Wayfinding Through the Storm of Medicaid Payment Reform

"Toward an Equal Partnership in Managing the Total Cost of Care"

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Healing • Learning • Innovation

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View From Sooriya's Farm – The Zen of Payment Reform

HEALTH
PLAN

"May the force be with you!"

The New Provider-Payer Partnership: The AHARO "APM" Model

1. **Key Aspect of Model:** The Health Center is accountable for the total cost of care of patients fairly attributed to them
2. **Key Strategy of Model:** Reduce preventable costs within this "risk pool" and share any savings created
3. **How do you measure FQHC performance in reducing preventable costs?**
    - Manage inpatient care transitions *(follow up within 7 days)*
    - Decrease hospital-based Emergency Department "High Utilization"
    - Reduce overall rate of hospital-based Emergency Department use *(ED visits/1,000 members)*
    - Manage high risk cohort patients
    - Increase Advance Healthcare Directives on file
4. **Addresses social determinants of health** by establishing standards for community selected PCMH standards and incentivizing for quality improvements in these areas.
5. **Key System Components:** Joint investment in community-based care coordination and HIT – Key drivers of change.

STORM FRONTS

Historical Perspective on Payment Reform
A Waianae Coast Comprehensive View from 1994

- States waive Federally Qualified Health Center (FQHC) cost-based reimbursement through 1115 waivers. (Governor's letter indicates Medicaid managed care plans would not enter market if they had to provide special payments to health centers.)
- HRSA hires consultant to encourage health centers to engage with Medicaid managed care organizations.
- National Association of Community Health Centers (NACHC) provides legal and technical advice to help Hawaii health centers establish AlohaCare.
- Waianae Coast Comprehensive Health Center accepts capitation for primary care with downside as well as upside risk sharing – volume based payments go away and so does affordability of enabling and preventive services.

EARLY NAVIGATION

View From 2006 – 2008: PPS system established "volume" or "blended" based payments for FQHCs – However, there is another wake-up call.

Journey to an Island Health Care Home

A Leadership Conference for Community Health Center Board Members and Those That Support Them

December 1-2, 2008 - Pre-Conference
December 2-4, 2008 - Conference
Ihilani Resort & Spa - Ko Olina, Oahu, Hawaii

Hosted by: Waianae Coast Comprehensive Health Center

Keynote Speakers:
Dr. Calvin Sia - Founder Healthcare Home Movement
Dr. Karen DeSalvo – Chair, Louisiana Health Home Committee

Participants:
NCQA, National Quality Center, Commonwealth Fund and 75 FQHC Consumer Board Members

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

REALIZATION #1

As we Plan our Voyage – 4 Realizations

The Medically Underserved Area (MUA)-Based Healthcare Home

- 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 may be the zip code lived in." Income – Schools – Crimes – Unemployment – Stress – Access Barriers

Insurance coverage does not equate to access.

REALIZATION #2

When Addressing Concentrations of Poverty, Community-Based Solutions Should be More Integrated and Comprehensive

Addressing Social Determinants + Community Development
Integrating Social Service Performance Metrics

Expanding the Healthcare Home Concept to Reflect Hidden Value that Health Centers Provide in Addressing Social Determinants Health

Community Engagement

Workforce and Economic Development

Cultural Proficiency

Care Enabling Services

REALIZATION #3

Technology Will Be a Driving Force in Change

New Healthcare Technology will lead to the (more precise) measurement of the relative value healthcare providers offer payers and patients.

Reimbursement will then be associated with this measured value.

- ✓ Medical Home: Primarily Measures Capabilities (NCQA)
- ✓ Accountable Care: Share the Savings

Key questions in both 2008 and 9 years later:

Will we be fairly valued?
Who picks the measures?
Who shares the savings?

- ✓ We must code and track everything we do!

REALIZATION #4

There is a long standing bias by state governments that community health centers are overpaid and volume based PPS payments must be eliminated for true value based healthcare to occur.

The March 24, 2016 NAMD Letter

"The role of State Medicaid programs in improving the value of the Healthcare System."

To inform HHS engagement to the State Medicaid Directors shared strategic goals:

- Align across Medicaid and Medicare
- Healthcare payment and learning network
- ***"Address conflict between the FQHC PPS System and reform"***
- Allow States to reinvest savings in healthcare infrastructure

NAMD Comments on PPS (Health Center Payment System)

- FQHCs should be included in value-based purchasing.
- **PPS is a deterrent to broad based and effective efforts to maximize quality and efficiency in Medicaid.**
- States would like to see flexibility in their obligations to provide PPS payments.
- In addition:
  - ✓ Including both fee-for-service and managed care into the payment model
  - ✓ Building in incentive payments (30%)
  - ✓ Addressing social determinants of health

A Key AHARO Hawaii Goal for 2016:

Respond to assumption highlighted above (regarding PPS)

Key Questions for AHARO Hawaii in 2016:

Are states reducing value as they seek cost reductions?

Are states effectively incentivizing change in its allocation of any savings?

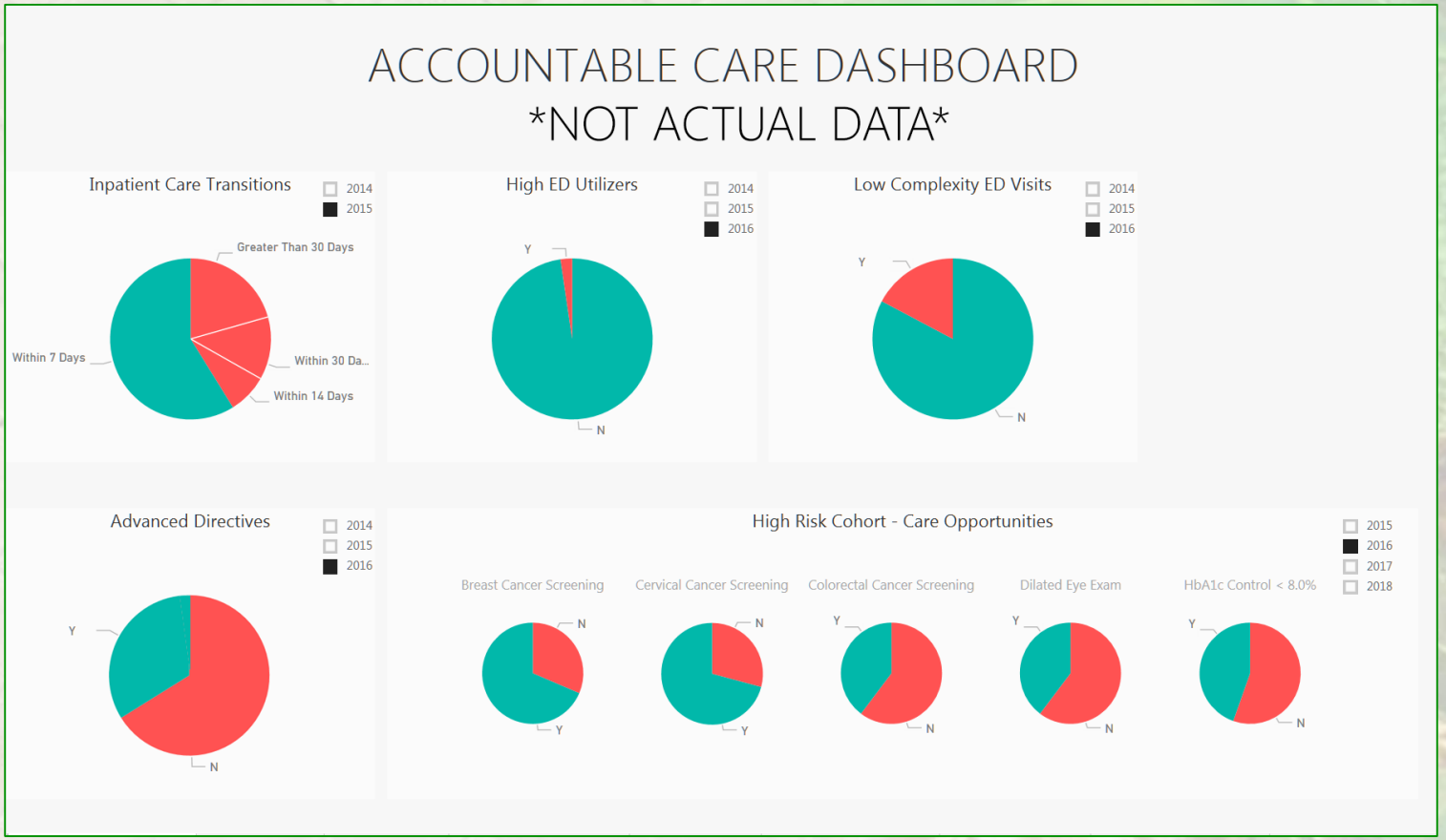
Do states have areas of improvements they can make in the 3 keys to transformation?

TRUST ● ALIGNED INCENTIVES ● TRANSPARENT DATA

Charting A New Course – Key Questions

1. **Where are the preventable (avoidable) cost in healthcare? (that do no harm when controlled)**

See our Accountable Care dashboard



2. **What entity or partnership of organizations are best positioned to address these costs (measures) while also improving quality?**

What Capabilities Should A "Virtual ACO" (ACO Partnership) have?

1. Brand Recognition
2. Access to Capital
3. Ability to Aggregate Lives
4. Ability to Manage Risk
5. Collaborate IQ
6. Ability to Change Patient Behavior
7. Strong Clinical Footprint

Governor Michael O. Levitt
(Former Chair Republican, Governor's Association)
January 2017 NACHC Winter Meeting

A "Virtual" or Partnership ACO Model

Pick Your Partners Well to Form WHOLE Accountable Care Organization

Allowing for FQHC Flexibility in a Virtual ACO Model

Payer Partners (Health Plans)

HEALTHCARE HOME

How far along do you push the needle?
Could affect % of gain share you're entitled to.

Assuming risk is a requirement of the partnership, not necessarily a requirement of the PCP.

Risk Management (& assumption) & Claims Processing	Vertical Network Formation Including Secondary & Tertiary Care	Care Coordination HIT System Development	Care Enabling, Social Services & Community Engagement	Pharmacy, Specialty & Behavioral Health Services	Primary Care Medicine & Ancillary Services

Sliding the Needle – How much do health centers do?

- Form specialty networks, build our own HIT systems, use our own care coordinators?
- Leave it up to individual health centers and their partners to define with Health Plans specific areas of responsibility.
- Honest open discussion with health plan regarding best approach to achieve common objectives.

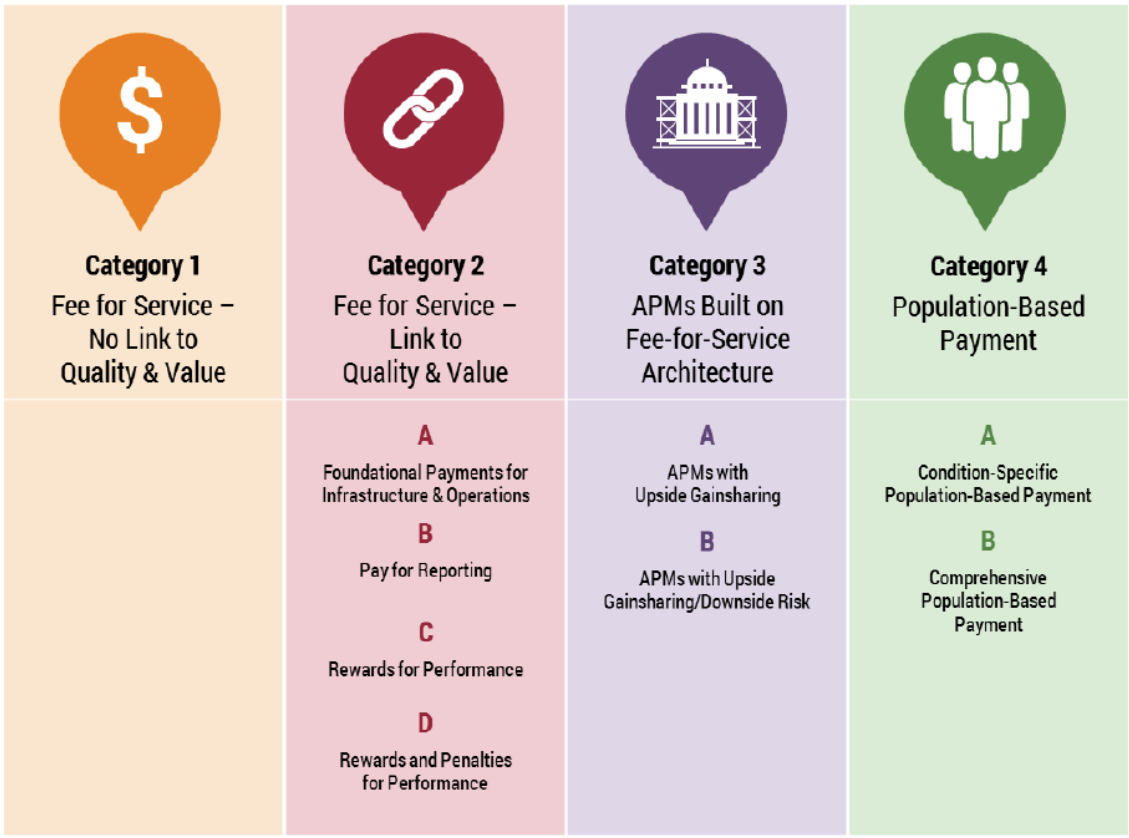
State Based Payment Reform

- Please do not undermine accomplishments to date — rather, support this momentum.

Moving Forward - Understand the Agenda – CMS 2017

Alternative Payment Models

Figure 1. APM Framework (At-A-Glance)



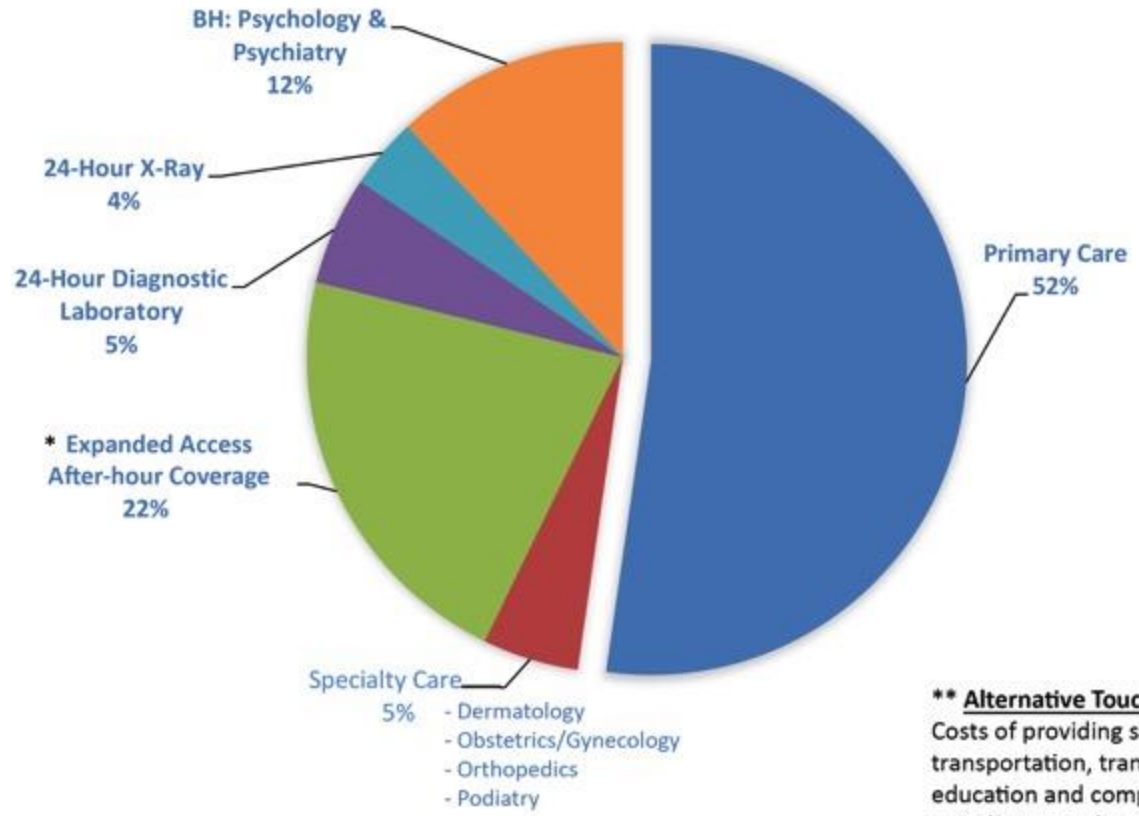
We propose equal partnership with health plans, creating a comprehensive system of population-based accountable care where each partners can benefit from each others strengths.

Addressing the False Assumptions – 1115 Waivers will be Plentiful

Consider Prospective Payment as a Blended Rate

PPS is Volume Payments on "Organic Nutrients" not Volume on "Steroids"

WHAT THE PAYER IS GETTING FROM WCCHC FOR ITS PPS BLENDED RATE



** **Alternative Touches**
Costs of providing services such as transportation, translation, and patient education and compliance are treated as indirect overhead costs and applied across each segment.

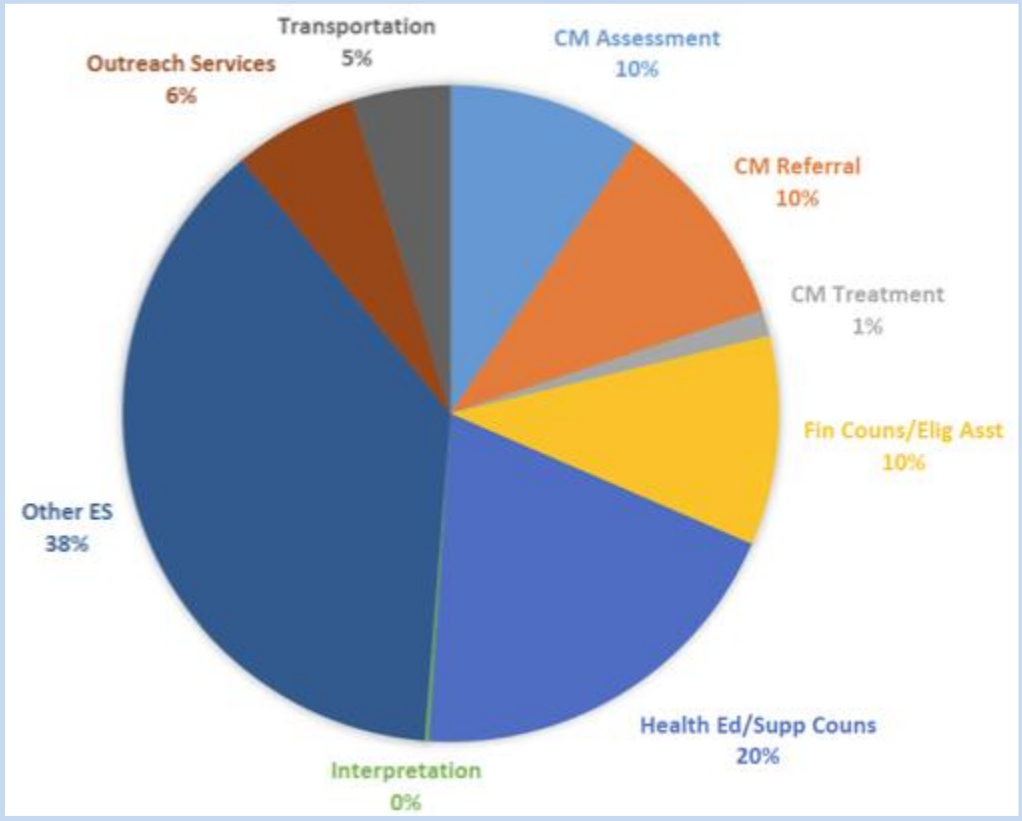
In addition to direct services, many Health Centers already offer alternative touches within PPS framework

Service Type

Enabling Service (ES)	2015
CM Assessment	2,371
CM Referral	2,603
CM Treatment	319
Fin Couns/Elig Asst	2,576
Health Ed/Supp Couns	4,890
Interpretation	44
Other ES	9,436
Outreach Services	1,524
Transportation	1,214
Total ES Patients	**24,977**

The Health Center has used approximately 200 codes for alternative touches tracked over 10 years – folded into the few categories above.

Alternative Touches at WCCHC (2015)

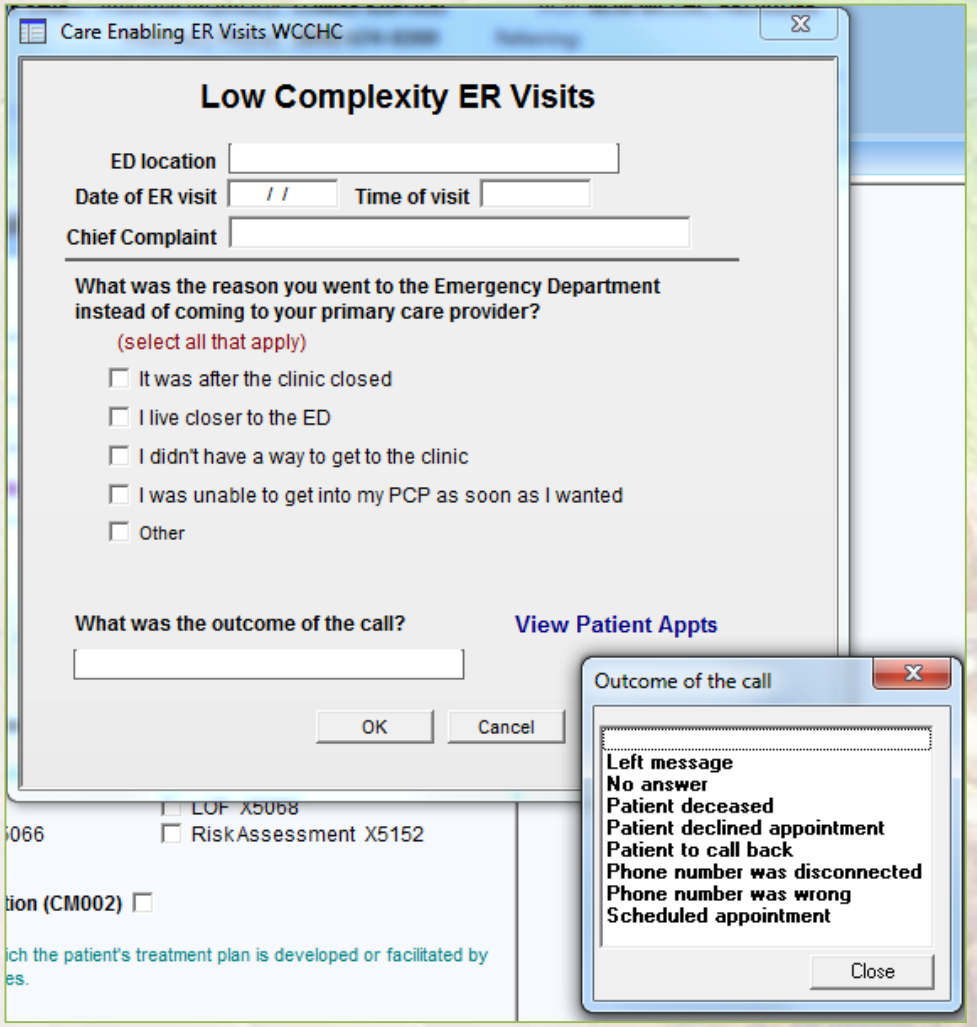


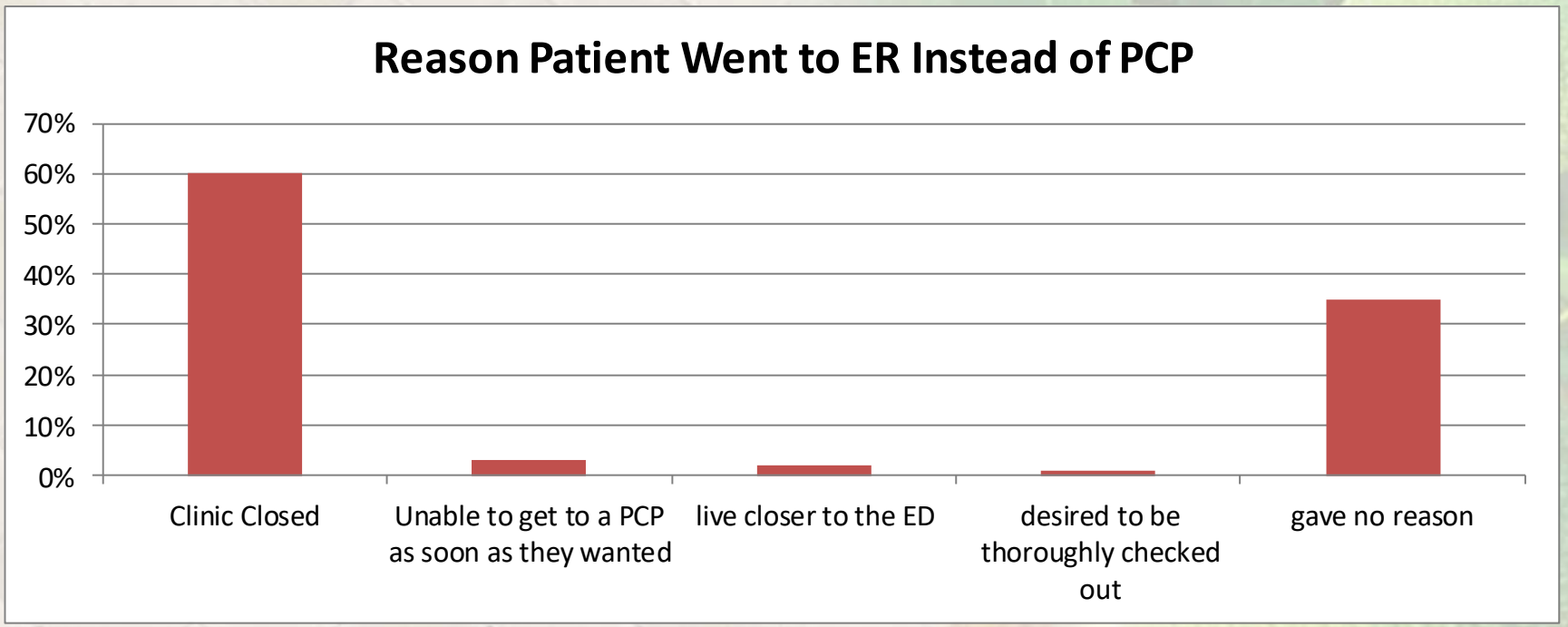
Experiences under our Partnership ACO Model

CASE STUDY #1 – Impacting on Preventable Costs

Why do patients use hospital ERs @ 5x cost per visit over PPS?

The Link Between Expanded Access and Preventable Costs





Common chief complaints:

- **Abdominal pain**
- **Cold symptoms**
- **Fever/chills**
- **Dizzy/spells**
- **Congestion**
- **Need Dr. Note**
- **Ear pain**
- **Recheck**
- **Sore throat**
- **Vomiting**

Health plans support 50% cost of our care coordinators – not part of PPS rate calculation.

We get direct hospital discharge summaries and our care coordinators follow up with patients who use hospital ERs.

Impact of Managing Low Acuity ER Visits on Total Cost of Care

As reported by one health plan:

Comparison ER Rates – ER Admissions per 1000 Members		
Measurement Period	Waianae	Total Plan
BLQ1 (Q1 2015)	483.31	633.64
BLQ2 (Q2 2015)	461.93	629.56
BLQ3 (Q3 2015)	452.65	662.31
BLQ4 (Q4 2015)	441.40	593.78
PIQ1 (Q1 2016)	448.77	624.67
PIQ2 (Q2 2016)		
PIQ3 (Q3 2016)		
PIQ4 (Q4 2016)		
PIQ5 (Q1 2017)		
PIQ6 (Q2 2017)		
PIQ7 (Q3 2017)		
PIQ8 (Q4 2017)		

Health centers are best positioned to expand volume to reduce hospital ER visits for medically complex patients.

NOTE: *This data is provided by health plan systems and has not yet been validated by WCCHC.*

Improving Access by Expanding Volume

Visits by Medicaid Patients – 5pm to Midnight
Calendar year 2015 (paid under PPS Blended Rate)

Category	Sum of Count
Chest Pain/Congestive Heart Failure	137
Labor	18
Mental Illness/Substance Abuse	76
Respiratory Distress	338
Severe Sign/Symptom	916
Trauma	558
Primary Care	3,736
Grand Total	**5,779**

CASE STUDY #2 – Assignment of Patients to Risk Pools

Importance of Patient Assignment to Risk Pool Management and Aligned Incentives

Factors affecting risk pool margins 2013/2014:

- Inadequate risk adjustment and/or patient attribution and other factors (listed below)
- State ratcheting down on plan payments
- Aged, Blind and Disabled population enters risk pool
- Re-enrollment and retro-enrollment
- State drops catastrophic coverage

More on Assignment and Retro-enrollment in Early 2016

As we negotiate transparent total cost of care risk pool data:

- *We study top ten expensive cases in our risk pool*

BILL:

$ **$9,000,000** Charged to our Total Cost of Care Pool $

Most costs were realized from newborns whose parents do not live in our service area or never used our services. In some cases, they had other primary care providers.

*Lesson learned #27 – **NEVER** enter into an accountable care partnership unless the payer/plan signs a data agreement that includes full disclosure of where the $$$ go!*

CASE STUDY #3 – Risk Adjustment

Pursuing More Value Driven Risk Adjustment

The Need for State Proficiency in Rate Setting and Risk Adjustment

Table 1. CHC Net Risk Pool Margins -

	FQHCs			Projected
Risk Pool	FY 2011	FY 2012	FY 2013	FY 2014
RP 1	$17.13	$17.66	$16.52	-$10.39
RP2	$6.67	$5.30	$7.96	-$7.31
RP 3	-$19.91	-$24.96	$5.41	$7.65
RP 4	-$23.21	$7.42	$5.46	-$29.38
RP 5	-$81.97	-$100.91	-$28.90	-$146.35 *
RP 6	$8.15	-$70.96	-$1.35	$4.21
RP 7	-$14.95	-$18.61	$9.99	$8.08
RP 8	$6.12	$5.66	$7.60	$6.29
RP 9	$4.39	$5.00	$6.54	$3.14
RP 10	$6.61	$6.56	$7.63	$5.49
RP 11	$5.46	$5.28	$5.96	-$35.42
RP 12	$6.46	$5.44	$7.17	$4.14
RP 13	$7.75	$6.69	$7.42	$6.24
RP 14	-$7.58	$9.91	$9.70	$0.41
RP 15	-$46.26	-$21.43	-$65.95	-$50.97

* Largest Homeless Healthcare Provider

It's 2017 – How do we move forward from here?

- Achieving ***clinical integration*** for community safety net ACO. Focus AHARO Hawaii on Medicaid and dual eligible Medicare.
- Expand ability to extract data from combined EHR and claims data under ***formal data agreements*** with health plans.
- ***Evaluate all*** involved in the healthcare continuum of payment, not just the politically vulnerable "FQs" and other private primary care providers.
- Advance the system's ***proficiency in coding*** and risk adjustment to help evaluate the best return on Medicaid dollars invested while more appropriately assigning patients to health homes.
- ***Produced evidence*** based research on the FQHC contribution to payment reform outcomes. (Arizona State University partnership)
- Standardize PRAPARE survey tool for ***assessing social conditions*** effecting health outcomes from community-based bridge agency for social services and develop Accountable Community concept (United Healthcare and AlohaCare).