Medicaid Payment Transformation – Community Perspective
“Toward an Equal Partnership in Managing the Total Cost of Care”

Richard Bettini, MPH, MS
President and Chief Executive Officer

Region IX Leadership Conference
May 1 – 2, 2017 | San Francisco, California
1. **Key Aspect of Model:** A network of Health Centers are individually accountable for the total cost of care of patients fairly attributed to them through a joint contractual relationship with multiple Medicaid plans.

2. **Key Strategy of Model:** Reduce preventable costs within this “risk pool” and share any savings created. Includes a 360° evaluation of health plans.

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.
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.
View From 2006 – 2008: PPS system established “volume” or “blended” based payments for FQHCs – However, there is another wake-up call.
REALIZATION #1 After 5 years of Consumer Leadership Conferences (2008 – 2013)

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
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!
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
Not a Good Starting Point for Transformation: 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 in the payment model
  - Building in incentive payments (30%)
  - Addressing social determinants of health

What if we could achieve CMS goals of transforming health centers to address the total cost of care through:

- Aligned Incentives
- Transparent Data
- Trust

...within the cost related assurance of prospective payment.
A Better Starting Point for Transformation

Where are the preventable (avoidable) costs in healthcare?
(\textit{that do no harm when controlled})

ACCOUNTABLE CARE DASHBOARD
\textit{*NOT ACTUAL DATA*}
What Attributes Should an ACO or 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
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.
Addressing the Elephant in the Room

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

And an incentive to outreach to high risk patients including extending hours of access to primary care.
In addition to direct services, many Health Centers already offer alternative touches within PPS framework.

Service Type

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

Alternative Touches at WCCHC (2015)

The Health Center has used approximately 200 codes for alternative touches tracked over 10 years – folded into the few categories above.
Creating a comprehensive system of population-based accountable care where center/plan partners can benefit from each other’s strengths.

Assumptions of risk is one value assigned to a shared savings distribution formula and can be assumed by either partner.
The Pilot Project
AHARO Contract 2015 – 2017 (and Related Case Studies)

1. A single health center contracting with 4 Medicaid Managed Care plans using the AHARO model.

2. Quarterly (Saturday) workshops with four FQHCs, including their Governing Board representatives, along with the Health Plans.

3. Completion of Corporate documents leading to 501(c)(3) status for AHARO.

4. Pursuit of Clinical Integration and establishment of common quality dashboard and remedial action.
Experiences under Pilot 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
Clinic Closed
Unable to get to a PCP as soon as they wanted
Live closer to the ED
desired to be thoroughly checked out
gave no reason

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:

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Waianae</th>
<th>Total Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLQ1 (Q1 2015)</td>
<td>483.31</td>
<td>633.64</td>
</tr>
<tr>
<td>BLQ2 (Q2 2015)</td>
<td>461.93</td>
<td>629.56</td>
</tr>
<tr>
<td>BLQ3 (Q3 2015)</td>
<td>452.65</td>
<td>662.31</td>
</tr>
<tr>
<td>BLQ4 (Q4 2015)</td>
<td>441.40</td>
<td>593.78</td>
</tr>
<tr>
<td>PIQ1 (Q1 2016)</td>
<td>448.77</td>
<td>624.67</td>
</tr>
<tr>
<td>PIQ2 (Q2 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ3 (Q3 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ4 (Q4 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ5 (Q1 2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ6 (Q2 2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ7 (Q3 2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIQ8 (Q4 2017)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 during Weekends and Evenings

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Sum of Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain/Congestive Heart Failure</td>
<td>137</td>
</tr>
<tr>
<td>Labor</td>
<td>18</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>76</td>
</tr>
<tr>
<td>Respiratory Distress</td>
<td>338</td>
</tr>
<tr>
<td>Severe Sign/Symptom</td>
<td>916</td>
</tr>
<tr>
<td>Trauma</td>
<td>558</td>
</tr>
<tr>
<td>Primary Care</td>
<td>3,736</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5,779</strong></td>
</tr>
</tbody>
</table>

Do the MATH: 5,779 x PPS rate vs. Hospital ER Facility plus Visit Fees
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
As we negotiate transparent total cost of care risk pool data:

- We study top ten expensive cases in our risk pool

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!

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.

BILL:

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RP 1</td>
<td>$17.13</td>
<td>$17.66</td>
<td>$16.52</td>
<td>-$10.39</td>
</tr>
<tr>
<td>RP 2</td>
<td>$6.67</td>
<td>$5.30</td>
<td>$7.96</td>
<td>-$7.31</td>
</tr>
<tr>
<td>RP 3</td>
<td>-$19.91</td>
<td>-$24.96</td>
<td>$5.41</td>
<td>$7.65</td>
</tr>
<tr>
<td>RP 4</td>
<td>-$23.21</td>
<td>$7.42</td>
<td>$5.46</td>
<td>-$29.38</td>
</tr>
<tr>
<td>RP 5</td>
<td>-$81.97</td>
<td>-$100.91</td>
<td>-$28.90</td>
<td>-$146.35</td>
</tr>
<tr>
<td>RP 6</td>
<td>$8.15</td>
<td>-$70.96</td>
<td>-$1.35</td>
<td>$4.21</td>
</tr>
<tr>
<td>RP 7</td>
<td>-$14.95</td>
<td>-$18.61</td>
<td>$9.99</td>
<td>$8.08</td>
</tr>
<tr>
<td>RP 8</td>
<td>$6.12</td>
<td>$5.66</td>
<td>$7.60</td>
<td>$6.29</td>
</tr>
<tr>
<td>RP 9</td>
<td>$4.39</td>
<td>$5.00</td>
<td>$6.54</td>
<td>$3.14</td>
</tr>
<tr>
<td>RP 10</td>
<td>$6.61</td>
<td>$6.56</td>
<td>$7.63</td>
<td>$5.49</td>
</tr>
<tr>
<td>RP 11</td>
<td>$5.46</td>
<td>$5.28</td>
<td>$5.96</td>
<td>-$35.42</td>
</tr>
<tr>
<td>RP 12</td>
<td>$6.46</td>
<td>$5.44</td>
<td>$7.17</td>
<td>$4.14</td>
</tr>
<tr>
<td>RP 13</td>
<td>$7.75</td>
<td>$6.68</td>
<td>$7.42</td>
<td>$6.24</td>
</tr>
<tr>
<td>RP 14</td>
<td>-$7.58</td>
<td>$9.91</td>
<td>$9.70</td>
<td>$0.41</td>
</tr>
<tr>
<td>RP 15</td>
<td>-$46.26</td>
<td>-$21.43</td>
<td>-$65.95</td>
<td>-$50.97</td>
</tr>
</tbody>
</table>

* Largest Homeless Healthcare Provider
AHARO Hawaii Moving Forward 2017 - 2019

• A single point of contracting for AHARO Hawaii Health Centers – potentially with four Medicaid health plans. AHARO Hawaii contract would cover majority of Hawaii’s Medicaid patients seen by FQHCs.

• Services and Commitment by Health Centers
  o Provides all FQHC services for members; some non-PPS covered services paid separately.
  o Offers expanded hours and improved access along with Care Enabling Services (most coded and tracked in EHR).
  o Requires completion of annual HIT/Care Coordination work plan and budget co-developed by partners.
  o Links co-investment in HIT/Care Coordination to Accountable Care performance metrics – AHARO Hawaii agrees to implement accountable care dashboard by second quarter 2019.
  o Commits AHARO members to establish an integrated clinical quality performance dashboard based on HEDIS and other quality metrics and jointly perform quality improvement initiatives.
Proposed AHARO 2017 - 2019 Reimbursement Model

Includes:

- PPS payments under Act 297 and Change of Scope Medicaid Amendment.
- Shared Savings under Risk Pool Structure/Attribution Exhibit in Contract. Health Centers may use alternative risk pool loss improvement bonus.
- Potential $2.50 per patient per member (PMPM) clinical quality improvement bonus.
- Potential $2-$3 prospective capitation to implement community-based supplemental health home improvements. This investment addresses social determinants of health levels and of community engagement. An optional veterans health home initiative is proposed. Continuance of capitation is dependent on prior year risk pool margin.
- Up to $5 PMPM contribution to investment fund for HIT/Care Coordination working capital to be matched by health centers. Cost not attributed to risk pools.
- Non-PPS services payment rates to be negotiated with potential risk pool carve out or bundled payments linked to opioid addiction co-hort (exploratory).
- Opens discussion for voluntary PPS visit reduction initiative using telemedicine or nursing visits for adult medicine patients – could redirect funds to additional improvement in social determinants.
• Introduces a common risk assessment tool for assessing social determinant needs at all AHARO Health Center sites by January 2019.

• Establishes standards for continuous quality improvement on social determinants of health at community level and empowers community boards to oversee improvement in these areas.

• Develops incentives and supplemental health home standards for “Veterans Health Home”.

• Commits health centers to develop comprehensive program to address opioid and other addiction problems in community.

• Expands use of pilot tested independent patient satisfaction survey and engages consumer Boards in reviewing survey results.
Key Exhibits Being Completed or Being Developed

A. Work Plan to Achieve Clinical Integration
B. Med-QUEST Clinical Quality Metrics
C. Social Determinants of Health Standards and Procedures (including community engagement)
D. Sample HIT/Care Coordination Work Plan and Sample Budget
E. HIT Data Agreement – AHARO Hawaii and Health Plans
F. Risk Pool Structure and Assignment of Patients (attribution issues)
G. Accountable Care Performance Metrics and Dashboard Design
H. Baseline Health Plan Proficiency (360°) - Scoring on HIT Capability (see following example)
I. Pilot Patient Satisfaction Survey Instrument
## Measuring the Performance of Health Plan
### A Whole System of Care Suggests a 360° Evaluation of Key System Components

<table>
<thead>
<tr>
<th>TASK/OBJECTIVE</th>
<th>PLAN A</th>
<th>PLAN B</th>
<th>PLAN C</th>
<th>PLAN D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care agreement reached</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Contract signed</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Member Roster</td>
<td>Yes</td>
<td>Yes</td>
<td>Testing</td>
<td>Not yet</td>
</tr>
<tr>
<td>Claims transactions</td>
<td>Yes</td>
<td>Yes</td>
<td>Testing</td>
<td>Not yet</td>
</tr>
<tr>
<td>Method of transmission</td>
<td>Download from secure site</td>
<td>Download from secure site</td>
<td>Still determining - download from secure site or automated file transfer</td>
<td>Undetermined</td>
</tr>
<tr>
<td>Frequency of transmission</td>
<td>Secure site uploaded monthly</td>
<td>Secure site uploaded monthly</td>
<td>Updated monthly</td>
<td>Undetermined</td>
</tr>
<tr>
<td>Identity of high risk cohort</td>
<td>Yes but glitches still being worked out in bidirectional transfer</td>
<td>Yes</td>
<td>In progress</td>
<td>Not yet</td>
</tr>
<tr>
<td>2016 Baseline data on accountable care measures available</td>
<td>In progress</td>
<td>Yes</td>
<td>In progress</td>
<td>Not yet</td>
</tr>
<tr>
<td>Baseline data validated</td>
<td>In progress</td>
<td>In progress</td>
<td>Not yet</td>
<td>Not yet</td>
</tr>
<tr>
<td>Agreement on calculations of accountable care measures</td>
<td>Almost complete</td>
<td>Almost complete</td>
<td>In progress</td>
<td>Not yet</td>
</tr>
<tr>
<td>Point of contact identified</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
MAHALO!

Visit our website at www.AHARO.net