Building the Bridge from Fee-for-service to Accountable Care

HMPRG CHC/MCO Forum
Art Jones, MD
October 1, 2013
The Triple Aim

- Improve individual experience
- Improve population health
- Control inflation of per capita costs

D. Serwick, Institute of Healthcare Improvement, 2007
Health Care Reform: National Context

With the Triple Aim as the ultimate goal, the Affordable Care Act has two inter-dependent objectives:

1- Make adequate **health insurance coverage** more available and affordable.

2- Reform delivery and payment systems to provide better care in a more cost-efficient manner.
Medicaid and Medicare Spending
Projections 2012 - 2023

Medicare and Medicaid Are the Primary Drivers of Future Federal Spending Growth and Deficits

Source: CBO.
Medicaid Spending Continues to Increase as a Share of State Budgets

1985 - 2012

Now ¼ of total State Spending

Source: HMA, based on NASBO reports, various years.
U.S. Medicaid Managed Care Enrollment Will Almost Double 2010 to 2020

Millions of U.S. Medicaid Enrollees in Managed Care Organizations

Illinois Medicaid Expansion under the Affordable Care Act 2013-22 per HFS

<table>
<thead>
<tr>
<th></th>
<th>Beneficiaries</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently eligible but newly enrolled</td>
<td>98,000</td>
<td>3%</td>
</tr>
<tr>
<td>Newly eligible under Medicaid expansion (assumes 50% uptake)</td>
<td>198,000</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>296,000</td>
<td>9%</td>
</tr>
</tbody>
</table>
Most Enrollees are Now in Managed Care, but **Most Medicaid Spending Is Still FFS**

Total U.S. 2009

- 78% in FFS
- 22% in Managed Care

Note: Managed care includes risk- and non-risk based, including MCOs, PCCMs, and limited benefit plans. Data are for 2009. Source: HMA, prepared from data in: MACPAC, *Medicaid and CHIP Program Statistics*, June 2012.
Impact of ACA on FQHCs

**Revenue by Source - 2010**
- 58.8% Patient Services Revenue
- 41.2% Grants and Other

**Patients by Insurance Status - 2015**
- 78.0% Insured
- 22.0% Uninsured

Source: NACHC estimates
## Illustrative Plan Designs for Single Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Actuarial Value</th>
<th>Deductible</th>
<th>Patient Coinsurance</th>
<th>Out-of-Pocket Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze 1</td>
<td>60%</td>
<td>$4,375</td>
<td>20%</td>
<td>$6,350</td>
</tr>
<tr>
<td>Bronze 2</td>
<td>60%</td>
<td>$3,475</td>
<td>40%</td>
<td>$6,350</td>
</tr>
<tr>
<td>Silver 1</td>
<td>70%</td>
<td>$2,050</td>
<td>20%</td>
<td>$6,350</td>
</tr>
<tr>
<td>Silver 2</td>
<td>70%</td>
<td>$650</td>
<td>40%</td>
<td>$6,350</td>
</tr>
</tbody>
</table>


SOURCE: Kaiser Family Foundation
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.
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
Population management *without a* financial model *is not* sustainable.
A Financial model without a population management model of care is not sellable.
Transition to Value-Based Care

Practice Transformation

Aligned Payment Transformation
Managed Care Financial Model

- FQHC PPS
- PCCM/PCMH
- P4P
- Shared savings
- Partial Capitation
Continuum of Risk-Based Contracting

- High Accountability
- Moderate Accountability
- Low Accountability

Financial Risk:
- Fee-for-service
- Care Coordination Fee
- Pay-for-performance
- Shared Savings up & down
- Partial Capitation
- Global Capitation

Accountability Continuum - Based Contracting
Illinois: Medicaid Program Enrollment

- 3 million + in Medicaid statewide
- ~251,000 in traditional Medicaid managed care
  - 215,000 in Voluntary MCOs, only in select counties
  - 36,000 ABD enrollees in Suburban Cook, Collar Counties
  - HFS dissatisfaction expressed in 2012 Bloomberg Report
- 1.8 million in PCCM program, Illinois Health Connect

<table>
<thead>
<tr>
<th>Medicaid Enrollment by Category</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>1,677,575</td>
<td>55.0%</td>
</tr>
<tr>
<td>Adults with Disabilities</td>
<td>260,228</td>
<td>8.5%</td>
</tr>
<tr>
<td>Other Adults</td>
<td>636,531</td>
<td>20.9%</td>
</tr>
<tr>
<td>Seniors</td>
<td>168,943</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Total Comprehensive</strong></td>
<td><strong>2,743,277</strong></td>
<td><strong>89.9%</strong></td>
</tr>
<tr>
<td>Partial Benefit</td>
<td>309,387</td>
<td>10.1%</td>
</tr>
<tr>
<td><strong>Total Enrollment (FY 2011)</strong></td>
<td><strong>3,052,664</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated Care Program (ICP)</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health Inc</td>
<td>18,049</td>
<td>50.3%</td>
</tr>
<tr>
<td>IlliniCare Health Plan (Centene)</td>
<td>17,814</td>
<td>49.7%</td>
</tr>
<tr>
<td><strong>Total ICP Enrollment (July 2012)</strong></td>
<td><strong>35,863</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voluntary MCO Program</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harmony Health Plan</td>
<td>133,587</td>
<td>62.1%</td>
</tr>
<tr>
<td>Family Health Network</td>
<td>74,330</td>
<td>34.5%</td>
</tr>
<tr>
<td>Meridian Health Plan</td>
<td>7,295</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total Voluntary MCO (July 2012)</strong></td>
<td><strong>215,212</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCCM Program</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois Health Connect (July 2012)</td>
<td>1,854,670</td>
<td>100%</td>
</tr>
</tbody>
</table>
## Current Contracting Options by MCO

<table>
<thead>
<tr>
<th></th>
<th>FHN</th>
<th>Harmony</th>
<th>Meridian</th>
<th>Aetna</th>
<th>Centene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Family HP</td>
<td>Family HP</td>
<td>Family HP</td>
<td>SPD</td>
<td>SPD</td>
</tr>
<tr>
<td>FFS</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>P4P</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Partial Capitation</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
State of Illinois Reform

• “Medicaid Reform (Illinois PA96-1501) requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by “managed care entities,” a general term that will include Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs) and Managed Care Organizations (MCOs).”
  – Passed House 111-4
  – Passed Senate 58-0
## HFS Care Coordination Roll-Out Plan: January 2013 – January 2015

<table>
<thead>
<tr>
<th>Focus of Plan</th>
<th>Population</th>
<th># of Clients</th>
<th>Geography</th>
<th>Beginning Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care Program: adding “Phase II” LTSS – by Centene/Aetna (“Phase III” for Persons with Developmental Disabilities approx. 1 year later)</td>
<td>SPD-Medicaid</td>
<td>36,000</td>
<td>Collar counties</td>
<td>2011</td>
</tr>
<tr>
<td>Care coordination for <strong>SPD adults</strong>, by provider-organized Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCN) - initially 5 CCEs, 1 MCCN</td>
<td>SPD-Medicaid and Duals; family members</td>
<td>16,000+</td>
<td>4 in Chicago area; 2 downstate – 6,000 initially (growth based on capacity)</td>
<td>2013-14 Contracting currently</td>
</tr>
<tr>
<td>Care coordination for <strong>SPD adults</strong> in additional regions – by variety of managed care entities</td>
<td>SPD-Medicaid</td>
<td>19,000</td>
<td>Rockford</td>
<td>July 1, 13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12,858</td>
<td>Aug 1, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7,794</td>
<td>Sep 1, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,895</td>
<td>Nov 1, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>69,000</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Care coordination for <strong>children with complex health needs</strong> – by CCEs and MCCNs</td>
<td>Children</td>
<td>5,000+</td>
<td>Statewide (growth based on capacity)</td>
<td>2013-14</td>
</tr>
</tbody>
</table>

SPD = Seniors and Persons with Disabilities, LTSS = long-term supports and services
<table>
<thead>
<tr>
<th>Focus of Plan</th>
<th>Population</th>
<th># of Clients</th>
<th>Geography</th>
<th>Beginning Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare-Medicaid Alignment Initiative – by MCOs</td>
<td>SPD-Duals</td>
<td>136,000</td>
<td>Cook and collar counties/Central Illinois</td>
<td>Jan-14</td>
</tr>
<tr>
<td>Care coordination for children/family and caregivers (ACEs and MCOs)</td>
<td>Children/families</td>
<td>1,476,000</td>
<td>Chicago region, Central IL, Rockford, Quad Cities, Metro East</td>
<td>Jul 2014</td>
</tr>
<tr>
<td>Care coordination for “Newly eligible Medicaid” clients under Affordable Care Act (County care, ACEs, MCOs)</td>
<td>Adults 19-64</td>
<td>198,000</td>
<td>Cook County, Rest of IL</td>
<td>Jan-13 July -14</td>
</tr>
<tr>
<td>Clients in fee-for-services as of 1/1/15 (rural counties/Duals opting out, etc.)</td>
<td>Various</td>
<td>1,000,000 +</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL MEDICAID ENROLLMENT AS OF JANUARY 2015</strong></td>
<td></td>
<td>3,100,000 (approx.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Projected MCO Options in Coming Months
(MCO selection pending for Family Health Plan & New Medicaid Eligibles)

<table>
<thead>
<tr>
<th></th>
<th>Family Health Plan</th>
<th>SPD Chicago</th>
<th>Duals MMAI</th>
<th>New Medicaid</th>
<th>Market-place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td></td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td></td>
<td>1/1/2014</td>
</tr>
<tr>
<td>BCBS of IL</td>
<td></td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td></td>
<td>1/1/2014</td>
</tr>
<tr>
<td>Centene</td>
<td></td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>current</td>
</tr>
<tr>
<td>FHN/CCAI</td>
<td>current</td>
<td>2/1/2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmony</td>
<td>current</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Springs</td>
<td></td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td></td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td></td>
</tr>
<tr>
<td>Meridian</td>
<td>current</td>
<td>2/1/2014</td>
<td>1/1/2014</td>
<td>1/1/2014</td>
<td></td>
</tr>
<tr>
<td>LOL Co-opt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/1/2014</td>
</tr>
</tbody>
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Accountable Care Entities

• Integrated delivery system (PCP, Specialist, Hospital and Behavioral Health)
• Direct Provider contracting with HFS rather than MCO intermediary
• Progressive Payment Accountability
  – Fee-for-service with share savings months 1-18
  – Capitation with risk protection months 19-36
  – Capitation without state risk protection mo. >=37
• As with MCOs, HFS takes 4% savings off the top
**TERMS/ASSUMPTIONS**

- 40,000 members.
- Care Coordination Fee (CCF) ≈ 50% of MCO administrative load ($9 pmpm).
- Exit Fee = Return 50% of the 18 months CCF if contract terminates prior to month 31.
- Shared Savings = 50% of total risk healthcare cost (including CCF) up to max of 5%.
- 4 Quality Measures, each worth 10% of shared savings, required for distribution of earned surplus.
- Measurement period for Shared Savings is months 7 – 18. 6 months ramp up.
- ACE financial proposal requires plan to reduce healthcare cost >= first 18 months of Care Coordination Fee ($9 X 40,000 X 18).
- Covered Services will be paid under FFS payment structure.
- PCPs will continue to receive PCCM fees.

**SHARED SAVINGS MODEL**

**SHARED SAVINGS POOL**

ACE Cap Rate – Risk Adjusted ACE Total cost of Care (Actual PMPM + Care Coordination Fee)

- MAX Savings = 5% ACE Total Cost
- Projected Savings ≤ $3,000,000 max

**Surplus**

- HFS 50%
- MHN ACE 50%

**Deficit**

- 10% cost
- 40% cost & quality

**Equity Fund**

- X%

**Primary Care**

- X%

**Specialists**

- X%

**Hospital & ED**

- X%

**Avoidable**

Practice Redesign:

- Support Medical Home
- Increase Access
- Enhance Quality
- Reduce Costs

**DIRECT PROVIDER CONTRACT MODEL**

**Direct Contract**

- FFS Service Payment
- PCCM Fee
- FQHC Wrap

**Care Coordination Fee**

- ACE Management
- Reserved for Exit Fee or Reserves

- $4.50 pmpm

- $4.50pmpm

**ACE Participating Providers**
ACE Partial Risk Model (19 – 36 months)

TERMS/ASSUMPTIONS

- ACE must be licensed as an HMO or MCCN by month 19.
- ACE must meet MCCN financial requirements.
- Payment based on risk adjusted pre-paid capitation.
- HFS shares risk through Stop-loss insurance and Risk corridors.
- ACE will be subject to a similar P4P structure as MCOs, and will have % of Cap withheld.
- ACE must have the capability to process claims, submit encounter data, and implement utilization controls.
- ACE will be required to self-monitor and analyze 29 HFS proscribed Quality Indicators, 4 of which are used for P4P withhold.

ACE

$XXX.XX Capitation pmpm - Pay For Performance Withhold

Less Stop Loss

Surplus

ACE 100%

Deficit

Risk Corridor <110%

Risk Corridor >110%

Equity Fund

Primary Care

Specialists

Hospital & ED

Practice Redesign:

• Support Medical Home
• Increase Access
• Enhance Quality
• Reduce Costs

Direct Provider Payment

ACE Back Office

Avoidable
ACE Full Risk Model (37+ months)

TERMS/ASSUMPTIONS

- ACE must be licensed as an HMO or MCCN and meet RBC or MCCN financial requirements.
- Full Risk Capitation.
- ACE capitation will be subject to P4P structure.
- ACE must have the infrastructure capability of an MCCN or voluntary managed care such as processing claims, submit encounter data, and implement utilization controls.
- MLR of 80% + 30 day claims turnaround

ACE

$XXX.XX Capitation pmpm - Pay For Performance Withhold

P4P Withhold

Surplus

Deficit

ACE 100%

Payback Deficit

Equity Fund X%

Primary Care X%

Specialists X%

Hospital & ED X%

Avoidable

Practice Redesign

- Support Medical Home
- Increase Access
- Enhance Quality
- Reduce Costs

Direct Provider Payment

ACE Back Office
FQHC Managed Care Contracting Considerations

• Don’t assume PPS will last forever
• Choose a strategy for each patient category
  – Family Health Plan
  – Non-dual SPD
  – Medicare-Medicaid Duals
  – New Medicaid Eligible
  – Medicare Advantage
  – Marketplace
  – Other commercial insurance
FQHC Managed Care Contracting Considerations

• Centralized vs. decentralized care management of high risk members
• Review contracts with both a strategy and legal perspective
• Develop a glide path to accountable payments
• Align incentives with an integrated delivery system but be careful whose pool you are in
• Choose partner friendly payer/plans
Contract Pitfalls

- Non-solicitation clauses
- Termination without cause clauses
- Transfer of members before cure period expires for breach of contract
- Indemnification, defending and hold harmless clauses
- Unilateral contract amendments
- Failure to review the provider manual
- Ability to terminate contract immediately for MCO insolvency or non-payment
FQHC Managed Care Contracting Considerations

• Leverage your
  – Patient loyalty
  – PCP capacity in your medically underserved community
  – Enabling services
  – Performance on withhold quality measures
  – Ability to manage downstream utilization and cost
  – Plans for practice transformation
  – Best deal
FINANCIAL PRINCIPLES OF CONTRACTING

• Understand your risk threshold
  – Managed care experience
  – Model of care/IT support
  – Don’t overestimate impact of care management
  – Financial reserves

• Structure contract to allow future assumption of additional risk

• Investment in future earnings (ROI)
Number of Payer Partners

Maximize if:
- Need new patient referrals
- Current membership demands this choice
- Multi-plan alignment of payment and requirements

Selective if:
- Unable to approximate your best deal
- Disparate plan requirements
- Leverage selectivity to maximize contract terms
Marketplace Plan Considerations

• Must offer FQHC services
• Exempt from any willing provider
• Must pay PPS unless FQHC accepts a lower rate
• Bronze and silver plans will likely be high deductible &/or high co-payment
• “Better than what I am currently being paid” may not be the case if your 330 grant is reduced
Achieving the Triple Aim

COST QUALITY CURVE

quality

insured

uninsured

cost
Sources of Potential Savings

1. Primary care
2. Specialty care
3. Outpatient diagnostics and therapeutics
4. Behavioral health
5. Pharmacy
6. Emergency department
7. Inpatient care
8. Long term services and supports
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
Investment Needed to Change some Face-to-Face FQHC Visits to Virtual Visits

- Nurse triage
- Patient portal
- Teaching member self-management
- Member notification of diagnostic results and next steps
- IT support to detect gaps in care with member notification
FQHC Success Will Require:

1. Clinical collaboration if not integration
2. Data analytics and connectivity
3. Eventual multi-payer outcomes based payment
4. Targeted and innovative model of care
5. Patient engagement/wellness programs
6. Leadership committed to CQI with the broadest perspective
Multi-payer Outcomes Based Payment

- **P4P** will give you good HEDIS scores
- **Care Coordination and PCMH Fees** prime the pump but don’t focus on outcomes
- **Shared Savings** alone ignores start-up costs and must be supplemented by short term gratification payments
- **Capitated Risk** without experience or reserves is fool hearted
- **P4P+CC/PCMH+SS => Capital + Risk Management Experience=>Capitated Risk**
P4P/shared savings with uniform incentive criteria & multi-plan aggregated basis for payment

**Reimbursement Structure:**
- MCOs offer PCP capitation with PPS reconciliation
- MCOs offer PCCM to fund up-front costs
- MCOs offer P4P with uniform quality/value parameters
- MCO offer Shared Savings payment based on global cost with % of premium target at mandated minimum MLR and uniform access parameters

MCO & ACO Based Contracts

- Aggregates data from multiple contracts for total actual performance & provides to MCOs/ACO
- Establishes a performance/incentive method to pass rewards to the practice level to providers that are creating value
- Provides performance reports, transparency & consultation to individual sites/providers
- Reinvests margin to create additional savings and to build reserves to manage additional risk
FQHC Leadership

Committed to:

• Venturing from the safety of the known
• Exploring new collaborations/integration with other healthcare providers
• Securing outcome-based payments from payers
Proving and Improving Value

Illinois FQHCs
in the New Paradigm of Accountable Care

October 3, 2013