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The Value of Federally Qualified Health Centers and Community-based Organizations to IPA Networks – Options and Keys to Success

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OVERVIEW

Independent Physician/Provider Associations (IPAs) are key mechanisms for physicians, health systems and federally qualified health centers (FQHCs) to align and engage in value-based payment arrangements that add value to payors and attributed members. This paper provides insights into the benefits to IPAs for engaging FQHCs and community-based organizations (CBOs) into their network, care model and funds flow methodology, particularly for challenging populations such as Medicaid, dual eligible and high-risk Medicare members.

In most parts of the country, an IPA is an entity owned and organized by one or more physicians, medical groups or FQHCs and in some cases, health systems. The IPA holds "upstream" contracts with managed care organizations (MCOs) and "downstream" contracts with independent physicians and other community providers. While most IPAs are for-profit, non-profit IPAs exist particularly in cases when they are created primarily by FQHCs, or in support of a non-profit health system. The three most common types of IPA models are (1) independent and community physician owned and driven, (2) health system aligned and driven and (3) FQHC-centric.

Common IPA Models

The three most common IPA models are:

1. **Independent and community physician owned and driven**
2. **Health system aligned and driven**
3. **FQHC-centric**

Although each of these models can include the other respective provider types in their network, they vary in relation to primary lines of business served (Medicaid, Medicare, commercial), overall business goals and operating challenges.

A health system IPA model enables a system under traditional fee-for-service arrangements to expand its geographic footprint and catchment area in order to increase admissions and volume of services provided.

Physician IPAs under value-based payment (VBP) arrangements tend to focus more on reducing total cost of care and avoiding unnecessary hospitalizations, a goal that likely runs counter to traditional hospital operations in their community.

IPAs made up of FQHCs focus mainly on providing access to care for vulnerable, primarily Medicaid and dual eligible populations that other systems may not emphasize. Although less common than health IPAs provide their contracted providers not only with improved bargaining power to negotiate contracts with MCOs, but also access to value-based payment arrangements that allow the IPA and its contracted providers to benefit from a reduction in the total cost of care for an attributed population. IPAs can also negotiate with MCOs for the delegation of administrative services such as care management, utilization review, utilization management, network development and others. This can provide an important source of financial sustainability for an IPA to build out population health management infrastructure and add value to various types of physicians and other providers, including FQHCs and CBOs.

IPAS AND THE ENGAGEMENT OF FQHCS, BEHAVIORAL HEALTH PROVIDERS AND COMMUNITY-BASED ORGANIZATIONS

A variety of factors influence the choice of an optimal IPA model, including geographic region, competitive landscape and populations served. Irrespective of the type of IPA, there is a missed opportunity in IPAs nationally to include FQHCs as key contracted providers. FQHCs, along with behavioral health (BH) providers and CBOs can play a critical role in any successful population health management strategy by addressing the enormous impact of social determinants of health on the ability to manage the health of a population. This challenge is undeniable and largely remains unaddressed in the health care community. This along with the impact of Medicaid expansion and the aging Medicare population on the total cost of care requires a new type of network to surround primary care providers, specialists, hospitals, ancillary, post-acute, durable medical equipment and other traditional providers of today.

FQHCs can address this missing link within an IPA population health strategy by integrating BH providers and CBOs into traditional physician or health system aligned IPAs, creating a care model that addresses both the medical and social determinants of health. Due to the nature of the largely Medicaid population they serve, FQHCs, BH providers and CBOs often have pre-existing care coordination relationships and have developed core competencies around managing complex Medicaid and dual eligible populations.

system and physician driven IPA models, FQHC IPAs are beginning to gain prominence as system strategy shifts away from traditional operations to community-based care models.

Furthermore, CBOs provide services that are necessary and complementary to any tertiary or quaternary-focused hospital system. These systems generally do not have the capacity or the specialization to provide the high-touch services (often non-reimbursable services) offered by CBOs, such as housing or transportation support. Similarly, hospitals often do not have the resources to provide comprehensive primary care services to the communities they serve. FQHCs fill this gap by providing high quality, integrated primary care and BH services targeted for all populations, particularly for those with complex disease states. This symbiotic relationship alleviates the challenge many FQHC IPAs experience with adequate specialty coverage by broadening their network to include hospitals.

If integration into existing IPAs is not an option, it may be beneficial for FQHCs to create their own IPA; thus enters the value proposition of the third IPA option – a network centered on providers closest to these fragile populations. An FQHC driven IPA that includes BH providers and CBOs can offer non-traditional services and decades of cultivated relationships that are far beyond current population health discussions at large health systems. FQHC-centric IPA models can ensure delivery of the right care, in the right place, at the right time, particularly for complex populations struggling with the challenges of behavioral health, substance abuse and social determinants of health.

FQHCs are in many ways well prepared for success in an IPA because their business model is already aligned with the focus on primary and preventive care. They are also able to adapt and thrive in new performance-based payment models due to their integrated service offerings and expanded ambulatory services for patients. Among other financial benefits, an IPA arrangement would allow FQHCs to receive a wraparound payment for care coordination and receive malpractice coverage for physicians.

However, despite their vast experience dealing with high risk populations, many FQHCs do not have a track record for operating in a VBP environment because behavioral health services have historically been carved out of managed care VBP arrangements. Today, these services are largely included in VBP arrangements. This paradigm shift in the approach to care delivery is due to recent recognition that social determinants of health drive total cost of care.

Since many health plan contracts neither previously included a VBP component nor an appropriately incentivized engaging in this structure, robust contract negotiation along with well-defined roles and metrics (service level, quality and total cost of care) for each provider type is key to ensuring FQHCs can be financially successful in this endeavor.

Key Factors for Success in integrating FQHCs, BH providers and CBOs into an IPA model:

1. A comprehensive network of services that ensures adequate access to care and a collaborative environment among the network to ensure that organizations are not working in silos
2. Clearly identified roles and consistent services with defined metrics for FQHCs, BH providers and contracted CBOs, along with a clearly defined financial value proposition for each role
3. Alignment of incentives across all provider types (FQHCs, BH providers, CBOs, other PCPs, specialists, hospitals and post-acute providers)
4. Commitment to and process for transparency of data and funds flow
5. MSO supportive services, care management model and centralized budget that enable the IPA to leverage payment for services from non-Medicaid-billing CBOs
6. Engagement of FQHCs and other critical BH or CBO partners in IPA governance

Independent FQHC-led IPAs can be highly successful vehicles of population health management alongside traditional health systems. Likewise, integrating FQHCs into existing health system and physician-led IPAs allows these entities to address the challenges associated with social determinants of health more effectively as FQHCs are uniquely positioned to work as the intermediary among BH providers, CBOs and hospitals to provide high-quality preventive care to the community. Provider organizations can leverage government programs and other market opportunities such as Medicare ACOs and Medicaid waivers to stand up and test FQHC IPAs and FQHC integration in their community.

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FQHC IPA SUCCESS: FINGER LAKES INDEPENDENT PROVIDER ASSOCIATION

The Finger Lakes Independent Provider Association (FLIPA) is a network of providers in upstate New York that has proven the value of a FQHC IPA model. The Finger Lakes region in upstate New York has a competitive health system model with two prominent health systems, Rochester Regional Health and University of Rochester Medical Center. FLIPA consists of five FQHCs (with 32 locations) and six behavioral health and social determinant of health providers that provide both Medicaid reimbursable and non-reimbursable services, and S2AY Rural Health Network (a partnership of eight local Public Health Departments). This inclusion of behavioral health and social determinant of health organizations in its IPA membership makes FLIPA the first of its kind in New York State and gives it an edge to integrating these services with primary care.

COPE Health Solutions supported the initial establishment of FLIPA in 2016 by organizing and working as part of the Finger Lakes Performing Provider System (FLPPS), the region's network implementing the New York State's Delivery System Reform Incentive Payment (DSRIP) program. The newly formed FLIPA continues to serve 70,000 managed Medicaid members in a 13-county region and has already negotiated VBP contracts effective January 1, 2019.

FLIPA has a strong focus on preventative care and primary care/behavioral health integration. Both are crucial to health care transformation and reducing health care costs. These efforts to ensure patients receive appropriate and timely services are driven

mainly by its FQHCs and have strong working relationships with CBOs. This approach to health care, which leverages the strength of independent community organizations, allowed FLIPA to be successful in their pilot VBP-like models under DSRIP, and set the stage for future VBP contracting success.

Carol Tegas, Executive Director of the Finger Lakes Performing Provider System, notes that "the FQHC IPA model allowed us to leverage the relationships we have developed under the Medicaid 1115 Waiver and bridge the gap between our health system and community partners to truly provide comprehensive care to our Medicaid population."

Mary Zelazny, CEO, Finger Lakes Community Health, shares that "what makes FLIPA different is that we intentionally brought in six behavioral health providers as full members because we understood that true integration would happen by working towards clinical integration together. I would argue that it has been very challenging work as we have to break down silos that were created years ago and learn each other's cultural norms and value proposition. This is important to us at FLIPA as we serve many of the same patients and our integration of primary care and behavioral health will provide better health outcomes, more access and reduced costs."

Bridgette Wiefling, MD, Senior Vice President, Chief Quality and Innovation Officer, Rochester Regional Health System, notes that "FLIPA has played an integral role in expanding access to primary care, behavioral health and social services for our most vulnerable patients through strengthened connections between our health system and high-quality community providers."