America’s Voice for Community Health Care
Recap of Webinar #1

- Review terminology and definitions
- Provide a basic overview of health insurance plans and their products
- Understand the structure of Managed Care Organizations; and
- Explore how Public Health programs can work with payers
Objectives

• Review key terms and definitions

• Provide a basic overview of how Managed Care Organizations are paid

• Understand how payers (MCOs, Medicare, Medicaid, etc.) reimburse providers; and

• Understand we are all learning to navigate in this new world and have an opportunity to learn from each other
Key Terms

• Benefits
• Premiums
• Reimbursement
• Patient Cost Sharing
• Volume to Value
Types of Health Insurance Products

- Medical (Physical)
- Behavioral Health
- Pharmacy
- Dental
- Vision
Key Terms

- Premiums (How are Insurance companies paid)
  - Employer
    - fully insured
    - self-funded
      - use of Third Party Administrator (TPA)
  - Individual
  - Medicare
  - Medicaid
How does the money flow in Managed Care Payments?

Individual person, employer, State, or CMS pays a pre-determined $ amount to MCO (i.e. PMPM) for a specified length of time (usually 12 months).

MCO uses Premium to pay for services utilized by patient covered by the MCO.

* Medicaid and Medicare Advantage plans are required to cover at a minimum the services Medicaid or Medicare covers.

- Medical Claims
  - Acute and preventative (hospital/ER/physician/lab/etc)

- Care Coordination / outreach services / reporting

- Other services
  - (vision/hearing/dental/transportation)
How does the money flow from Payer to Provider?

Claims adjudication and payment

- Insurance Company Generates EOB and Send to Provider with Payment
- Insurance Company generates EOB and send to Provider, but without payment.
- Provider office can appeal for payment or can resubmit after correcting the errors
Reimbursement – what and how is the provider paid?

• Reimbursement and the Models
  – Fee for Service (FFS)
  – Capitation (Primary Care)
  – Other types
    • Care management fees for chronic disease
  – Bundled payments
Reimbursement Models

Indemnity
- Least amount of Risk
- Unrestricted Network
- See members and receive payment
- 80/20 Reimbursement

Fee For Service
- Medium Risk
- Contract and Network Participation Required
- Must submit a claim to receive payment
- Will the negotiated fee be sufficient to cover your costs long term

Capitation
- High Risk
- Contract and Network Participation Required
- Actuarially derived
- Must submit encounter data
- Makes provider responsible for the delivery of care
Reimbursement and Cost Sharing

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500  Co-insurance: 20%  Out-of-Pocket Limit: $5,000

January 1st
Beginning of Coverage Period

Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

December 31
End of Coverage Period

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200
Volume to Value

Bundled Payments

**Total Knee Replacement Surgery**

<table>
<thead>
<tr>
<th>Multiple Insurance Payments</th>
<th>Bundled Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consultation</td>
<td>Total: $26,384</td>
</tr>
<tr>
<td>2. Anesthesia</td>
<td></td>
</tr>
<tr>
<td>3. Surgery</td>
<td></td>
</tr>
<tr>
<td>4. Implants</td>
<td></td>
</tr>
<tr>
<td>5. Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>6. OR, Recovery Rm, Hospital</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$26,384</td>
</tr>
</tbody>
</table>


Volume to Value

CARE TEAM

- Doctor
- Occupational therapist
- Nurse
- Physiotherapist
- Acupuncturist
- Clergy
- Lawyer?
- Nutritionist
- Social worker
- Employment counselor?
Volume to Value

Rita H. Orr
Director, Provider Programs and Payment Innovation
AmeriHealth Caritas

June 9, 2016
Overview of AmeriHealth Caritas

AmeriHealth Caritas is a leading national Medicaid managed care company.

- Operates in 17 states and Washington D.C.
- Integrated model of care incorporates physical health, behavioral health and pharmacy health services
- Serves more than 6.8 million members across various product lines
- Expertise in caring for challenging populations, offering Medicaid, Medicare dual eligibles, behavioral health, pharmacy benefits management and specialty pharmacy solutions in urban and rural settings

Owned by two of the largest and most respected Blue plans: Independence Blue Cross (majority) and Blue Cross Blue Shield of Michigan.

**Our mission:** We help people get care, stay well and build healthy communities.

**Our vision:** Leading America in health care solutions for the underserved.
Integrated Care Through Multiple Product Lines

Medicaid managed care (TANF/CHIP/ABD)
  • Full-risk
  • Non-risk (MSA/ASA/TPA)

Medicare services for duals eligibles (D-SNP, MMP)

Behavioral health care

Pharmacy health care
  • Pharmacy benefits management (PBM) services
  • Medication therapy management services
  • Specialty pharmacy services
Who We Are

AmeriHealth Caritas Coverage Area
Touching the lives of more than 5.9 million members nationwide

* Medicaid and behavioral health coverage effective April 1, 2016.
CMS Value Based Models

HCP LAN - Population-based Payment Models

- Population-based payment (PBP) models fall into categories 3 & 4.
- Typically, we think of PBP as involving prospective payment.
- However, PBP can, and often does, build on a FFS chassis.

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Population-Based Accountable APMs
CMS Value Based Models

LAN PBP Models: Category 3 and 4

**Category 3**

A. **Upside Gain-sharing**
   (Shared Savings)
   - Built on FFS chassis
   - Providers share a portion of savings when costs are below negotiated payment / budget
   - No provider responsibility for costs above payment / budget

B. **Downside Risk**
   (Shared Risk)
   - Built on FFS chassis
   - Providers bear responsibility for percentage of costs above negotiated payment / budget
   - Stop-loss often used to mitigate risk exposure

**Category 4**

Population-based payment
(Partial or full capitation)
- Prospective payment
- 4A Condition-specific PBP
- 4B Comprehensive PBP
- Providers retain savings below negotiated payment / budget.
- Providers bear full responsibility for costs above payment / budget.
- Stop-loss often used to mitigate risk exposure

Quality is a significant payment model component in each of these categories
**Definition of Value-Based Payment**

**Value-based Payment** is a term used to describe a payment model where the amount of payment for a service depends in some way on the quality or cost of the service that is delivered.

There is no accepted minimum standard as to how much the payment must vary or what type of value measure must be used, so some payment models have been described as “value-based” even though there is very little difference in the amount of payments based on differences in quality or cost.

**Value-Based Purchasing** is a term used to indicate that a purchaser is contracting for healthcare services in ways that are designed to improve quality, reduce costs, or both. Value-Based Purchasing may include the use of some form of Value-Based Payment, but it also can include Value-Based Insurance Design, Narrow Networks, and other approaches.
Definitions

• APM Framework – Alternative Payment Model
• Person Centered Care – high quality care that is both evidence based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs and values are paramount.
  • rests on three pillars: quality, cost effectiveness and patient engagement
• Population based payment – payment models are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget, holding providers accountable for meeting quality and person centered care goals for a population of patients or members.
• Condition-specific capitation - A fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.
• Bundled payment - Also known as "Episode-based payment" means a single payment to providers or healthcare facilities (or jointly to both) for all services to treat a given condition, or, to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.
• Hospital-physician gainsharing - Arrangement in which hospitals and physicians share the cost savings achieved through collaborative efforts resulting in improved quality and/or efficiency
Definitions

Pay for performance - Provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment models.

Shared savings - Provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared-savings programs can be based on a FFS payment system. Shared Savings can be applied to some or all of the services that are expected to be used by a patient population and may vary based on provider performance.

Shared risk - Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets; examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules.

Value pricing - Concept in which buyers hold providers of health care accountable for both cost and quality of care by paying providers differentially based on value. "Value" can have a variety of definitions under value-based purchasing, and typically brings together metrics on the quality of health care (such as patient outcomes and health status) with metrics on the dollar outlays going towards health.
Value Proposition

- Patient Engagement, Care Navigation and Surveillance
- Informatics Excellence
- Value added Provider & Community Partnerships
- Treating the Whole Person
- True Integrated Care Management

Treating the Whole Person
Solutions – AmeriHealth Caritas Comprehensive Strategy

Provider Infrastructure Support
- Clinical Risk Stratification
- Robust Analytics
- Quality Measures
- Transparency
- Best-in-Class Reporting & Functionality
- Strong Provider Partnership Account Management Team

Value-Based Programs & Initiatives
- Shared Savings
- PerformPlus
- Pay for Performance
- Specialty Value Based Programs
- Dashboards
- QEP – PCP
- FQHC Community Partners

Stakeholder Engagement
- ACO Contracts
- TCOC
- % MLR
- Full Risk Contracts
- Provider Partnerships
- Joint Ventures

The Transition to Accountable Care

Road to Provider Partnerships
Scalability

A Tailored Approach

- Adaptability – our understanding that there is no one-size-fits-all approach
- Solidification of our own core set of accountable care metrics that can be transferred from market to market (state to state)
- Maintaining the ability to augment our programs for state specific initiatives
### Value Based Programs (Examples)

<table>
<thead>
<tr>
<th>PMPM Care Coordination/Population Health Management Fees (Examples):</th>
<th>Quality Enhancement Program (P4P) - PCPs</th>
<th>Primary Care Partners Program</th>
<th>Health Homes</th>
</tr>
</thead>
</table>
| • access and continuity  
• care management  
• comprehensiveness and coordination;  
• patient and caregiver engagement  
• planned care and population health  
• practice transformation support  
• PCMH recognition | • Quality  
• HEDIS  
• PCMH Status  
• Efficiency | • Quality  
• HEDIS  
• Efficiency  
• Controlled upside only shared “savings” | PMPM Payment for care management for targeted chronic conditions:  
• Comprehensive Care Management  
• Care Coordination  
• Health Promotion  
• Comprehensive Transitional Care  
• Member and Family Support Services  
• Referral to Community and Support Services |

<table>
<thead>
<tr>
<th>Integrated Health Homes</th>
<th>Shared Savings Program – Integrated Delivery Systems</th>
<th>Partial Risk Model</th>
<th>Full Risk Model</th>
</tr>
</thead>
</table>
| Serves adult members who have a serious mental illness/members who are children with an SED.  
PMPM payment for member outreach activities or care management monitoring for treatment gaps defined as Health Home services | • Quality  
• Efficiency  
• Controlled upside only shared “savings” | • Continually enrolled population identified by specific risk stratification  
• Excludes non users, maternity members and those with malignancies and catastrophic health conditions  
• Outcomes capped at upside and downside corridors | • Quality based guardrails governing risk allocation/sharing.  
• MLR targets  
• Outcomes capped at upside and downside corridors |
Person-centered Approach

With 30 years of experience serving Medicaid populations, AmeriHealth Caritas understands the needs of at-risk populations. Our person-centered approach includes:

- Engaging, educating and empowering members to actively participate in improving their health outcomes.
- Providing members with the information they need to improve and manage their health.
- Involving members, parents or guardians, care team members, providers, behavioral care providers, social services and community group representatives in the care planning and management process.
- Utilizing community-based services to avoid or delay institutional-based care, supporting members who desire to remain in the home and community-based setting.
- Incentivizing and rewarding healthy member-specific behaviors.
Member Engagement Programs (Examples)

Bright Start®
• Prenatal maternity program that provides support for members who are pregnant
  — Educational materials and promotion of the use of 17-P
  — Outreach calls and events, including Community Baby Showers
  — Moms2be (federal lifeline phones and care management support)

4 Your Kids Care
• Focused education for mothers of young children
  — How to care for a sick child
  — When to call the PCP
  — Importance of regular PCP visits
• Group setting fosters sharing and empowerment

Healthy Hoops®
• Innovative childhood asthma and obesity management program
• Approved by the National Committee for Quality Assurance (NCQA)
• The program has demonstrated decreases in inpatient and ER utilization, an increase in the use of prevention inhalers and a decrease in the use of rescue medications
Role of MCO Community Health Workers (Example)

Community health workers (CHW) are hired from within a community and share language and life experiences of members served.

CHWs are able to develop a critical trustworthy link between the medical delivery system and individuals in the communities where they live.

CHW’s become knowledgeable about the local ecosystem for social services, and help members sort through complex and competing needs (many of which are not medical).

CHW are passionate about helping others and become anchors in a chaotic life.
TACOS - Toward Totally Accountable Care:

“TACOs integrate a full range of physical health, behavioral health, dental services, long-term services and supports, relevant social services, and public health initiatives and pay for these services through a global payment. While other accountable care approaches can help improve patient outcomes and incentivize cost savings, totally accountable care may require a greater effort. For totally accountable care to take hold, it is imperative to reward providers for keeping patients well, not just treating them when they are sick, and global payments offer a possible pathway to achieve this goal.”

Source: Health Affairs Health Blog 1-23-2014
Thank you!
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