in summary, five strategic responses to consider again. Every state is up against different policies as federal initiatives are being implemented. There's also state level initiatives, Medicaid expansion is the big example of that, where we know there's huge detriments to health insurance access, et cetera for individuals uninsured in Medicaid non expansion states.

But again, these are all things to kind of keep in mind and keep abreast of as new policy comes out, new memos from CMS, new funding opportunities for HHS-- from HHS and other federal partners. So it's important to just be aware of that and make sure you're as educated as possible as you move forward and re strategize to ensure sustainability of your program.

So the next slide I have, questions. I think we have about five minutes left, so I'm happy to take some questions. And I also can have some resources to point you to as well.

STEVE LUCKABAUGH: OK. So we have a few moments here to take some questions. If you have any questions, please enter them into the Questions pane or the GoTo Webinar toolbar. We have the resources here.

MARISSA TONELLI: As we are waiting for questions or maybe-- we'll see if we get some. I can-- since we're on this site I can point out that Health HIV does have a few resources on our website. There's many organizations that are doing a lot of great work as well around sustainability. And we've done through our HRSA funded programs, that we have done a lot of work around fiscal sustainability.

So I just wanted to point out some opportunities that we have webinars that have been archived, including theories on medical documentation coding, which I believe the P4C program also had access to as well. So you should have access to some of those materials. We have a desk reference guide. But if you didn't, we also have it on Health HIV's website. And also some contracting services for HIV prevention.

So if any of you are interested in any of those, please feel free to go to Health HIV's website and check out our webinars and some of our other guides that we posted on there.

STEVE LUCKABAUGH: OK, we did get one question here. Does insurance pay for case manager services?

MARISSA TONELLI: So, that's a great question, I don't know where the individual is from. But the easy answer is yes. So technically, counseling is covered through private insurance. It's one of-- it falls under one of the essential health benefits. It is a covered preventive services, counseling is a covered preventive service, whether it's prevention counseling and some other-- and linkage to care and retention care I think I mentioned on one of the first slides, so some of those case managers type services.

Where it becomes an issue is who is delivering the service and is it a credentialed, a licensed credential provider. And is that provider credentialed or [? paneled ?] with the health plan? So it is variable depending on who is providing the service, but in theory, if it is a clinic-- a licensed clinical provider providing the case management services, it would be billable.

As I mentioned, some states are looking at how to credential community health workers and non clinical, non licensed staff to be able to bill for those types of services, case management services and other prevention and testing services. So that could be an opportunity down the road depending on your state policy.

STEVE LUCKABAUGH: OK. Anyone else have any questions? Not seeing any right now. We'll just use the other list of resources, here.

MARISSA TONELLI: Right, so I referenced this earlier, the ACE TA center, which has outreach and enrollment resources for clients particularly living with HIV but also can be utilized across the board. And then wanted to point out the ADAP contacts, which since you downloaded, or if you downloaded the handout for the ADAP member directory you'll have the same information. But it is here on the slide for the four P4C states.

So again, wanted to highlight the importance of connecting people living with HIV that you're seeing in your centers that may or may not be insured or are not insured, don't have access to health insurance, to go to these ADAP contacts or connect with these ADAP contacts to help them have access to the resources that ADAP has to offer for medication and other connectivity there as well.

STEVE LUCKABAUGH: Yeah, I'm not seeing any more questions. So if you have any final thoughts before I wrap it up.

MARISSA TONELLI: That's it. Thank you, just wanted to say thank you again to MayaTech for inviting me to speak. And I hope you were all able to get something new, a new strategy from this presentation to take back to your organization and your decision makers to really forward and ensure sustainability of you're HIV program.

I wanted offered that if you have any other questions you can of course reach out to your MayaTech contacts. But feel free to reach out to me directly. My email and direct phone line are here. We are based in Washington DC. So again, we're on East Coast time and if you're ever in the DC area, feel free to come by and visit us at Health HIV as well. And we can chat in person about some of the discussion today as well.

STEVE LUCKABAUGH: All right, thank you again for participating in today's webinar. And thank you Ms. Tonelli for that excellent presentation. If you have any additional questions for the P4C project or for Ms. Tonelli, please email us at P4CHIVTAC@mayatech.com. Take everybody and we'll see you next time.

MARISSA TONELLI: Thank you. Bye-bye.