

Alaska Health Care Commission

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“To provide the highest quality care with compassionate and accessible service for all”

Agenda

What is a community health center?

Defining the scope of the problem

FQHC vs. Fee for Service Comparison

Solutions/Ideas

What is a Community Health Center?

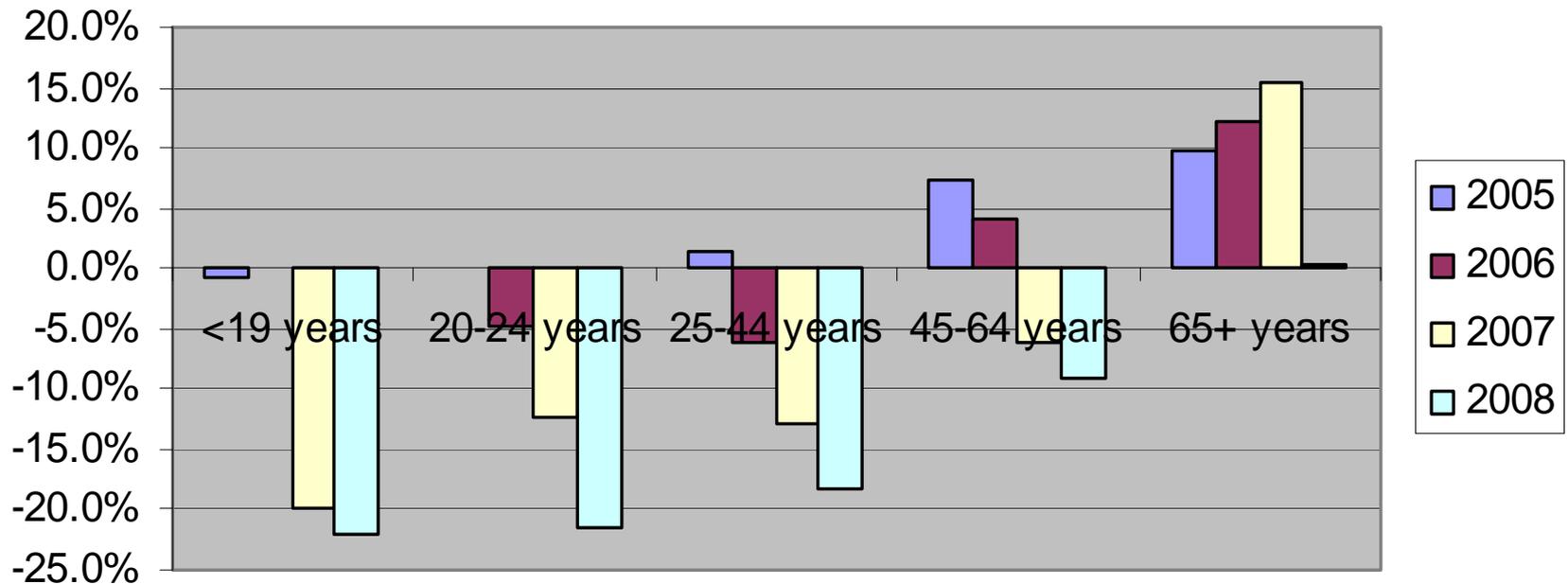
- President Johnson's War on Poverty Initiative
- Federal grant program funded under Section 330 of the Public Health Service Act
- Must provide primary and preventive health care services in medically-underserved areas or to medically underserved populations (MUA/MUP)
- Governance requirement – 51% consumers
- Stand alone Not for profit

Overview of ANHC

- 10,500 patients (2008)
- 36,000 Medical, Dental, Mental Health Visits
- Medicare patients were 16% of total
- Medicare visits were 27% of total
- 37% of ANHC patients are < 65 y/o
 - Disabled/SMI

Patient Population by Age (4 yr trend)

of Patients by Age



The problem: Simple Economics

- Increased demand for Primary Care at all ages
- + Decreased supply of Primary Care providers
- + Increasingly complex care
- + Low reimbursement rates
- + Bureaucratic oversight
- = Current situation

With or without the reimbursement factor, there will be an access issue for all patients seeking primary care

The “problem:” Scope of care is “comprehensive”

I received a note from Providence Horizon House Psych NP making rounds there. She was concerned that Ms. [redacted] was more depressed with increasing social isolation and tendency to stay in bed. Staff also concerned that she is not eating as much as usual. Her Paxil dose was increased from 20mg QD to 30mg QD - unclear if this is making any difference yet.

I received a note from Horizon House that they could not check patient's weight on a daily basis to adjust lasix dose - this would require "skilled" level of care. After review of her weight log and her prn use of lasix, it appeared that she would receive on 1 to 2 doses of prn lasix during the course of a month. It was decided to check her weight 2 x weekly and give Lasix if weight went over 140# only. This appears to be working well. She has no pain complaints to day.

Labs were done at Providence 3/3 and today in evaluation of potential change in MS and FTT - see below.

Ms. [redacted] herself is not aware of any change in her mood or sleep and denies feeling hopeless or depressed.

She denies any increase trouble swallowing.

She does not have much of an appetite.

Staff report that she is up every day.

Unclear if she is not sleeping well at night.

She sometimes feels "heaviness" in her chest with shortness of breath when supine.

The “problem:” Scope of care is “collaborative”

- Beneficiaries typically see 7 physicians/year from 4 different practices
- For every 100 Medicare patients a primary care physician treats, the physician potentially must interact with 99 other physicians in 53 different practices.

Annals of Internal Medicine, 17 Feb 2009

Source: National Medicare billing data

The “problem:” Bureaucratic oversight

- Paperwork for equipment and services
- Fear of audit

The “problem:”

Chronic care, done right, takes time

Summary of Primary Care Time Requirements for 10 Chronic Diseases, Assuming the Disease is Stable and in Good Control

Chronic care 6.7 hours *Annals of Fam Med, 2005*

Preventive care 7.4 hours *Am J Public Health. 2003*

Acute care 4.6 hours *J Fam Pract. 1998*

> 18 hours/day

CAD	120	1	10	10	20
Total hours per year					828
Total hours per work day					3.5

Annals of Family Medicine 3:209, 2005

The “problem:”

Economics

FQHC Reimbursement

Federally Qualified Health Centers get paid one rate for a **face to face encounter** with a physician or mid-level (but there’s more...)

Medicare Urban Encounter rate is: \$119.29

Medicare Rural Encounter rate is: \$102.58

Fee for Service* Reimbursement

***Maximum Allowable by Medicare**

Visit level	2008 rates	2009 w 35% incr.	FQHC rate
99212	\$ 39.44	\$ 53.24	\$ 95.43
99213	\$ 62.85	\$ 84.85	\$ 95.43
99214	\$ 94.32	\$ 127.33	\$ 95.43
99215	\$ 127.05	\$ 171.52	\$ 95.43

Fee for Service Comparison 99213

Charge	= \$152.00
Maximum allowable	= \$ 84.85
80% of \$84.85	= \$ 67.88
20% of \$84.85	= \$ 16.97 (co-pay)
Total to Doctor	= \$ 84.85
Loss to Doctor	= (67.15)

FQHC Reimbursement Example: 99213*

Charge \$152.00

80% of 119.29 = \$ 95.43

20% of 152.00 = \$ 30.40 (different co-pay)

Total to ANHC = \$125.83

Loss to ANHC = \$ (26.17)

* FQHC Pays per encounter: pay is same regardless of visit level

The “problem:” Reimbursement comparisons

Visit	Charge	Fee-for-service Max allowable charge	Delta	FQHC rate	Delta
99212	119	\$53.24	(\$65.76)	\$95.43	\$0.23
99213	152	\$84.85	(\$67.15)	\$95.43	(\$26.17)
99214	221	\$127.33	(\$93.67)	\$95.43	(\$81.37)
99215	353	\$171.52	(\$181.48)	\$95.43	(\$186.97)

It's about the money, honey!

The “problem:” Summary

- Shortage of primary care providers
- Complex Care
- Requires coordination between visits
- Doesn't pay well enough

Ideas/Solutions

- Lobby Medicare to increase reimbursement for primary care services (cut pie differently)
- Lobby Medicare to allow secondary insurances to pay for the full amount of the visit (“balanced billing”)
- Offer loan forgiveness/incentives on a State level to Geriatricians/Internal Medicine physicians
- Fund Family Medicine medical tuition in exchange for service to underserved communities
- Subsidize a Medicare clinic (underwrite operations)
- Fund care coordination throughout care
- Compensate for “medical home” services