Structuring Effective Value-Based Partnerships with Federally Qualified Health Centers (FQHCs)

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Conflict of Interest Disclosure: Faculty/Planning Committee/Reviewers/Staff

Participating speakers in “Structuring Effective Value Based Partnerships with Federally Qualified Health Centers, (FQHC’s)” have no conflict of interest to disclose relative to the content of the presentation.
Agenda

Improving Medicaid Managed Care (MMC) Sustainability through Partner Collaborations
Clifford Barnes, Partner, Epstein Becker Green

The Role of FQHCs in MMC Networks
Shawn Frick, VP, PCA and Network Relations, National Association of Community Health Centers

WellCare’s Experience with Expanding the Role of FQHCs
John A. Johnson, MD, MBA, Senior Medical Director, WellCare Health Plans, Inc.

The FQHC Urban Health Network (FUHN): A Case Study
Natalie Ellertson, Vice President, Medicaid ACOs, Optum
Improving Sustainability Through Collaborations
Clifford Barnes, Partner
Epstein Becker Green
Concept

• Multiple MCOs developing common value-based protocols
• Jointly contracting with Integrated FQHCs
• FQHCs Integrating through Clinical Practice Transformation
• Integrated FQHCs jointly contract with MCOs
• MCOs and FQHCs Implementing protocols that result in, among other things, reducing unnecessary emergency room and inpatient encounters and thereby raising quality and reducing costs
The Rise of Medicaid ACOs

- At least 9 states have developed and launched Medicaid ACO programs
- 8 states are actively pursuing ACO programs
- In the last 3 years, 4 states have launched active Medicaid ACO programs
- Alabama, Maryland, Massachusetts, and Michigan could launch ACO programs in 2016/17
- **Payer-led ACOs**: OR & UT
- **Provider-led ACOs**: IL, ME, MN, NJ, VT, RI

Multi MMC Approach

- Critical patient mass to get FQHCs attention
- Shared investment defrays costs
- No compromise of competitive network
- Enables payors to more efficiently meet state quality initiatives and increases ability to earn back a greater proportion of withheld premiums
- Significant costs can be categorized as medical expense rather than administrative expense (for Medical Loss Ratio calculations and related targets)
Business Reason MMCs Focus Collectively on Integrated FQHCs

Multi MMC Approach

• Enables common understanding of the means to measure, monitor and improve quality in a common value based payment model

• CMS is actively supporting Medicaid Programs that transition from rewarding volume to paying for value with financial incentives to improve outcomes for Medicaid beneficiaries

• Unlike Medicare, no one definition of Medicaid ACO is required

• States have expressed concern that traditional managed care model can no longer achieve fiscal savings or improve client outcomes
Business Reason MMCs Should Focus Collectively on Integrated FQHCs

Integrated FQHCs

• Access to higher quality primary and preventive care can move MMC quality scores
• Lower use of more expensive emergency department and inpatient services
• As FQHCs code more accurately.
  • Quality scores are likely to become more accurate
  • Enrollees included in most appropriate rate cell
  • More accurate premiums to MMCs
• Data sharing enables FQHCs to more effectively coordinate care for MMC enrollees
• Decreased time that MMCs' care managers spend trying to get and assemble enrollee information as a basis for care planning and care management, including utilization management
Integrated FQHCs

• Reduced provider abrasion by integrating with FQHCs' Electronic Medical Records (EMRs) for easier collaboration - connected once and done vs with multiple MMCs systems/integrations

• Improved quality results by integrating data in ways that capture better hybrid data information

• Extended reach of existing care management resources - automation enables MMCs to monitor the health risks of a broader swath of the total population for cost and quality risks, using clinical information at point of care to more rapidly identify and communicate health risks,

• Increases the capabilities of FQHCs to increase quality and reduce costs and thereby strengthen FQHCs in the marketplace.
## I. Benefits to All Key Stakeholders

<table>
<thead>
<tr>
<th>FQHC</th>
<th>MCO</th>
<th>ENROLLEES</th>
<th>STATE</th>
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</table>
| Resources and training to improve coding specificity | More accurate coding leads to:  
- More accurate quality scores  
- Enrollees in more appropriate rate cells  
- More accurate premiums | More targeted and timely health care | More effective program |
## II. Benefits to All Key Stakeholders

<table>
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<tbody>
<tr>
<td>Data Sharing and more effective care coordination</td>
<td>MCO care managers more effective and lowers clinical costs</td>
<td>Coordinated Health Care</td>
<td>Addresses pressure to improve quality</td>
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## III. Benefits to All Key Stakeholders

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<tbody>
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<td>Shared value-based protocol</td>
<td>Increases FQHC participation and greater potential for savings</td>
<td>Program sustainability</td>
<td>Addresses mounting economic pressures</td>
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## IV. Overall Benefits to All Key Stakeholders

<table>
<thead>
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<th>MCO</th>
<th>FQHC</th>
<th>ENROLLEES</th>
<th>STATE</th>
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<tr>
<td>• Better outcomes and data</td>
<td>• Clinical transformation to succeed in value-based contracting</td>
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<tr>
<td>• Improved revenue</td>
<td>• Improved patient care</td>
<td>• Better access, coordination and care</td>
<td>• Improved program sustainability</td>
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<td>• Administrative efficiencies</td>
<td>• Additional revenue</td>
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Elements of Collaboration

MMCs

- Develop “utility” analysis for FQHCs
- Agreed upon value-based protocols
- Shared IT Platform
- Joint contracting with integrated FQHCs
- State becomes partner for fee-for-service Medicaid
Elements of Collaboration

FQHCs

• Agree to engage in clinical transformation
• Agree to value-based protocols
• Shared IT platform
• Collective negotiations on behalf of FQHCs
• State becomes a partner for fee-for-service Medicaid
How FQHCs are Positioning for Medicaid Payment Reform

Shawn Frick
VP, PCA and Network Relations
National Association of Community Health Centers (NACHC)
2015 Health Center Program: 24.3 Millions Patients

**People Served By Age**

- Age 18-64: 61%
- Age 0-18: 30%
- Age 65+: 9%

**People Served By Payer**

- Medicaid: 49%
- Uninsured: 25%
- Private: 17%
- Other: 9%

Information from Bureau of Primary Health Care, HRSA, DHHS, 2015 Uniform Data System
Services Provided by CHCs

All Services Provided to All Ages

- Primary Health Care
- Dental Care
- Behavioral Health
- Pharmacy

- Basic Lab
- Emergency Care
- Radiological Services
- Transportation
- Case Management
- After Hours Care
- Hospital/Specialty Care

*FQHC Services are a mandatory benefit under Medicaid and Medicare
*Please refer to Program Requirements as this is not a complete list of services.

Note: all services required on site or through established written arrangements/referrals
Health Center’s Path to Value?….Clinically Integrated Networks

- 54 Primary Care Associations (state level advocacy & technical assistance)
- 80 Health Center Controlled Networks (back office functions)
- PCA + HCCN leads to:
  - HIE which leads to:
    - IPA (messenger to integrated) which leads to:
      - Clinically Integrated Networks (MSSP, ACOs and other opportunities)
- Practice population health – PCMH and MU are not enough
- Become expert at coding and billing – HC Health Plan vs. HC Coding vs. Health Plan Data
- Partner with equals - share your values (patient first, prevention focused)
Health Center’s Path to Value?….MEDICARE!

- **10,000** new Medicare patients a day are enrolling

- **Significant Revenue Generators**: Enhanced 1st visit rates - Annual Wellness Visit (AWV) averages $150, Care Coordination Fees ($46 PM/PM), Medicare PPS increased by 30%

- **Medicare cost data is transparent** – allows for a “safe system” to transition

- Health Center Medicare **population is small** – **TEMPORARILY** bifurcate our care delivery teams, learn the model and become proficient

- Once **proficient**, we can apply lessons to other payers / populations
Clinically Integrated Network Activity - 2015

States with PCA and/or HCCN involvement with ACO or IPA

KEY:
- Yes
- No
- No, but in process of learning more

[Map of the United States showing states with PCA and/or HCCN involvement with ACO or IPA, with different colors indicating the level of involvement.]

MHPA16
2016 Health Center led ACO Activity

- Red states (PCAs or HCCNs) have fully implemented ACO with a national plan or by themselves.
- Impossible to count all ACOs as many are private through an MCO or locally controlled
What We Need from Medicaid Plans

- **Meaningful** Data Feeds on our patient panels
- Real time information about our patients (ER, inpatient, discharges)
- A common set of metrics from MCOs
- Incentives based on outcomes, not indicators
- Multi MCO standard contracts
WellCare’s Experience with Expanding the Role of FQHCs

John A. Johnson, MD, MBA
Senior Medical Director
WellCare Health Plans, Inc.
Agenda

• Overview of WellCare
• Description of Patient-Centered Medical Home (PCMH) Incentive
• Support for Federally Qualified Health Centers (FQHCs)
• Success Year-to-Date
• Benefits From Our Partnership through Value-Based Purchasing Agreements (VBPs)
WellCare Health Plans, Inc.

Company Snapshot

OUR PRESENCE

Founded in 1985 in Tampa, Fla.:
- Serving 3.8 million members nationwide
- 374,000 contracted health care providers
- 68,000 contracted pharmacies

Serving 2.4 million Medicaid members, including:
- Aged, Blind and Disabled (ABD)
- Children’s Health Insurance Program (CHIP)
- Family Health Plus (FHP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

Serving 1.3 million Medicare members, including:
- 331,000 Medicare Advantage members
- 1 million Prescription Drug Plan (PDP) members

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid)
- Health Care Marketplace plans
- Managed Long Term Care (MLTC)

Spearheading efforts to sustain the social safety net:
- The WellCare Community Foundation
- WellCare Associate Volunteer Efforts (WAVE)
- Advocacy Programs

Significant contributor to the national economy:
- A FORTUNE 500 and Barron’s 500 company
- 7,100 associates nationwide
- Offices in all states where the company provides managed care

All numbers are estimates as of June 30, 2016.
The states where WellCare currently offers Medicaid and/or Medicare Advantage plans and the year WellCare began operations in the state.

1 WellCare of Florida, Inc. was incorporated in 1985 and began offering Medicaid services in the state in 1994.
2 WellCare acquired Missouri Care in 2013 and offered managed care plans in Missouri through Harmony Health Plan from 2006 – 2014.

All numbers are estimates as of June 30, 2016.
WellCare’s direct economic impact* on the state of Georgia is $29 million annually.

WellCare of Georgia

- Serves 641,000 Members across the state
  - 580,000 Medicaid
    - 520,000 LIM
    - 56,000 CHIP
    - 4000 P4HB
  - 61,000 Medicare
    - 38,000 MA
    - 23,000 PDP
- Has a local presence with 5 office locations
- Employs 325 Associates

*Direct economic impact includes employee salaries and facilities expenditures in the state.
All numbers are approximations and are as of June 30, 2019.
Members Assigned to FQHCs under VBP Agreements in GA

- Medicaid:
  - 91.5% Total FQHC
  - 8.5% Total Membership

- Medicare:
  - 92.6% Total FQHC
  - 7.4% Total Membership

- Combined Membership:
  - 8.4% Total FQHC
  - 91.6% Total Membership
In 2013, the PCMH incentive program was launched and provided an additional payment to PCMH recognized Providers, including FQHCs, in the Georgia Medicaid network with a current PCMH recognition.

WellCare recognizes the added value provided to Members who have a medical home when a Provider group has received a Level 1, 2 or 3 recognition using the NCQA PCMH recognition standards.

- There are 20 eligible E/M CPT codes included in this incentive which are paid at a flat rate.
- The incentive rates increase based upon the PCMH recognition level, with level 3 being the highest.
- Payments are made within 60 days after a calendar quarter.
- The incentive program does not require changes to the FQHC Provider contract.
PCMH Coaching Assistance

Moving the Needle

• July 2014 – implemented the PCMH Coaching Assistance Program for the Georgia Medicaid network
  • WellCare of Georgia has increased the number of PCMH-recognized Providers in the network by over 90% since the program was implemented

• January 2016 – launched a WellCare-branded PCMH web-based platform with 35 training modules and several templates to assist Provider with achieving PCMH requirements

• August 2016 – working with 3 rural FQHCs on obtaining PCMH recognition renewal efforts
  • Have educated 3 other FQHCs on PCMH recognition requirements
WellCare is in the process of identifying and recruiting other FQHCs that are in need of assistance with either initial PCMH recognition or renewal.

WellCare offers advice on Quality Improvement as part of the PCMH coaching program and other assistance to support FQHCs with improving effectiveness and efficiency.
Quality Practice Advisors (QPA) provide education and consultative support to Providers on State-specific and National Committee for Quality Assurance (NCQA) HEDIS measures.

• Serve as the market clinical subject matter expert in the field for:
  • HEDIS measures
  • Appropriate medical record documentation
  • Appropriate coding

• Support:
  • Development and implementation of quality improvement interventions
  • Medical records audit re-education to resolve deficiencies impacting plan compliance to meeting State and Federal standards for HEDIS
Success - Year-to-Date HEDIS Measures for Medicaid

YoY improvement on some quality measures and health outcomes for Members as a result of forming a partnership.
Success - Year-to-Date HEDIS Measures for Medicare

Each of the quality measures depicted have either already met or are on track to meet or exceed the baseline year and the 75th percentiles.
Operations Account Representatives (OAR)

10 Operations Accounts Representatives located in the GA Market

- Conduct root-cause analysis on claims
- Educate Providers on common billing practice errors and reimbursement policies
- Drive adoption of self-service tools (WellCare portal, State Medicaid portal, etc.)
- Coordinate with both internal and external partners to review and resolve outstanding claims-related issues
Types of services FQHCs are reimbursed for include:

- Evaluation and Management Services (E/M)
- Preventive Medicine – including EPSDT/Health Checks
- Telehealth Consultations
- Obstetric/Maternity Codes
- Dental Services
- Vision Care Services
- Behavioral Health
Benefits From Our Partnership

The Triple Aim:
• Quality – Improved Health Outcomes
• Member Satisfaction Increased
• Cost Containment

Additional support for FQHC Providers:
• Community Advocacy
• Care Management
• Telemedicine
Motivational Quote – A Call To Action

“Tell me and I forget, teach me and I may remember, involve me and I learn.”

-Benjamin Franklin
The FQHC Urban Health Network (FUHN): A Case Study

Natalie Ellertson
Vice President, Medicaid ACOs
Optum
FQHCs are:

- Recognizing their value to MCOs in payment reforms—accessible, high quality primary care in underserved areas that affect MCO EPSDT and HEDIS performance
- Participating in formal Medicaid payment and service delivery reform programs in over a dozen states (OR CCOs, CA DSRIP PRIME, Minnesota IHPs)
- Collaborating with each other (IPAs, CINs, ACOs, new MCOs/PLEs)
FQHC Urban Health Network (aka FUHN)

A Brief History

- MNACHC planning committee in response to legislation and anticipated DHS RFP
- Steering committee established by 10 metro FQHCs with 140,000 unique patients
- Selected Optum as administrative partner in Aug. 2011
- Responded to RFP from DHS
- Neighborhood Health Care Network (NHCN) “repurposed” as FUHN using existing 501(c)3 organization
- Participated in DHS plenary sessions with all nine RFP responders over 3–4 month period
- CQI and CFO committees convened, along with other formal governance actions
- Negotiations with DHS throughout remainder of 2012
- Contract with DHS signed by FUHN in December—the only “virtual” project among the initial five Integrated Health Partnership (IHP) pilots

Decision to drive the bus instead of getting run over by it

- Project considered operational as of Jan. 1, 2013
- Staff hiring in Q2 2013 and simultaneous IT infrastructure development
- Deployed performance improvement advisors into clinics to help illuminate care coordination opportunities based on analysis of more complete patient data
- Lots of lessons learned as project and network evolve ...

Learning to steer the bus...

Change is coming

2011

2012

2013–Present
Goals – Achieve the triple aim + 1

1. Reduce total cost of care
2. Improve clinical quality
3. Improve patient access and satisfaction
4. Rebalance spending towards primary and preventive care

Element: Clinical practice transformation
Drives operating efficiency around standard care pathways

Element: Program Governance
Drives operating discipline and accountability

Element: Population analysis
Integrated clinical/claims data analysis provides intelligence for all stakeholders

Element: Care management
Keeps stakeholders coordinated in serving patients and populations
Results to Date

- Reduced total cost of care (TCOC) for 32,000 attributed patients:
  - Down 3.1% in 2013
  - Down 4.6% in 2014
  - Down 4.9% in 2015

- Improved clinical quality for ALL 140,000 patients:
  - Earned full quality based withhold in 2013
  - Earned 99% of quality based withhold in 2014

- Rebalanced spending towards primary and preventive care:
  - Primary care spending as proportion of TCOC increased
  - 2%, ED use decreased over 20%
FUHN board and committees
(access, quality, financial performance and patient/family satisfaction policies and performance)

Optum administrative services:
• Data management
• Population health analysis
• Board and committee support
• Contract monitoring and compliance
• Operational adaptations (work flow efficiency, standard clinical pathways, health home certification, etc.)
• Dissemination of best practices

Continuous improvement support:
• Quality improvement framework development
• Patient ID/Stratification and other clinical analysis for targeting
• Patient registries and information exchange
• Process redesign
• Job redesign
• Other care management support, including Health Home certification

State of Minnesota
Shared frameworks, multi-payer data access and project level performance monitoring/reporting
Lessons Learned

Things MCOs can do to help

• Collaborate – recognize aligned interests in, and tremendous prospects for, reducing avoidable IP/ED encounters through stronger FQHCs with improved primary care access for your members

• Align around the following – with or without Medicaid agency direction:
  • Total costs of care definitions
  • Attribution methods
  • Performance measurement frameworks
  • Savings calculations

• Consider that most FQHCs are passionate about ensuring that all their patients receive better services—not just those belonging to one or two payers

• Empathize - it’s hard to live with one foot on the dock and the other on the boat as payment reforms change FQHC operations

• Meet FQHCs wherever they are - growing robust clinical management capacity takes 3–5 years but a rising tide lifts all boats