

## *Disclosure Statement*

- *Faculty: Robert Moore, MD*
- *Disclosure:* I have no real or perceived vested interests that relate to this presentation nor do we have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic areas.

# Start with a great idea!

Help us prevent  
**1 MILLION** heart attacks  
and strokes by **2017**

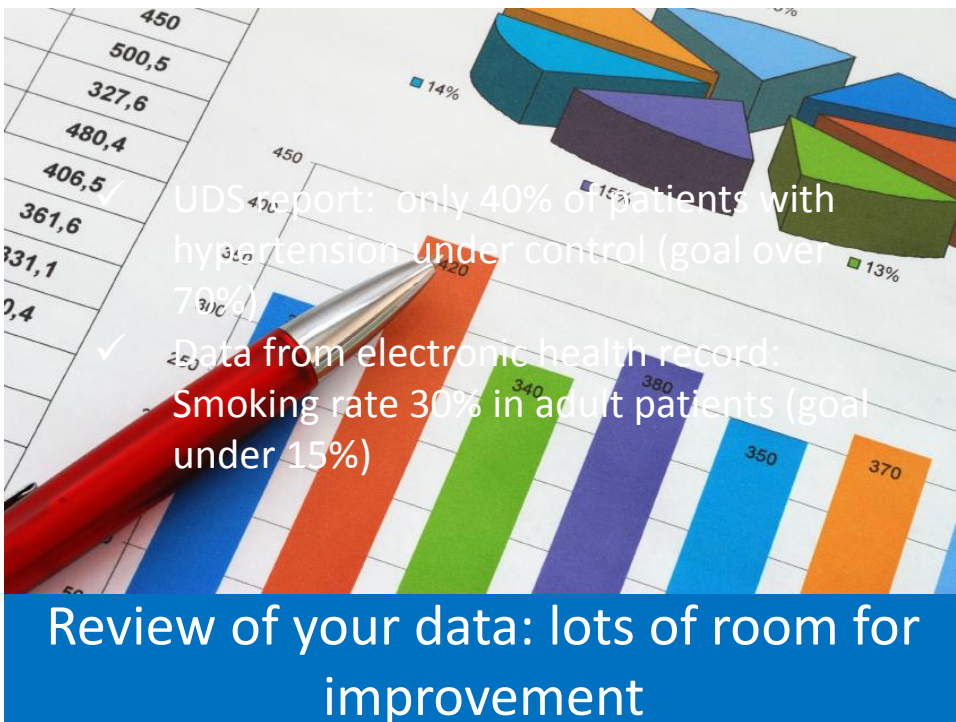


## Applying this to your Health Center

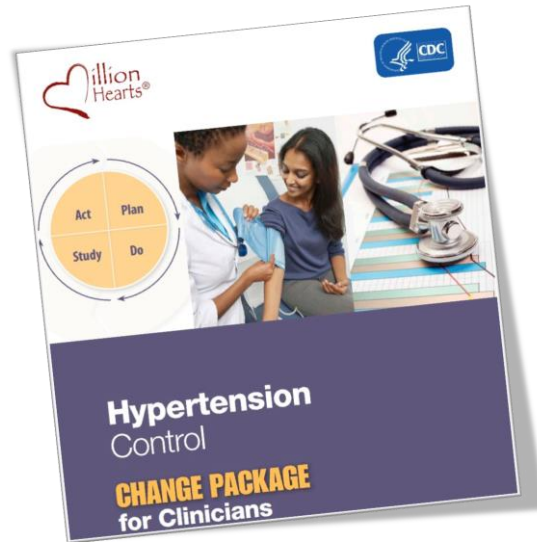




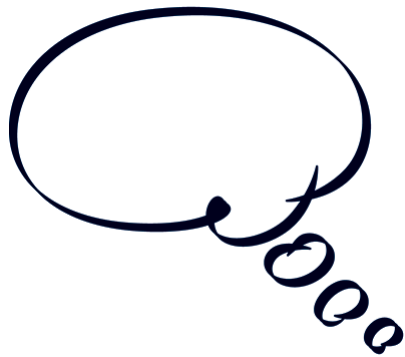
One of your favorite patients (with diabetes, hypertension, high cholesterol) dies suddenly of myocardial infarction.



Change package from Million Hearts Campaign includes having special follow-up clinics staffed by RN with protocol from counselling and medication adjustment.



## Response from Executive Team



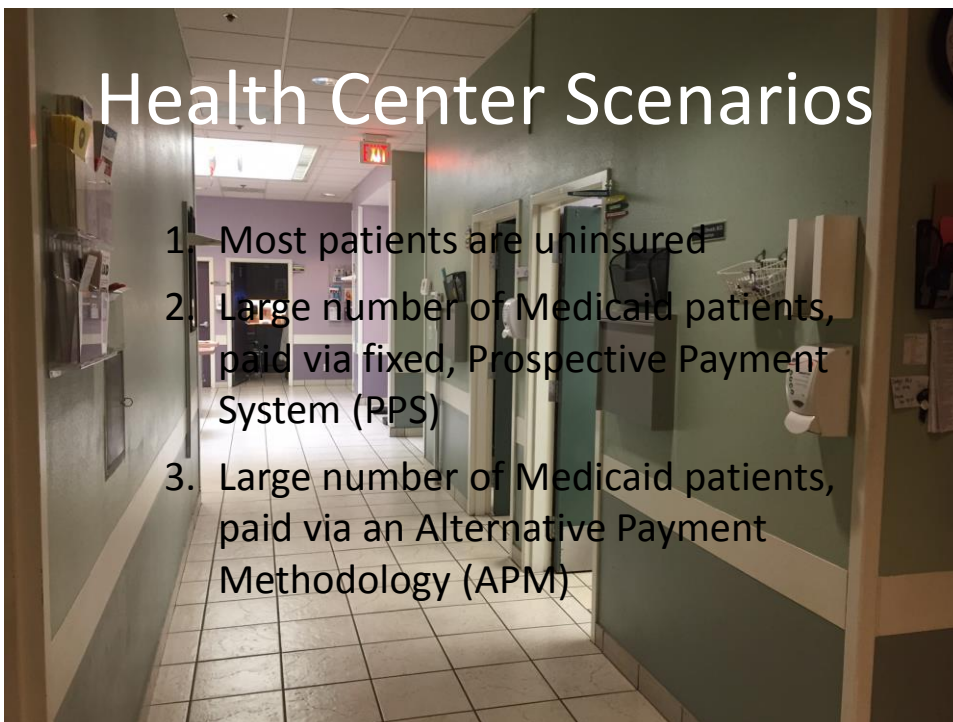
### Great idea, but . . .

- “No money for new projects”
- “RN visits with patients cost money and won’t bring in revenue.”
- “No time off to work on this project, need to have clinicians focus time on patient care”



# Presentation Objectives

1. Understand three dominant methods by which health centers are reimbursed for services.
2. Learn how to structure clinical improvement efforts with each of these three methods in a way that is financially viable for the organization.
3. Learn how to communicate these proposals to the Health Center leadership team.





## Scenario I: Mostly Uninsured Patients



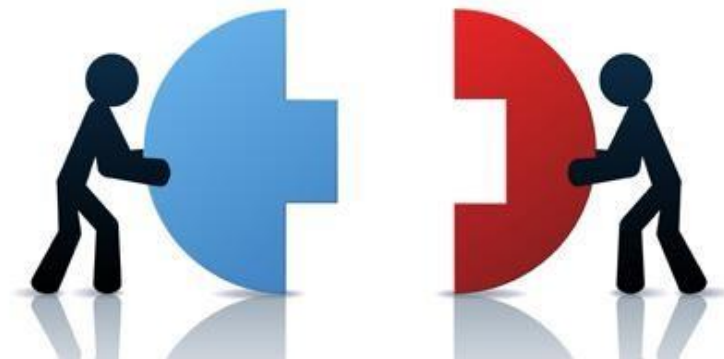
- ✓ Grants
- ✓ Shared resources with larger, more financially stable organizations
- ✓ Heavy use of volunteers

### Implications:

- Stay small, focused
- Low margins; not much time for practice transformation



## Aligning Health Center with Million Hearts Campaign



## Use lower cost workers to perform tasks more cost effectively:

- Train Medical Assistants to repeat blood pressure, perform basic counselling activities.
- Use Community Health Workers (volunteer or paid) to focus on prevention activities, in groups or for individuals



Photo ©earldotter.com

## Increase outside revenue sources

- ✓ Use 340B program for small number of patients with Medi-Care to generate revenue to use on Million Hearts transformation efforts.
- ✓ Seek new grants from the local community or from national organizations (American Heart Association) for specific prevention activities







## Scenario II: Major driver of Health Center revenue is Medicaid PPS

### Funding Source: Understanding PPS

1. What is PPS?
2. Which patients?
3. What type of organizations?
4. What provider types are eligible?
5. Pros and cons of PPS
6. Workarounds



Marin City Health and Wellness

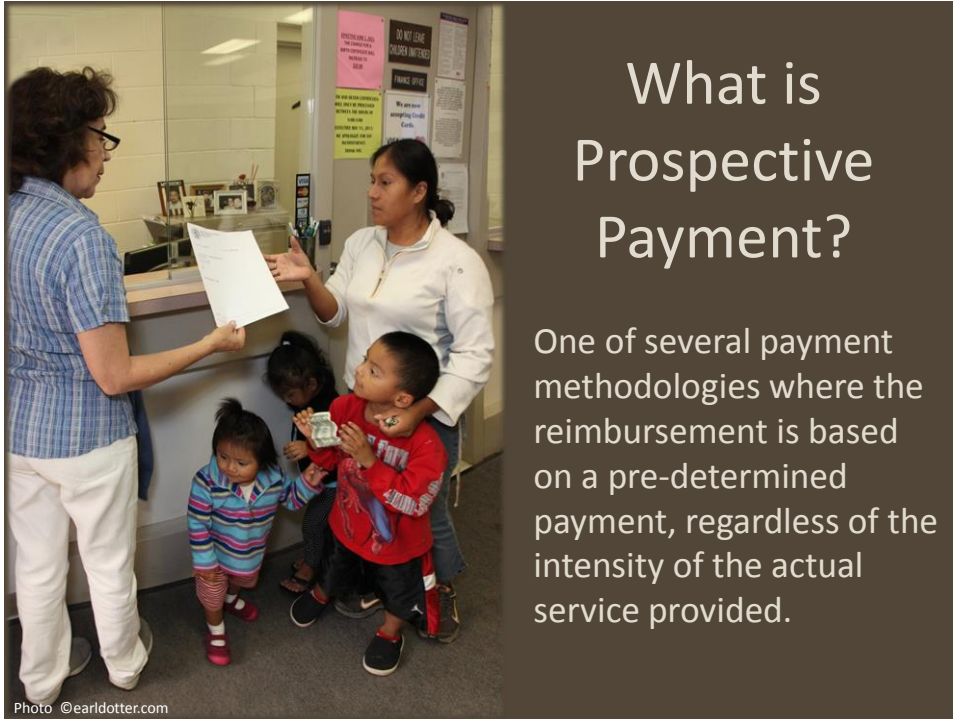


Photo ©earldotter.com

## What is Prospective Payment?

One of several payment methodologies where the reimbursement is based on a pre-determined payment, regardless of the intensity of the actual service provided.

## What is PPS in Health Centers?

Primary Care PPS: Payment based on a per visit rate no matter how long or short the visit,

- if seen by an eligible clinician
- for a medically necessary visit
- at a PPS-eligible healthcare organization.

This is called the “PPS rate”

## When did PPS begin?

### Hospital Prospective Payment

Payment by Diagnostic Related Groups (DRG), no matter how long the hospitalization, with stop loss for very long or expensive hospitalizations



1983



2000

1989



FQHC PPS System  
Retrospective payment

Changed to prospective payment  
Designated by the federal government

## Before PPS:

- Medi-Cal Fee for Service pays on average 1/3-1/2 of commercial rate
- Uninsured patients pay what they can afford
- Deficit: made up by donations/grants
- Effect: Limited capacity to grow; limited overall access



Winters Healthcare Foundation, Main Street, Winters, CA

## Benefits of Medicaid PPS



- Ensures stable payment for enhanced services
- “Packages” enhanced services together with visits for eligible patients.
- Pays health centers at a rate that is sustainable (covers salaries and other costs, which a FFS Medic-Aid rate cannot).

## Who is eligible for a PPS visit?

Any person who has Medi-Cal or Medicare who is visiting a PPS-eligible provider



Potawok Health Village,  
Arcata, CA

## Where does the PPS system apply?

### PPS-Eligible Providers:

- Federally Qualified Health Centers (FQHC)
- FQHC-Look alike: follow rules of FQHC, but no section 330 federal grant (none left in PHC region)
- Rural Health Centers
- Some county-affiliated health system medical providers (e.g. SF, LA county health systems)
- Indian Health Service (IHS) clinics, also known as Tribal Health Centers.

Sutter Lakeside Family Medical Clinic,  
Rural Health Center Lakeport, CA

## PPS Eligible Providers



- Physicians (MD, DO)
- Podiatrists
- Optometrists
- Doctors of Chiropractic (D.C.)
- Nurse practitioners
- Physician assistants
- Midwives
- “Visiting Nurse”
- Dentists
- Dental hygienists
- Licensed clinical social workers
- Psychologists
- Comprehensive Perinatal Services Program visits

For state-by-state list of covered providers, consult your local Primary Care Association or (for the 2011 list) see this NACHC summary:

<http://www.nachc.com/client//2011%20PPS%20Report%20SPR%2040.pdf>



## Non-PPS-Eligible Providers

- Nurse (In office setting)
- Registered Dieticians
- Medical Assistants
- Health Educators
- Physical Therapists
- Accupuncturists (LAc)
- Naturopathic Physicians (NP)
- Marriage and Family Therapists (MFT) --May change soon



Northeastern Rural Health Center,  
FQHC in Susanville, CA

### Expenses not allowable for PPS cost report

- Services not listed on the federal scope of the FQHC
- Administrative expenses related to services not on the federal scope.
- Example:
  - Home office oversees a Federally Qualified Health Center and a non-FQHC Free Clinic. The FQHC spends 75% of the budget, the Free Clinic spends 25%
- The portion of the administrative overhead allocated to the Free Clinic (25% of all administrative costs) is excluded from the FQHC Cost Report.

## How PPS works with Managed Care

### Varies by state

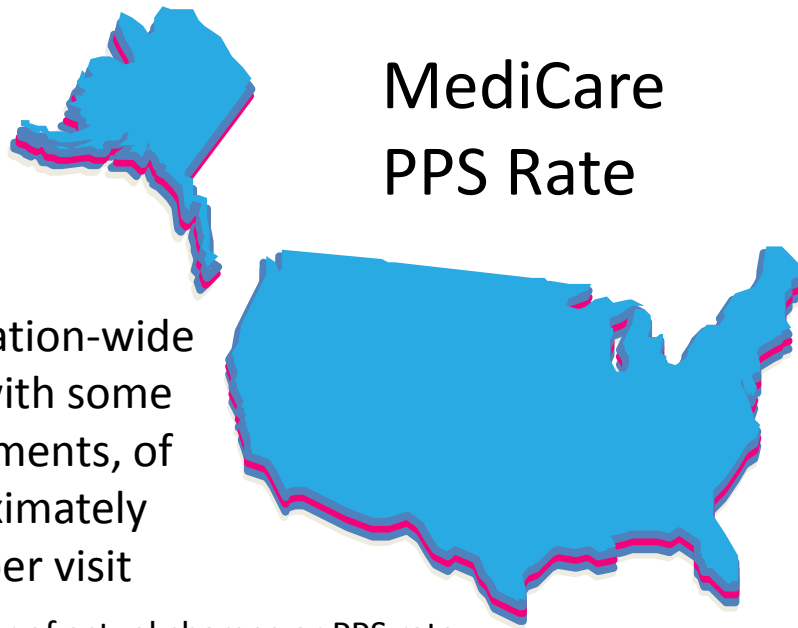
- California:
  - Claim for visit sent to Managed Care Plan
  - Separate claim sent to the state for the “wraparound payment” which is fixed.



## Health Plan payments to Health Centers

1. Payments for Medical Services:
  - Capitation (PMPM)
  - Fee for service payments for non-capitated members/services
2. Substantial Quality Incentive Payments (Includes payments for elements of PCMH)
3. Grants for specific Programs

## MediCare PPS Rate



One nation-wide rate, with some adjustments, of approximately \$150 per visit

Lesser of actual charges or PPS rate.

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**Medicaid PPS:** Incentivizes face-to-face visits with eligible providers

**Structural Impact** Dis-incentivizes visits by non-eligible providers: Registered Dietitians, Nurses, etc.

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PPS is a counter-incentive to adopting innovative care models that are key to becoming patient-centered health home

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Global payment by a Health Plan in the PPS setting is meaningless: PPS system trumps global payment

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Changing PPS base rate is challenging, time-consuming and often delayed.

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Structural inequity: large, fixed variation in PPS rates, and thus substantial differences in enhanced services provided at different health centers.

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## Apply for Change of Scope to cover additional services

- ✓ Services not currently included in PPS rate (increasing quantity of a particular approved service doesn't qualify; must be a new service)
- ✓ Rules vary, but many states require a minimum percentage change in PPS rate to consider a change in scope

## Income outside the PPS process:

1. Risk pool payouts (no longer allowed by DHCS in California; may be allowed in other states)
2. Quality Improvement Incentive Payments (May Include PCMH payments)
3. Grants (if particular position is explicitly paid for, may need to be excluded from cost calculation for PPS)

These may be paid by a Medic-Aid Managed Care Plan or other Community Organization

## Aligning Health Center with Million Hearts Campaign





If PPS rate below max allowable, apply for change in scope to cover additional enabling services.

Couple shorter clinician visit with enhanced services by non-PPS billable provider



Use Quality Incentive Payments to cover the cost of enhanced services

Work with local Managed Care Organizations or State Medicaid agencies to develop grants to support practice transformation, which will fall outside of PPS.



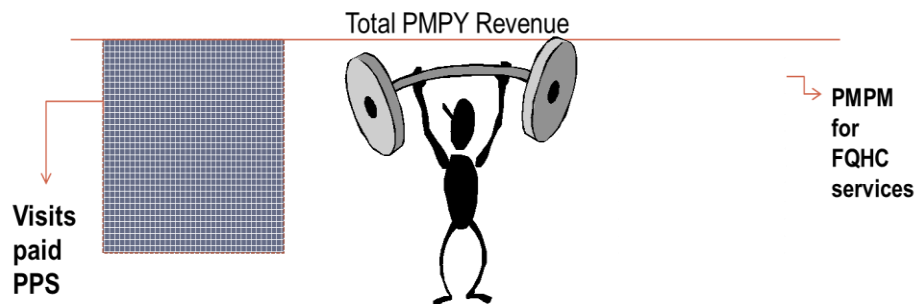
## Scenario III: Alternative Payment Methodology in a Health Center with a large Medicaid population

### Alternative Payment Methodology (APM):


- ✓ Different way of being paid than the federally approved PPS method
- ✓ Requires special state-specific waiver from CMS; structure varies widely by state
- ✓ Must be structured to pay at least as much as PPS, but reconciliation NOT required.
- ✓ Politically sensitive topic; many health centers concerned about losing the funding security of PPS

## Health System Transformation

Today: PPS FFS	PPS-Equivalent Capitation
<ul style="list-style-type: none"> <li>• Volume-based payment</li> <li>• Face-to-face visits</li> <li>• Qualified providers</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly payment per member</li> <li>• Some visits converted to new modes of care (phone, email, group)</li> <li>• Care teams</li> </ul>



Courtesy of California Primary Care Association



## Clinical Readiness

- ✓ **Clinical leadership**
- ✓ **Team** identified
- ✓ Commitment to **transformation**
- ✓ Medical home **commitment**

Courtesy of Oregon PCA

## Alternative Touches

1. Currently Billable PPS-provider interacting with patient in non-face to face way
2. Alternative provider (non-PPS eligible clinician or support person) provides services instead of PPS-eligible provider





*The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.*

-World Health Organization



## Aligning Health Center with Million Hearts Campaign

Design team visits to provide optimum support of Million Hearts interventions:

Health educators provide support with smoking cessation, diet, activity counselling, medication adherence

Nurse has BP follow-up visits to follow BP and labs and adjust medication by protocol.

Alternative (non-face-to-face) touches with clinicians

Secure Email

Phone calls

Office-to-home video-conferencing

Community activists address Social Contributors to Hypertension

Unsafe neighborhoods

Food deserts

Stress of unstable housing



# Summary

1. Many options for optimizing clinical outcomes in Health Center.
2. The approach that makes the most financial sense varies depending on the patient mix and payment models in place.
3. Clinicians need an understanding of the major financing mechanics to design the most cost effective interventions.



## Any questions ?



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