NATIONAL ASSOCIATION OF
Community Health Centers

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NACDD and CDC Health Payer 101 Webinar Series

Webinar #3: Setting the Table Proactively

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Setting the Table Proactively

Objectives

- Key points from previous webinars
- Understanding Data
- Key is Relationships; and
- Example of how a state health department is working with Payers

Where are we Today?
Provider perspective

- **Volume based (previous and current models)**
  - See patient → Bill the payer → Receive payment
  - Paid on number of patients seen or assigned to provider
  - Reimbursement based on current Medicare Fee Schedule
  - Providers have to see a minimum # of patients to cover costs
  - Expectation is to treat the patient (not manage their care)

Triple Aim

A Revolution in Health Care Delivery

- Patients
- Services
- Data / Information

Goals of Managed Care Organizations

- Providers deliver high-quality care in an environment that manages or controls costs
- Care delivered is medically necessary and appropriate for the patient's condition
- Care is rendered by the most appropriate provider
- Care is rendered in the most appropriate, least restrictive setting
- Keep the amount and type of services duplicated to a minimum (VERY difficult)

Volume to Value

Common Denominator - the Patient

**What is driving the cost of care,
which patients are driving the cost,
and who is held responsible?**

Patient Definition

-person receives a service (physician, nurse practitioner, dentist, behavioral health, pharmacy, lab, x-ray, etc.)

-a bill or encounter is produced by someone (patient, managed care company, state Medicaid agency, etc) for payment or acknowledgement of these services performed

-having a medical record on them

-person covered by an insurance plan (the HC has a contract with) AND never been seen by the provider before

Attribution

Plan is accountable for all **'patients'** – starting on the patient's effective date with the plan

- *Attribute / assign the patient to a PCP via hierarchy*
  - *patient chooses*
  - *automatic assignment (zip code)*
  - *use claims data*

- *most plans only 'count' or use claims for patients seen by a Primary Care MD or DO in the past 12 months*
- *NPs, PA-Cs, and Specialists claims are usually not used for attribution*

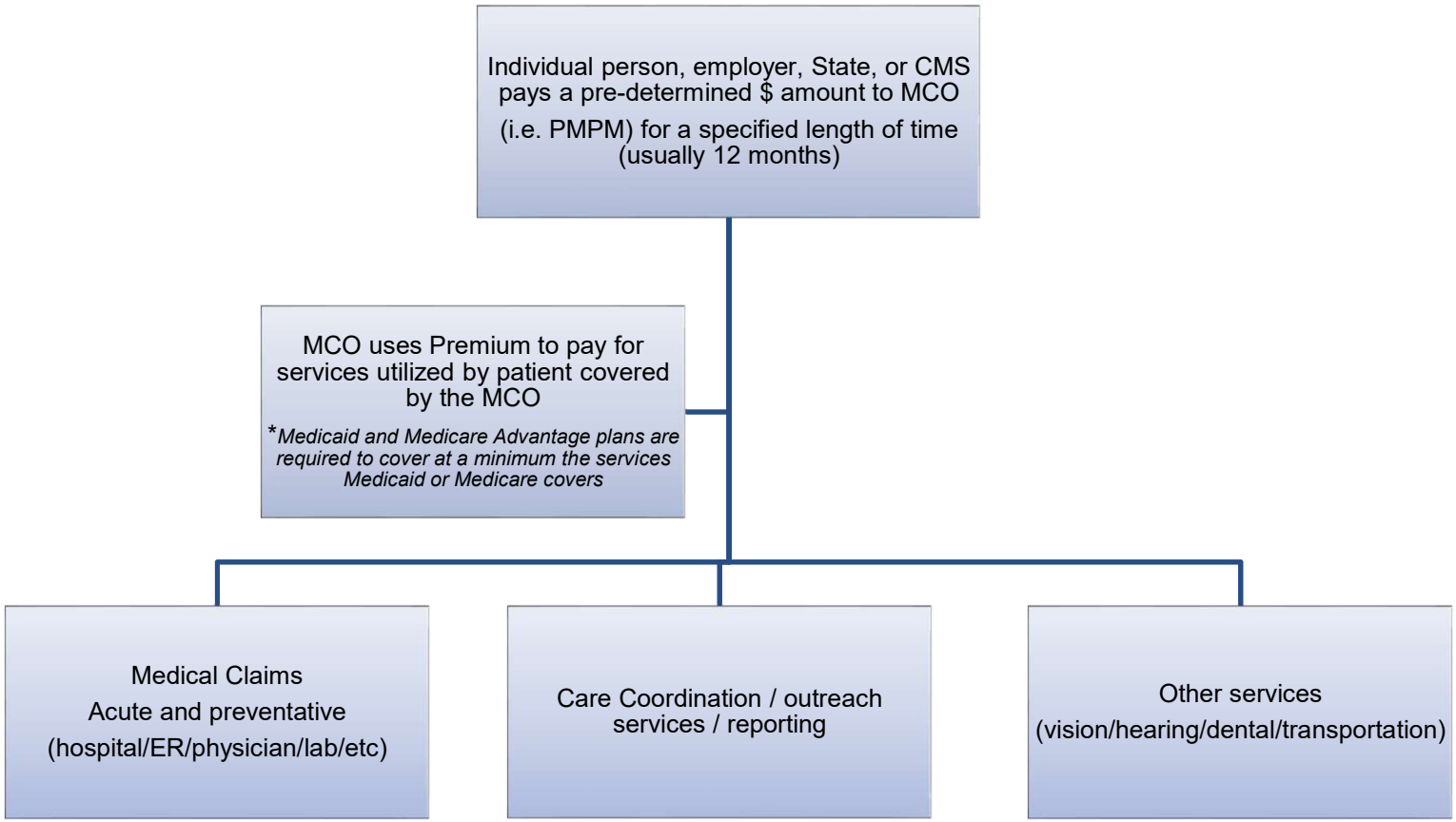
Collaboration *Is Key*

- Clinicians share information across the continuum
  - to coordinate care
  - apply evidence-based medicine and
  - manage patient populations
- Providers and payers collaborate to align incentives with mutual goals
- Patients take a more active role collaborating with their care team
- Information / trends in the community that impact health outcomes should be shared

How does working together complement each other's strategy?

- Common interest in controlling overall cost of care and finding ways to improve health and get the best outcomes for the community
- Need to be efficient and effective in trying to improve the health in our communities
- Health Information Technology (HIT) and Health Information Exchange (HIE)
  - more collaboration all the way to local level
- Better systems coordination in prevention efforts
  - community – based prevention, policy changes, AND clinical data needed to address barriers to good health
  - bridge the clinical focus with a community focus to create awareness of the community resources and have the data to focus on what the community really needs

How does the money flow in Managed Care Payments?



Where are we today?
Payer Perspective

The opposite is true for Managed Care Plans - especially Medicare and Medicaid plans

- State or CMS pre-pays Health Plans a Per Member Per Month (PMPM) monthly premium
- This amount is analyzed and can be reduced annually due to:
  - patient noncompliance (HEDIS, STARs)
  - poor quality outcomes (HEDIS, STARs)
  - unnecessary utilization (HEDIS, STARs)
  - excessive total cost of care (HEDIS, STARs)
  - poor customer service / patient satisfaction (CAHPS survey)
  - level of complexity based on ICD 10 claims data (risk score)

Where are we all heading?

– HHS goals
  - End of 2016: tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements **ALREADY BEEN ACHIEVED**
  - End of 2018 - tying 50 percent of payments to these models

– Aligns payment more directly to the Quality and Efficiency of care provided:
  - Processes (i.e. diabetic has an A1c test annually)
  - Outcomes (i.e. diabetic A1c is =/< 8.0; patient with HTN blood pressure < 140/90)
  - Appropriate utilization (ER, Inpatient admissions/readmissions)

– Additional reimbursement (in addition to being paid for volume)

– Portion of Payment is ‘at risk’ and contingent on how the provider accomplishes contractual requirements (shared savings, capitation, etc)

Medicare Access & Chip Reauthorization Act (MACRA) of 2015

Quality Payment Program:

- Streamlines quality reporting programs into a new Merit-based Incentive Payment System (MIPS)
  - Providers receive a Composite Performance Score (CPS) for performance in the following categories:
    - Quality
    - Resource use
    - Clinical practice improvement activities
    - Advancing care information
- Provides incentive payments for participation in advanced Alternative Payment Models (APMs)

Volume to Value

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
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk

Category 4

Population-Based Payment

- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment

Volume to Value

- Why does Data Matter?
  - provides a strong foundation
  - payers and public health often receive their data from the same source(s)
  - important to understand the similarities and differences of how each entity (i.e. provider, PH department, NACDD, CMS, etc) uses the data
  - use it to determine a better or different way to impact the same population

Volume to Value

- Data to Information
  - claims (diagnosis, procedure codes, and cost)
  - outcomes of what was done or ordered
    - Lab reports, diagnostic tests, medical records (chart review)
  - pharmacy claims
  - utilization (type, frequency, and cost) of services
  - other items that influence health status / outcomes – social determinants of health
  - patient satisfaction surveys

Volume to Value

- Moving from reactive to proactive using data
  - trends (demographics, tests, diagnosis, etc.)
  - use of state claims databases (HIE, Medicaid, etc)
    - ‘hot-spotting’
    - medication adherence
  - ID the ‘triggers’ your organizations use
  - collaboration

In Summary

- Working together
  - promote aggregate data sharing back and forth
  - learn about each other
  - ID what each party has, is promoting, and what is needed by the other
  - how do you fit together?
  - what is it you bring to the table?

Thank you!

For More Information

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