

All You Need to Know about Financing Specialty Access

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For: Round Table # 6 Specialty Care Financing
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10/20/08

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You can learn from Star Trek:

Humans are highly illogical and therefore, so is specialty funding for the uninsured.

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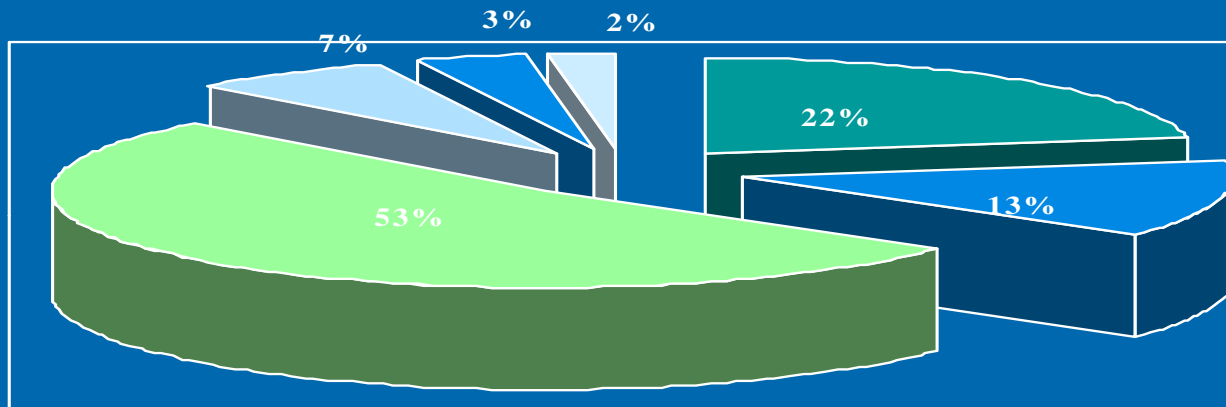
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Seek out New Life and New Civilizations

- Mandatory universal health insurance
 - Lower costs and health insurance coverage for all
 - Populations to be insured increase
 - Marginal costs decrease
 - Majority of uninsured are healthy workers
 - Low risk will not seek insurance under present system



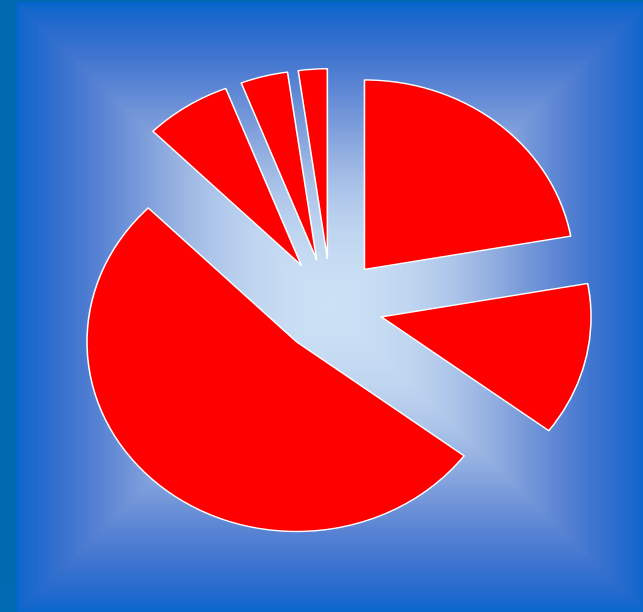
Infinite Diversity in Infinite Combinations (IDIC) Clinic Revenue Sources



Increasing the 53%

➤ Two Options

- Generate additional revenue if costs are low, PPS rate is high, productivity is high
- Apply for Scope of project and Change of scope for specialty services to increase PPS rate for each visit



Federal

➤ Scope of Project

- Approved section 330 grant related project budget, providers, populations and service area for which grant project budget includes program income and other non-section 330 funds
- Defines approved sites and services for State PPS
- Defines the approved service sites necessary for the determination of eligibility for FQHC inclusive rate
- Provides site information under section 340B
- Determines the maximum potential scope of coverage for FTCA coverage

State

➤ Change of Scope.

- A change in the type, intensity, duration, or amount of services, or any combination thereof.
- The addition of a new FQHC/RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC/RHC service that is incorporated in the baseline rate.
- A change in service due to amended regulatory requirements or rules.
- A change in service resulting from relocating or remodeling an FQHC or RHC.
- A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.
- An increase in service intensity attributable to changes in the types of patients served, including but not limited to populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.
- The services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, or in the provider mix of an FQHC or RHC or one of its sites.
- Operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.
- Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.
- Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

Requesting PPS Rate Change
due to Scope of Service Qualifying Event
What Triggered the Event?

You have an event
Your FY is July 2008 to June, 2009
Event occurs January, 2009

Triggering event is not capital purchase,
but a change in the FQHC services
Not just change in cost
Allowable under Medicare Cost Principles (45CFR part 413)
Depreciation is allowable, follow AHA guidelines
Change in type, intensity, duration or amount of services or
combination
Net changed in rate exceeds or equals 1.75% OF VISIT

Costs are gathered; within 90 days after end of FY
Clinic Change in Scope of Service Completed
And submitted to DHS, A & I , Financial Audits Branch
September 2009
DHS has 90 days to approve
December 2009
30 days to make payment
January 2009

Cash flow considerations are critical at this point you have
incurred
An increase in costs but you will not be reimbursed for any costs
January to June 2009
the new PPS rate will not take effect until as late as seven
months into
The new FY January 2009
Cash Flow Planning is Critical

Scope is approved; rate is retroactive
to First day of FY following the event
July 1, 2009

Changes in scope of project must be approved by the health center's governing board and documented in the minutes	60 days in advance of addition or deletion of service or site notify project officer, HRSA	HRSA Policy Information Notice ("PIN") 2008-01, pp. 4 and 25.	11/1/08
	30 days you will get a response via NGA or EHB	PIN No. 2008-01, pg. 25.	12/1/08
Must meet change in type, intensity, duration or amount of services or combination, not just change in cost, cost must be allowable under Medicare cost principles (42 CFR Part 413)	FQHCs/RHCs can request Audits & Investigations ("A&I") to give you some feedback, however be certain to verify the accuracy of such feedback by reviewing the applicable statute or consulting qualified experts.	Calif. Welfare & Institutions Code § 14132.100(e); see http://www.leginfo.ca.gov ; see also http://www.dhcs.ca.gov/provgovpart/Pages/FinancialAuditsBranch.aspx	
	Start new "triggering" event	Calif. Welf. & Inst. Code § 14132.100(e)(2)(A) – (I)	1/02/09
New PIN 2008-01	Must Notify State Medi-Cal Agency, Audits & Investigations within 90 days of HRSA approval	PIN No. 2008-01, pg. 27.	3/1/09
Net change in rate must be =>1.75% of current rate	End of fiscal year		6/30/09
Submit required form, scope of project approval by HRSA, audited financial statements	Within 150 days after fiscal year end must submit to A and I, Financial audits branch	Calif. Welf. & Inst. Code § 14132.101(a)	9/30/09 (90 days) 11/30/09 (150 days)
	90 days DHS must audit, audited rate will become new PPS rate. Rate will be retro to 7/1/09	Calif. Welf. & Inst. Code § 14132.107	12/31/09
Cash and expense considerations. 6 months of increased costs no reimbursement; 7 more months of cash flow concerns	30 more days to make payment if approved	Calif. Welf. & Inst. Code § 14132.107	1/31/09



Insufficient data does not compute

- Can a scope change fund specialty services: Answer: depends
 - How long has it been since clinic received an increased rate?
 - What specialty services are being added; low utilization high cost; high utilization low cost?

The 53% and specialty services

- Divide allowable costs by allowable visits
 - Cost per visit vs PPS Rate
 - If costs are higher, clinic using some of the other 47% to cover costs of MediCal
 - If costs are lower, clinic is generating funds for the uninsured/underinsured

Scope of Service Cost Report

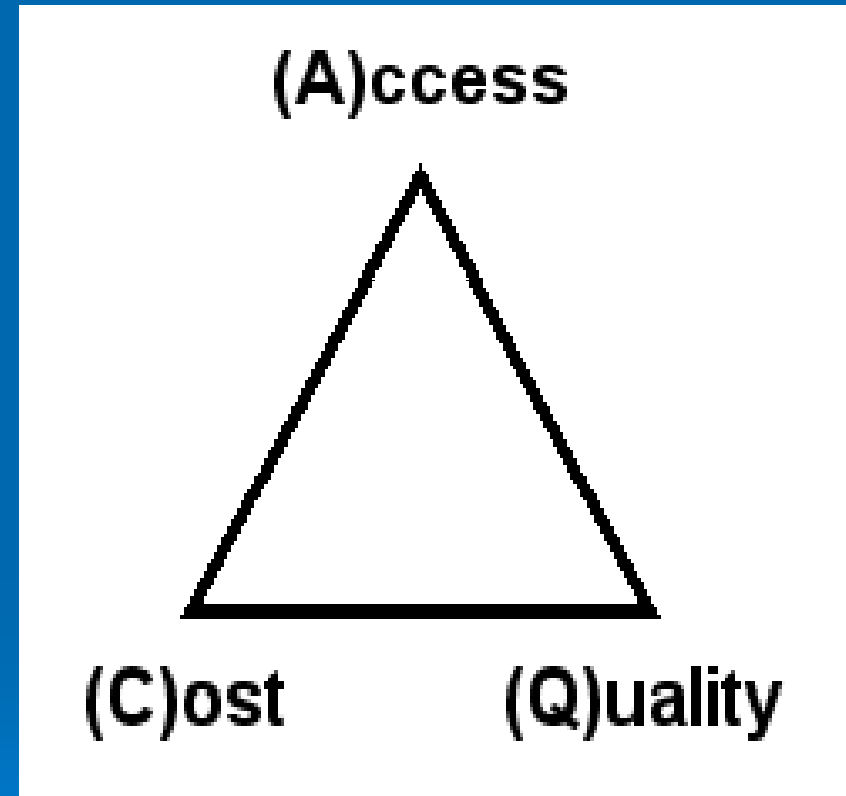
- Home Office Cost Report:
 - Allocates overhead to various clinics and unallowable costs
- New rate must be greater than 1.75% of old rate
- New rate is reduced by 20% of difference between old and new rate

Expenses				
Total	\$	26,000,000		
Overhead	\$	5,000,000		
Direct Clinic	\$	20,000,000		
Unallowable	\$	1,000,000		
Visits		166,000		
	Clinic A	Clinic B	Unallowable	Total
Direct	\$ 15,000,000	\$ 5,000,000	\$ 1,000,000	\$ 21,000,000
Overhead	\$ 3,571,429	\$ 1,190,476	\$ 238,095	\$ 5,000,000
Total	\$ 18,571,429	\$ 6,190,476	\$ 1,238,095	\$ 26,000,000
Allowable Vists	\$ 124,500	\$ 41,500		\$ 166,000
Cost per visit	\$ 149.17	\$ 149.17		
Add 14,000 moe specialty visits				
Total Costs	\$ 15,000,000	\$ 5,000,000	\$ 1,000,000	\$ 21,000,000
Specialty Costs	\$ 1,500,000	0	0	\$ 1,500,000
New Total	\$ 16,500,000	\$ 5,000,000	\$ 1,000,000	\$ 22,500,000
Overhead	\$ 3,666,667	\$ 1,111,111	\$ 222,222	\$ 5,000,000
Total w o/h	\$ 20,166,667	\$ 6,111,111	\$ 1,222,222	\$ 27,500,000
Allowable visits	135,000	45,000		180,000
Rate Per Visits	\$ 149.38	\$ 135.80		
		75% Medicaid	25% uninsured	
Payor Mix	135,000	101,250	33,750	
Rate Analysis	Old Rate	Increase	20% adjustment	Additional Revenue
	\$ 116.00	\$ 33.38	\$ 26.71	\$ 2,704,000
	\$ 140.00	\$ 9.38	\$ 7.51	\$ 760,000
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Mutually Orthogonal Constraints of Access, Cost and Quality

- Introduction of disruptive process or strategy will cause a shift.



Disruptive Processes

- Primary Care providing specialty services
- Specialists added to clinic work flow
 - Access to increased need for ancillary and pharmaceutical services
 - Decreased utilization per provider
 - Potential increase in malpractice and other costs

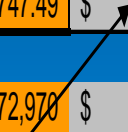
CATTANEO & STROUD PHYSICIAN TO POPULATION RATIOS				
SPECIALTY	PER 100,000 POPULATION			
	HIGH	MEDIUM	LOW	
PRIMARY CARE:				
Pediatrics	10.6	9.8	9.0	
All Other	60.0	55.0	50.0	
Subtotal Primary Care	70.6	64.8	59.0	
OB/GYN	11.0	10.0	9.0	
MEDICINE:				
Cardiology	3.4	3.0	2.6	
Endocrinology	1.0	0.9	0.8	
Gastroenterology	2.8	2.2	1.5	
Infectious Disease	1.1	1.0	0.9	
Nephrology	1.1	0.9	0.7	
Neurology	3.3	2.3	1.2	
Oncology/Hematology	2.4	2.1	1.8	
Physical Medicine/Rehab	1.9	1.4	0.8	
Pulmonary	2.0	1.7	1.4	
Rheumatology	0.7	0.6	0.5	
SURGERY:				
CVS & Thoracic	1.0	0.8	0.5	
General Surgery	9.4	7.7	6.0	
Neurosurgery	1.2	1.0	0.8	
Orthopedics	6.0	5.5	5.0	
Otolaryngology	3.2	2.9	2.6	
Urology	2.9	2.6	2.3	

Source: Cattaneo & Stroud, Inc.

Utilization and Costs

<u>Uninsured Totals (1)</u>	<i>Utilization (3) Per 1,000 members per year</i>					<i>Costs (5) PMPM</i>				
	Ophthalmology	Gastroenterology	Cardiology	Podiatry	Total	Ophthalmology	Gastroenterology	Cardiology	Podiatry	Total
2,846	290	221	198	132	841	\$ 3,358.28	\$ 2,931.38	\$ 2,656.27	\$ 1,356.59	\$ 10,303
9,698	990	752	675	450	2,867	\$ 11,443.64	\$ 9,988.94	\$ 9,051.47	\$ 4,622.71	\$ 35,107
6,821	696	529	475	316	2,016	\$ 8,048.78	\$ 7,025.63	\$ 6,366.27	\$ 3,251.34	\$ 24,692
15,417	1,574	1,196	1,073	715	4,557	\$ 18,192.06	\$ 15,879.51	\$ 14,389.20	\$ 7,348.77	\$ 55,810
3,019	308	234	210	140	892	\$ 3,562.42	\$ 3,109.57	\$ 2,817.73	\$ 1,439.06	\$ 10,929
1,030	105	80	72	48	304	\$ 1,215.40	\$ 1,060.90	\$ 961.33	\$ 490.97	\$ 3,729
8,891	907	689	619	413	2,628	\$ 10,491.38	\$ 9,157.73	\$ 8,298.27	\$ 4,238.04	\$ 32,185
47,722	4,871	3,701	3,320	2,214	14,106	\$ 56,311.96	\$ 49,153.66	\$ 44,540.53	\$ 22,747.49	\$ 172,754
572,664						\$ 675,744	\$ 589,844	\$ 534,486	\$ 272,970	\$ 2,073,044

Costs PMPY



Final Thoughts



- Kids are getting appropriate primary care only 47% of the time
- U.S. adults receive appropriate medical care 55% of the time
- To insure the uninsured 6% increase in spending for the uninsured and 1% increase overall (California)