From Accountable Communities to Accountable Care Partnerships

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Healing • Learning • Innovation

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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 **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

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

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

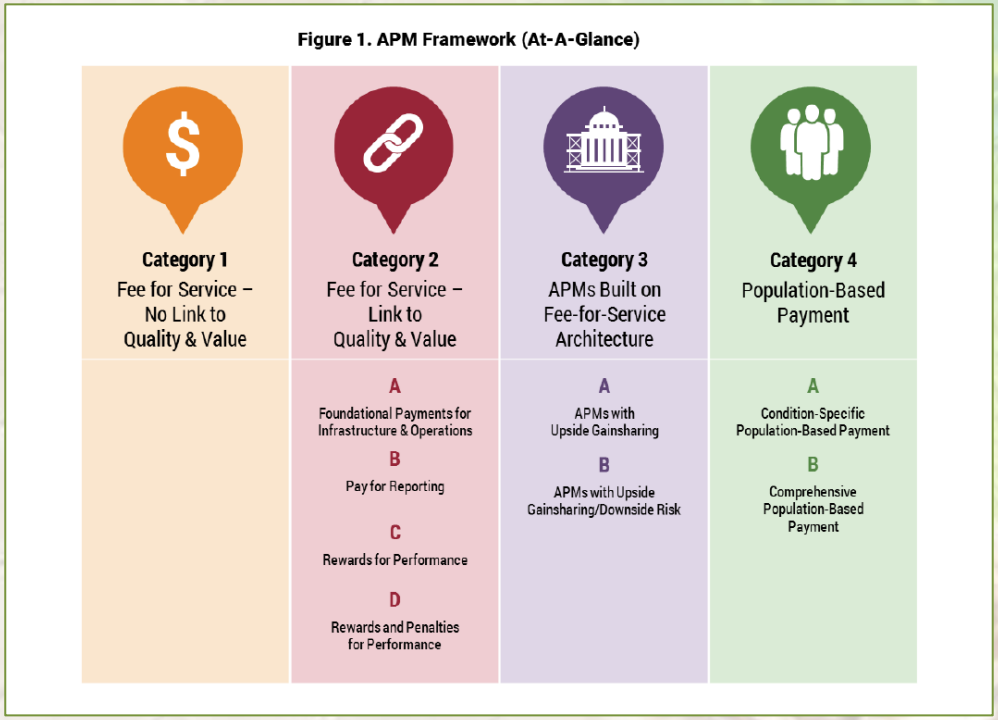
What if we could achieve CMS goals of transforming health centers to address the total cost of care through:

- ✓ Including both fee-for-service and managed care into the payment model
- ✓ Building in incentive payments (30%)
- ✓ Addressing social determinants of health

Within the cost related assurance of prospective payment.

Moving Forward - Understand the Agenda – CMS 2017

Alternative Payment Models



- Creating a comprehensive system of population-based accountable care where center/plan partners can benefit from each others strengths.
- Assumptions of risk is one value assigned to a shared savings distribution formula and can be assumed by either partner.

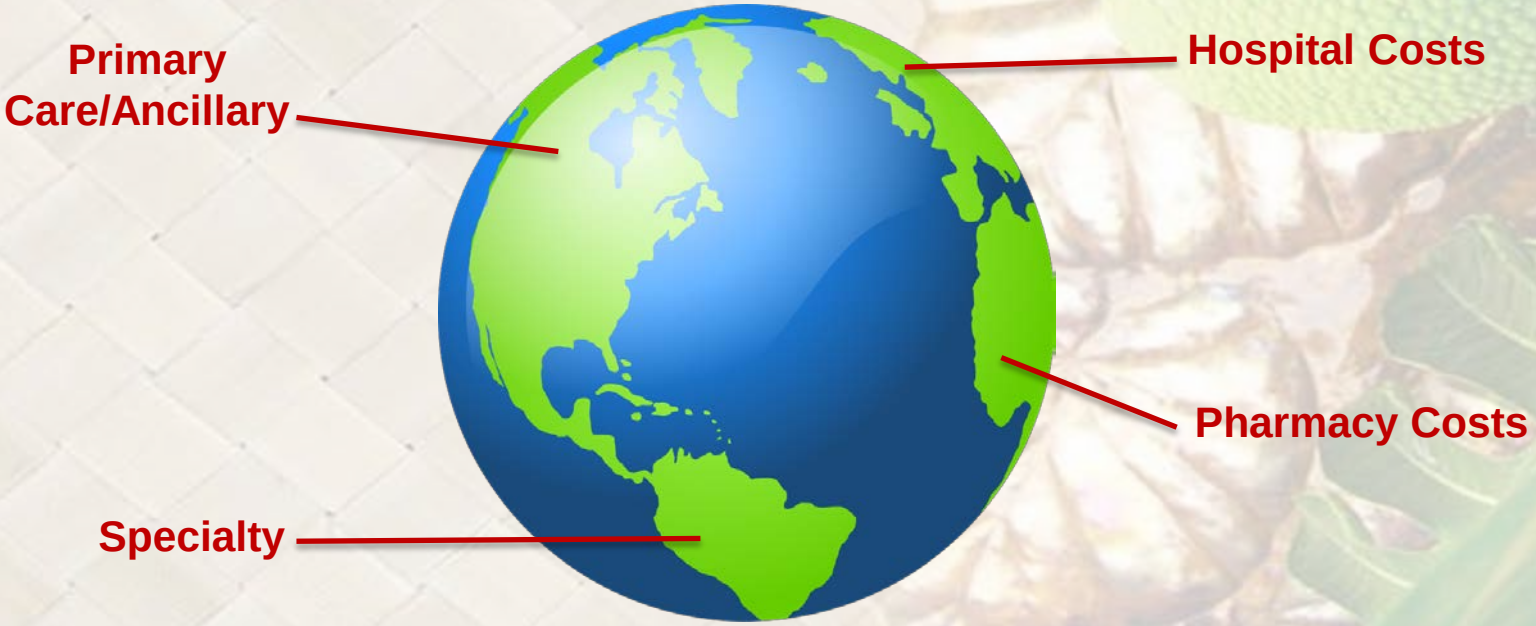
Can a partnership between Health Plan and Health Center complete a whole entity in order to achieve level 4 integration?

Health Plan + **Health Center** = **Level 4 Integration?**

- **Fundamental goals in payment transformation**
  - Transformation so centers are focused on total cost of care
  - Incentive must be sufficient to make change
  - Taking risk optional – A carrot works as well as a stick – however taking risk is worth 40% of gain.
  - If you have reserves and there is adequate risk adjustment – Try a little risk taking

Transformation Goals we can Accept and Strive for Movement Towards Global Payments Co-Managed by FQHCs

- Holding Health Centers financially accountable for the total cost of care provided to the patient population assigned to them.
- Financial incentives must be sufficient to motivate health center transformation – (let's assume a goal of 30% of total payment potential being linked to performance based incentives).
- We should not compromise our mission of providing access to the most medically and socially complex patient.



Adjusting our course towards a Health Center/Health Plan Partnership

The 3 Keys to Transformation:

- Trust
- Correctly Aligned Incentives that motivate all involved
- Useful and Transparent Exchange of Data

Community Health Center Transformation Goals

Medical Model → **Healthcare Model** → **Community Development Model**

Health Plan Transformation Goals (Assumed):

- Fulfill mission to assist health centers in healthcare transformation.
- Facilitate quality and efficient care for its enrollees.
- Serve medical network as preferred Medicaid and Medicare health plan in Hawaii.

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 FQHCs 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 FQHC

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.

Hawaii State PPS Legislation has helped create an "alternative payment methodology" not an "Alternative Payment Methodology"

IMPORTANCE OF STATE AND FEDERAL POLICY ON Health Center/Health Plan Partnerships

To facilitate a valued based payment model, The Hawaii State PCA initiated a State Plan Amendment through legislation and submitted it to CMS who approved it.

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

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

This is in effect an alternative payment methodology (in small letters) that allows Prospective Payment to co-exist with value based payment and systematically shift up to 30% of their reimbursement to performance.

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

1. **Key Aspect of Model:** The Health Centers 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.

The Pilot Project – AHARO Contract 2015 – 2017 And Related Case Studies

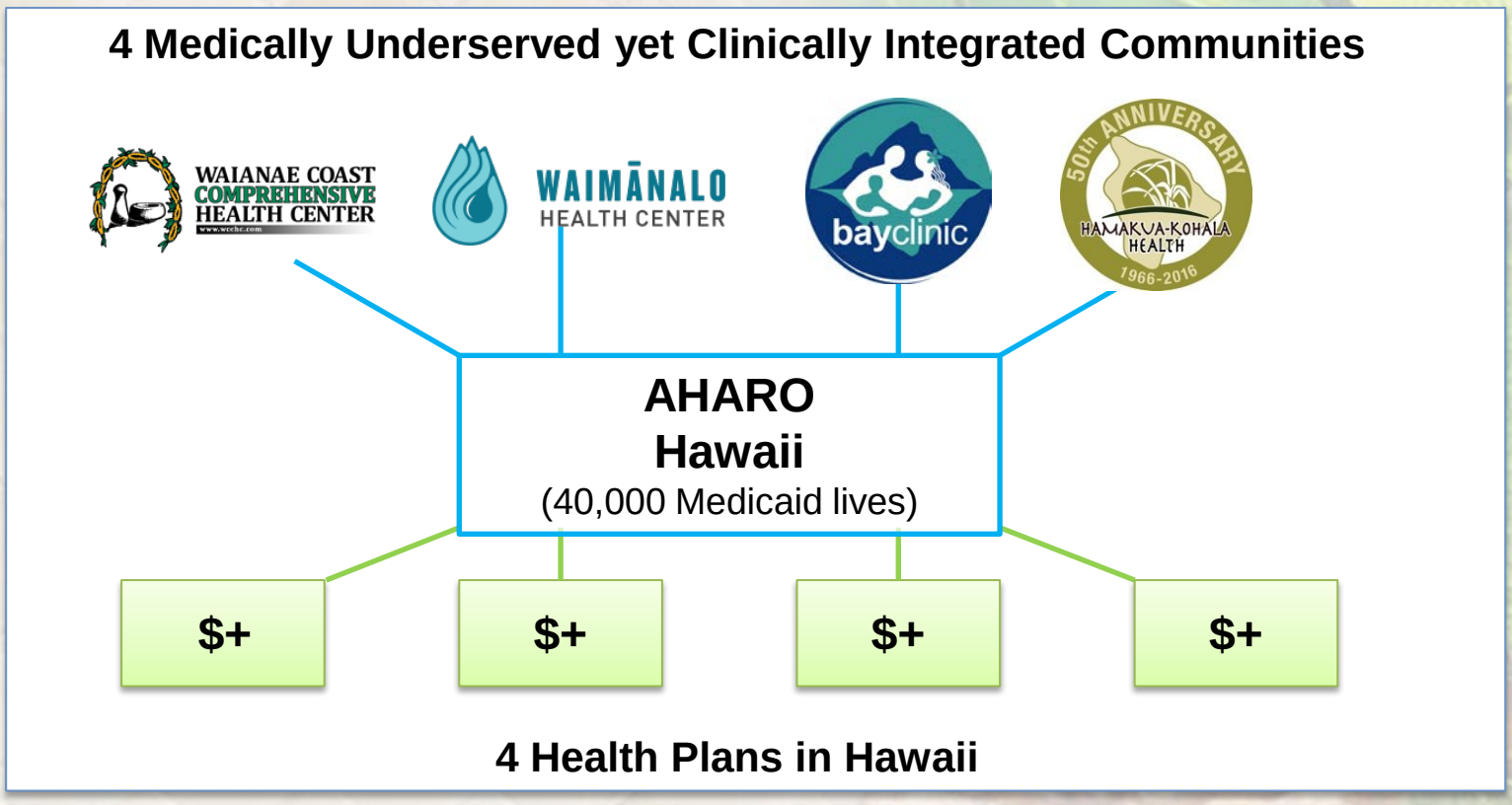
1. A single health center contracting with 4 Medicaid Managed Care plans using the AHARO model.

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.

“Accountable Care” Model in Hawaii



- Single point of contracting for plans
- Clinical integration agreement links FQHCs to AHARO
- Plans pay Health Centers directly however agreement moves $1 PMPM to AHARO
- Health Centers responsible for own risk pools

AHARO Hawaii Moving Forward 2017 / 2019

- This single point of contracting for AHARO Hawaii Health Centers come with added value for Health Plan partners.
- Services and Commitment by Health Centers
    - Provides all FQHC services for members – Some non-PPS covered services paid separately. We are exploring capitation for these.
    - Offers expanded hours and improved access along with – Care Enabling Services (most coded and tracked in EHR).
    - Requires completion of annual HIT/Care Coordination work plan co-developed by partners.
    - Commits AHARO members to establish an integrated clinical quality performance dashboard based on HEDIS and other quality metrics and jointly perform quality improvement initiatives.
    - Incentivizes community based boards to reduce avoidable costs while also addressing social determinants of health.

It helps if you started your own Health Plan, however, it's best to work with multiple plans

AlohaCare's Commitment

One Health Plan Partner's Commitment

By **"Empowered, healthy communities"** and by **"ensuring and advocating access to quality health care for all"**, we mean that:

- AlohaCare's core business will focus on being recognized as the best and most successful plan in serving the Medicaid and the dually-eligible Medicaid and Medicare populations of Hawaii; and,
- AlohaCare's core role will be that of a facilitator in helping communities to become more empowered to ensure access to quality health care for all.

By **"serve individuals and communities"**, we mean that we must constantly build and maintain special health plan expertise and capabilities that can successfully and effectively contribute to solving the most persistent challenges in meeting the health care needs of individuals within population in the communities in which they live.

AlohaCare

- By the **"spirit of aloha"**, we mean that the principles of aloha by which we conduct our core business will result in the highest levels of member and provider satisfaction and of member retention among those organizations who serve these populations.
- By **"with emphasis on prevention and primary care through community health centers"**, we mean that our main emphasis as a health plan in achieve our mission will come about largely through our core partnership and collaboration with the community health centers and a focus on primary care and prevention.
- By **"with others that share our commitment"**, we mean that, in addition to our emphasis in working with community health centers, we will also work in close partnership and collaboration with physicians, communities that share our mission commitment.
- AlohaCare has **grown to enable community health centers and other healthcare providers** to address the total cost of care and quality in our state while also retaining its original founding principle.

Some Recent Thoughts from Health Centers on the Model

Shared Savings – we need to evolve gain share distribution model

1. Should be related to relative utility provided by each partner.
2. Assumption of risk could be linked to % of gain share (40% upside = 100% downside risk).
3. Scope of services provided by FQHC could be linked to gain share (distribution formula).
4. Performance on accountable care metrics could link to gain share distribution.

Volume Based Payments and PPS – we need to link alternative touches to an enhanced patient experience. Link bundled payments to non-PPS services.

1. Primary care volume growth is valuable if it enhances patient access and early intervention.
2. Bundled payments for FQHCs may be best linked to non-PPS services and care out populations (opioid addiction interventions).

Risk Adjustment

1. We are looking for a model that recognizes zip code based population adjustments that include social factors.
2. A Health Plan/Health Center partnership could find pilot projects in risk adjustment however, ultimately the goal should be state Medicaid agency driven risk adjustment.

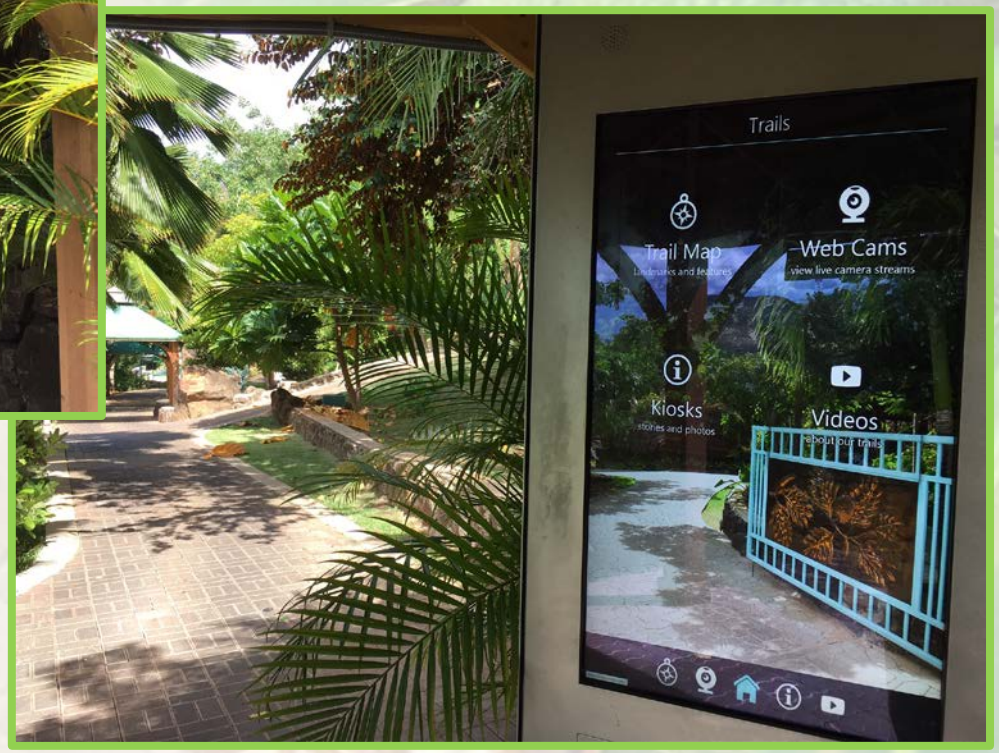
Addressing Social Determinant Needs

1. We must determine whether CMS Accountable Community Survey can fit with PRAPARE
2. We need to continue to build link from PRAPARE to Risk Stratification

2017 AHARO Hawaii – Document List

- Journey to an Island Healthcare Home – (Report on Leadership Conferences) August 1, 2015
- Clinical Integration Agreement between Health Centers and AHARO Hawaii
- Discussion Paper – Addressing Social Determinants of Health through Community Engagement and Supplemental Health Home Standards
- Surveying value added services provided by Health Centers
- AHARO Hawaii – Attribution of Patients and Gain Share Distribution Discussion Paper
- AHARO HIT/Care Coordination Work Plan
- AHARO Accountable Care Metrics
- AHARO 360° Evaluation of Health Plans

MAHALO!



Visit our website at www.AHARO.net