23rd Best Practices Forum

April 27 – 30, 2014 ~ Austin, Texas

WAIANAE COAST COMPREHENSIVE HEALTH CENTER
www.wcchc.com

Richard Bettini, President and CEO
Waianae Coast Comprehensive Health Center

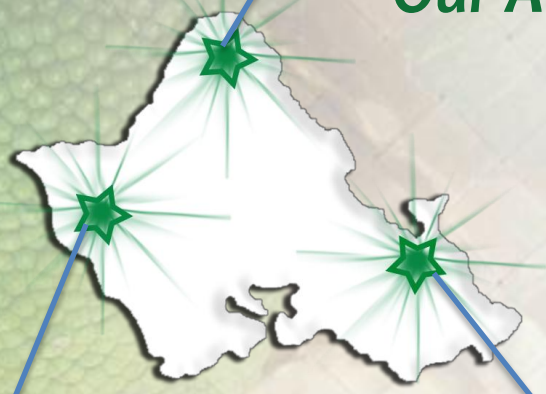
CREATIVE CONTRACTING WITH MEDICAID MCOs

Designing a Medicaid Payment Methodology Around Shared Savings and Community Development

Ko'olauloa Community Health & Wellness Center
Total Patients: **6,027**
Uninsured Patients: **17%**
Medicaid Patients: **14%**
Top two ethnic groups served:
Native Hawaiian = **29%**
Other PI = **24%**

Hamakua Health Center:
Total Patients: **7,723**
Uninsured Patients: **11%**
Medicaid Patients: **31%**
Top two ethnic groups served:
White = **35%**
Asian = **28%**

Our AHARO Member Health Centers



AHARO

Accountable Healthcare Alliance of Rural Oahu (or Organizations)

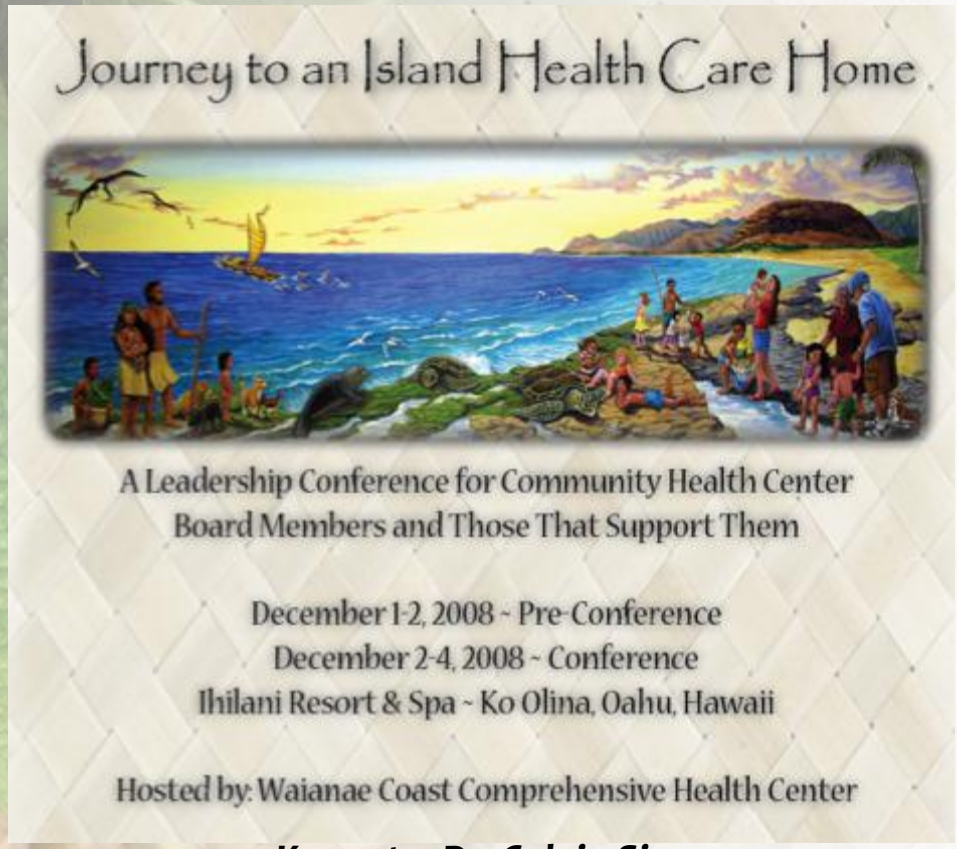
Waianae Coast Comprehensive Health Center:
Total Patients: **32,905**
Uninsured Patients: **3,328**
Medicaid Patients: **59%**
Top two ethnic groups served:
Hawaiian/Part Hawaiian = **52%**
White = **16%**

Waimanalo Health Center:
Total Patients: **4,312**
Uninsured Patients: **30%**
Medicaid Patients: **50%**
Top two ethnic groups served:
Native Hawaiian = **47.4%**
White = **15.7%**

Bay Clinic, Inc.:
Total Patients: **18,314**
Uninsured Patients: **29%**
Medicaid Patients: **51%**
Top two ethnic groups served:
Native Hawaiian = **32%**
Asian = **18%**

Recognizing we must be constructive partners with healthcare payers in containing healthcare costs and creating better value for our patients and payers.

The AHARO Model has its "ROOTS" HERE:



Keynote: Dr. Calvin Sia,
Founder Healthcare Home Movement

Participants: NCQA, National Quality Center, Commonwealth Fund and 75 Federally Qualified Health Center (FQHC) Consumer Board Members

And even back to here:

NATIONAL PAY FOR PERFORMANCE SUMMIT

The Leading National Forum on Pay for Performance to Enhance Healthcare Access, Quality and Efficiency

February 6 - 9, 2006
Hyatt Regency Century Plaza
(formerly the Westin Century Plaza Hotel & Spa)
Los Angeles, CA

Take A Look:

http://www.aharo.net/sites/default/files/FINAL_Consumer%20Leadership%20Conference%20Report_3-12-14.pdf

Health Center's Goals in Medicaid Contracting

- Co-Investment in health information technology (HIT) and Care Coordination.
- Value Based with Emphasis on *Addressing Preventable Cost* in transparent risk pools.
- Shift from Medical Model to Healthcare Model with recognition that Health Centers offer value added services.
- Accountable to and Driven by Patients and Community in *Partnership* with Medicaid Managed Care Plans using 360° evaluation tools.
- Requires *Aligned Incentives and Shared Savings* through Risk Adjusted Healthcare Home Based Risk Pools.

Designed to produce MORE VALUE for the state, patients and low income communities
ALL WITH NO ADDITIONAL COST TO STATES

Medicaid Managed Care Risk Pool $$ Flow

State pays plans Medicaid Capitation to plans with HEDIS based incentives withheld

State auto assigns 35% of Plan Enrollees.

$200 PMPM

Health Plans Deduct
- 10% Admin Fee
- Incurred but not reported claims

Plans set up Risk Pools & Incentivize Health Homes

$175 PMPM

Health Home Based Risk Pool Jointly Managed By Plans & Health Home

Payments to Pharmacy Benefit Manager

Outside Pharmacy

Payments to Health Home
- Primary Care
- Some Specialists
- Lab/Radiology
- Evening Hours
- Pharmacy
- Behavioral Health
- Care Enabling

Payments to Hospitals

Payments to Specialists

Cooperation with Plans and Choices for FQHCs

HEALTH PLAN
$$$

HEALTHCARE HOME

How far along do you Push the needle?

Risk Management (& assumption) & Claims Processing NO THANKS	Vertical Network Formation including Secondary & Tertiary Care SOME	Care Coordination HIT System Development SOME	Care Enabling Social Services & Community Engagement WE DO IT	Pharmacy, Specialty & Behavioral Health Services WE DO IT	Primary Care Medicine & Ancillary Services WE DO IT

How much do we do?

Form specialty networks, build our own HIT systems, use our own care coordinators.
(We already integrate our own pharmacy and behavioral health services into primary care.)

IMPORTANCE OF STATE AND FEDERAL POLICY ON MEDICAID CONTRACTING

To facilitate the model, we passed a State Plan Amendment through legislation and submit to CMS for approval.

Excludes from PPS Revenue Basis (Wraparound) Plan Payments to FQHCs for:

- Risk Pool Bonuses
- Pay For Performance Bonuses
- Quality Improvement "Grants"

Provider Incentive Payment (PIP) *– Limits payments by plans for risk pool bonuses to 25% of total payments to FQHCs.*

How Health Center is Compensated under AHARO Payment Model – Three Key Components

BEYOND PPS (In addition to PPS based payments and fee payments for a few other services:

- Both health plan and health center contribute to a care coordination and HIT matching fund. Continued investments are contingent on performance on financial performance measures.
- The health center is capitated for continuous quality improvement on consumer-developed standards. Cultural Proficiency, Engagement of Community, Care Enabling Service, and Community Economic Development.
- Balance remaining in the risk pools at the end of the year is shared between the health center and payer based on the 360° evaluation criteria.

NOTE:

Continuation of some of these "beyond PPS services" are contingent on generating risk pool surpluses.

Center Develops HIT/Care Coordination Plan – 2013/2014 Budget About $1,000,000

- Financial metric baseline scores and goals.
- HEDIS/CAHPS measures baselines, measures and goals.
- Implementation of population management system
- Development of predictive modeling system.
- Data exchange development.
- Progress towards NCQA PCMH and consumer-developed supplemental standards.
- Development of new patient satisfaction tools.

To Continue to Receive Funding Must Produce Financial Impact Addressing Preventable Costs Financial/Risk Pool Performance Metrics

Targeted at these goals:

Facility Costs:

- Decrease hospitalizations
- Decrease hospital days
- Decrease 30-day hospital re-admissions
- Decrease inappropriate ER use

Drug Costs:

- Increase generic medication dispensing rate
- Improve medication adherence

Other:

- Increase Advance Health Care Directives on file

After Capital Investment HIT/Care Coordination we are Incentivized for Continuous Quality Improvement Supplemental Health Home Standards

- **Meets Transformation Goals**

Medical Model → Healthcare Model → Economic Developmental Model

Accountable to and driven by Patients and Community

- **Addresses PIP Rule**

Expanding the Healthcare Home Concept

The Waianae Coast Comprehensive Health Center is expanding the model of the Patient Centered Healthcare Home to include four additional areas valued by our community:

Community Involvement

Workforce and Economic Development

Cultural Proficiency

Care Enabling Services

Examples of Supplemental Patient-Centered Healthcare Home Standards

In each of 4 healthcare home areas – community board sets important goal

Element B: Cultural Proficiency				
The practice addresses the cultural background of consumers in its policies, procedures and practices through the following:		YES	NO	N/A
1.	Assesses the diversity of consumers and trains staff, providers, and others about the diversity.			
2.	Has a panel of cultural advisors engaged in developing and evaluating cultural practices.			
3.	Has an established plan for cultural sensitivity training and professional development for staff.			
4.	Providers follow culturally specific protocols based on patient background and demographics.			
5.	Buildings and facilities that reflect the patient population's culture and background (e.g. male family planning clinic design to make men feel welcome).			
6.	Provides and/or promotes complementary and/or alternative healing practices in alignment with primary and preventive health services.			

Goal for 2013/2014: Reengineer employee orientation and Medicaid student training to include cultural proficiency training.

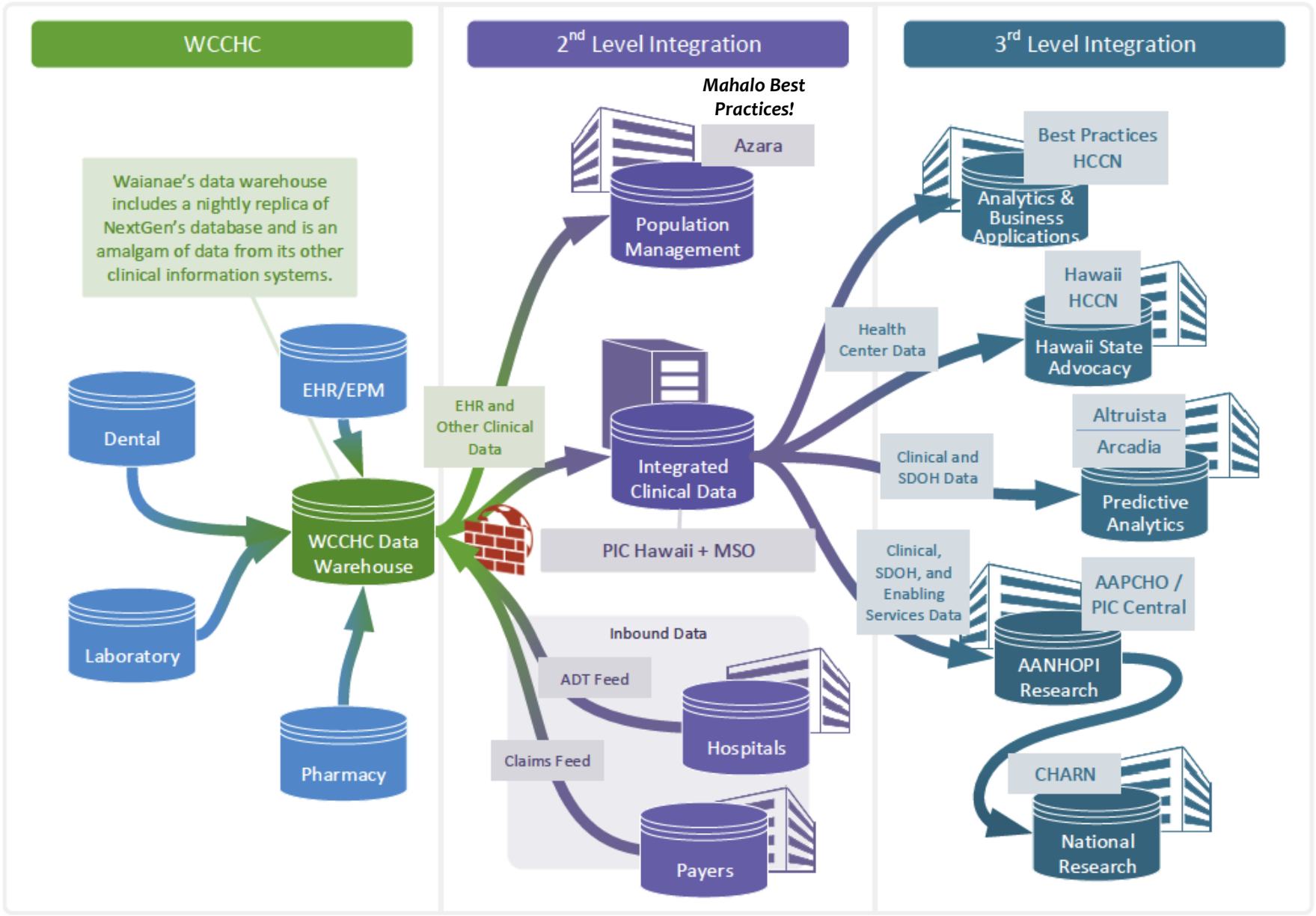
Element C: Community Involvement				
The practice is an integrated part of the community, encouraging participation and elevating the level of health education and organization through the following:		YES	NO	N/A
1.	Has a panel of patients or Consumer Board that reviews and approves an annual plan that identifies health care needs and disparities within the community; establishes an action plan to address these issues.			
2.	Reviews adequate data to measure performance to promote access, quality, cost effectiveness and makes recommendations for consideration.			
3.	Has a systematic process in place to measure patient satisfaction and performs any remedial actions deemed necessary.			
4.	Has a volunteer program that involves community members and various activities to promote a healthier community.			
5.	Conducts outreach with community participation through health fairs, etc.			
6.	Engages in Community Based Participatory Research with patients trained as the investigator (PI).			
7.	Has patients sitting on internal committees, (for example, Quality Improvement Committee or Cultural Competency Committee.)			

Goal for 2013/2014: Contract with Waianae High School to engage students in design of new adolescent clinic at Waianae Mall.

How has this contract (model) affected us? What's next?

- Expanding HIT Vision and Capability
- Developing Care Coordination towards reducing Preventable Costs
- Growing Network – Specialty Care
- Expanding Access to Primary Care
- Initiating Hospital Integration and Community Initiatives
- Facilitating Movement toward Community Economic Development Model

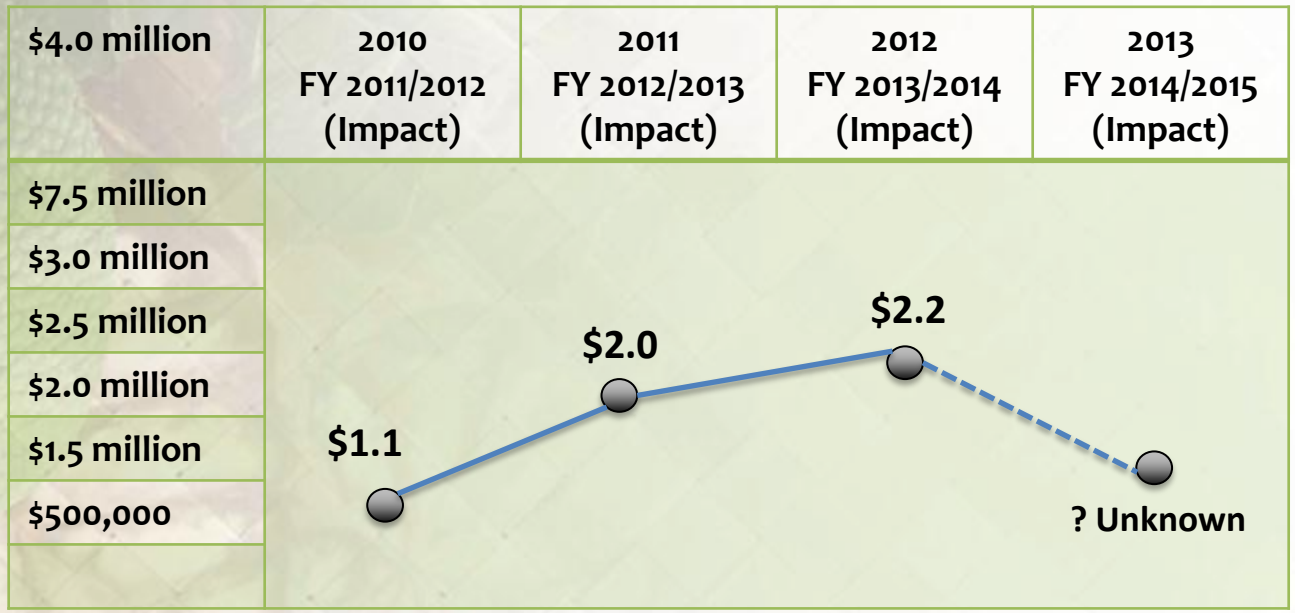
Expanding HIT Plan and Vision



Risk Pool Distribution

- Based on 360° Evaluation – with deficit to 75% share to Health Center.
- Should follow principle that gain share should be distributed based on relative utility provided by each provider (see sliding needle diagram).

Risk Pool Gain Share Approximation Per 10,000 Medicaid Patients - Outlook



? Factors affecting risk pool margins currently:

- State ratcheting down on plan payments
- Inadequate risk adjustment and/or patient assessment
- Unknown aspects Aged, Blind and Disabled population preventable costs

Care Coordination and Addressing Preventable Costs

DECREASE HOSPITALIZATIONS	HOSPITALIZATION RATE
Baseline	11.71%
04/01/2011 – 03/31/2012	9.90%
DECREASE HOSPITAL DAYS	**HOSPITAL DAYS PER 1000 STANDARD MBRS**
Baseline	6.06
04/01/2011 – 03/31/2012	5.37
DECREASED 30 DAY HOSPITAL READMISSIONS	**READMISSION RATE**
Baseline	7.62%
04/01/2011 – 03/31/2012	8.89%
DECREASE HIGH ER UTILIZATION	**HIGH UTILIZATION RATE**
Baseline	1.67%
04/01/2011 – 03/31/2012	1.57%

INAPPROPRIATE ER USE RATE	99281 AND 99282
Baseline	18.05%
04/01/2011 – 03/31/2012	17.30%
DECREASE OVERALL ER USE	**USE RATE**
Baseline	2.18
04/01/2011 – 03/31/2012	2.29
GENERIC DISPENSING RATE	**GDR**
Baseline	99.83%
04/01/2011 – 03/31/2012	99.90%

Waianae's Specialty Clinic

CURRENT SPECIALTIES	APPROVED SCOPE OF PRACTICE	SPECIALTY NEEDS MEDICAID/UNINSURED
Orthopedics	Orthopedics	Gastroenterology
General Surgery	General Surgery	Neurology
Dermatology	Dermatology	Pulmonology
Podiatry	Podiatry	Cardiology
	Nephrology	Urology
	Ophthalmology	Allergy
	Acupuncture	
	Occupational/Physical Therapy	

- Waianae is developing a specialty clinic in Kapolei to meet the needs of AHARO Medicaid patients.
- Specialties within Waianae's approved scope of practice are likely covered by tort protection and FQHC payment rates when employed part time as a Health Center provider.

Sample Analysis of Adult Patient Low Acuity Hospital ER Visits
January 1, 2014 – March 31, 2014

Total Low Acuity Visits for Quarter: 32

Patients Healthcare Home

Main Health Center Site

- Adult Medicine 8 patients (25%)
- Women's Health – 6 patients (19%)

SUBTOTAL: 14 (44%)

Satellite Sites

- Nanakuli Clinic – 5 patients (16%)
- Kapolei Clinic – 6 patients (19%)
- Waipahu Clinic – 6 patients (19%)

SUBTOTAL: 17 patients (53%)

Subtotal Non-WCCHC: 1 patients (3%)

TOTAL: 32 Patients

Hospital ERs Utilized

- Pali Momi – 19 (59%)
- Queens – 8 (25%)
- Kapiolani – 4 (13%)
- Straub – 1 (3%)

A need to Grow Access to Primary Care

Low Acuity ER Adults Visit Profile

Patients Seen by Time of Day

- 8 am – 6 pm: 15 (47%) of which 8 (25% total) were seen during open clinic hours (M-F)
- 6 pm – 12 am: 9 (28%)
- 12 am – 8 am: 8 (25%)
- Times seen available for 32 patients

Patients seen by Days of Week

- Sunday – 10 (31%)
- Monday – 2 (6%)
- Tuesday – 3 (9%)
- Wednesday – 1 (3%)
- Thursday – 6 (19%)
- Friday – 6 (19%)
- Saturday - 4 (13%)

Patients' PCP's by Specialty

- Adult Medicine: 14 patients (44%)
- Family Medicine: 10 patients (31%)
- Women's Health: 7 patients (22%)
- Unassigned: 1 patient (3%)

Follow-up By Care Coordinators

Attempts to Schedule Follow-up Appointments

- Care Enabling Workers Follow-up:
  - 13 (41%) had an appointment scheduled
  - 19 (59%) declined to have an appointment scheduled

Reasons given for being seen in ER

- Clinic Closed – 11 (34%)
- Live closer to ER than Clinic – 2 (6%)
- Lack of Transportation – 1 (3%)
- PCP not Available – 9 (28%)

Other samples of patient comments:

- Ran out of pain medications
- It was a weekend
- Changed PCP to a non-WCCHC provider
- No health insurance
- PCP on leave – no available appointments
- Patient didn't know who PCP was
- Just started new job and didn't want to take off for appointment
- "I was in so much pain"

Partnerships with Hospitals and Community Initiatives

Hospital Partnerships

The Affordable Care Act requires all 501(c)(3) hospitals to conduct a community health needs assessment in order for them to maintain their tax exempt status beginning March 23, 2012.

- Have health centers really been involved?
- What are best practices examples?
- Is this an opportunity?

Community Initiatives

The Purpose Built Model:

Housing ✚ *Lifelong Education* ✚ *Wellness* 〓 ***Long-term improvement in population health***

New Market Tax Credits

Training Programs (Beyond A.T. Still University)

Medical Issues and Population Health on the Leeward Coast

Well Documented	• High risk pregnancy • Diabetes/Hypertension
Under - reported issues	• Early onset of chronic disease and secondary conditions • Substance abuse and behavioral issues

- The nature of the FQHC payment system has resulted in the underreporting of risk factors.

Moving from Medical Model ⟹ Healthcare Home Model ⟹ Community Development Model

- As we understand more clearly the health conditions of the Leeward coast, we begin to recognize the need to improve access to primary care and address social conditions.

And Other Lessons… Moving Forward

Our health center could better address preventable costs by:

- ✓ **Developing comprehensive pain management program.**
- ✓ **Expanding hours to improve access and reduce low acuity ER visits.**
- ✓ **Launching population management system with predictive analytics.**
- ✓ **Partnering with health plan on risk adjustment pilot program.**
- ✓ **Partnering with hospitals to integrate our community needs assessment and solving problems together.**
- ✓ **Add Pediatrics to low acuity ER visit analysis.**

States could help achieve more value by:

- ✓ **Risk adjusting payments to health plans for social determinants, early onset of disease or other population risk factors.**
- ✓ **Using the auto-assignment algorithm to more effectively consider population adjustments and value-added services.**
- ✓ **Aligning incentives throughout the continuum of care.**
- ✓ **Linking community economic development with healthcare.**
- ✓ **Engaging health centers and their consumers in dialogue *(thank you!)***

Building a Home for the Waianae Coast

ACCESS DOES NOT EQUATE TO INSURANCE COVERAGE AND NOT ALL HOUSES ARE BUILT ALIKE

A Healthcare Home in Waianae is NOT the same as a Medical Home in Kahala…

Just like beachfront homes in the two places are NOT the same

"The most reliable predictor of population health is the zip code lived in."

Income – Schools – Crimes – Unemployment – Stress – Access Barriers