COMPETITION TO COLLABORATION

A CAH/FQHC SUCCESS STORY

Rural Health Care Leadership Conference
February 2014
The Presenters

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• **Darrold Bertsch** – is currently the CEO of Sakakawea Medical Center (CAH) in Hazen, North Dakota and Coal Country Community Health Center (FQHC) in Beulah, North Dakota. Darrold has over 39 years of experience in healthcare, the last 20 years as a Chief Executive Officer.
Please note…

The views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum
A CAH/FQHC Success Story

- What is an FQHC?
- How has recent legislation and regulation incentivized FQHCs to collaborate
- Examples of collaborations
- A Successful Rural CAH/FQHC Collaboration
- Benefits Realized & Future Opportunities
Location of Critical Access Hospitals
Information Gathered Through June 30, 2013

Legend
- Critical Access Hospital (1,332)
- Metropolitan County
- Nonmetropolitan County
- State Not Eligible or Not Participating


*Note: Core Based Statistical Areas are current as of the February 2013 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs. Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Rural Health Clinics (RHCs)

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 2, 2011.

Note: Alaska and Hawaii not shown to scale
What is an FQHC - Regulatory

• An entity receiving a grant under Section 330 of the Public Health Service (PHS) Act
• Is receiving funding from a grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act
• Is not receiving a grant under Section 330 of the PHS Act but meets the requirements for receiving such a grant, i.e qualifies as a FQHC Look Alike
What is an FQHC- Regulatory (cont’d)

• Was treated by the Secretary of the Department of HHS for purposes of Medicare Part B as a comprehensive Federally Funded Health Center – FFHC - before 1/1/1990

• Is operating as an OP health program or facility of a tribe or tribal organization under the Indian Self-determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of 10/1/91
What is an FQHC - Governance

• Almost always must be a 501(c)(3) nonprofit corporation
  • May not be owned or operated by any other entity
    • May be a public entity – such as a public health department ~5%
    • A public entity may have a sole corporate member

• Board of Directors
  • 9-25 members
  • At least 51% must be users of the health center
  • Include representatives of the user population
    (Income, race, ethnicity, age)
  • Less than 50% of the non-users may derive more than 10% of their income from the healthcare industry
  • Must be self-perpetuating
What is an FQHC - Services

- Must serve a Medically Underserved Area (MUA) or Population (MUP) Designated by DHHS
- An FQHC generally furnished the following services:
  - Physician services
  - Services and supplies incident to services of physicians
  - Midlevel practitioner services: Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, Clinical Psychologist, Clinical social worker
  - Services and supplies incident to services of a midlevel
  - Visiting nurse services where it has been determined there is a shortage of Home Health Agencies
  - OP diabetes self-management training and medical nutrition therapy for patients with diabetes or renal disease
What is an FQHC – Services (cont’d)

- Services provided directly or through agreement:
  - Primary care
  - Dental
  - Mental health
  - Substance Abuse
  - Diagnostic lab and x-ray
  - Prenatal and perinatal
  - Cancer and other disease screening
  - Blood level screenings
    - Lead levels
    - Communicable diseases
    - Cholesterol
  - Well child services
  - Child and adult immunizations
  - Child eye and ear screening
  - Family planning services
  - Emergency medical
  - Pharmaceutical
  - Case management
  - Outreach and education
  - Eligibility/Enrollment services
  - Transportation and interpretation
  - Referrals
What is an FQHC - Services

- An FQHC must agree to provide a very specific set of services – Form 5a
- Services may be provided:
  - Directly by the applicant
  - Under a formal written agreement
    - The FQHC pays for the service
  - Under a formal written referral arrangement/agreement
    - The FQHC does not pay for the service

<table>
<thead>
<tr>
<th>Required Services</th>
<th>DIRECTLY BY APPLICANT</th>
<th>FORMAL WRITTEN CONTRACT/AGREEMENT (Applicant pays for service)</th>
<th>FORMAL WRITTEN REFERRAL ARRANGEMENT/AGREEMENT (Applicant DOES NOT pay)</th>
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<td>Clinical Services</td>
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<td>General Primary Medical Care</td>
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<td>Diagnostic Laboratory</td>
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<td>Screenings</td>
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<td>2. Communicable Diseases</td>
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<td>3. Cholesterol</td>
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<td>4. Blood Lead Test for Elevated Blood Lead Level</td>
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<td>5. Pediatric Vision, Hearing, and Dental</td>
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<td>Emergency Medical Services</td>
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<td>Voluntary Family Planning</td>
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<td>Immunizations</td>
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<td>Well Child Services</td>
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<td>Gynecological Care</td>
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<td>Obstetrical Care</td>
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<td>Prenatal and Perinatal Services</td>
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<td>Preventive Dental</td>
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<td>Referral to Behavioral Health</td>
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<td>Referral to Substance Abuse</td>
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<td>Referral to Specialty Services</td>
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<td>Pharmacy</td>
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<td>Substance Abuse Services (Required for HCH Programs):</td>
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<td>6. Detoxification</td>
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<td>Non-Clinical Services</td>
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<td>• Follow-Up/Discharge Planning</td>
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<td>• Eligibility Assistance</td>
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<td>Health Education</td>
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What is an FQHC- Payment

• Currently: Medicare pays FQHCs an all-inclusive rate based on reasonable costs as determined through a year-end cost report
  • Medically necessary, face-to-face visit with a physician, Midlevel practitioner, Clinical psychologist, Clinical Social Worker
  • Patient pays no deductible
  • Co-insurance payment is based on the health center’s charge, not the Medicare customary fee
  • The Medicare rate is capped: CY 2013 per visit rate – Rural $110.78, Urban $128.00
  • Medicaid payment methodology will vary from state-to-state
    • Typically, a prospectively set, all-inclusive rate
    • Based on average costs in 1999 and 2000 or in relation to the Medicare all-inclusive reimbursement rate, or in a few cases, based on actual costs as determined through the use of a year-end cost report
What is an FQHC- Payment (Cont’d)

• Beginning After October 1, 2014: Medicare will pay FQHCs a prospectively set rate
  • Base rate of $155.96
    • Adjusted by region using the Geographic Adjustment Factor
  • A new patient all-inclusive payment rate will be greater than the base rate by a factor of 0.33
    • Adjusted by region using the Geographic Adjustment Factor
    • Estimated to be approximately $202.75 per visit
Historically, the FQHC reimbursement mechanism follows the Rural Health Center (RHC) all-inclusive payment mechanism

- RHC rates lower (freestanding and P-based to hospital w/50 or more acute care beds
  - CY 2013 all-inclusive Medicare reimbursement rate: $79.17 per visit
- RHC co-insurance payments based on the RHC’s charges, not the Medicare customary fees
- RHC patient pay the usual Medicare deductibles
Incentivizing FQHC Collaborations

- Increased competition between FQHC and other health care providers – How we got here
  - Historically, FQHCs have operated on a “deficit funding” basis – Zero-based budgeting, where expenses equal revenues
    - Difficult to strengthen the balance sheet
  - Over the past 2 decades, HRSA has been encouraging FQHCs to improve their financial stability
    - Operating financially fragile health centers was recognized as unsustainable
    - Encouraged FQHCs to broaden their patient mix to include commercial and other patients who could pay for the services they were provided
Incentivizing FQHC Collaborations (Cont’d)

• Disincentive to provide Non-FQHC services have virtually disappeared
  • In a cost-reimbursement world, providing non-FQHC services would result in more overhead costs being allocated to non-FQHC service areas and would result in low cost-based reimbursement
  • As costs have exceeded the Medicare reimbursement rate cap, the allocation of overhead costs to non-FQHC service areas have had less and less impact on Medicare reimbursement
  • As Medicaid moved to a non-cost-based reimbursement methodology, there is even less negative impact on reimbursement as an FQHC provides more non-FQHC services
Incentivizing FQHC Collaborations (Cont’d)

- Increased FQHC/Non-FQHC entity competition has resulted in an increased outcry from those negatively impact by the increased competition.
- HRSA has initiated efforts to limit duplication of services related to increased FQHC expansion, primarily in rural areas.
- In 2010 HRSA published a Program Assistance Letter (PAL) no. 2011-02 addressing an FQHC collaboration effort.
The ACA of 2010 includes language that specifically allows FQHCs to collaborate with a CAH, RHC, sole community hospital, low-volume hospital or Medicare dependent hospital in order to provide FQHC services

- Contracting entity must have policies in place to ensure nondiscrimination based on a patient’s ability to pay for services
- Contracting entity must establish a sliding fee scale for low-income patients
  - A hospital’s free-care policies have been deemed to satisfy this requirement in the past
Incentivizing FQHC Collaborations (Cont’d)

• Where is this collaboration Effort Headed?
  • HRSA appears to be committed to increasing collaborative efforts between FQHCs and other health care providers
    • Reduce costly duplication of services
    • Level the playing field in regards to the real or perceived unfair competitive advantage that FQHC may have
  • The FQHC program has historically been well supported by the Administration as well as both sides of the isle in Congress and HRSA does not want to see that support erode

• How real are the incentives to collaborate
  • There has been a push to develop strategies to increase collaborations through the FQHC grant process
  • The teeth in this push appears to be lacking due to inadequate follow up on collaboration strategies delineated in grant applications – but progress in being made
Collaboration Opportunities

- Open lines of communication
- Visit the FQHC to see it in operation
- Embed FQHC web page link on your web site
- Encourage provider staff involvement to identify opportunities for collaboration
- Share board members
- Understand how to leverage provider status and reimbursement mechanisms: CAH, RHC, FQHC
  - Identify services each entity is best at providing
- Look for ways to reduce duplication of service
Collaborative Opportunities – (cont’d)

- Explore ways to contract with FQHCs to provide FQHC services – be sure to do it right!
- Provide a Community Benefit Grant to the FQHC
  - General financial support to help support enabling services or other services that cannot be supported with patient revenues or grant dollars
- Provide an employed practitioner to the FQHC under a contractual agreement
- Turn over a primary care practice to the FQHC
- Merge with the FQHC
Collaborative Opportunities
HRSA Web Links


- [http://bphc.hrsa.gov/policiesregulations/policies/pin199824.html](http://bphc.hrsa.gov/policiesregulations/policies/pin199824.html) - Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers

- Policy Assistance Letter (PAL)
- Policy Information Notice (PIN)
Barriers to CAH & CHC Collaboration
Barriers to CAH/CHC Collaboration

- Regulatory/reimbursement silos
  - Hospitals, RHCs, FQHCs, Public Health, etc.
- Unique issues in rural areas
  - Economic factors, workforce, market share
  - Duplication of clinic or ancillary services
  - Hospital ER coverage and inpatient services
- Personalities and priorities
  - Governance, providers, leadership
  - CAH, CHC or both
- “Pervasive Conflict of Interest”
Examples of Negative Relationships

- The hospital helped start CHC, then things change
- CHC providers don’t have hospital privileges
- Coverage of Hospital ER, day, evening, night
- Monday – Friday versus 24/7
- CHC will duplicate ancillary services
- Hospital will duplicate primary care clinic services
- Cost of ancillary services sold to CHC by the hospital
- CHC gets grant funding, hospital does not
- “We are the only safety net provider”
- Most often personalities are the issue
- Patient is often caught in the crossfire
Our Organizations

CHC

Coal Country Community Health Center - Beulah

CAH

Sakakawea Medical Center - Hazen
Our Organizations

• **Service Area - Rural**
  - Population - approximately 10,000
  - West central North Dakota, edge of Bakken oil activity
  - Major industry - Energy
  - Facilities/communities located 9 miles apart

• **SMC (Sakakawea Medical Center)**
  - Non Profit Corporation
  - 25 bed CAH in 2001, located in Hazen, ND
  - Hospice, Home Health, Basic Care, RHC

• **CCCHC (Coal Country Community Health Center)**
  - Non Profit Corporation
  - Designated an FQHC in 2003, located in Beulah, ND
  - Additional service delivery sight in Center, ND (25 miles)
North Dakota Hospitals

North Dakota Critical Access Hospitals & Referral Centers
SMC/CCCHC Historical Relationship

- Poster child of CAH/CHC conflict & competition
- Community rivalry
- Lack of trust
- Duplication of primary care clinic (Beulah)
- Duplication of ancillary services
  - CT, Ultrasound, Mammo, Bone Density, PT, Stress Test
- Relationship with different tertiary provider
- Lack of common Mission/Vision
- Providers work together well, hospital privileges, cover hospital ER, follow inpatients
CAH/CHC Cooperation
How Did Our Collaboration Start

• Initiated in January 2011
  • CHC Board & CEO ended the employment relationship
  • Hospital was approached to provide interim leadership
  • Boards agreed to a shared CEO relationship
  • HRSA approved an Interim Management Agreement
  • Assistance provided with billing & operational analysis

• Stroudwater was engaged to develop recommendations

• Joint Board meetings held to develop a plan

• Worked hand in hand with HRSA
  • Bureau of Primary Healthcare
  • Office of Rural Health Policy
Where Are We Today

• Transitioned from a culture of..
  • Reasons we can’t work together to how can we do even more!
• Maintain our separate organizations
• Transparency – integrated governance
• Added public health director to the Health Center Board
• Shared CEO last 3 years
• Shared Mission, putting patient & community first
• Eliminated duplicate RHC Clinic in Beulah
• Eliminated most duplicative ancillary services
• Share staff and resources
• Medical Staff
Results of Our Collaboration

- Board, Staff, Provider & Community Support
- Improved combined financial position *(2011 to 2013)*
  - Days Cash on Hand increased from 50 to 90
  - Net Margin increased from -2.1% to +8.7%
  - Long Term Debt decreased by 50%
- Collaborative Community Health Needs Assessment
  - CAH - Sakakawea Medical Center
  - Health Center - Coal Country Community Health Center
  - Public Health - Custer Health
  - Nursing Home - Knife River Care Center
  - Ambulance - Mercer County Ambulance
- Strategic Planning Includes All Entities
Where Are We Going From Here?

- We intend to continue our collaboration
- Implement our strategic plan
  - Joint provider needs assessment
  - Partners in population health
  - Patient Centered Medical Neighborhood
  - Integration of Primary Care and Behavioral Health
  - Partners in ND Rural Behavioral Health Network Grant
  - Partners in rural PACE CMS Innovation Grant
  - Outreach and enrollment
  - Joint advocacy
What Are Our Challenges

• The oil activity in the Bakken
  • Workforce
  • Housing & cost of living

• Regulator requirements can be a road block
  • Collaboration is encouraged BUT…
  • The round peg must fit in the round hole
  • Most effective solution may not be an option

• Reimbursement, uncompensated care

• Health Care Reform/Affordable Care Act
• Deficit Reduction
• But, no longer are we are own worst enemy
Possible opportunities/strategies

- Open communication between leadership
- Integrate Governance
- Cooperative Medical Staff
- Become interdependent/share staff & resources
- Understand each other’s programs/needs
- Understand regulatory requirements
- Refrain from duplicating services
- Collaborate on CHNA & Strategic Planning
- Push the envelope for what’s best for the community
- Did I mention it starts with the leadership?
Closing Thoughts…

• CAHs, RHCs & CHC Are vital safety net providers
• Collaboration In rural areas is essential
• Maximize strengths/benefits of each program
• Greater Regulatory flexibility would be helpful
• While we need to remain cognizant of regulations:

  “Local Challenges Need Local Solutions Developed by Local People”

• Questions?

• Thanks For Letting Us Share Our Thoughts!
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