CICP Clinics Executive Forum

Transforming CICP and Clinic Funding

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Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Transformation Objectives

Objectives of Transformed CICP for Clinics

- Relevant in the post-ACA environment
- Administratively efficient
- Funding rewards measurable quality care
- Enhanced stakeholder engagement
- Acknowledges “legacy” CICP providers
- Institutes meaningful audits

Key Elements of Legislative Proposal for Clinics

Clinics will be the qualifying entity, not the patient

- The State will not be involved in eligibility of individuals and individual circumstances– this is more administratively efficient
- Qualifying clinics must be either
  - Free-standing FQHC or FQHC look-alike, or
  - Rural health clinic, or
  - Licensed by DPHE as a community health clinic and serve a federally-designated medically underserved area or population, or demonstrate to the Department that it serves a population or area that lacks adequate health care services for low-income, uninsured persons

Key Elements of Legislative Proposal for Clinics (cont.)

- Qualifying clinics must
  - ✓ Serve primarily low-income populations (under 200% of the FPL)
  - ✓ Report to the Department how they determine income
  - ✓ Screen for and refer patients to Medicaid and CHP+
  - ✓ Establish and implement a multi-tiered sliding fee scale
  - ✓ Report costs and utilization data to the Department
  - ✓ Report quality metrics to the Department in accordance with the HRSA UDS standards

Key Elements of Legislative Proposal for Clinics (cont.)

Language will be broad to allow for future modifications to:

- Types of services covered under the grant (medical, dental, etc.)
- Quality metrics used to determine the quality grant portion of payment
- Funding formula

Stakeholder advisory council will be statutorily required

- Council will be appointed by the Department's Executive Director
- Council will make policy recommendations

State will conduct annual audit of participating clinics

- Similar to current Primary Care Fund data validation process
- Proposed $50,000 taken from the clinics' appropriation for this purpose

Timeline for Implementation July 1, 2017

DATE	TASK
April 2016	Submit proposal to Department's Executive Leaders
Summer 2016	Refine legislative proposal
September 2016	Draft legislation
January 2017	Introduce legislation
February 2017	Initiate MSB rule process
March 2017	Appoint Stakeholder Advisory Council
April 2017	Clinics submit applications
May 2017	Final approval of rule to be effective July 1, 2017

Questions?

New Funding Proposal

Funding will have two components:

- **Base Grant**
  - Calculated using write-off costs
- **Quality Grant**
  - Calculated using quality metrics and visits

The $6 million appropriation for the clinics will be apportioned into a “bucket” for the Base Grant and another for the Quality Grant.

25% will be bucketed for the Quality Grant

New Funding Proposal (cont.)

Quality Grant will be "points-based"

- ✓ Points will be awarded to meet goals
- ✓ Points will be awarded to reward improvement
- ✓ Quality Grant calculation will factor in the volume of clinic visits so that small clinics with high quality points will not be awarded a larger Quality Grant than large-volume clinics.
- ✓ Quality Grant calculation will be tiered such that the Payment Rate/Quality Point awarded will be graduated (For example, clinics that fall in the top tier for quality performance will be awarded a higher Payment Rate/Quality Point.)

Proposed Quality Metrics

- Metrics reported annually by FQHCs to HRSA through the Uniform Data System (UDS)
  - Metrics are validated by HRSA and are consistent year to year.
  - Metrics align with the Heathy People 2020 Goals
  - Metrics pertain to all patients treated at clinics (not just Medicaid, for example)
  - UDS metrics are numerous and provide state and national comparisons, allowing the Program flexibility over time in revising selected metrics to calculate the Grant Payment

Specific Quality Measures

- Adult Weight Screening and Follow-Up
  - ✓ Healthy People 2020 Goal– 42.7% screened and follow-up
- Hypertension
  - ✓ Healthy People 2020 Goal- 58.5% with hypertension controlled
- Diabetes
  - ✓ Healthy People 2020 Goal- 83.9% achieve HbA1c $\leq$ 9.0%
- Depression Screening
  - ✓ Healthy People 2020 Goal has not been set yet, so the average of the clinics was used- 19.0% screened

Questions on Quality Measures?

Determining Quality Score

Quality Score = Goal Points + Screening Points

(Maximum Quality Score is 28)

- **Goal Points**
  - Providers are awarded Goal Points for meeting or exceeding the Healthy People 2020 goal for each metric, and also for maintaining or improving their score from the year before.
    - **2 points** if clinics meet/exceed the HP 2020 goal AND maintain/improve their score from the previous year
    - **1 point** if clinics meet/exceed the HP 2020 goal AND do <u>not</u> maintain/improve upon their score from previous year.
    - Maximum Goal Points possible is 8. (2 points per goal x 4 goals)

Determining Quality Score (cont.)

- UDS reports percentage of patients screened for each Quality Measure
- **Screening Points** are assigned for each Quality Measure

Screening Points	Percentage of Patients Screened
1	0 % to 20%
2	20.1% to 40%
2	40.1% to 60%
4	60.1% to 80%
5	80.1% to 100%

- ✓ **Example:** 25% of patients screened for depression awards a clinic 2 points for its Depression Screening Score.
- ✓ Maximum Screening Points possible is 20. (5 points x 4 quality measures)

Quality Score Payment Tier

- Quality Scores are distributed into five tiers
- Each tier is assigned a Payment Rate
- Higher tiers earn higher Payment Rates

TIER	Quality Score Points	Payment Rate
1	4 to 8	$0.38
2	9 to 12	$0.76
3	13 to 16	$1.13
4	17 to 20	$1.51
5	21 to 28	$1.89

Quality Grant Calculation

- Quality Score x Total Visits = Quality Points
- Quality Points x Tier Payment Rate = Quality Grant

Hypothetical Example of Quality Grant Calculation

ROW	Description	Statistic	Calculation
1	Clinic Quality Score	17	
2	Clinic Visits	2,500	
3	Clinic Quality Score Tier #	4	See Quality Score Payment Tier Slide #16
4	Tier 4 Payment Rate	$1.51	See Quality Score Payment Tier Slide #16
5	Clinic Quality Points	42,500	Row 1 x Row 2
6	**Clinic Quality Grant**	**$64,175**	Row 5 x Row 6

Questions?

Base Grant Calculation

- Base Grant = Clinic's share of total program Write-Off Costs multiplied by Total Base Grants Funding
- **Hypothetical Example:**
- Assume 75% of appropriation is bucketed for Base Grants
  - Total Base Grants Bucket= $6 million x 75% = $4.5 million
- Assume Total Clinic Program Write-Off Costs = $9 million
- Assume Individual Clinic Write-Off Costs = $450,000
- **Calculations:**
  - Clinic Base Grant = ($450,000/$9 million) x $4.5 million
  - Clinic Base Grant = 5% of $4.5 million
  - **Clinic Base Grant = $225,000**

Demonstration

- Taryn will lead us through the spreadsheets
- Assumptions for Today's Demonstration
  - 25% of appropriation bucketed to the Quality Grant
  - UDS data reported for calendar year 2014
  - CICP write-off costs from FY 2014-15
  - CICP visits from FY 2014-15
- Assumptions for FY 2017-18 Payments
  - 25% of appropriation bucketed to the Quality Grant
  - UDS data reported for calendar year 2016
  - Uninsured (up to 200% FPL) write-off costs from FY 2015-16
  - Uninsured (up to 200% FPL) visits from FY 2015-16

Next Steps

- ✓ Today's proposal will be presented to the Department's executive leaders
- ✓ Legislation drafted this summer
- ✓ Department will rename the CICP this summer to reflect this new approach
- ✓ Draft legislation discussed at September 2016 Executive Forum
- ✓ Department will initiate the rules process to ensure rules will be in effect by July 1, 2017
- ✓ Advisory Council will be appointed in March of 2017
- ✓ Clinics will submit UDS and utilization data in April 2017

Final Comments?

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Thank You!