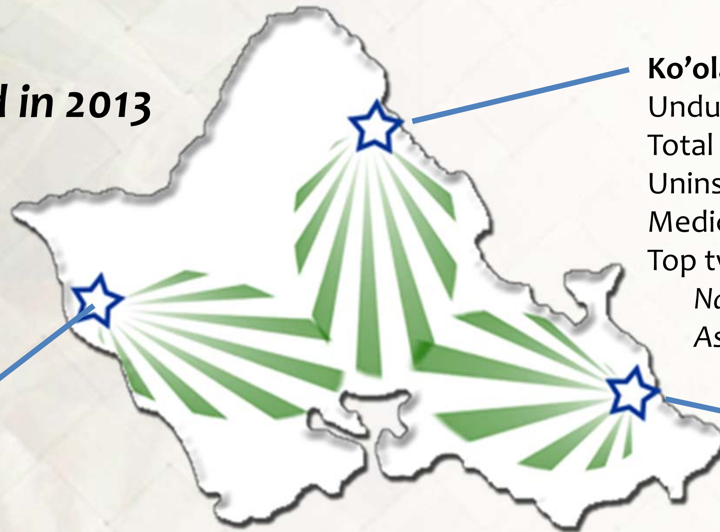
26th Annual State Health Policy Conference
What's Brewing in State Health Policy

October 9-11, 2013 ~ Seattle, Washington

Richard Bettini, President and CEO, Waianae Coast Comprehensive Health Center

Our AHARO Founding Member Health Centers

Two new members joined in 2013
(Bay Clinic, Inc. and Hamakua Health Center)



Ko'olauloa Community Health & Wellness Center
Unduplicated Patients: **6,027**
Total Patient Visits: **22,406**
Uninsured Patients: **1,015**
Medicaid Patients: **940**
Top two ethnic groups served:
- *Native Hawaiian =* ***43%***
- *Asian =* ***9%***

Waianae Coast Comprehensive Health Center:
Unduplicated Patients: **31,152**
Total Patient Visits: **176,533**
Uninsured Patients: **11%**
Medicaid Patients: **58%**
Top two ethnic groups served:
- Hawaiian/Part Hawaiian = **52%**
- Caucasian = **15%**

Waimanalo Health Center:
Unduplicated Patients: **4,312**
Total Patient Visits: **22,914**
Uninsured Patients: **1,276**
Medicaid Patients: **2,156**
Top two ethnic groups served:
- *Native Hawaiian =* ***47.4%***
- *White =* ***15.7%***

Recognizing we must be constructive partners 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

WE HAVE AN OPPORTUNITY!

THE EMERGING HEALTHCARE ENVIRONMENT

New Healthcare Technology will lead to the 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:

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

AHARO Payment Reform as Component of a Healthcare Home

1. **Accountable to and Driven by Patients and Community in *Partnership* with Medicaid Managed Care Plans.**
2. **Shift from Medical Model to Healthcare Model**
3. **Value Based with Emphasis on *Addressing Preventable Cost***
4. **Recognition of the Delivery of Value Added Services**
5. **A 360º Evaluation of both Health Plan and Healthcare Home.**
6. **Co-Investment in health information technology (HIT) and Care Coordination.**
7. **Requires *Aligned Incentives and Shared Savings* through Risk Adjusted Healthcare Home Based Risk Pools.**
8. **Establishes transparent risk pools and partnerships with health plans.**

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

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

$200 PMPM

State auto assigns 35% of Plan Enrollees.

Plans set up Risk Pools & Incentivize Health Homes

$175 PMPM

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

Outside Pharmacy

Payments to Pharmacy Benefit Manager

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

Payments to Hospitals

Payments to Specialists

Summary of the Key Elements of the AHARO Payment Model

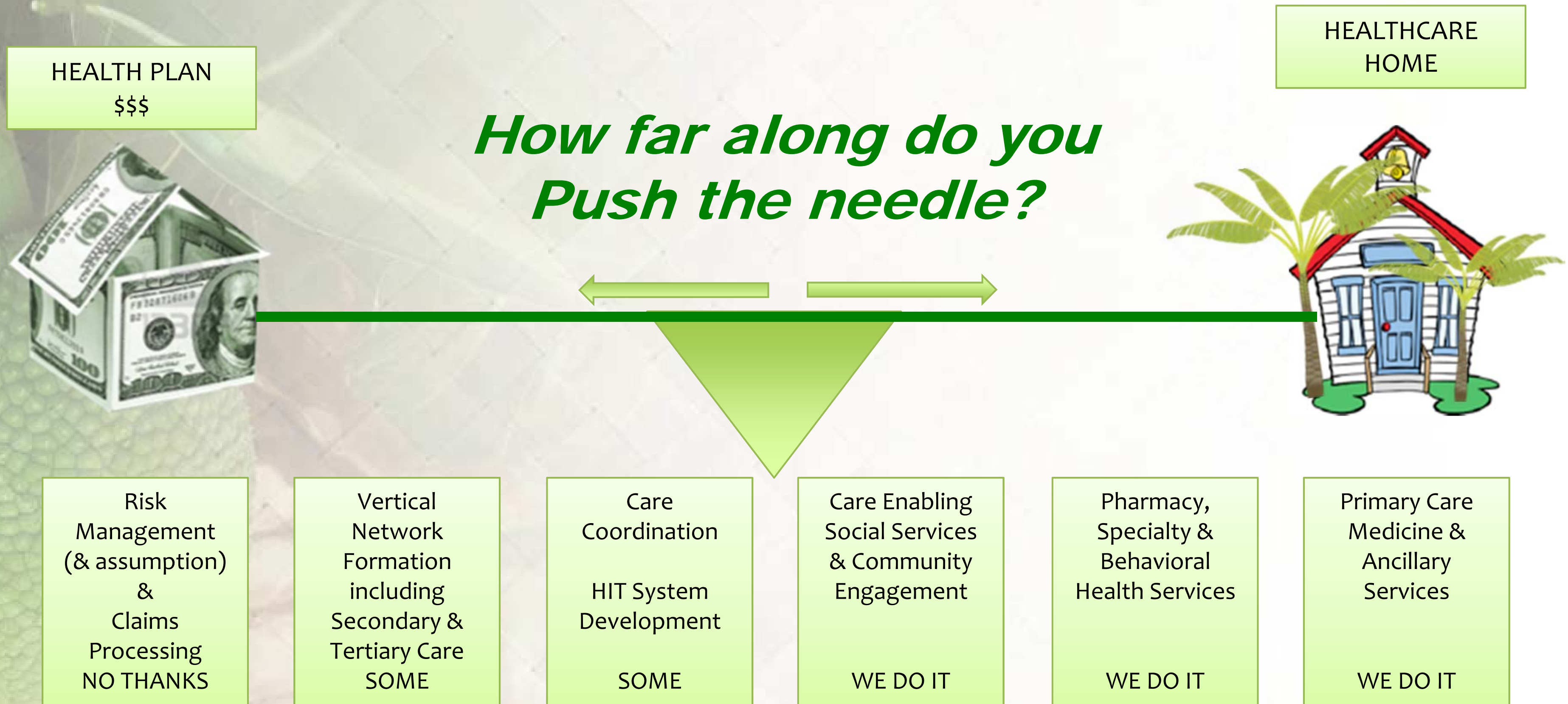
1. **State adjusts capitation to health plans and they pay Prospective Payment System (PPS) rates to "in network" health centers. Some additional payments for non-PPS services if requested by health plans.**

2. **AHARO health centers are capitated for continuous quality improvement on consumer-developed standards. Continuation of capitation is dependent on creating risk pool margins.**

3. **Both health plan and AHARO health center contribute to a care coordination and HIT matching fund. Continued investments are contingent on performance on financial performance measures.**

4. **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.**

Cooperation with Plans and Choices for FQHCs



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.)

A virtual Accountable Care Organization (ACO) because HRSA never produced regulations for basic health plans or safety net ACOs.

Examples of Supplemental Patient-Centered Healthcare Home Standards

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.

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

360° Evaluation of Health Plan

Why? Because their capability is linked to our ability to address preventable costs.

Element A – Specialty & Other Network Capability

Element B – Claims Processing Capability

Element C – HIT and Care Coordination Capability (and Integration)

Element D – Value Added Support Services and Healthcare Home Model

Element E – Aligned Incentives and Shared Savings Process

Element F – Effectiveness and Efficiency Incentives (Other)

Element G – Inpatient Management and Care Transition Management

Element H – Non-Emergent ER Reduction

See www.AHARO.net for details

What Goes Into the HIT/Care Coordination Workplan?

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

… and much more.

To facilitate the model, we needed to pass 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"

Our model maintains PPS as a blended rate for broad scope of service

- Incentives are on top of base payment – allows us to outreach to highest risk patients.
- Necessary because of inadequate population risk adjustment.

Are we aligned with payment reform?

- *We can shift 30% of our reimbursement away from FFS through population risk adjusted performance incentives and shared savings.*
- *We **do** improve access. Insurance does not equate with access; enabling services and the full scope of FQHC integrated services do.*
- *We do not need to accept risk to be incentivized to address preventable cost. We need positive incentives – (insurance companies get shared savings because they have the capital to take risk.)*

A WORTHWHILE GOAL:

Health Centers and State Medicaid Agencies working together to reduce Medicaid costs while positively incentivizing health centers to bring more value to their low income communities.

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.**

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.**
- ✓ **Engaging health centers and their consumers in dialogue (*thank you!*)**

MAHALO (thank you!)

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