HealthCare LA, IPA

Presented by William D. Hobson, Jr., President and CEO
Watts Healthcare Corporation

Best Practices Presentation

HEALTH CARE L.A., IPA

- Established in 1991
- A California Non-Profit Mutual Benefit Corporation
- Mission to support safety net community clinics and FQHCs
- Provides a vehicle for member primary care centers to access HMO enrollment for most managed care product lines including commercial HMO products
- Currently has 35-member organizations that operate over 83 clinic sites incorporating 500 primary care physicians and physician extenders

Health Plan Affiliations & Products

- Anthem Blue Cross: Healthy Families & Medi-Cal
- Blue Shield: Commercial HMO
- Care1st: Healthy Families, Medi-Cal, Medicare Advantage & Medi-Medi
- Cigna: Commercial HMO
- Health Net: Commercial HMO, Healthy Families, Medi-Cal, Medicare Advantage & Medi-Medi
- LA Care: Healthy Families, Healthy Kids, Medi-Cal, Medicare Advantage & Medi-Medi
- Molina: Healthy Families, Medi-Cal, Medicare Advantage & Medi-Medi
- SCAN Health Plan: Medicare Advantage & Medi-Medi (Both termed as of 1/1/14)

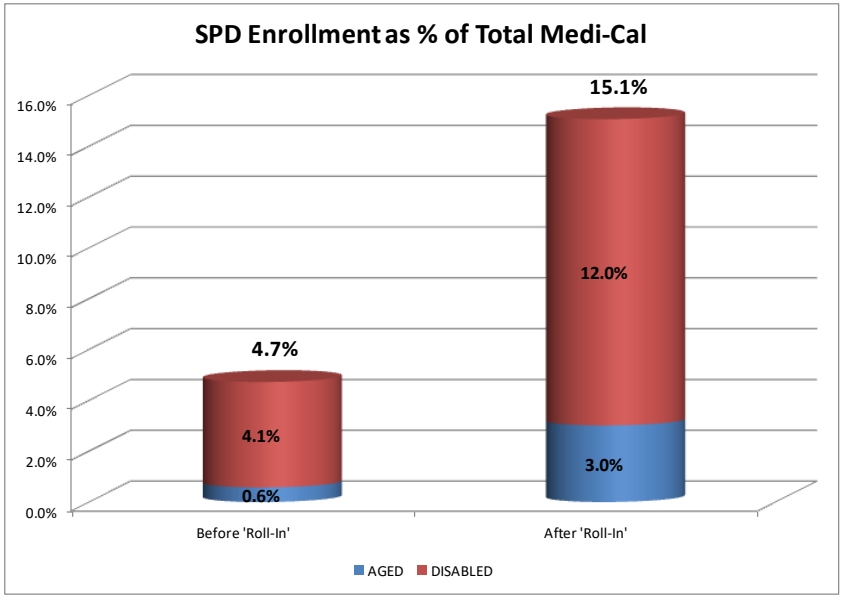
Network Dimensions

- Enrollment: 210,000 members
- Largest safety net IPA in the state of California
- The top five (5) member clinics have 33% of the total enrollment
- Watts Healthcare Corporation has 6.1% of the enrollment (12,200 enrollees)
- Contracted specialty providers: 1,200
- Affiliated Hospitals and Medical Centers: 20
- Full risk partner hospitals: 4

Impact of the Mandatory SPD 'Roll-In' from FFS to Managed Care - Enrollment

- HCLA member Health Centers (primarily FQHCs) serve the most needy and medically underserved Californians.
- SPDs have always been a part of the Medi-Cal population served by HCLAs Health Centers.

- State of California started mandatory enrollment of all SPDs into managed care starting 7/1/11 in12-monthly stages by birthday month
- Prior to the mandatory roll-in, which converted SPDs from Medi-Cal FFS to Medi-Cal Managed Care, SPDs made up approximately 4.7% of the total Medi-Cal population.
- During the transition period, SPD enrollment sky-rocketed, and now comprise 15.1% of the total Medi-Cal population.
  - AGED enrollment grew by 550%
  - DISABLED enrollment grew by 261%
  - TANF/Family enrollment only grew by 10%



Impact of the Mandatory SPD 'Roll-In' from FFS to Managed Care – Professional Costs

- SPDs have always been a population that utilizes services at a much higher rate than TANF/Family enrollees.
  - AGED enrollees FFS specialty costs are 3x more than the TANF population on a PMPM basis.
  - DISABLED enrollees FFS specialty costs are 4x higher.
- When evaluating FFS Specialty costs by Date of Service, the SPD population PMPM grew at a substantially higher rate when comparing the period before the roll-in to after the roll-in.
  - AGED PMPMs increased more than 36%
  - DISABLED PMPMs increased more than 32%
  - Revenue PMPMs for AGED and DISABLED remained constant
- The SPDs who rolled into Managed Care had higher and more intense needs than those already in Managed Care.
  - High frequency of one or more chronic conditions, such as Diabetes, CHF, ESRD and Cancer.
  - Significant pent-up demand for high cost procedures, equipment, prosthetics and other necessary medical care for patients previously seen at County facilities.
  - New SPDs required much more intense case management and care coordination than seen previously.
  - Significant increase in high dollar cases than seen in previous years.

Impact of the Mandatory SPD 'Roll-In' from FFS to Managed Care – Professional Costs

- The cost impact of the SPD conversion to Managed Care was compounded by the combination of:
  - Substantial growth in AGED and DISABLED enrollment, and…
  - Significant increases in per-member costs for AGED and DISABLED patients
- The result was an overall increase in the Medi-Cal PMPM Professional Specialty costs of 55% since the mandatory roll-in.
  - SPD enrollment, which comprise only 15% of the total, now drive 41% of the FFS specialty costs.
- SPDs also drove up other costs:
  - Primary Care visits are 15% more frequent for SPDs as well as significantly more complex in nature and time duration
  - Case management & care coordination staffing & costs increased
  - Claims volume is substantially higher than TANF enrollment
  - Reinsurance premiums increased substantially
- Hospital Facility costs increased dramatically as well
  - Admissions per 1,000 members for SPDs are 7 times higher than TANF members

Financial Impact Summary

- The capitation payments received by HCLA for the newly enrolled SPDs was no greater than for those in place before the roll in, even though the SPD costs increased by approximately 35%

- HCLA gets 3x the capitation for SPDs than for TANF enrollees but the costs are 4x

Care Management Challenges

- Pent-up demand for care from the fee-for-service system and corresponding rush to compensate
- Patient confusion and /or inexperience with medical system navigation
- Patient education and awareness of medical benefits and programs under the new SPD program
- Provider confusion about program changes
- Erroneous patient contact information
- Coordination of care for indigent/homeless populations
- Patients with multiple co-morbidities, including behavioral health and substance abuse problems

Care Management Challenges – Contd.

- Incidence of missed appointments, compounded by transportation and other barriers
- Availability of appropriate community behavioral health and substance abuse treatment resources
- Improper usage of emergency room and urgent care centers
- Difficulty in obtaining medical records

Observations on Population Health

- Population not necessarily geographically-defined
- Enrolled population not necessarily in terms of a financial transaction but in terms of a "commitment to a healing relationship" (Berwick)
- Recognition that actual causes of most mortality and morbidity are factors such as smoking, violence, physical inactivity, poor nutrition, poverty, lack of education and unsafe choices
- "Health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig)

Observations on Pop. Health – Contd.

- Population medicine is centered around evidence-based interventions and disease management categories so as to triage and allocate healthcare resources in a cost-effective manner
- Organizing patients into clusters for specific interventions using stratification methodologies, determining out-of-clinic needs and organizing patients into panels that meet specific criteria
- Public Health Perspective: Start with the geographic population and move inwards to interventions, focused on broad notions of determinants of health and incorporating interventions from clinical care to social services and environmental interventions

Population Health Issues for FQHCs

- Improved metrics for capturing the utilization and cost characteristics of the specific population
- Getting acceptance of the social determinants of health as being directly related to the cost of *effectively* caring for a specific population
- **Expanded and improved risk adjustment methodologies**

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