Successful Practices in Accountable Care: 
Miami Beach Community Health Center

Health Center Profile

**Name:** Miami Beach Community Health Center

**Location:** 11645 Biscayne Boulevard, Suite 207, North Miami, FL 33181

**Patients Served:**

**Services Provided:** Adult health, behavioral health, dental, health education, pediatric, vision

**Patient Mix:**

**Awards:** 2017 HRSA Health Center Quality Leader

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**Background – Driving Towards Risk**

In 2012, a managed care company presented Miami Beach Health Center (MBHC) with a contract. The only potential problem for MBHC was that the contract required them to take on full risk when they had previously only participated in contracts where the risk was partial and they only shared in the upside portion. MBHC, faced with this choice, ultimately decided to participate in the contract and as a result, learn how to manage their risk. They chose this for two reasons. The first reason was that the health center leadership felt that Medicaid managed care, which was increasingly present in the state, was changing the paradigm and soon they would be forced to accept risk or face losing patients, payers, and financial opportunities. The second reason, and one that was increasingly compelling, came from the results of a few internal “thought experiments”. Within the health center, the senior leadership decided to calculate what the impact of accepting or not accepting the contract would be on their revenue. Based on those calculations, which looked at payments received on a fee for service basis and projected capitation payments as well as factors such as age and disease states of their then-current patient population, the decision was clear. Rejecting the contract would have caused the health center to lose approximately $1 million in revenue. The “thought experiments” also showed that rejecting the contract would not save anything in overhead and would have likely changed their payer mix to reduce the number of privately insured patients resulting in even greater expenses. Once MBHC accepted the contract, and the risk that came with it, the health center utilized the contract as a mechanism to drive learning how to take care of patients in managed care.

The process of learning however was not always smooth and to-date, they claim that many of the lessons learned were through trial and error. When they reached out to many experienced members in the field of managed care, including managed care company employees who had worked with other providers before, they actually found that many did not understand the unique challenges of health centers nor the crucial differences between health centers and other providers. MBHC quickly learned the importance of finding partners and models that understood the statutory requirements of the section 330 grant and
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Considerations for a Full Risk Contract (from MBHC’s experience)

- Payments received on a fee for service basis
- Projected capitation payments
- Total payments received from the Managed Care Organization (MCO) if already contracted
- Risk factors such as age and disease states which will impact future Medical Loss Ratios (MLRs)
- Monthly income statements from MCO
- Detailed claims
- Pharmacy coverage
- Any known future increases or decreased in MCO payments

the pre-existing FQHC prospective payment system, which will affect the transition to managed care. Several of the lessons they learned through experience had to do with gaps in care, which they now excel at addressing, and panel management.

Resources Required

Members of MBHC’s senior leadership team share that while it is not “hard” work, there is a lot of work that one must do under full risk. They provide the example of a pediatric patient who is required to get a series of vaccines. That patient (or the parent/guardian of the patient) needs to be informed and the vaccines need to be addressed when they are in the health center. Following up with the patient to visit the health center requires effort; specifically, it requires every member of the health center from the front desk staff to the providers, including the board and the leadership, to understand all of the requirements so that the entire health center can provide a consistent message and care. Since missing one vaccine can have a domino effect, staff need to understand the implication of each task. Of the 450 employees at the health center, everyone has to understand “some medicine” such as what the HEDIS score means (Healthcare Effectiveness Data and Information Set) in order to understand the implication of how their part of the process affects the patient in the end. To help educate all of the employees specifically on the impact of their work, they held a round of ten meetings on different measures and metrics to help provide a deeper understanding and answer questions. They continue to provide training on a regular basis as needs shift and new priorities emerge.

Miami Beach Health Center also created a ‘gadabase’ (their term for a database of gaps in care) document in which they list every single gap for every single population they serve and assign each gap to someone on the care team. In addition to the education around the gadabase, they held meetings with each department to explain the importance in addressing the gaps in care. Addressing the gaps in care isn’t simply about managing their risk or the financial implications but rather about the importance of providing excellent care to their patients. The employees at MBHC are proud of the care they are able to provide, not just because of their high quality scores and resulting financial gains from the contract, but because each day they know their patients are receiving the best possible care. By focusing on the impact to patient care over financial implications, MBHC has been successful in getting all of their employees on board with a new way of managing their patient population, even though it was a lot of work requiring a lot of time.

In focusing on compliance, and what measures are needed to push the needle, MBHC was able to improve on their quality. MBHC encourages health centers to look at their numbers and see actionable next steps: who needs potential screenings, why those screenings haven’t occurred, and what can we do to get this patient in for a screening? They recommend constant quality improvement cycles with a focus on educating patients, motivating providers, and sharing potential burdens. The quality improvement cycles should include a role for
everyone in the organization from the front desk to the senior leadership. Large-scale participation is essential and they have found these quality improvement cycles to be key in their rising quality scores and successful participation in risk-based contracts.

Putting It Together

As Mark Delvaux, Chief Financial Officer of MBHC, stated at the 2018 Policy and Issues Forum, "if we say "no" to every MCO who wants risk, one day there will be no one left to say no to." As one of the primary reasons driving them to accept risk over three years ago, they have continued to see a shift towards risk-based contracting. After learning how to manage risk, they have found their relationships with managed care plans have never been better. They also realized that both the managed care plans and the health center have the same objective of increasing the quality of care, improving the health of populations, and reducing the per capita cost of care, even if for different reasons. All parties agree that working towards that shared objective has been mutually beneficial.