Financing a Primary Health Center
KHA Rural Health Visioning TAG Conclusions

After the Primary Health Center Model was designed and tested, the TAG turned to the concept of how the new model or a model like it should be financed. These discussions were particularly challenging as TAG members were asked to consider non-traditional approaches.

While the PHC model had been loosely defined, consensus had not identified the set of specific services that would be included in the payment method. There had been consensus that all CAHs or rural PPS facilities < 50 beds would be eligible to transition to PHC; however even with a set of essential services, it was understood that the services would not be completely the same in each community.

The TAG took previous discussions, augmented by the AHA Task Force on Vulnerable Communities’ materials, to develop the following hierarchical list of essential services:

• Services considered core or essential that must be provided by a PHC:
  – Primary health care including prenatal care (AHA, RHV)
  – Urgent care (RHV)
  – Emergency care (AHA, RHV)
  – Emergent and non-emergent transportation (AHA, RHV)
  – Observation (AHA, RHV)
  – Outpatient and ambulatory services (AHA, RHV)
    • Minor procedures
    • Ancillary services to support primary care and basic diagnostic (AHA, RHV)
  – Care coordination, chronic disease management (RHV)
  – Active telemedicine (RHV)
• Services that should be available in the community and may be provided by a PHC based on community need and local sustainability and may be included in the payment model:
  – Behavioral health (AHA essential)
  – Dentistry (AHA essential)
  – Transitional care (RHV essential)
• Services that could be available in the community and may be provided by a PHC based on community need and local sustainability, but would not be included in the payment model:
  – A mechanism to include unique local/regional services would need to be established.

As articulated above, payment model must include funding for five service lines not always provided in CAH’s. EMS/Ambulance, Primary Care, Care Management, telemedicine, and capital allowances should all be built into or allowed as budget line items in any PHC financing approach. Depending on size, service area and projected volumes, the actual amount will vary. The test process along with the experience of the CPAs who conducted the tests concluded that these five areas would cost a minimum of $1.9 million for all levels of staffing and expenses. It was recognized that the cost of new or replacement ambulances was not included in this amount. These costs should be incorporated whether or not the PHC “owns” the service as costs will be incurred for assuring access to these services through contracted services as well.

Adopted by RHV TAG November 8, 2016
Much discussion was held on the basic principles that should be present in any payment method that met the larger initial RHV TAG principle that any model “be reimbursed and financed fairly by federal, state and local resources, private payers and patients such that the health of the population can be improved.” Further consensus was reached in the following areas:

- To preserve access and improve health, low volume facilities like the PHC model must be supported with additional financial resources.
  - Federal grants or support along with commitment from the local community to assist in supporting the continued access to services
  - One time grant or transitional funding will be required to bridge the difficulties as CMS makes payment process changes and to fund the local costs of transition
- Some form of reporting consistent with the nature of the facility should be required both on quality and operational efficiency measures and expense. These measures should be consistent with the scope of services provided by the facility.
  - Components of a value incentive should be included to support the triple aim
  - A few key measures should be identified that relate to the scope of operations and services that are actually provided in a PHC and used to set targets for value incentives
- Consideration should be given to utilizing an inclusive budget or financial proposal which encompasses all services to incentivize flexible use of limited staff and resources.
  - All essential services should be included in the payment method to allow the most flexibility to adjust to day-to-day changes in volume and service needs
  - Multi-year agreements will help to assure stability
- Ideally, all payers should participate in a demonstration to determine exactly how the model can balance the support of access and optimal health for a community as well as incentives for efficiency and high quality.

Based on these consensus points and the service set to be included, the TAG considered a number of approaches to financing the Primary Health Center. As it is not an FQHC nor a full service CAH, components of each of these models were considered along with principles embodied in the movement from volume based payment models to value based models. Five options and their pros and cons were identified, but no single model of payment was recommended.

The TAG believes that some form of value incentive should be included in any payment method while some models proposed nationally do not have this component. However, the TAG is concerned that a value incentive could be difficult to develop as the general low volumes of this type of facility will make measures a challenge to identify. Measures tied to emergency room processes, primary care measures and operational measures such as meeting budget and volume projections should be considered.

The TAG also believes that communities must make a commitment to sustain their local health care access point. Any payment model will have challenges as the Primary Health Center is new to the community, so estimating volumes will depend on community acceptance and confidence in the medical care provided. Payments are also generally dependent on historical experience of costs and usage, which will change based on the services provided and the medical staff available.

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The five options and their general benefits and challenges were:

1. **Global budget based fixed payments** – This option provides monthly equal Medicare payments based on a negotiated multi-year budget for all services provided by the PHC. The negotiated budget would include federal support for the emergency infrastructure in the form of a grant or additional budget amount along with local support. This option would also require local financial support and carry a value incentive for meeting designated measures.

   **Discussion of benefits and challenges:** This approach has the opportunity to stabilize payments and assure continued ER coverage regardless of volume fluctuations. It promotes planning and efficiency as budgets are developed and followed. Assuming that all services are included, this approach would allow for the flexibility to move resources between services as the need arises. Establishing a budget will present challenges as CAHs historically have had inpatient and longer stay swing bed patients. Community acceptance of the new model may take time to establish. Other challenges would include new processes for reporting along with treatment of deductibles and coinsurance. Fixed payments also may not cover the variable costs of large upward swings in volume. Identifying what the value incentive was tied to with a fixed budget would also be challenging.

2. **FQHC-like payment method with extended encounter/visit payments** – This option would combine the process of the FQHC payment approach setting visit or encounter payments based on a budget incorporating all services. Extended or add-on payments would have to be established for patients who remain in the facility for longer term or overnight services. Additional federal support for the emergency infrastructure would be provided in the form of a grant from Medicare at the same level as current FQHCs, a maximum of $650,000 per year. This option would also require local financial support and carry a value incentive for meeting designated measures.

   **Discussion of benefits and challenges:** Utilizing this approach provides a familiar and existing payment framework. It has the opportunity to stabilize payments and assure continued ER coverage regardless of volume fluctuations and promotes planning and efficiency as budgets are developed and followed. The grant approach identifies federal support for the emergency infrastructure and assure coverage. It also provides for variable payment tied to volume so that larger increases in volume are covered. On the downside, the majority of payments are still tied to volume so that low volume periods may be challenging. While this is a known process to CMS, it is a new process for former CAHs. Establishing a budget will present challenges as CAHs historically have had inpatient and longer stay swing bed patients. Community acceptance of the new model may take time to establish. In addition, extended encounter payments will need to be developed. Learning from the Alaska FESC Model will be important. There will be differences as this model uses the infrastructure from a 24/7 operation rather than taking a clinic and converting it to a 24/7 operation.

3. **Blending fixed payment and encounter payments** – This option would have components of the fixed payment combined with the encounter method. The federal grant, local support requirement and value incentive would be the same as above.

   **Discussion of benefits and challenges:** Utilizing this approach provides the best of both options above. It has the opportunity to stabilize payments and assure continued ER coverage regardless of volume.
fluctuations and promotes planning and efficiency as budgets are developed and followed. The encounter payments account for changes in volume which have an impact on the variable costs of staff and supplies. The grant approach identifies federal support for the emergency infrastructure and assure coverage. This is however, a complicated approach. Which has more moving parts than either of the above options. Some of the payments will still be tied to volume so that low volume periods may be challenging. This would be an entirely new approach and may take significant time to develop the correct balance between the fixed payments and the proportion of volume based payments. Volume based payments, or encounter fee schedules would need to be developed to take into consideration the funding provided by the fixed payments.

4. **Global cost based approach** – This approach retains the traditional cost-based system of payment currently used for CAHs with several modifications. The intent is to avoid current carve-outs as all services in the PHC would be included in the cost base. Modifications to the definitions of “allowable costs” would be needed to assure that the emergency infrastructure is supported. The Grassley proposal suggests 110% of costs. The TAG would suggest that the local support and value incentive be included as well.

**Discussion of benefits and challenges:** Without question, a cost based approach is the most well-known and accepted approach for CAHs transitioning to a new model. A cost based model is proposed in the Grassley bill at 110% of costs. The inclusive approach would eliminate the complex carve out processes as well. Federal support for the infrastructure is provided in the percentage over 100% of costs. Local commitment would assist in retaining access to services as well. On the other hand, major changes would be required both to be inclusive of all services and to minimize, wherever possible, the complexities of the process. Vulnerability to efforts such as sequestration still exist that could reduce the percentage of reimbursement. Other challenges in the current cost based approach such as the wide variation in costs will still exist. Even with a value incentive, there is no real incentives to control costs. This approach, while it may be the most appropriate for a low volume rural facility, also fails to provide incentives for communities to engage in the move from volume to value.

5. **Grant + fee schedule** – This approach is suggested by MedPAC in their recent release of Improving Efficiency and Maintaining Access to Emergency Services in Rural Areas (June 2016). The report suggests a grant of $500,000 with services paid according to the PPS fee schedule. Local support is also suggested.

**Discussion of benefits and challenges:** This is a simple approach that ties payment to a fee schedule already in existence with a minimal grant to support access to emergency care. The TAG is concerned that the PPS fee schedule proposed is based on economies of scale that will not exist in the low volume rural communities and the grant proposed is less than that provided to FQHCs which are not required to accept all patients and do not have the emergency services that are so costly to staff and support. While it is similar to the FQHC like proposal proposed above, it fails to recognize a budget based approach. It also is limited in its services, especially those so necessary in rural communities such as observation and “transitional care” as proposed in the Primary Health Center model. Payments are entirely tied to volume and impact the co-pay amounts currently allowed in CAHs which will greatly impact cash flow and the ability to cover fixed costs in times of low volume.
Regardless of the payment method used, the TAG developed a number of conclusions. First, any effort to preserve access and improve health through low volume facilities like the PHC model must be supported with additional financial resources in the form of federal grants and local tax or other support. Volumes are simply not sufficient to sustain an emergency infrastructure in these instances. Classic fee based reimbursement will not be sufficient to cover expenses in low volume facilities.

Second, reporting requirements as stated earlier, especially quality measures should be consistent with the scope of services and operations. Recognition that these facilities will be limited in their staffing and services, reporting requirements should be identified that truly show the value of the services and operations, but should not be burdensome.

Third, payment models should incentivize integration of all essential services and the flexibility needed to apply staff and financial resources flexibly as service volumes fluctuate. Efforts are underway in Kansas and other parts of the country to integrate public health and behavioral health with primary care as examples. Integration of EMS is also critically important. Methods that carve out services or allocate space and staff will limit the effectiveness of these facilities.

Finally, while Medicare is the predominant payer for Kansas facilities, success will depend on the participation of Medicaid and private payers. A common payment model from key payers would maximize the success of the model and simplify new processes. It will be important for a new payment method to cover necessary costs, provide stability and at the same time provide incentives for collaboration, efficiency, clinical alignment and accountability.