North Carolina Community Health Care Association

Past & Future:
Recent Developments in Health Center Finance and Future Trends

September 10, 2019

Curt Degenfelder
curt@degenfelderhealth.com
310-740-0960
www.degenfelderhealth.com

Agenda

- Recent activity in 330 funding
- Forgotten items from the Compliance Manual
- One slide about telemedicine
- Title X and other proposals
- Recent accounting changes
- Current & future megatrends

Recent Activity in 330 Funding

HRSA FY 2019 New Funding

- New Access Point – 75 grantees
- Integrated behavioral health services expansion - $200 million
- Quality improvement - $100 million
- Oral health infrastructure - $76 million – estimated 250 awards, can request up to $300,000. Renovation, equipment, IT, and other infrastructure that improves access. Grants.gov due April 22; final EHB submission due May 21.
- Health center controlled networks - $42 million
- FY 2020 ?

330 Funding Basics

- The health center program is authorized under Section 330 of the Public Health Service Act

- Authorized means the program can be given funding, but it does not permit the government to cut a check or enter a contract. It is designed to set parameters for the government

- The 330 program is then funded through two streams:
  - Health center fund (mandatory) - $4.0 billion. Currently on 2 year cycle, this cycle expires 9/30/19
  - Annual appropriation (discretionary) - $1.63 billion

Proposed Legislation for Health Center Fund

- Community Health Investment, Modernization, and Excellence (CHIME) Act – 5 years (compared to current 2) with 4% annual growth

- Community and Public Health Programs Extension Act – 5 years level funding

- Community Health Center and Primary Care Workforce Expansion Act – 10% annual increase over 5 years (to $8.2 billion in funding)

Compliance Manual Chapter 19

- The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditure

- Three-year financials should include

- Capital plan
  - Replacement of fixed assets (plant fund)
  - Additional capital expenditures
  - Excess working capital to fund new site startup

One Slide on Billing for New Modalities of Communication

- Can now bill Medicare FQHC for “virtual communication services”, at least 5 minutes for an issue not discussed in the last 7 days or next 24 hours. Payment rate is $13.69

- Various states allow billing at FQHC rate or Medicaid fee schedule

- Issues on:
  - Location of patient
  - Location of provider
  - What happens when clinical services are delivered on both ends of the telecommunication

- Note that many areas have implemented e-consults, which are not the same thing as telehealth, and may not be reimbursed

IRS - Parking

- While the *Tax Cut and Jobs Act* lowered many taxes, it also included provisions to help raise some offsetting revenue

- One of these changes was that qualified transportation fringe (QTF) was no longer an expense deduction for businesses. QTF includes employee parking

IRS - Parking

- In December 2018 (notice 2018-99), the IRS issued preliminary guidance regarding when nonprofit organizations that own or lease their own parking lots must pay tax on the value of parking benefits provided to employees.

  - The IRS will allow organizations to use "any reasonable method" to determine the value of employee parking benefits.

  - It will not consider these benefits to be taxable if the lot has no spaces exclusively reserved for employees and at least half of the spaces are normally available for patient or public use.

IRS - Parking

Two types of parking arrangements:

- Employer pays a third party for parking for its employees. In this case the full expense is non-deductible up to $260/month. Anything over this amount is considered taxable income to the employee

- Calculating parking expense:
  - Repairs and maintenance
  - Utilities
  - Snow removal
  - Lease
  - Insurance
  - Taxes
  - Security (building or parking?)

IRS - Parking

Two types of parking arrangements:

- Employer owns or leases parking space
  - Parking expense can be calculate by “any reasonable” method; generally includes: repairs and maintenance, utilities, Snow removal, Lease, Insurance, Taxes, Security. Depreciation not included
  - Calculate % of total spots used for employees
  - Include the applicable amount as Unrelated Business Taxable Income on 990

Changes in Non-Profit Accounting Rules

- Option of two current standards – Healthcare Organization (used by most CHCs) or Voluntary Health & Welfare – consolidated into one
- Financial statements will need to show operating income – revenues over expenses – adjusted out for variances due to capital grant accounting
- No more permanently restricted net assets – either restricted or unrestricted
- Definition of grant vs. contribution – 330 grant may be defined as a contribution. More to come.

Changes in Non-Profit Accounting Rules

- More disclosure required in audit for contractual allowances and bad debt

- Operating leases (in addition to capital leases) on balance sheet – right to use equipment. Materiality applies. Goes into effect 2020 or 2021

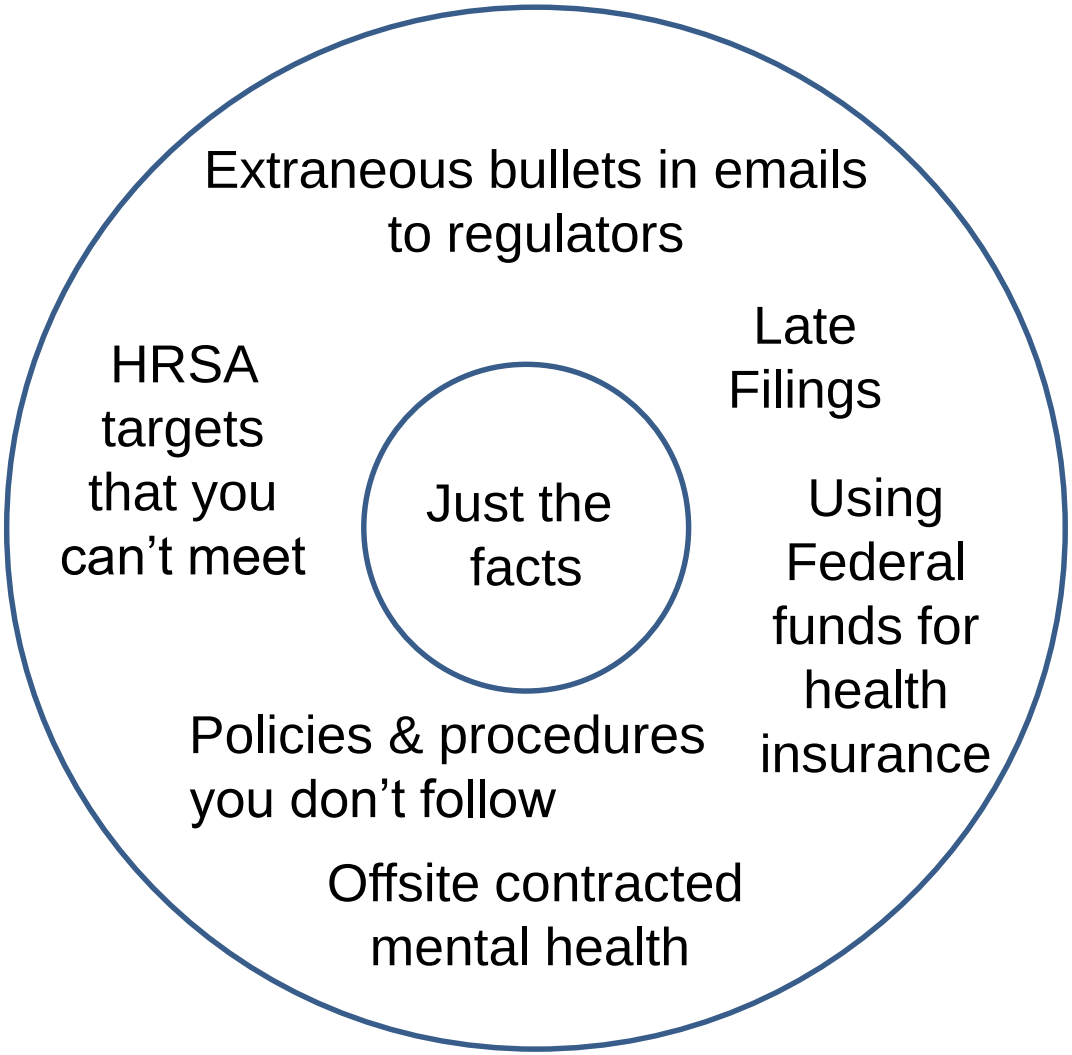
Title X Regulations

"By requiring that Title X projects be physically and financially separate from abort ion-related activities conducted by the grantee or subrecipient" – note that this includes referral to abortion

Physical and financial separation is defined as:

- The existence of separate, accurate accounting records;
- The degree of separation from facilities (e.g., treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites) in which prohibited activities occur and the extent of such prohibited activities;
- The existence of separate personnel, electronic or paper-based health care records, and workstations;
- The extent to which signs and other forms of identification of the Title X project are present, and signs and materials referencing or promoting abortion are absent.

The Regulatory Small Target



Healthcare Merger Activity

- Baylor Scott & White merging with Memorial Hermann (Texas) to create a $10.5 billion health system
- CVS finalized acquisition of Aetna in November 2018, a $69 billion deal
- Dignity Health (CA) and Catholic Health Initiatives (CO) merging to create a $30 billion health system
- Advocate Health Care (WI) and Aurora Health System merging to create a $11 billion health system
- CIGNA acquired Express Scripts for $71 billion in late 2018
- Amazon acquired Pillpack for $1 billion
- Overall there were 1,182 deals in 2018, according to PWC

Market Concentration

		Health care provider market concentration				
		Unconcentrated	Moderately concentrated	Highly concentrated	Super concentrated	Total
Health insurer market concentration	Unconcentrated	0.0%	0.6%	1.1%	1.9%	3.6%
	Moderately concentrated	0.0%	5.5%	16.5%	14.9%	36.9%
	Highly concentrated	0.3%	3.3%	27.5%	23.4%	54.5%
	Super concentrated	0.0%	0.3%	1.9%	2.8%	5.0%
	Total	0.3%	9.6%	47.1%	43.0%	100.0%

Both the hospital and health insurance market are becoming more concentrated (in part to increase bargaining power with each other). In addition, health insurers are starting to merge with pharmacies and pharmacy benefit managers (PBMs).

Market concentration tends to disadvantage smaller market players. The level of M&A also threatens to disrupt current health center arrangements.

Healthcare Merger Activity

- Two thoughts for health centers:

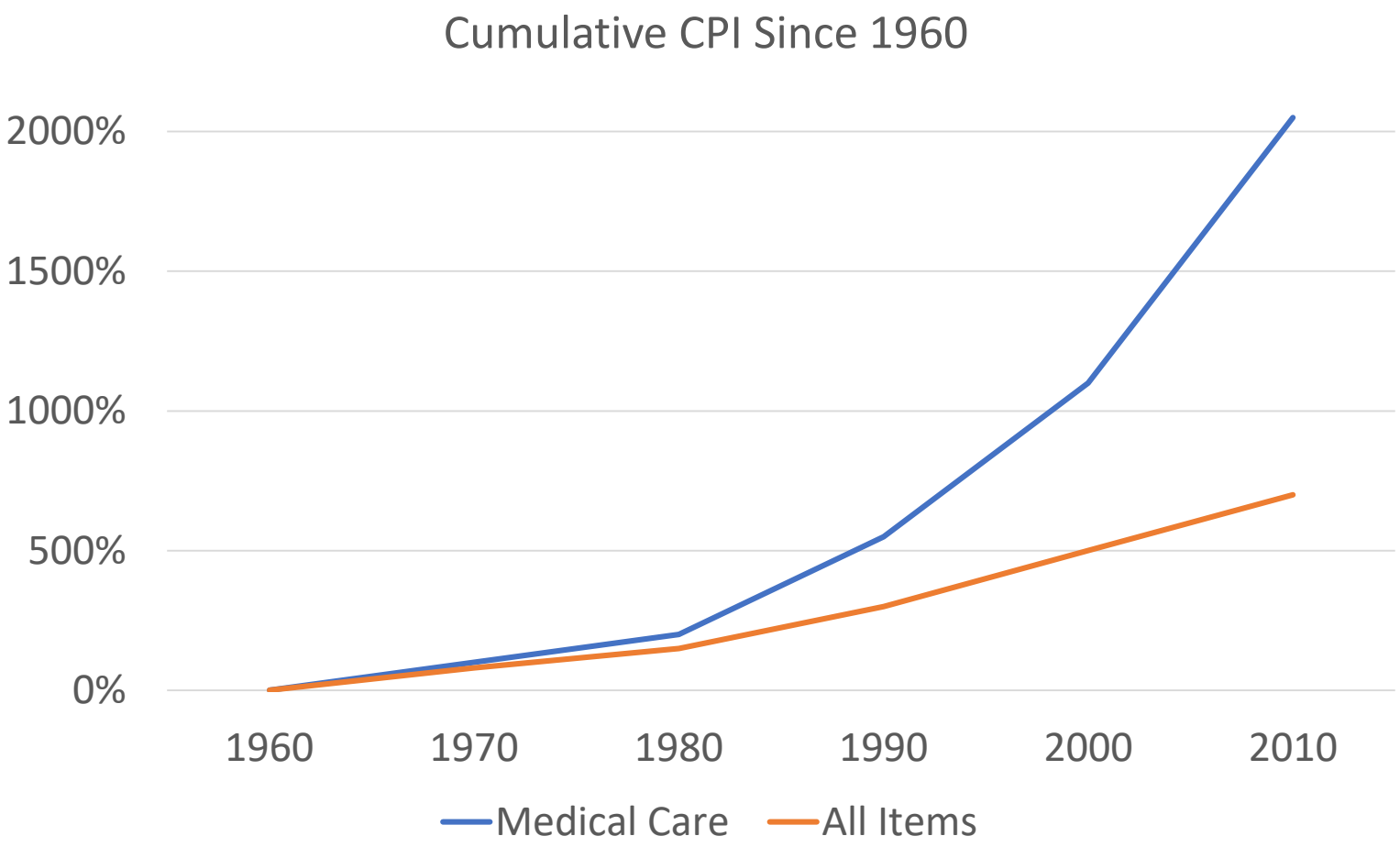
  - As entities with which health centers contract/to which health centers refer grow larger, will they change their arrangements with the health center unfavorably (either by omission or commission)?

  - If bigger is better everywhere else in healthcare, is that also true in community health?

Macroeconomic Picture

- Q2 2018 GDP growth: 4.1%, Q3: 3.4%; Q4: 2.6%; 2019 Q2: 2.1%
- 2010 – 2017 growth: 2 – 2.5%
- May 2018 unemployment rate: 3.8% (18 year low). Jan 2019: 4.0%; July 2019: 3.7%
- S&P 500, August 7, 2018: 2,858.45 (all time record: 2,872.87)
  March 27, 2019: 2,810.80; August 2019: 2,888.17
- Projected federal budget deficit, FFY 2019, per White House budget office - $1.1 trillion (4th largest of all time, #1 – 3 2009 – 2011). White House projected budget deficit: $1.1 trillion, includes cuts to Medicare and Medicaid
- Total assets on Federal Reserve balance sheet, 9/1/08 - $905 billion; 7/23/18 - $4.28 trillion; 3/18/19 - $3.963 trillion; 8/21/19 - $3.765 trillion

Macroeconomic Picture

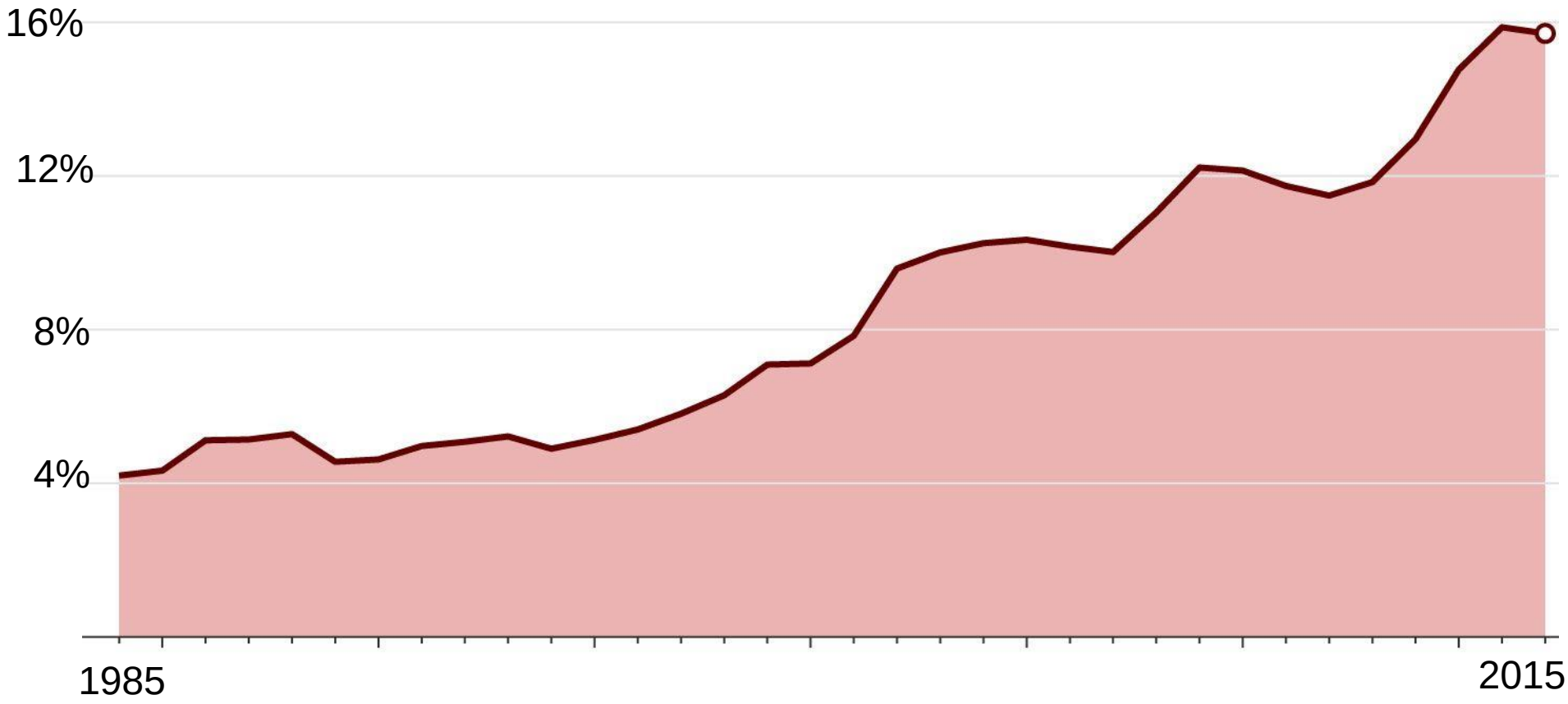


Source: Labor Department, WSJ 7/31/18

Macroeconomic Picture
Price Growth Since 2000

Physician & Clinical Services	23%
Hospital Care	60%
Prescription Drugs	69%

Macroeconomic Picture
Health Care Companies % of S&P 500



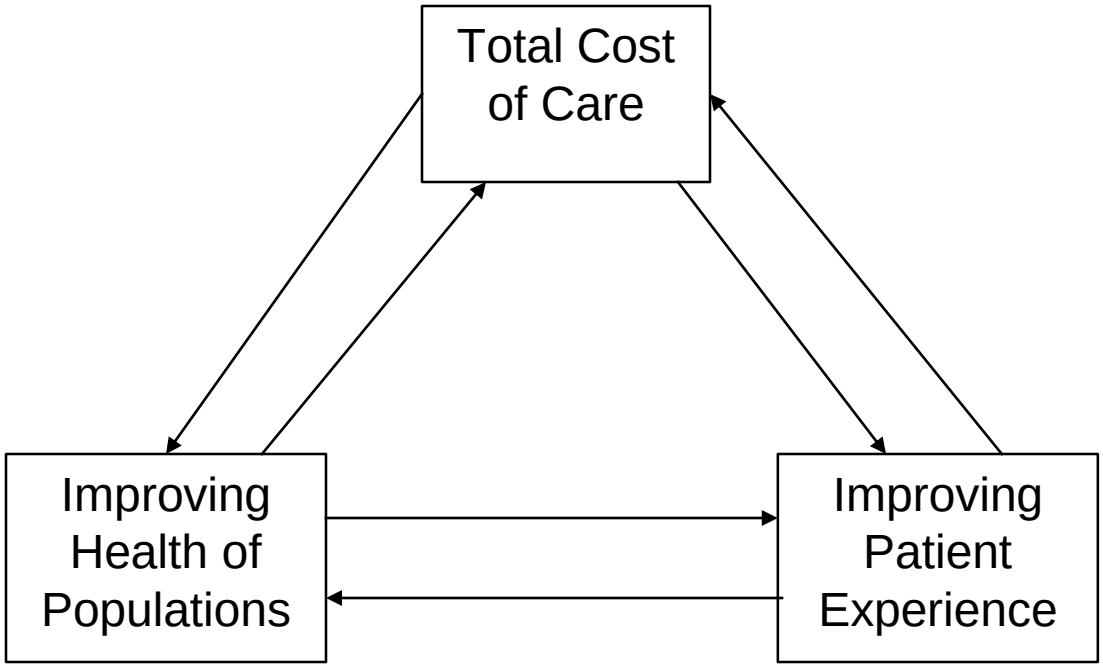
A Final Thought on the Healthcare Marketplace

“Medical costs are the tapeworm of American economic competitiveness”

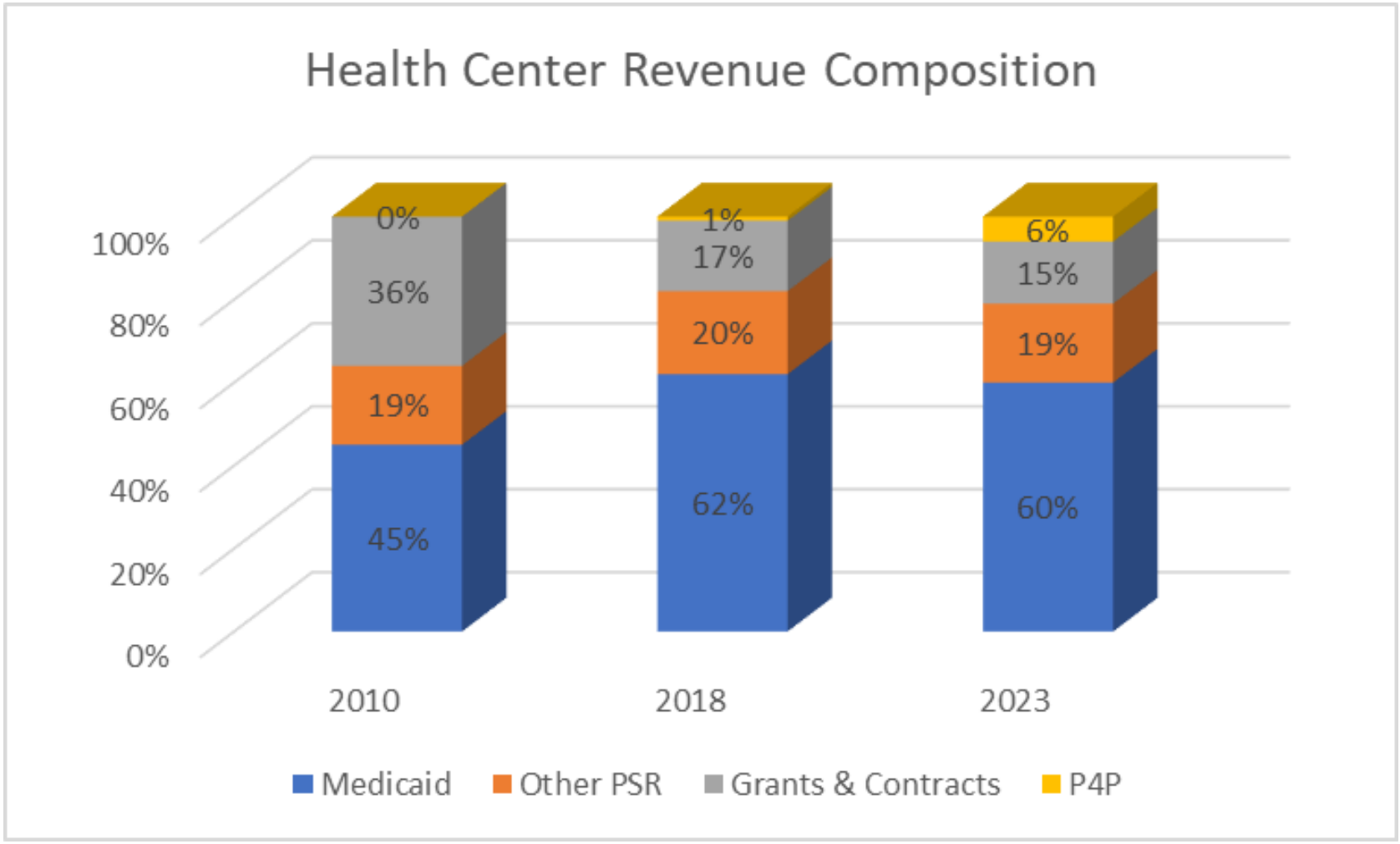
Warren Buffet - 2018

A Discussion of the Future

The Triple Aim

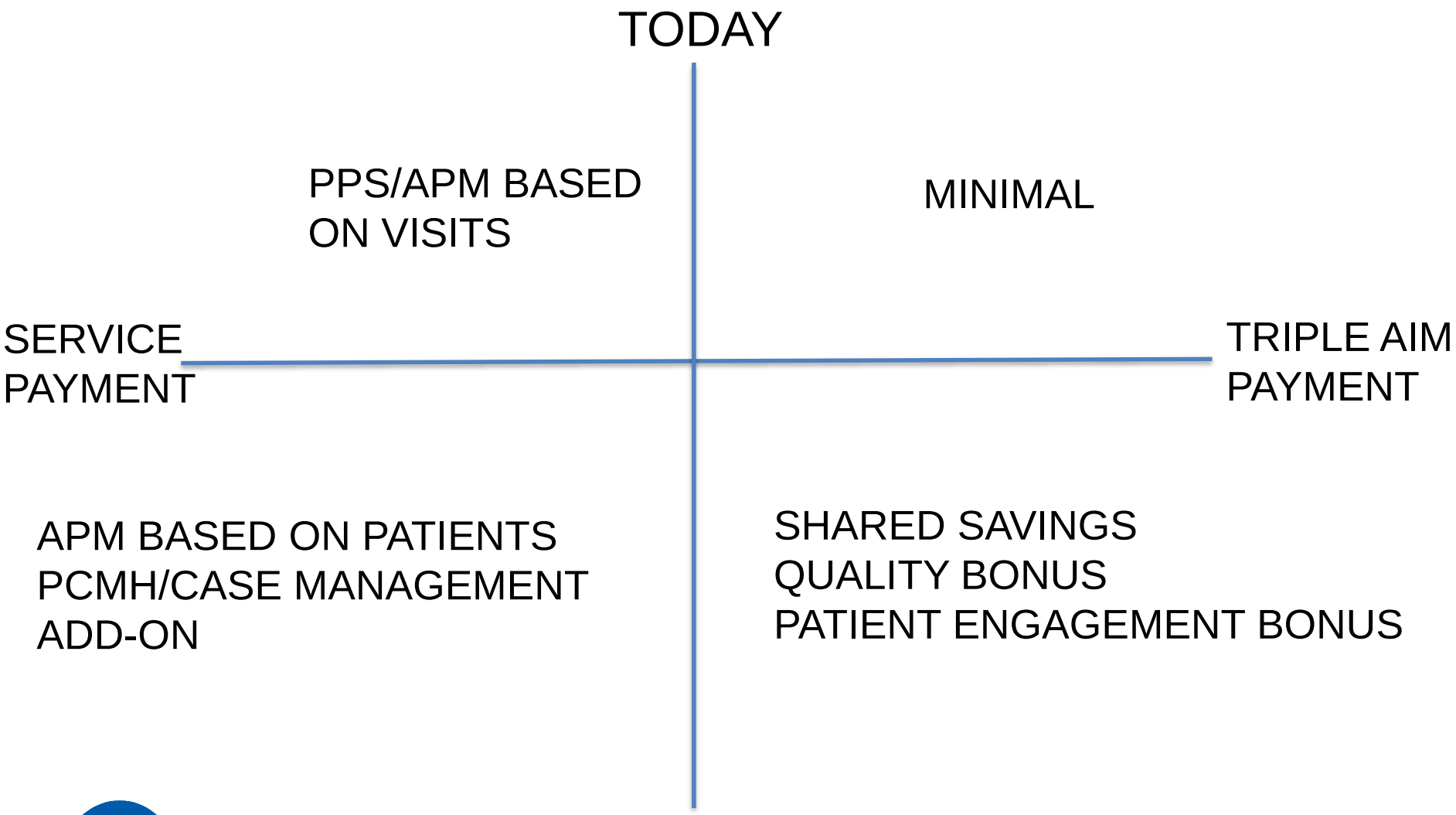


FQHC Revenue Today & In The Future



Note that this graphic excludes consideration of 340b, which varies by health center but may decline in the future

FQHC Revenue Today & In The Future



Changes in the Revenue Model

FQHC APM

Modifications to Per Visit

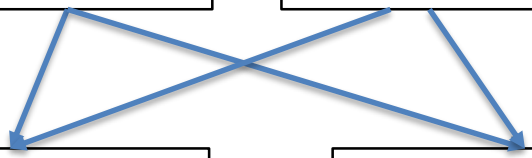
Capitated Per Member

VALUE BASED PAY

MCO Driven

State Medicaid Driven

Medicare ACO



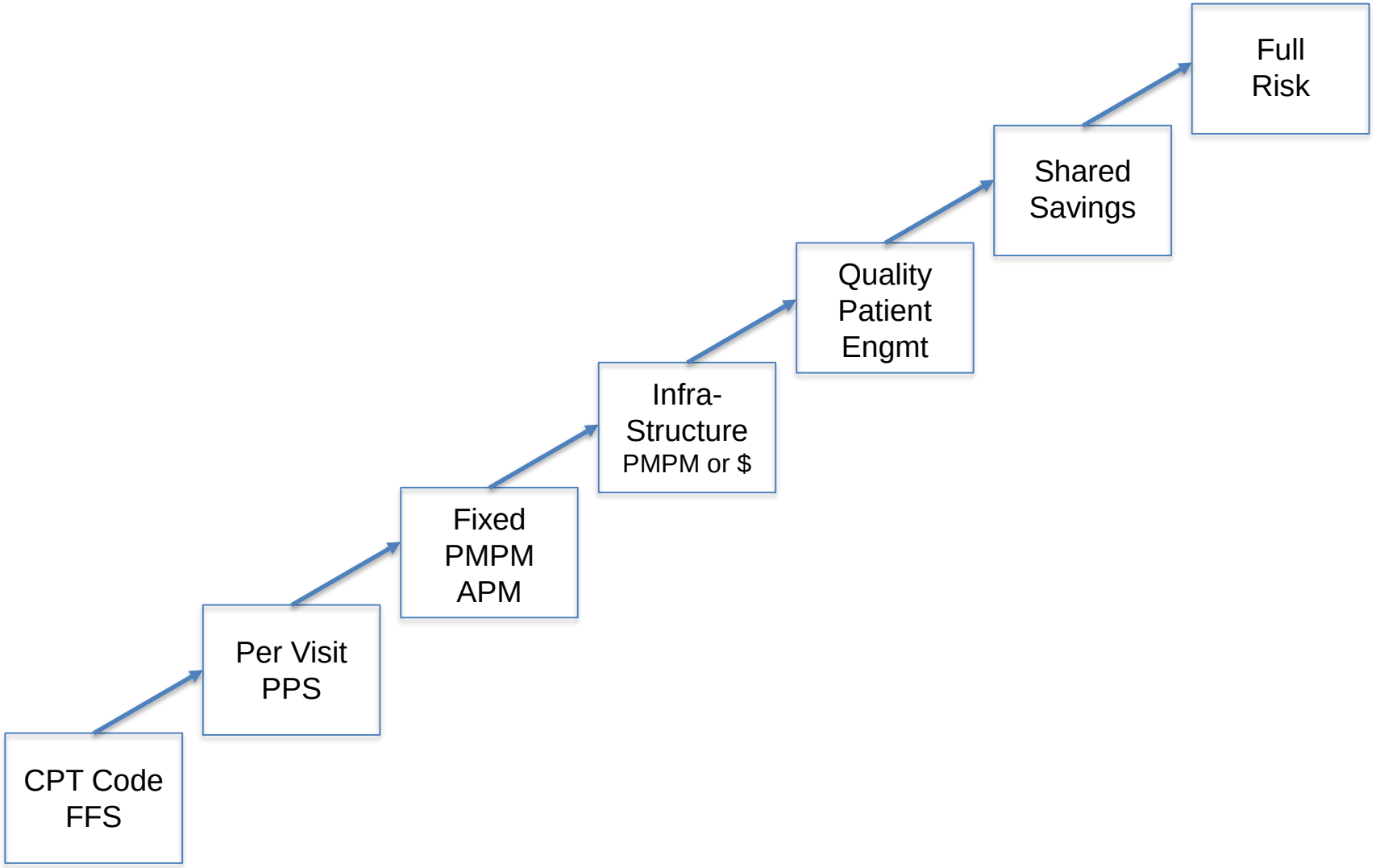
Process Based
- Access
- HEDIS quality
- Gaps in care
- Infrastructure

Outcomes Based
- UDS Quality
- Total Cost
- Inpatient/ED Usage

Sample Infrastructure System

- Risk stratification – “providers use risk stratification from payers”. Three payment tiers in the P4P program:
  - Tier 1 - $1 PMPM – healthy, history of significant acute disease (chest pains), single minor chronic disease (migraine)
  - Tier 2 - $8 PMPM – minor chronic disease in multiple systems, significant chronic disease, significant chronic disease in multiple organ systems
  - Tier 3 – $22 PMPM - dominant chronic disease in 3 or more organ systems (diabetes mellitus, CHF, and COPD), dominant mestatic malignancy , catastrophic
  - Relies on coding
  - Relies on accurate managed care data capture

Progression of Value Based Payment



What Does It Take to Maximize Pay for Performance Revenue?

- Good managed care contracts
- Good data – health center
- Good data – plan
- Good performance – health center
- Good performance – health center members outside of health center
- Ability to locate/change behavior of all ASSIGNED health center members

UDS vs. HEDIS – Sample

	Attributed Not Seen	Timely Entry Into Prenatal Care		Childhood Immunzation*	
		UDS	HEDIS	UDS	HEDIS
Health Center A	11%	74%	48%	68%	1%
Health Center B	11%	85%	66%	93%	0%
Health Center C	12%	86%	60%	84%	0%
Health Center D	9%	56%	53%	97%	1%
Statewide Administrative			59%		4.7%
Statewide Hybrid					64.7%

*Combination of Dtap, IPV, MMR, HiB, HepB, VZV, PCV

UDS vs. HEDIS – Sample

	Cervical Cancer Screening		Asthma Pharm Therapy	
	UDS	HEDIS	UDS	HEDIS
Health Center A	61%	47%	79%	84%
Health Center B	43%	72%	90%	84%
Health Center C	60%	66%	75%	86%
Health Center D	70%	69%	91%	92%
Statewide Administrative		66%		87%

What Drives Total Cost of Care?

Top (Costly Pts):	10%	20%	Everyone Else
# of Pts:	11,539	23,078	92,311
% of Total Costs:	59.3%	75.1%	24.9%

Risk Adjustment of Total Cost of Care

	Predicted Risk Score	Predicted Total Cost PMPY	Actual Total Cost PMPY	Actual % of Predicted	Actual Total Cost PMPY
Health Center A	1.52	$ 7,894	$ 7,700	98%	$ 6,860
Health Center B	1.21	$ 6,307	$ 5,419	86%	$ 5,026
Health Center C	1.59	$ 8,276	$ 8,233	99%	$ 7,420
Health Center D	1.03	$ 5,370	$ 5,318	99%	$ 4,775
Health Center E	1.54	$ 8,007	$ 7,417	93%	$ 6,781
Health Center F	1.08	$ 5,605	$ 5,590	100%	$ 5,167
Health Center G	1.21	$ 6,267	$ 5,654	90%	$ 5,052
Health Center H	1.37	$ 7,101	$ 6,810	96%	$ 6,393
Health Center I	1.30	$ 6,756	$ 6,299	93%	$ 5,496
Health Center J	0.98	$ 5,086	$ 5,707	112%	$ 5,160
Health Center K	1.78	$ 9,245	$ 8,784	95%	$ 8,275
Health Center L	1.25	$ 6,471	$ 6,004	93%	$ 5,121
Health Center M	1.94	$ 10,099	$ 9,583	95%	$ 8,683
Health Center N	0.99	$ 5,137	$ 4,758	93%	$ 4,593
FQHC Average			**$ 6,663**		
Statewide Average	**1.00**		**$ 5,197**		

Thoughts on Provider Recruitment and Retention in 2019

1973

1982 Ford Escort

1972 Chevy Impala

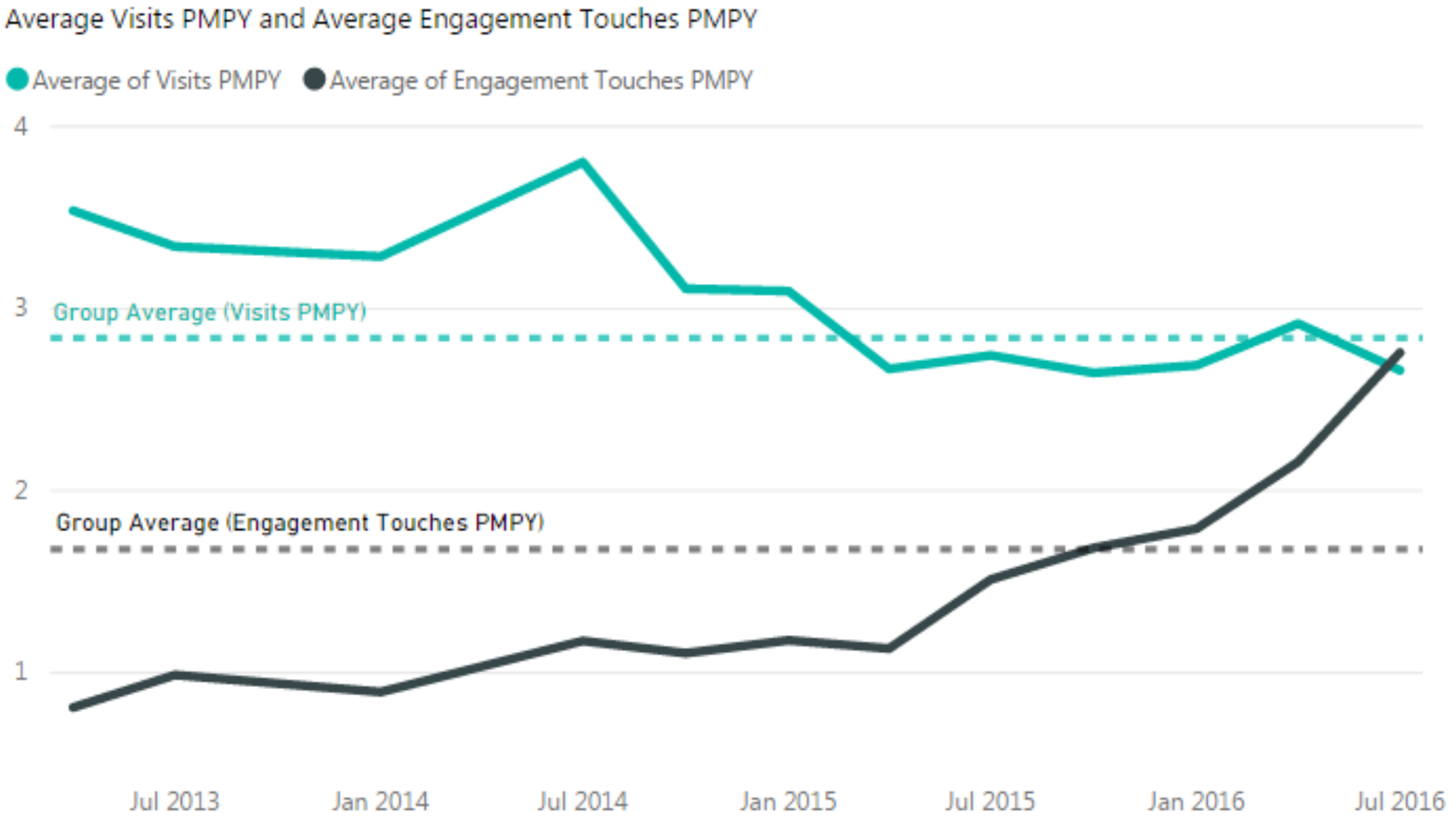
1974

In 2019, what is expensive and in short supply in the future?

PCMH Cost/Benefit Analysis

- Physician - $170,000 – $220,000
- PA & NP - $105,000 - $130,000
- RN - $70,000 - $85,000
- Integrated behavioral health provider
- Medical assistant 1 - $12/hr
- Medical assistant 2 - $14/hr
- Medical assistant 3 - $20/hr
- Care coordinator - $20/hr
- Front desk - $13/hr
- Scribe

APM– Actual – Visits to Touches



APM Financial Scenarios

	Current	PPS Provider Vacancies	PPS PCMH	APM PCMH	APM PCMH Vacancies
Provider FTEs	10	8	10	10	8
Visits/FTE	3,900	3,900	3,900	3,900	3,900
Total Visits	39,000	31,200	39,000	39,000	31,200
Patients	13,000	10,400	13,448	13,929	11,556
Visits PPPY	3.0	3.0	2.9	2.8	2.7
Provider Panel Size	1,300	1,300	1,345	1,393	1,444
Net Revenue/Visit PMPM	$ 120.00	$ 120.00	$ 120.00	$ 30.00	$ 30.00
Patient Service Revenue	$ 4,680,000	$ 3,744,000	$ 4,680,000	$ 5,014,286	$ 4,160,000
Grant & Other Revenue	$ 1,300,000	$ 1,300,000	$ 1,300,000	$ 1,300,000	$ 1,300,000
Total Revenue	$ 5,980,000	$ 5,044,000	$ 5,980,000	$ 6,314,286	$ 5,460,000
Provider Compensation	$ 1,750,000	$ 1,400,000	$ 1,750,000	$ 1,750,000	$ 1,400,000
Variable Staff Compensation	$ 1,200,000	$ 960,000	$ 1,400,000	$ 1,500,000	$ 1,260,000
Fixed Staff Compensation	$ 1,600,000	$ 1,600,000	$ 1,600,000	$ 1,600,000	$ 1,600,000
Total Compensation	$ 4,550,000	$ 3,960,000	$ 4,750,000	$ 4,850,000	$ 4,260,000
Variable OTPS	$ 600,000	480,000	$ 600,000	$ 600,000	$ 480,000
Fixed OTPS	$ 780,000	$ 780,000	$ 780,000	$ 780,000	$ 780,000
Total OTPS	$ 1,380,000	$ 1,260,000	$ 1,380,000	$ 1,380,000	$ 1,260,000
Total Expense	$ 5,930,000	$ 5,220,000	$ 6,130,000	$ 6,230,000	$ 5,520,000
Net Income	$ 50,000	$ (176,000)	$ (150,000)	$ 84,286	$ (60,000)

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