No safe harbor: Why the dynamic healthcare market threatens to leave some FQHCs lost at sea

by Christopher DeMarco, PhD, MBA; Daniel D’Orazio, MBA

FQHCs are operating in a new landscape. As the historic protection they’ve received from HRSA and other groups erodes, private organizations are doing all they can to attract new patients away from FQHCs. This white paper examines this market shift, and provides insight on how FQHCs must evolve to continue their critical missions.
As the Federally Qualified Healthcare Center (FQHC) movement celebrates 50 years of delivering quality care to underserved populations, it’s time to face a stark truth: the achievements of the past 50 years are not necessarily indicators of future success.

Why? A new competitive landscape. In many ways, FQHCs have historically operated in a competitive bubble. Recognizing the value of FQHCs and their critical role in the healthcare delivery system, the federal government—with support from both sides of the aisle—made investments in FQHC growth and efficacy. Those benefits, including HRSA-defined FQHC geographic operating areas, enhanced revenue per visit, and early investment in new technologies (such as EHR), kept FQHCs operating in protected harbors. In addition, past market conditions made it easy for hospitals and private practices to allow FQHCs to care for underinsured and uninsured patients.

The U.S. government, through Medicaid, Medicare, Tricare, and other public funding, is far and away the single largest payer in the country, accounting for nearly 60 percent of all reimbursement. As the number of commercially insured Americans drops, mainstream systems are simply following the money.

To put it more bluntly, mainstream providers simply have not been interested in FQHC populations. They ignored the complexities presented by the social determinants of health, as there was little financial incentive to address them. The FQHC population was viewed as marginal—too difficult to serve and too small to drive profit.

That landscape has changed; the new economics of healthcare are challenging legacy FQHC markets. The expansion of Medicaid with health reform has created a market that is too large for FQHC competitors to ignore. States such as Kentucky, Oregon, and Colorado have grown their Medicaid populations by 40 percent. Other states, including Arizona and New Jersey, that decried Medicaid expansion on political grounds have now caved and expanded the program.¹

Chase Brexton Health Care, an FQHC in Baltimore, Maryland, maintains its HIV/AIDS legacy while embracing changes to prepare for the future.
While HRSA will continue to protect FQHCs to the best of its ability, regulatory changes have created market forces and payment reform that connect FQHCs directly to the broader healthcare market. FQHCs—whether intending to or not—are now part of this new economic landscape. How FQHCs respond to the new market today will greatly determine their sustainability in the next three to five years.

Meet the Challenge Head On
As large provider groups and health systems engage the new market, they bring their deep pockets, vast marketing engines, large provider networks, and sophistication in payer negotiations to capture market share. While FQHCs may not have the same complement of assets, they do have the knowledge, experience, skill, and proven track record of success in providing holistic, comprehensive, and outcomes-driven care.

“The role of FQHCs is second to none. We are actively taking steps to grow our patient population and expand our services to a broad patient population. I believe FQHCs have a unique opportunity to lead a much needed change in the U.S. delivery model.”

–RICHARD LARISON,
CEO of Chase Brexton Health Care

FQHCs have long been leaders in care coordination, population health management (the new term for what FQHCs have been doing for decades), and risk stratification (i.e., disease collaborative). Accounting for these facts, a key truth becomes clear: FQHCs are powerfully positioned to deliver the type of care that is now called “population health.” A care delivery model, however, is not the same thing as a sustainable business model.

FQHC sustainability requires assessing expanded rosters of competitors, evaluating how to measure success and outcomes, advancing patient engagement strategies, expanding patient bases beyond traditional markets and populations, and realigning staff mindset. It’s a lot to address, but all of these factors are critical to protecting the FQHC mission—and margin.

Private healthcare organizations are realizing that the FQHC care and delivery model works—and there’s money to be made. Medicare is now funding providers to manage patients with two or more chronic conditions—and commercial insurers are following suit. So ask yourself: Who is better positioned than FQHCs to capitalize on this shifting landscape?
Understand the Competitive Threat

Mainstream providers are taking aggressive tactics to bolster their ambulatory and primary care strategies. By setting up or buying ambulatory care centers staffed by primary care physicians—often right around the corner from established FQHCs—they’re hoping to more effectively manage the total care of their patients.

Consider the example from Washington, DC, below—patients in a half square mile area have four facilities competing for their attention. One of these, MedStar Health, is a traditional mainstream provider who is now staking a claim in a historic FQHC operating area. According to their 2014 Annual Report, MedStar reported $4.62 billion in net operating revenue in 2014.

Reassess for Sustainability

The competitive threat demands attention—and a strong, strategic focus on where individual FQHCs fit in this landscape. Successful FQHC leaders evaluate and view their centers as business entities that must make a profit to fuel their missions. Investing in that change—even from an analysis standpoint—can seem far riskier than any potential benefit. The risks FQHCs run by not innovating, evolving, and growing, however, are significantly higher than the risks associated with hesitation or inaction.

Achieving a successful implementation is often easier said than done—especially when individual FQHCs are at different stages of readiness for this shift. Based on our research and experience working with stakeholders across the FQHC spectrum, we have identified three major categories of FQHC practice models: traditional, transitional, and optimized.
The chart below breaks down the major characteristics of those models. We encourage FQHC stakeholders to assess themselves in these terms, and consider what steps they can take to help their organizations evolve.

<table>
<thead>
<tr>
<th>Traditional FQHCs</th>
<th>Transitional FQHCs</th>
<th>Optimized FQHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Little or no PCMH infrastructure</td>
<td>• Fear of “treading water”</td>
<td>• Actively transitioning to an enhanced and competitive business and clinical model</td>
</tr>
<tr>
<td>• Traditional FQHC business model—not exploring new value-based models</td>
<td>• Engaged with some PCMH</td>
<td>• Joining ACOs and similar groups</td>
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<tr>
<td>• “Check the box” planning and research efforts—focused primarily on FQHC grants and service areas</td>
<td>• Engaged in research and policy shifts for VBC, but reluctant or unsure how to make full shift</td>
<td>• Increased patient engagement</td>
</tr>
<tr>
<td>• Business model complacency—admin workflows, revenue cycle process, and clinical practice are all relatively stale</td>
<td>• Attempting to drive revenue through larger populations and margin through population health and network management</td>
<td></td>
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Measure Effectively

More than ever before, capturing information to measure performance and outcomes is critical to continued sustainability. These metrics are now directly tied to payments and penalties. Effectively tracking performance and delivery data achieves several goals FQHCs should be concerned about: improving the quality of patient care; enhancing population health management, care coordination, and care delivery; and protecting continued margin growth.

There are four key questions FQHCs need to ask themselves when it comes to the initial reassessment:

1. Does your organization measure the outcomes needed in the new value-based environment?
2. How do you compare to other FQHCs?
3. How do you compare to commercial providers delivering similar services?
4. Do you have a complete understanding of all the new healthcare measurements brought on through healthcare reform?

“Avoiding the legacy trap is important to our organizations’ continued viability. Instead, leveraging our legacy to propel our work forward is our focus.”
– Jenny Englerth, CEO of Family First Health
Recalibrate the Measurements

FQHCs are familiar with HRSA-defined reporting metrics, especially on the financial side of the ledger. Yet, driving future success requires analyzing additional measurements. The table below features typical, frequently used measures in blue, and examples of new metrics in light blue. These new metrics are critical; they will help to define value-based performance in the eyes of HRSA, the patient, and the market.

### Traditional and Value-based Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Metric</th>
<th>CHC National Median</th>
<th>Do you track?</th>
<th>Do your competitors track?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Benchmarks</td>
<td>Operating margin¹</td>
<td>2.1%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Days cash on hand¹</td>
<td>44</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Current ratio¹</td>
<td>2.4</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Cost per patient²</td>
<td>$673</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Revenue per patient²</td>
<td>$678</td>
<td>?</td>
<td>Yes</td>
</tr>
<tr>
<td>Emerging alternative payment models</td>
<td>Expense per patient/ by team</td>
<td>?</td>
<td>?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction by team/department</td>
<td>?</td>
<td>?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Expense per patient by chronic condition</td>
<td>?</td>
<td>?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Expense per patient (high utilizers)</td>
<td>?</td>
<td>?</td>
<td>Yes</td>
</tr>
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</table>


### Plan Short-and Long-Term Actions to Change

Dealing with this market change requires a strategic shift in business practices and new benchmarks to measure success. After FQHCs reassess their place in the market and define those metrics, taking the time to perform a strategic analysis will pay off dividends for the implementation of short- and long-term changes.

Implementing these changes effectively requires input from the top down (leadership initiating new trainings, processes, and practices), and from the bottom up (more effective patient and community engagement). Getting effective buy-in from stakeholders demands a demonstration of how important this shift is. Engage the board of directors, community stakeholders, the network of physicians and care delivery associates, industry analysts, and, if possible, the local state’s Primary Care Association in a strategic assessment and planning process.
In a highly functioning FQHC practice, outcomes are the barometer of success, not just patient volumes. Maintaining a holistic, comprehensive view of patient health—at the individual and population level—helps to achieve the triple aim of reducing costs, improving quality, and increasing patient satisfaction. Below, we have outlined a few strategies to drive practice and business model transformation.

Manage whole populations

- Optimize data gathering methods; effective analysis and use of data is critical to attract, assess, and retain patient panels
- Use analytics to prioritize the populations requiring the most care management—more than EHRs, more than registries
- Enhance existing enabling services and care coordination to provide care beyond the confines of the clinical walls.
- Grow advisory and subject matter expertise
- Focus on efficiency in all processes and workflows

Choose your partner before they choose you

- Strengthen your ability to partner by convening and learning more about state accountable care and shared savings programs to reduce costs and enhance your financial viability
- Identify FQHC and non-FQHC delivery partners in the market as either potential partners, threats, or neutral actors; create active strategies for the top partners and top threats
- Frame a payer strategy: The expansion of Medicaid, growth of Medicare Advantage, and enrollment in newly insured Health Exchanges makes FQHCs powerful allies to payers—approach payers about how you can support their members as part of the payer network
- Consider partnerships with complementary health systems—this can help you better serve the needs of your patients
- Understand as fully as possible your goals—as well as the goals of potential partners—as early as you can

Enhance your patient engagement strategy

- View your patient holistically—as patients, they receive care from the clinic; as consumers, they have a growing list of care options and choice; as “payers,” patients are increasingly funding first dollar care with rising deductibles, copays, and soaring out of pocket expenses.
- Ramp up investments in care outside the clinic, by re-examining how to overcome barriers presented by social determinants of health
- Invest in advanced software solutions that enable mobile outreach, patient centered workflows, and consumer-oriented processes such as automated scheduling, waitless waiting rooms, and mobile payments

Key Steps to Success

Empower the staff

To protect your margin and continue your mission, focus on these factors during business transformation

Deliver new education and training opportunities to highlight value over volume

Embrace your partners

Reach out to competitors to make them cooperative collaborators

Enlighten the board

Educate on new opportunities and enhance the competitive mindset

Engage the C-Suite

Assess your operations, finances, and talent to optimize your technology
“What I think changed… [was recognizing] that we were a business and that where we were going, if we were going to continue to do that soft side and those services, we needed to have a businesslike approach. And I think it changed a lot of minds, or at least opened people’s perspective.”

– Ellie Tinto-Poitier, Compliance and Risk Specialist, CrescentCare Health

Savvy FQHC leaders see their roles as part of the greater healthcare market. The stigma of being a clinic for the poor is being replaced with a concerted effort to grow and make both the uninsured and recently insured aware of the quality of services and providers that exist in FQHCs.

Case Study: Go Big or Go Home

New Orleans FQHC Embraces Change

Understanding the marketplace and being willing to change are critical—for example, consider what the New Orleans AIDS task force, known locally as NO/AIDS, did to ensure they’re able to serve their community today and in the future. In a city with a critical need for its services, NO/AIDS had expanded its roster of care, counseling and outreach programs over the years. But the AIDS epidemic started to ebb in the 1990s—just as community health centers were becoming more popular—doubts were raised about the viability of a single-issue organization.

Even though there were fewer new cases of AIDS, the number of survivors was increasing. Thousands of people depended on care that only NO/AIDS offered; that care was in jeopardy. The board struggled with the issue for a number of years. Then, Hurricane Katrina happened. NO/AIDS depended on government grants. That aid had been reliable in the past, but now there was a greater need and increased demand. They had to consider what options they had if their Ryan White funding were to decrease.

The Board wanted to honor their AIDS Service Organization patients and roots while building a bridge to a new primary care focus. They were willing to reassess their abilities, and critically examine what they had to do to stay afloat. Through a series of educational and strategic assessments, the board saw that while many of their practices were effective, and their infrastructure was sound, they needed to go big or go home.
Summary

The long and short of the new healthcare landscape is this: If FQHCs are not worried about market competition, they should be—otherwise competitors will aggressively challenge their business sustainability. Hospitals, provider groups, and others are targeting FQHC patient populations to benefit from their revenue. To continue to enhance the lives of patients, FQHCs must explore partnership opportunities while enhancing patient communication and engagement strategies.

The good news is that no one should be better positioned to do this than an FQHC. The strong community partnerships and effective relationships with patient populations mean they already know their markets well. FQHCs must take transformative steps to stay competitive, protect their missions and margins, and be prepared for changes to how payments are handled.

As FQHCs face one of the most fundamental shifts in the healthcare landscape in the past decade, effective partnerships and short- and long-term strategies are critical to stay afloat.

“Every FQHC should find a way to have one full time staff member dedicated solely to exploring and establishing...collaborative efforts...to affect the health of our patients and populations. That’s in everybody’s interest.”

– Dr. Jack Geiger, Founder and Director of the nation’s inaugural community health centers

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