REDWOOD HEALTH COMMUNITY COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

Symposium on the Future of Complex Care
Welcome and Keynote

November 28, 2017

California Primary Care Association

Symposium on the Future of Complex Care: Setting the Stage

November 28, 2017

Outline

- National and State Climate
- Why health centers?
- Payment Models

Overall Market Forces

- Healthcare costs still outpace inflation and quality is not commensurate with cost
- Consolidation – of health systems and payers
- Medicaid Expansion: windfall in expansion states
- Slow adoption of value-based payment models
  - ACOs prevalent in commercial and Medicare markets
  - Medicaid payment reforms being adopted more slowly and in places where state support is strong
  - FQHC payment reforms advancing very slowly

National/State Political Climate

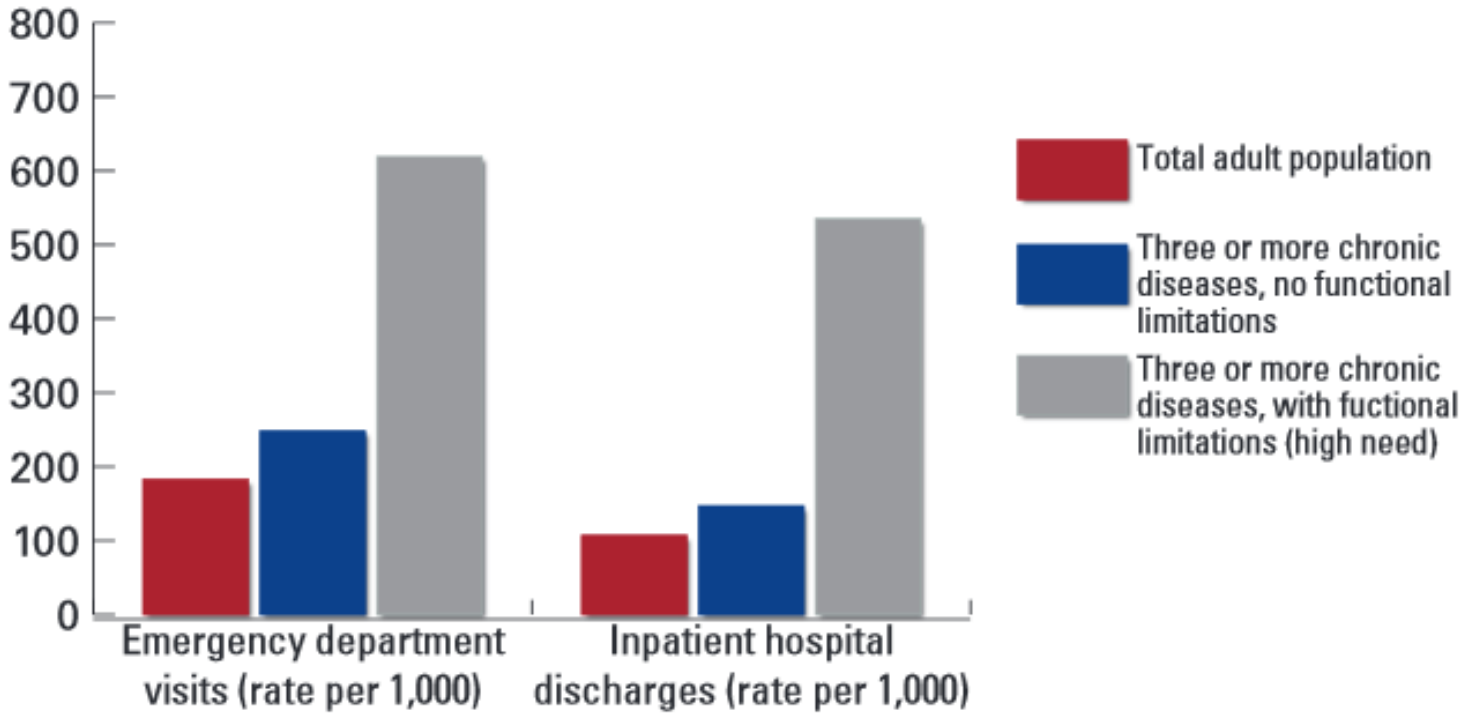
- **Alex Azar- Administrations choice for new Secretary of HHS**
  - Value-based pricing: "I worry a lot when we talk about moving to value-based systems"
  - Azar has been skeptical of the federal government's efforts to tie health care payments to quality of care, especially for the drug industry, saying competition and the private market provide the best remedies to pricing distortions.
  - Medicaid block grants: "A lot to commend"
  - "Block-granting really says, state Medicaid program, state, here's an amount of money. You figure out the best way to provide insurance to those who are unable to afford it in your state," Azar said in a February video for the Zetema Project, which promotes health policy debates. "It becomes their money again to make the choices, make the trade-offs, and turn these sovereign states and these governors from supplicants to the HHS secretary into people running their own health insurance system for the poor."
- **CMS Administrator Seema Verma**
  - Stream lined approaches to 1115 Waivers
  - Work requirements
  - Creating smaller programs so that no one is "enabled" and stays on too long

National/State Political Climate

- GOP and Trump Administration may try repeal and replace in 2018
  - Political campaign promise
  - Need the money for their other priorities
- California likely to be conservative with 2018 budget
- Medi-Cal rates…..windfall to many Medi-Cal Health Plans….procurement in next couple of years
  - Prove Quality and Value
  - Much more interest among plans to enter the market
- DHCS interested in high cost utilizers
  - Palliative care
  - C-sections
- Future changes in CA…. new Administration/ new 1115 Waiver

High Need High Cost

Figure 1. High-need, high-cost adults have more emergency department visits and hospital stays



Source: The Commonwealth Fund, 2017.

Focus on High Cost Utilizers/ Services

- To what end?
  - Save money?
  - Improve quality of care?
  - Both?
- Focusing on highest cost patients may not effectively target the spending that needs to be reduced
- Long term patient investments for coordination and quality might not be a priority if we just focus on cost
- NEJM article suggests that the focus be on identifying the lowest value services and eliminating those

Medicare Spending

Medicare Spending and Low-Value Service Use in 2013, According to Patient Risk for High Spending.*

Group	Group Size		Medicare Spending			Low-Value–Service Use		
	No. of Patients	% of Total	Spending per Patient ($)	Total Spending ($ billion)	% of Total	Services per Patient	Total No. of Services	% of Total
All Medicare beneficiaries	29,524,850	100	9,356	276.2	100	0.37	10,924,790	100
High-risk beneficiaries†	5,014,295	17	23,076	115.7	42	0.59	2,941,475	27
Other beneficiaries	24,510,555	83	6,549	160.5	58	0.33	7,983,315	73

* Analyses were conducted using Part A and B Medicare claims and a random 20% sample of beneficiaries. Totals were multiplied by a factor of 5 to approximate totals for the entire Medicare population. Low-value–service use was assessed using 31 measures in six categories: cancer screening, diagnostic and preventive testing, preoperative testing before low- or intermediate-risk surgical procedures, imaging, cardiovascular testing and procedures, and other invasive procedures.[1,2]

† High-risk beneficiaries were defined as having both a Hierarchical Condition Category score and a count of conditions in the Chronic Condition Data Warehouse in the top quartile of the distributions of these characteristics.

From system to health center

- Have your organizations applied the national and state dialogues to your own systems?
- Do you know who is high cost?
- Do you know which of your sites or providers or teams or services is more high cost than others?
- Have you tracked it against quality or “value”?
- Have you identified potential margins?
- Have you compared your data to your competitors?
- Have you gotten below the symptoms to ask the patient why?

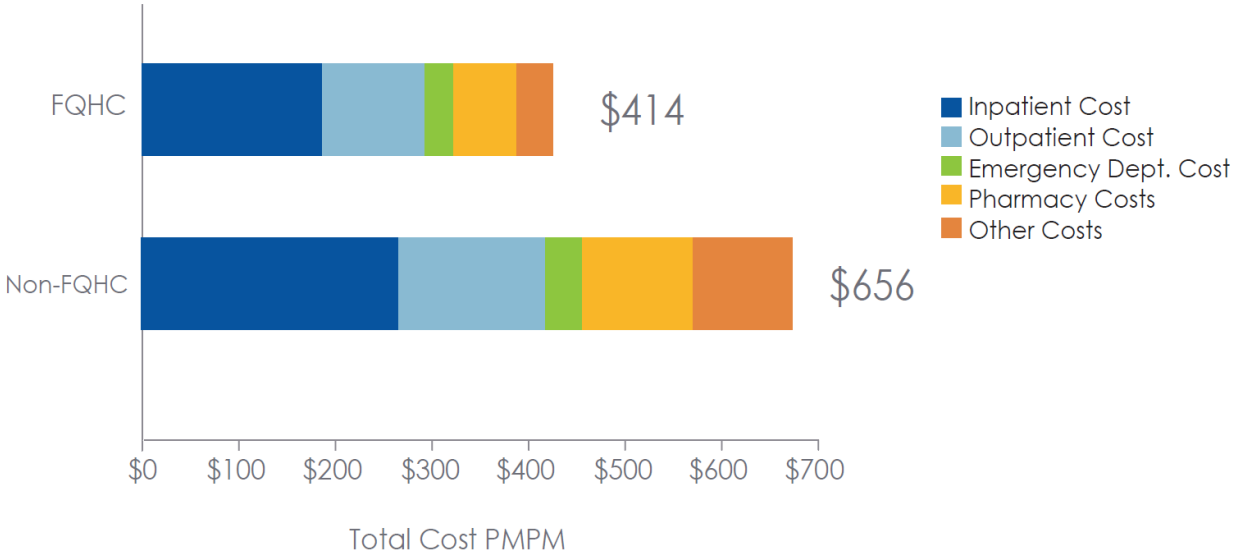
Today

- Nationally
  - 1400 FQHCs….over 10,000 sites
  - Serving 24 million patients
- State
  - 180 clinics and health centers…..over 1300 sites
  - 6.5 million patients
  - Serving 54% of new Medi-Cal managed care beneficiaries

FQHCs in Context

- Health center value studies are demonstrating health center value to the total health system

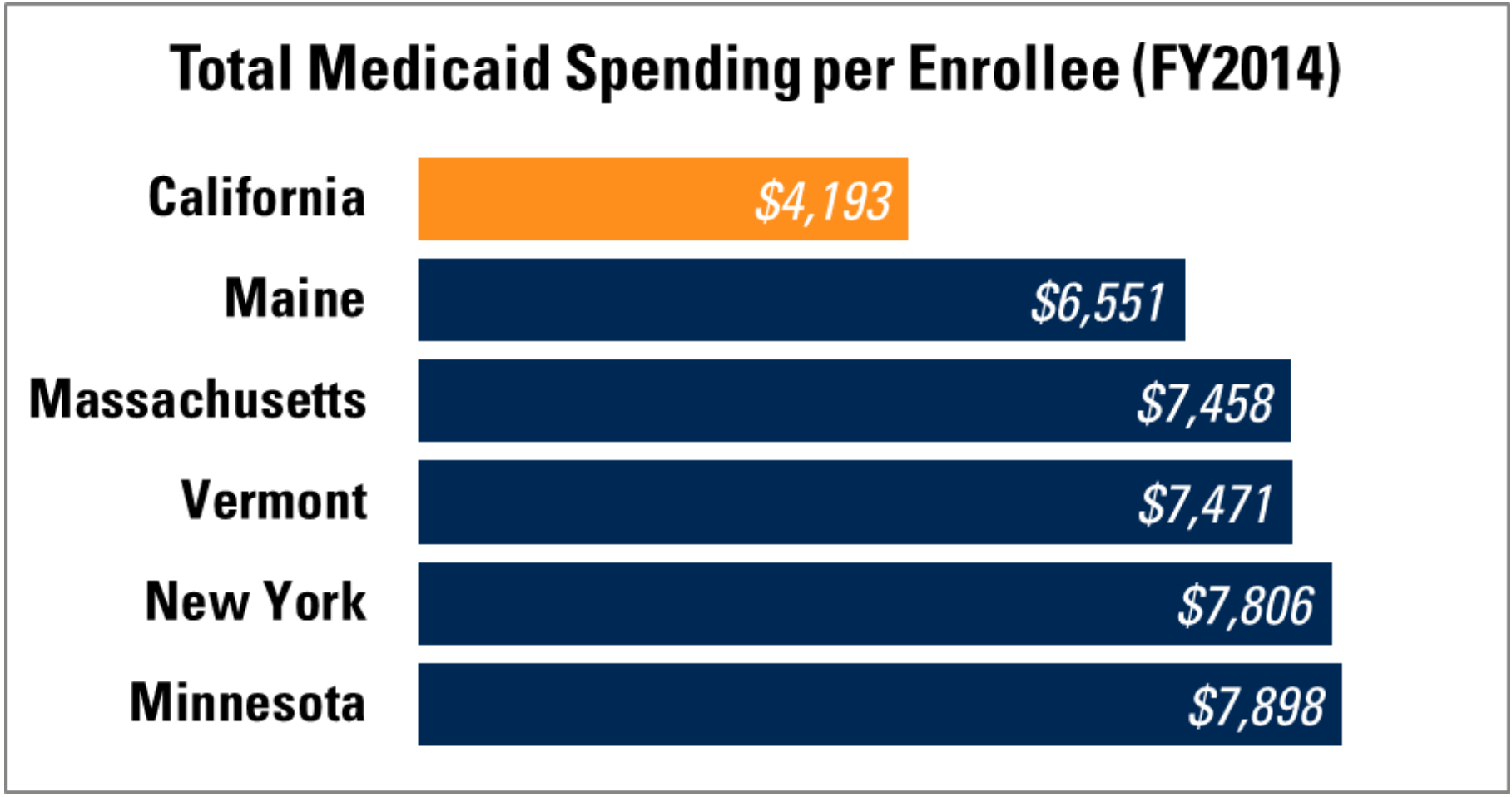
Figure 2. Unadjusted Total Cost PMPM by Component - Adults (18-64)



- CPCA Value Study 2013
- Michigan 2014 PCA released Value Study showed FQHCs are creating total health system value
- HRSA conducted12-state Value of CHCs study 2015

Source: CPCA Value Study 2013

Medicaid Payment Nationally



What DHCS sees

- **FQHC: 3 (visits) * 5,000,000 (patients) * $170 (avg statewide PPS rate) = $2,550,000,000**
- **Avg Provider: $12 Per Member Per Month…..$144/year**
- **$170 * 3 = $510**
  - **$144 30% of what they pay FQHCs**
  - **Managed care plans oversee**

= for better or worse, it's a glass half empty view of A LOT OF MONEY being spent with FQHCs with no real accountability

Why health centers?

- From the embers of the civil rights movement
  - Moral and just reasons to exist
- The formalization of a robust and comprehensive care structure (Primary care/Dental/ Behavioral/ Vision/ Enabling)
  - FQHC
- The theory of the model solidified in a payment structure (at one point considered innovative)
  - Prospective payment system

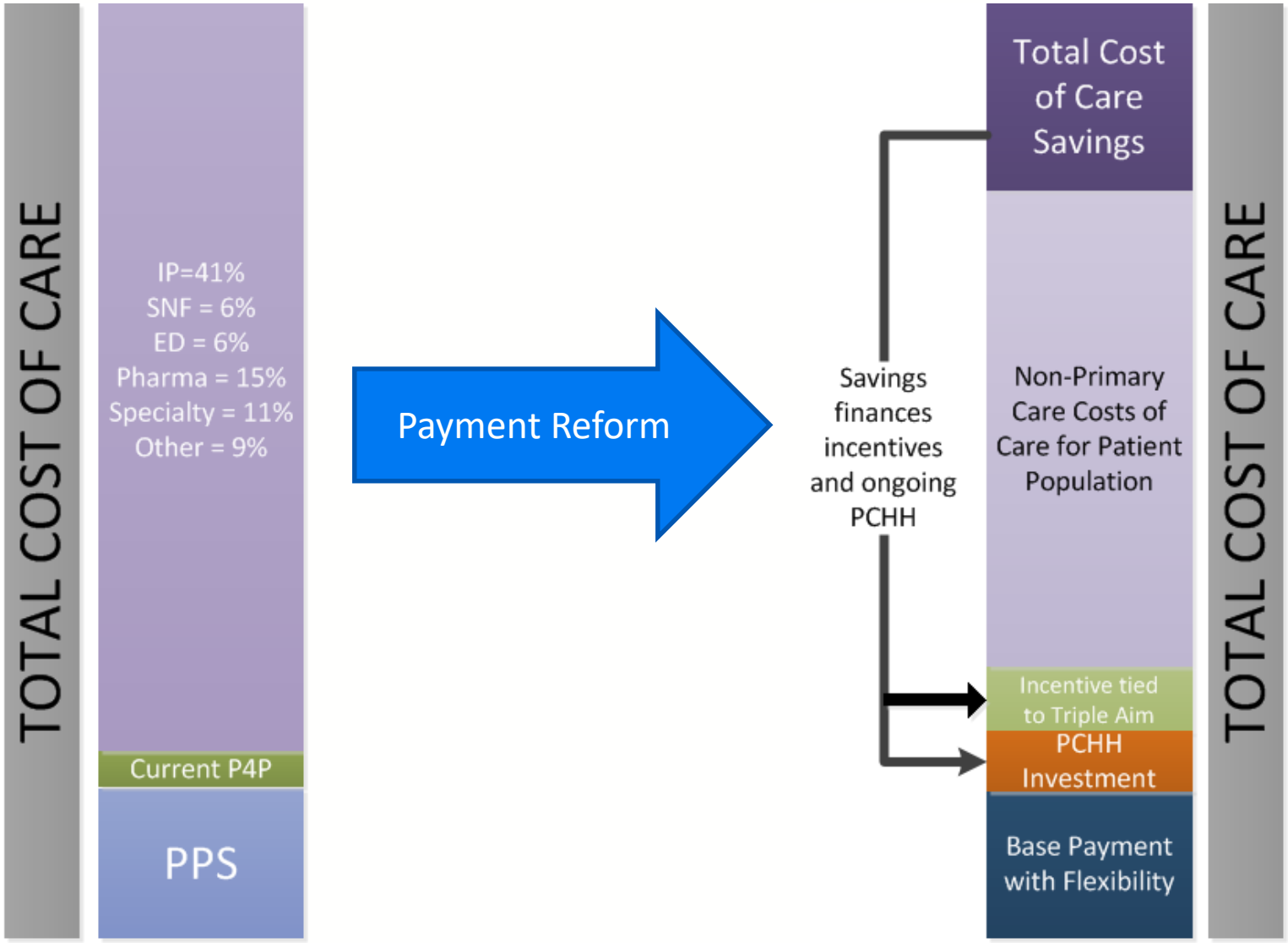
Glass Half Full

- A lot of health centers
- Resources to commit to improvement
- A model based on people, on solving complex issues, a commitment from the legislature both federally and state
- Opportunity to be better and to improve people's lives
- AND…we know the siloed health care system is not good for patients, we have to **"lean out"** and help bridge if we are going to achieve the triple aim

Payment Reforms

- Health Homes
- Whole Person Care
- Pay for Performance
- APM

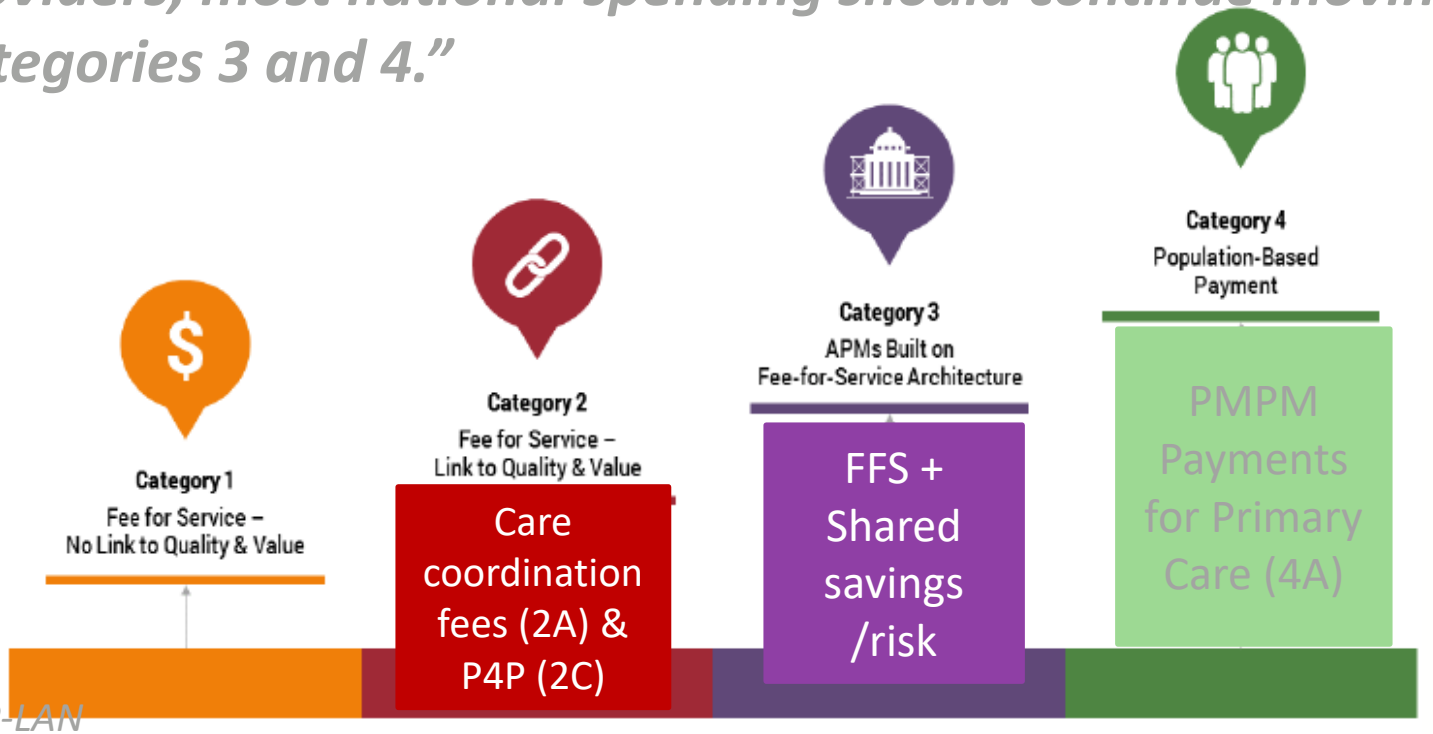
CPCA Comprehensive Payment Reform Strategy



National Landscape – Payment Reform

Health Care Payment Learning and Action Network (HCP-LAN)

"The goal for payment reform is to transition health care payments from FFS to APMs. While Category 2C (pay-for-performance) APMs can be the payment model for some providers, most national spending should continue moving into Categories 3 and 4."

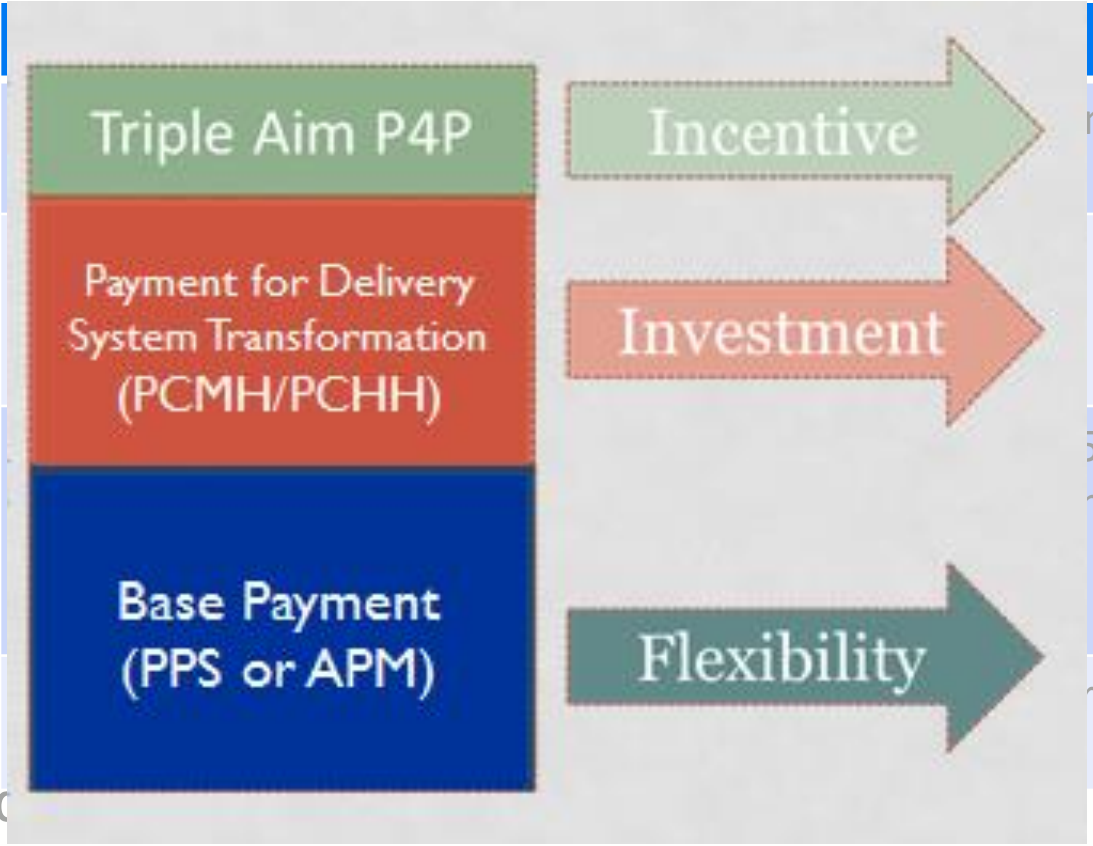


Source: HCP-LAN

Multi-layer primary care payment reform

Example of MACRA Advanced APM: **Comprehensive Primary Care Plus** – Track 2

Performance-based Incentive	nd
Care Management Fee	
Comprehensive Primary Care Payment (PMPM Base Payment)	5%, n
Reduced FFS Base Payment	rt at



- Validates CPCA mod

CATEGORY 1

FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N

Risk Based Payments NOT Linked to Quality

CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery Systems

(e.g., global budgets or full/percent of premium payments in integrated systems)

4N

Capitated Payments NOT Linked to Quality

Summary

- Health care system needs improvements
- Too many siloes between providers and payers and decision makers
- Results are costly care, not very healthy people
- Feds want dramatic changes/ politics makes it hard
- Local decision making could mean less resources
- Health centers were born to look at a whole person, not just a scrape during a visit.
- We need to **LEAN OUT** from our own silos, from the visit, and be the bridge our patients and the system is demanding
- And we have to do it before the system is functionally ready

Andie Patterson
Director of Government Affairs
California Primary Care Association

apatterson@cpca.org