Proving and Improving Value
Iowa FQHCs in the New Paradigm of Accountable Care
October 24, 2013

The Single Aim is Value

Fee-For-Service = More Services
“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity”
—George Bernard Shaw, 1911
Reimbursement: Today

- **Volume over Value**
  Providers paid primarily on how many services they deliver, not on the quality of services or their effectiveness in improving a patient’s health. Research shows that more services may not result in better outcomes. For FQHCs, wrap-around payments often dwarf primary care capitation.

- **Better Quality Can Hurt the Bottom Line**
  Under most payment systems, health care providers make less money if a patient stays healthy.

- **Payment and Accountability are Fragmented**
  Each provider involved in a patient’s care is paid separately; results in duplicative tests and services for the same patient, and provides no incentive for providers to coordinate services.

- **Care coordination often not reimbursed**
  Many valuable preventive and care coordination services are not paid for adequately (or at all), which can result in unnecessary illnesses and treatments.

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The **Three Key Pillars of Health Reform** in the Affordable Care Act

1. **Health Insurance and Coverage Reform**
   - Healthcare Delivery System Transformation
   - Value Based Purchasing

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**CMS’s Five Key Performance Results Improvement Areas**

- **Quality of Care and Patient Safety**
  - Patient safety
  - Primary care quality
  - Chronic care
  - Readmission

- **Care coordination**
  - Transition of care
  - Admission and readmission
  - Care coordination and integration

- **Community Centered Prevention and Community Health**
  - Health of communities
  - Reduction of health disparities
  - Population health

- **Efficiency & Cost**
  - Per beneficiary total cost
  - Categories of cost, utilization, and resource use

- **Patient and Person Centered Experience**
  - Patient experience of measured measure in each type patient setting
  - Shared engagement
  - Readmission and health literacy and cost performance index
Medicaid Spending Continues to Increase as a Share of State Budgets

1985 - 2012

Now ¼ of total State Spending

- 1985: 8%
- 1990: 13%
- 2000: 20%
- 2012: 24%

U.S.

Source: HMA, based on NASBO reports, various years.

REINING IN PAYER HEALTH CARE COSTS

1. Limit rates
2. Limit services (covered benefits, covered population, utilization review)
3. Limit administrative costs
4. Transfer risk to enrollees or providers

MIGRATION OF RISK TO CONSUMERS

- Increase premium sharing
- Increase deductibles and co-payments
- Replace coverage with vouchers
- Employers dropping coverage
MIGRATION OF RISK TO MEDICAL PROVIDERS

- Uninsured
- High deductible plans
- Risk sharing
- Capitation
- Accountable care organizations
- Direct provider contracting

U.S. Medicaid Managed Care Enrollment Will Almost Double 2010 to 2020


FQHC Payment

Source: NACHC estimates

Patients by Insurance Status – 2015

* Source: NACHC estimates
Reimbursement: *Future*

- **Value over Volume**
  Incentives to promote improved outcomes and enhanced member satisfaction; there must be a clear link between payment and service value.

- **Better Quality is Rewarded**
  High-quality, evidence-based care is recognized and rewarded by payers.

- **Payment and Accountability are Aligned**
  A distribution of savings within integrated provider groups that rewards providers responsible for generating, but also those who willingly sacrifice traditional revenue in order to create savings. Integrated provider organizations must create a more even balance of power than has been the case traditionally.

- **Cost-effective care management seen as an investment**
  A gradual progression of provider accountability with payment models that recognize the up-front investment needed to change delivery models.

**PPS Based Payment** Does Not:

- Add revenue for transformation to a population health model
- Reflect the value of physician and non-physician staff patient centered care management work that falls outside of the face-to-face visit
- Support adoption and use of health information technology for quality improvement and cost reduction
- Support provision of enhanced communication access such as secure e-mail and telephone consultation
- Recognize case mix differences in the patient population being treated within the practice

**PPS Based Payment** Does Not:

- Align my payment incentives with those of my partners in the delivery system
- Provide an incentive for achieving measurable and continuous quality improvements
- Distribute a share of the savings from reduced hospitalizations, ED visits and other non-PCP costs associated with physician-guided care management in the office setting
**PPS Based Payment** Incents FQHCs To

Count visits

When it should be counting:
- Assigned and attributed lives
- Patient convenience and satisfaction
- Cycle times
- Compliance with evidence-based care
- Non-emergent ED visits
- Hospitalizations for avoidable conditions
- Re-hospitalization

**Accountable Payment: Uninsured**

As number of uninsured decline, anticipate seeing changes in payments for the uninsured, including Section 330 grants:
- Section 330 grant funding could decline overall as number of uninsured decline and ACA funds are exhausted
  - Precedent: DSH
- Section 330 funding could be tied more closely tied to volume of uninsured
  - Precedent: formula-based funding for enrollment assistance and ARRA
- Section 330 funding could be tied more closely tied to quality metrics

**Achieving the Triple Aim**
Accountable Care Organization

A local health care organization and a related set of providers that can be held accountable for the cost and quality of care delivered to a defined population.

FQHCs Reduce Downstream Costs
Illinois 2011 Experience Adjusted for Age, Sex, Disabled Status, SMI Status

<table>
<thead>
<tr>
<th>Cost categories</th>
<th>FQHCs/RHCs</th>
<th>Other Physicians</th>
<th>FQHC &amp; RHC/MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost</td>
<td>$2,534.60</td>
<td>$2,518.75</td>
<td>100%</td>
</tr>
<tr>
<td>LTSS</td>
<td>$ 78.21</td>
<td>$ 83.10</td>
<td>94%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$ 499.84</td>
<td>$ 507.11</td>
<td>91%</td>
</tr>
<tr>
<td>Emergency Dept.</td>
<td>$ 119.41</td>
<td>$ 95.57</td>
<td>125%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$ 700.63</td>
<td>$ 770.30</td>
<td>91%</td>
</tr>
<tr>
<td>Rehab/SA/MH</td>
<td>$ 66.06</td>
<td>$ 53.34</td>
<td>124%</td>
</tr>
<tr>
<td>Other</td>
<td>$1,090.43</td>
<td>$1,009.35</td>
<td>100%</td>
</tr>
<tr>
<td>Wrap</td>
<td>$ 255.00</td>
<td>$ 0.00</td>
<td></td>
</tr>
<tr>
<td>Non-wrap</td>
<td>$ 835.43</td>
<td>$1,009.35</td>
<td>83%</td>
</tr>
</tbody>
</table>

Continuum of Risk-Based Contracting
Population management *without a* financial model

*is not* sustainable.

A Financial model

*without a*

population management model of care

*is not* sellable.

Practice Redesign *or* Payment Reform
**Transition to Value-Based Care**

**Managed Care Financial Model**

**Historical Strategy for Management of PPS under PCP Capitation**

- Reconciliation by the State Medicaid agency: Supplemental payment = (# visits X PPS) – PCP capitation
- Negotiate lowest PCP cap PMPM (cannot be lower than market rate)
- Negotiate for highest downstream potential (PPS is unaffected by financial incentives linked to utilization outcomes and other reductions in downstream patient cost)
- Doesn’t work if State delegates wrap to MCOs
**New Strategy for Management of PPS under PCP Capitation**

Replace Some Wrap with More Cap
- Complies with current Federal legislation protecting PPS
- Rewards FQHCs for transitioning from high volume to high value care
- Reduces State Medicaid wrap costs on a per member per year basis
- Increases PCP capacity for underserved
- Improves FQHC competitiveness

**Replacing Wrap with Cap**

- Creates a financial incentive for FQHCs to reduce non-emergent ED visits & replace some in-person, non-preventive PCP visits with virtual encounters and patient self-management
- Assigns FQHC at least a portion of the resultant savings

**Replacing Wrap with Cap**

- Preventive visits paid fee-for-service @PPS
- Paid market rate cap PMPM for non-preventive PCP visits by MCO
- Paid presumptive wrap PMPM for non-preventive visits by State Medicaid calculated by FQHC historic experience (PPS*average visits PMPY/12 mos.)
- Quarterly reconciliation if visits increase
- Annual reset of benchmark that is new benchmark plus a portion of the difference between previous and new benchmarks dependent on ED utilization reduction
- No reset once reach target non-preventive visit rate; 100% share when reaches target ED visit rate
Example:

- Market PCP cap $18 PMPM
- PPS $125/visit
- PCP productivity 3500 visits/yr.
- % Medicaid 100%
- ED visit reduction 0-5%
- Reduce non-preventive, face-to-face encounters 3.5—3.2—3.0

Example:

<table>
<thead>
<tr>
<th></th>
<th>Baseline Year</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Visits PMPY</td>
<td>3.5</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>PCP Panel Size</td>
<td>1,000</td>
<td>1,094</td>
<td>1,167</td>
</tr>
<tr>
<td>Wrap Permanent PMPY</td>
<td>$222</td>
<td>$284 current</td>
<td>$139 proposed</td>
</tr>
<tr>
<td>PCP Panel Rev</td>
<td>$437,200</td>
<td>$457,200 current</td>
<td>$497,000 proposed</td>
</tr>
<tr>
<td>Increase PCP Panel Revenue</td>
<td>$8,508 current</td>
<td>$8,051 proposed</td>
<td></td>
</tr>
<tr>
<td>FQHC/Private PCP Rev</td>
<td>203%</td>
<td>185% current</td>
<td>174% proposed</td>
</tr>
<tr>
<td>State reduced wrap/panel vs. adding PCP @ 3.5 visits PMPY</td>
<td>$8,508 per 1,094 Medicaid members</td>
<td>$25,396 per 1,167 Medicaid members</td>
<td></td>
</tr>
</tbody>
</table>

Example: varying ED reduction

<table>
<thead>
<tr>
<th>ED reduction</th>
<th>51%-59%</th>
<th>51%-79%</th>
<th>2%-59%</th>
<th>0% No share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel size</td>
<td>Baseline Year 1</td>
<td>1,000</td>
<td>1,094</td>
<td>1,167</td>
</tr>
<tr>
<td></td>
<td>Year 2</td>
<td>1,094</td>
<td>1,167</td>
<td></td>
</tr>
<tr>
<td>Increase PCP Panel Revenue</td>
<td>Year 1</td>
<td>$72,917</td>
<td>$80,762</td>
<td>$80,508</td>
</tr>
<tr>
<td></td>
<td>Year 2</td>
<td>$81,016</td>
<td>$86,484</td>
<td>$85,321</td>
</tr>
<tr>
<td>State reduced wrap/panel vs. adding PCP @ 3 visits PMPY</td>
<td>Year 1</td>
<td>$8</td>
<td>$10,254</td>
<td>$80,508</td>
</tr>
<tr>
<td></td>
<td>Year 2</td>
<td>$8</td>
<td>$86,432</td>
<td>$87,396</td>
</tr>
</tbody>
</table>
Practice Redesign

1. Determine reasons that low value of care is being provided
2. Identify and target the sub-population choosing lower value options and who are also potentially amenable to intervention
3. Identify an intervention using evidence-based practice guidelines and protocols when available
4. Develop a corrective plan using an interdisciplinary care team approach including care coordination and care management when appropriate

Opportunities to Improve the Value of Care Provided

Primary Care

- Requiring face-to-face encounters when virtual encounters and other forms of communication would suffice
- Inability to access your own PCP when needed
- Uninformed patient expectations
- Underdeveloped patient self-management skills
- Lack of pre-visit planning
Investment Needed to Change some Face-to-Face FQHC Visits to Virtual Visits

- Nurse triage
- Patient portal visits
- Teaching member self-management
- Member notification of diagnostic results and next steps
- IT support to detect gaps in care with member notification
- Pre-visit screening

ED Utilization Target Population

- Approximately 40 percent of ED visits are not urgent
- 48% of EDs are at or over patient capacity which can be a threat to patient safety and public health
- More than 65% of people visiting EDs spent more than 2 hours in the facility
- Poor communication between ED providers and PCPs lead to duplicative testing and patient error
- It is more expensive to provide non-urgent care in the ED than the PCMH

MHN Analytics: Top Inpatient and Emergency Room Utilization
Diagnosis for Patients with >10 ED Visits (past 12 Months)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe mental illness</td>
<td>32.9%</td>
</tr>
<tr>
<td>Multiple diagnoses without pattern</td>
<td>24.2%</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>11.2%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>6.8%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>4.3%</td>
</tr>
<tr>
<td>Headaches</td>
<td>2.5%</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.5%</td>
</tr>
<tr>
<td>Chest pain</td>
<td>1.9%</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>1.9%</td>
</tr>
<tr>
<td>Gastrostomy complications</td>
<td>1.9%</td>
</tr>
<tr>
<td>All other</td>
<td>10%</td>
</tr>
</tbody>
</table>

Opportunities to Improve the Value of Care Provided Emergency Department

- New member disorientation
- Lack of timely access to PCMH
- Unfamiliarity with PCMH access
- False expectations of ED care
- Failure of PCMH to address patient needs

New Members Welcome Calls

1. Are you having any trouble getting medication, home medical supplies or getting an appointment with a physician or healthcare provider? (YES or NO)
2. Have you needed to go to the emergency department more than once in the last 6 months? (record number of times) (YES or NO)
3. Have you needed to go to the hospital more than once in the last 6 months? (record number of times) (YES or NO)
4. Do you have a specialist or specialty clinic that you go to regularly for your medical or mental health needs? (YES or NO)
5. Do you have any concerns about your personal safety or current living situation? (YES or NO)
6. Do you have any immediate needs that interfere with your ability to take care of yourself? (YES or NO)
Access to the PCMH

1. Open access scheduling with adequate capacity
2. Empanelment with appropriate panel sizes
3. Evening and weekend hours
4. 24/7 access to the care team/virtual encounters
5. Eliminate financial barriers

Unfamiliarity with PCMH Access

1. PCP bonding
2. Identify inappropriate utilizers
3. Outreach calls for member education and PCP scheduling
4. Reinforce PCMH access next visit s/p ED visit
5. Monitoring for change in habits

Failure to Address Patient Needs

1. Care management of frequent ED utilizers
2. Team approach with behavioral health specialists, pain specialists, social workers and other community agencies
3. Provider responsiveness to urgent conditions for those requiring long term services and support
False Expectations of ED Care

1. ED diversion efforts
2. ED provider education
3. Patient education in the ED
4. Follow-up calls from PCMH

MHN Analytics: ED/K Initiative, Intervention Reports

Clinic Connect: Proactive Care Management Tracking
ER Connect: ED Referral to Medical Home Print Out

Printable referral forms will be generated at the patient’s discharge from the ED. Each referral form will include:

- Clinic contact information & operating hours
- A map detailing public transportation options
- An image of the clinic façade

The Ale carte Approach to Risk

1. Primary care
2. Pharmacy
3. Outpatient diagnostics and therapeutics
4. Emergency department
5. Behavioral health
6. Specialty care
7. Inpatient care
8. Long term services and supports

P4P/shared savings with uniform incentive criteria & multi-plan aggregated basis for payment

- Aggregates data from multiple contracts for total actual performance & provides to MCOs/AO
- Combined performance/incentive method to pass incentives to the practice level to providers that are creating value
- Provides performance reports, transparency & consultation to individual clinicians
- Rewards margin to create additional savings and to build reserves to manage additional risk
**FQHC Success Will Require:**

1. Clinical collaboration if not integration  
2. Data analytics and connectivity  
3. Progressive assumption of risk  
4. Targeted and innovative model of care  
5. Patient engagement/wellness programs  
6. Leadership committed to CQI with the broadest perspective

**State, Plan, Provider & Stakeholder Leadership**

**Commitment to:**
- Venturing from the safety of the known  
- New collaborations/integration with  
- Demanding delivery system and payment reform

“But I have been successful with the current approach for many years”  
Kodak

**Inspiration...**

One does not discover new lands without consenting to lose sight of the shore for a very long time.  
*André Gide*