Clinically Integrated Networks:
A National Perspective

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PIN 2007-09 “Service Area Overlap: Policy and Process”

- **F. Target Population**
  The target population is the population to be served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area.

- Section 330(e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay. Centers are also free to extend services to those residing outside the service area. However, HRSA recognizes that health centers must operate in a manner consistent with sound business practices. As such, health centers are not expected to extend services to additional patients residing inside or outside of the service area if
  1. the demand for services exceeds available resources, and/or
  2. doing so would jeopardize the center's financial stability. However, grantee health centers and FQHC Look-Alikes should address the acute care needs of all who present for service, regardless of residence.

- Some health center programs receive funding to target special populations: specifically, migrant and seasonal farmworkers and their families, persons who are homeless, and residents of public housing. Health centers receiving such funding (i.e., grants under section 330(g), (h), or (i) of the PHS Act) are not subject to the requirement to serve all residents of the service area; however, they should make services available to all members of the special population targeted, and, as stated above, address the acute care needs of all who present for service.
MEDICAID EXPANSION: A NATIONAL LANDSCAPE

Current Status of State Medicaid Expansion Decisions

- Medicaid expansion
  - 31 states & DC have expanded Medicaid
  - 6 states have 1115 Waivers for expansion: AR, IA, MI, IN, NH, PA
  - A number of states are actively working on Medicaid expansion
  - A number of expansion states are currently considering changes (NH, MI, AZ, OH)
PAYMENT REFORM: A NATIONAL LANDSCAPE

- Alternative payment models for health centers (e.g. CA, OR)
- Accountable Care Organizations (e.g. MN)
- National trend toward payment reform
  - e.g. State Innovation Models Initiative, Section 2703 Health Homes
- State Medicaid Directors tend to follow the crowd...

More at: www.nachc.com/states

2015 Survey: Is your PCA/HCCN tied to an IPA/ACO?
Red states (PCAs or HCCNs) have fully implemented ACO with a national plan or by themselves. (Impossible to count all ACOs as many are private through an MCO or locally controlled)

The Players in HC led ACOs

Previously focused exclusively on large, well run HCs. Now branching out to partner with PCA: and HCCNs. Significant training and technical assistance is provided up front and ongoing.
The Players in HC led ACOs

Have 22 ACOs overall. 6 are affiliated with PCAs. See HCs as the corner of their future success. Significant training and technical assistance is provided up front and ongoing.

The Gold Standards for HC led Networks

The Process:
PCA + HCCN leads to:
HIE which leads to:
IPA (messenger to integrated) which leads to:
MSSP, ACOs and other opportunities
### CHC Owned HMO Plans

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Name</th>
<th>Owner(s)</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>Community Health Network of Connecticut</td>
<td>CHCs</td>
<td>$52,983,148</td>
</tr>
<tr>
<td>Colorado</td>
<td>Colorado Access</td>
<td>Colorado Community Managed Care Network; 2 other non CHCs/HCCNs</td>
<td>800,000+</td>
</tr>
<tr>
<td></td>
<td>Denver Health</td>
<td>Denver Health and Hospital Authority</td>
<td>$191,914,042</td>
</tr>
<tr>
<td>Florida</td>
<td>Prestige Health Choice</td>
<td>CHCs; others</td>
<td>$12,934,972</td>
</tr>
<tr>
<td>Hawaii</td>
<td>AlohaCare</td>
<td>CHCs</td>
<td>$236,980,676</td>
</tr>
<tr>
<td>Illinois</td>
<td>Family Health Network</td>
<td></td>
<td>$101,733,625</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Neighborhood Health Plan</td>
<td>Partners HealthCare - created by CHCs</td>
<td>$1,290,379,075</td>
</tr>
<tr>
<td>Maryland</td>
<td>Priority Partners</td>
<td>Network (MCHS): Johns Hopkins Health Care</td>
<td>231,544</td>
</tr>
<tr>
<td>New York</td>
<td>Amida Care</td>
<td>Harlem United; 5 non CHCs</td>
<td>$218,975,795</td>
</tr>
<tr>
<td></td>
<td>Hudson Health Plan</td>
<td>Open Door Family Medical Centers; Hudson River Community Health</td>
<td>150,000</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Neighborhood Health Plan of Rhode Island</td>
<td>13 CHCs</td>
<td>$426,344,634</td>
</tr>
<tr>
<td>Washington</td>
<td>Community Health Plan of Washington</td>
<td>CHCs</td>
<td>$886,878,365</td>
</tr>
</tbody>
</table>
How you make money in accountable care?

The Biggest Issues We Face in Transformation

So Many Decisions!
APM
Join Other Providers
Shared Savings
MSSP
Population Health
PCMH/MU
Hospital Led ACO
Integrated Networks

What direction do we go??

Too much noise – To whom should we listen??
Consultants: “It’s the next big thing!”
Demonstration Projects – state and Federal
Grant opportunities
Anti-Obamacare rhetoric: “Repeal/Replace!”
Insurers/payers

Can we afford to wait and see??

Nobody – just listen to ourselves
A Brief History: Health Center program and the ACA

2010 – 2013

HC program focus was new starts, expansions, new buildings

• Accountable Care Organizations
  – First CMS rules had attribution for HC mid-level providers
  – Very few HCs involved in Pioneer ACO or later MSSP model
  – Hospitals actively recruited HCs - **PROBLEMS for HCs:**
    • lack of understanding of how ACOs works
    • lack of understanding of up front investments to be successful
      – Need to hire staff and change care delivery model
    • not part of governance structure
    • ROI (if shared savings is reached) not worth investment

• As a result, NACHC’s unofficial position - avoid hospital **LED** ACOs

Enter MACRA (HR2 or The Cliff Fix)!

2015 CMS Goals: 30% of US Healthcare spend in value based models by 2016, 50% by 2018
Medicare Access & CHIP Reauthorization Act of 2015

• What we **know** it does:
  – replaces Medicare’s Sustainable Growth Rate (SGR) with a Merit Based Incentive Program
  – provides incentives for joining Alternative Payment Models
  – no **direct** impact on our Medicare Prospective Payment System

• What we **expect** it will do – and why:
  – Force ALL payers (they will likely go willingly!) to move toward value based payments
    • As Medicare goes, so goes the rest of the health care delivery system – some MCOs are well ahead of CMS’ pace for value based goals
MACRA IMPACT

The lesson of the Menendez Amendment...

Medicaid Departments follow the herd!

So How Do We Get to Value?....MEDICARE!

• 10,000 new Medicare patients a day are enrolling – Where are your patients going?

• Enhanced 1st visit rates - Annual Wellness Visit (AWV) averages $150 – accurate coding is a must!

• Care Coordination - starting 1/1/16 HCs eligible for $46 PMPM for Medicare patients with chronic conditions – This is one of the keys to clinical integration

• New Medicare PPS rates increased by an average of 30% - Did yours?

• Medicare cost data is transparent – allows HCs a "safe system" to transition to value over at least 3 years

• Health Center Medicare population is small – that's OK! – TEMPORARILY bifurcate your care delivery team, learn the model, become proficient without risking your major patient revenue generator (Medicaid)

• Once proficient apply same skills can be applied to other payers / populations
### CMS MSSP Results

<table>
<thead>
<tr>
<th>ACO Self-Reported Composition</th>
<th>All ACOs</th>
<th>Shared savings</th>
<th>Positive w/in corridor</th>
<th>Negative w/in corridor</th>
<th>Negative outside corridor</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ACOs</td>
<td>333</td>
<td>28%</td>
<td>27%</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Has a Hospital</td>
<td>130</td>
<td>24%</td>
<td>25%</td>
<td>34%</td>
<td>18%</td>
</tr>
<tr>
<td>Has FQHC or RHC, No Hospital</td>
<td>18</td>
<td>44%</td>
<td>33%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Physicians Only (Group and/or Individual Practices)</td>
<td>185</td>
<td>29%</td>
<td>28%</td>
<td>21%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: RTI analysis of PY14 financial reconciliation data.

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### Volume vs. Value

"I skate to where the puck is going to be, not where it has been." — Wayne Gretzky

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In 5-7 years, nearly all Medicaid Plans will pay for value, not services!
Understanding the Cost Drivers of Health Care

What are the critical issues we must address for value based success?

• Practice population health – PCMH and MU are not enough
  – Defining the HC population – MCO, Medicaid, Medicare, HRSA
  – PCMH / MU principles: ALL Patients and Beyond the four walls of your HC

• Become expert at coding and billing – PPS will not save you!
  – HC Health Plan vs. HC Coding vs. Health Plan Data
  – Impacts revenue, quality, shared savings, ACO metrics

• Partner with equals - share your values
  – Look for partners who respect the mission and can still have a successful business model

• Quality Metrics are Interesting but Total Cost of Care is where the money will be moving forward!

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QUESTIONS?