Orcas Island Health Care District

Board of Commissioners - SPECIAL Meeting Minutes
Orcas Island Fire & Rescue – Eastsound Firehall
Tuesday, December 10, 2019
9:00 am – 4:00 pm

Commissioners Present:
Art Lange
Diane Boteler
Patricia Miller
Pegi Groundwater
Richard Fralick

Commissioners Absent:
None

Staff:
Superintendent Anne Presson

Guest:
Katie Jo Raebel, Partner, WIPFLI
Steve Rousso, Partner, WIPFLI

I. Call to Order

President Fralick called the meeting to order at 9:12 am and noted that all Commissioners were present. He introduced the two guests from WIPFLI CPAs and Consultants, Katie Jo Raebel and Steve Rousso. Before turning the meeting over to the consultants, President Fralick reminded the Board how they got to this point. He reviewed the challenges faced by rural communities related to health care, and how the remote nature of Orcas and reliance on an unpredictable ferry system make the delivery of health care even more challenging.

President Fralick summarized the work of the Board over the past 18 months, which was largely focused around organizing and stabilizing health care on Orcas. The Board's efforts have also committed to establishing subsidies for the two island Clinics. As the Board looks to the future, their efforts are focused on trying to identify the best structure for a sustainable health care model over the long-term. President Fralick hoped this meeting will help map a path forward and identify key decision points along the way. He also hopes to gain an understanding of what additional homework the Board is going to need to do to be able to make an informed decision.

Other Commissioners shared their goals for the meeting and what they hoped to walk away with at the end of the day. Commissioner Miller would like to gain clarity around the economic model that was presented by Shar Shaefer, DZA Consultants. Commissioners Boteler recognized the importance of the financial model yet believes of equal importance is a focus on which model will deliver the best health care. She feels strongly that creating a system of health care on the island that works for all should be balanced against the financial considerations.

II. Review of Economic Model

The meeting was turned over to the consultants who led the Board through a review of the findings from the DZA economic model and went deeper into the pros/cons of each of the federal models under consideration. Steve Rousso asked the Board to think about what he sees as a critical question to answer. That being, does the Board sees itself as a Clinic operator or an entity that subsidizes someone else to serve as the Clinic operator. The two offer very different levels of control and risk.

Katie Jo provided a very high-level overview of the DZA economic model. She felt there was nothing inherently incorrect in the model; however, it was important for the Board to understand that everything is an estimate, and some numbers can swing dramatically based on whatever assumptions are used.

III. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs)

Steve review the options available under to the Board:

1. Partner with an existing FQHC – timeline is dramatically reduced (90 days) to open a new site, and it guarantees FQHC Look Alike status. Also, the FQHC can be based anywhere and doesn't have to be in WA.
2. FQHCs can be private or public, and the PHD could create a new FQHC Look Alike. This is a much longer process (12-18 months) and there is no guarantee that it will be approved. Since the OIHCD Board doesn't meet the requirement of an FQHC Board, a new non-profit Board would need to be created to run the day to day operations of the Clinic.
3. To maximize control, the District could take over and consolidate the two Clinics and make a single, stand-alone RHC. This would allow for a reset of the Medicaid cost-based rate, which is how reimbursement is determined. Medicare is subject to a cost-per-visit limit of $84.70 for 2019 and cost basis for Medicaid. OFHC's current Medicaid rate is $114.
4. The District could follow #3 and then partner with a Critical Access Hospital (CAH) or a small hospital (under 50 beds) to become Provider-Based. As a Provider-Based RHC, reimbursement is enhanced and there are some advantages for the under 50-bed hospital. Not the case with a CAH.
5. Continue the status quo and try to make changes that will enhance reimbursement and increase operational efficiencies.

A few key takeaways from FQHC discussion:

1. FQHCs provide enhanced Medicare/Medicaid reimbursement and were designed to support the low income, vulnerable populations. The reimbursement structure encourages providers to take these patients; however, the true value of an FQHC is associated with the possible grant funding. It's important to note when the government gives you something it comes with a lot of requirements.
2. FQHCs that receive grant funding are called 330s, and those without grant funding are called FQHC Look-Alikes. Look-Alikes operate like an FQHC and almost all FQHC Look-Alikes eventually become 330s.
3. FQHCs are paid at a prospective rate for Medicare and WA Medicaid is based on the cost/visit.
4. FQHC status isn't a given, even when operating as a Look-Alike. The District would need to prove the need and show its worthiness as an FQHC. This could include: (1) # of patients served from a Medically Underserved Area (MUA); (2) # of low-income people served; (3) and how many of the low-income people are being treated elsewhere. Based on all of this, there was concern as to whether Orcas would pass the first test. Discussion was held as to whether the District should complete an initial needs assessment to see if it's worth going further.
5. An FQHC must have a Board made up of 9-25 individuals, more than half of whom receive care from the FQHC, and who are representative of the patients served. The consultants didn't recommend having Hospital District Commissioners serve on the non-profit Board although there are several instances in the state where this occurs and appears to work.
6. Contracted providers (e.g. x-ray and lab) must accept the FQHC sliding scale which can be problematic.
7. HRSA performs an onsite audit every three years and any findings must be rectified within a certain period of time.
8. The additional administrative burden was estimated to be in the $150-$200,000 range, with additional Clinic positions needed to handle some of the service requirements (e.g. Case Management) unless those services were contracted out.
9. The co-applicant agreement in the FQHC Look-Alike model allows for the public entity (PHD) to retain some budgetary authority and say over HR procedures related to hiring/firing. The non-profit Board decides who to hire/fire and oversees all day to day operations.
10. There are no productivity requirements/minimums.

A few key takeaways from the Provider-Based RHC discussion:

1. The reimbursement of a free standing RHC is very different from a Provider-Based RHC. Free standing Medicare rate-per-encounter is capped at the rate in effect for that period (2020 rate is updated to $86.31, a 1.9% increase over the 2019 rate of $84.70). There is currently no upper payment limit for RHCs that are Provider-Based to a hospital with less than 50 beds (including CAH).
2. As a Provider-Based RHC to a hospital with less than 50 beds, the Medicare rate-per-encounter is paid at the full cost-per-visit, with no limit (unlike freestanding RHCs). Provider-based RHCs rates typically range from $120.00 - $300.00 (every PBRHC is different).
3. Both freestanding RHCs and Provider-Based RHCs are subject to productivity standards.
4. Medicare Productivity Standards apply: Physician 4,200 patient visits annually for 1.0 FTE; Midlevel 2,100 visits annually for 1.0 FTE. Important to only count time spent seeing patients. This is an area to revisit in the DZA model, as Katie Jo indicated that the productivity requirements should never be an issue.
5. Medicaid's cost basis is determined by taking the Clinic's total allowable RHC costs divided by total RHC visits to get an RHC cost/visit (rate). Currently, OFHC's Medicaid rate is $114, updated yearly by the Medicare Economic Index (the MEI for 2020 is 1.9%). Should the Clinics combine, a new rate could be calculated via a change in scope or a change in ownership.
6. As a new Provider-Based RHC, a new Medicaid RHC rate would be calculated after the first Medicare cost report is finalized. That rate is then updated yearly by the MEI, making it a prospective rate.
7. Low hanging fruit – change scope of OFHC RHC to increase reimbursement

IV. Next Steps

The afternoon discussion began with the question of where to start in pursuing one or more of these options. The consultants recommended the Board's first step be to reach out to several likely partners and assess interest. The consultants felt it would be prudent to start with either an FQHC affiliation or Provider-Based RHC model.

Next steps include:

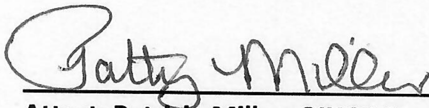
1. Identifying all possible affiliations (Provider-Based and FQHC Affiliations)
2. Add a section into the District Prospectus which speaks to how the PHD will be able to execute a consolidation or move to another structure since the District doesn't currently own either practice.
3. WIPFLI to help identify the contacts at identified organizations. This should include the Board Chair, CEO and CFO of each entity.
4. Board Members were assigned to Work Groups to tackle the work:
    a. Prospectus (Superintendent Presson)
    b. Business Case for FQHC and PBRHC (Art/Pegi)
    c. Further review of FQHC legal requirements and services; costs associated with combining clinics into a new entity (Pegi/Steve)
    d. List of FQHCs and Hospitals for affiliations with noted contacts (Diane/Richard)
    e. Interface with current Clinics (UW - Richard/Patty); (OFHC – Art/Patty)
    f. Legal requirements associated with ownership of a new practice; work with legal counsel (Patty/Pegi).
    g. If no interest from any of the identified contacts, Plan B will include Family Care Network (FCN) yet this will not be part of the initial outreach (ON HOLD)

There was a consensus of the Board to cancel the December 17th Regular meeting and allow the work groups to move forward with the work as summarized. Reports will be brought back to the January 7, 2020 Regular Board meeting.

V. Meeting adjournment

MOVED by Commissioner Miller, seconded by Commissioner Groundwater to adjourn the meeting at 3:09 pm. VOTE 5:0:0. MOTION CARRIED.

Minutes approved this 7th day of January 2020.



Attest: Patricia Miller, OIHCD Board Secretary

attachment: WIPFLI Power Point