October 26, 2015

Minnesota's Federally Qualified Health Center Urban Healthcare Network - FUHN

Learning Objectives

- Overview of Minnesota's Integrated Health Partnerships (IHP) – Medicaid ACO Model
- Introduction of Federally Qualified Health Center (FQHC)
- FQHC Urban Healthcare Network (FUHN)
  - History
  - Model
  - Successes, Lessons Learned, and Challenges
- Our Vision of the Future

Community Health Centers Today

- **Largest national network of primary care providers**
  - US: 1300+ organizations with 9000+ sites nationally
  - MN: 17 organizations with 70 sites throughout MN
- **Serving low-income patients**
  - US: 24+ million
  - MN: 175,000
- **Record of accomplishments**
  - Savings
    - US: $24 billion annually
    - **MN: ROI – 9% of non-disabled MHCP with 0.6% of budget**
  - More preventative care
  - Improved outcomes
  - Narrow health disparities

MN FQHC Demographics

Chart 3 | 2014 CHC Patient Race/Ethnicity

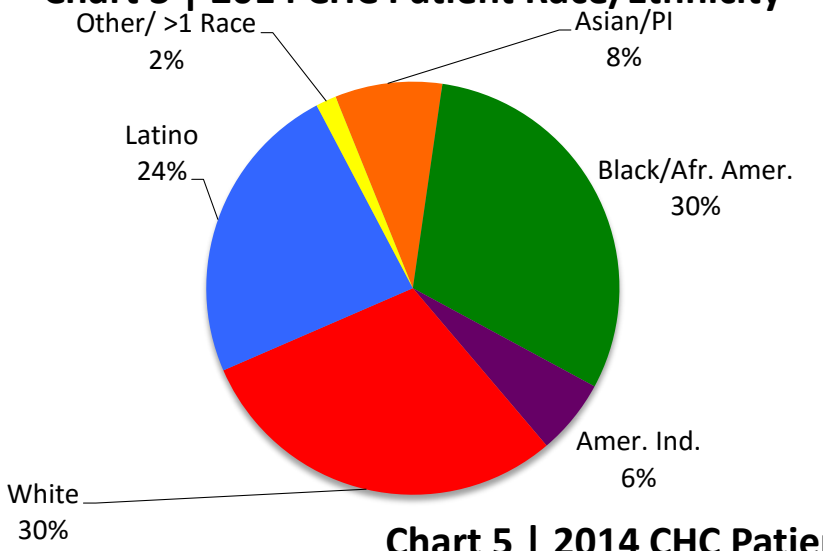


Chart 4 | 2014 CHC Patient Insurance Status

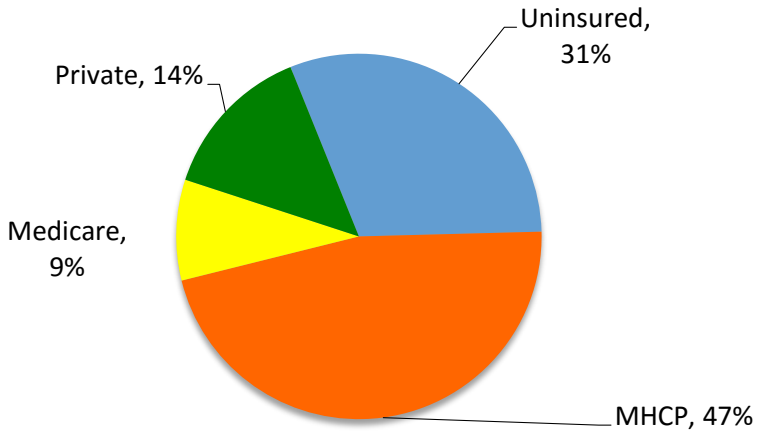
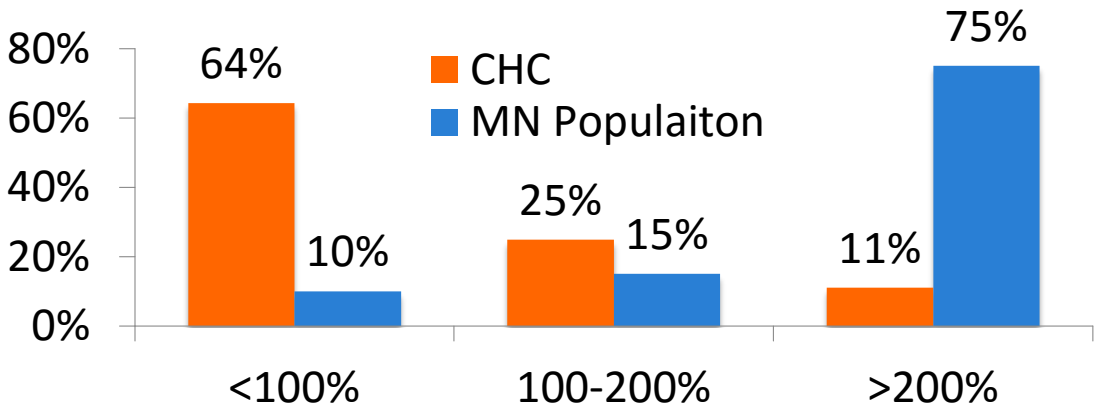


Chart 5 | 2014 CHC Patient Poverty vs. MN General Population

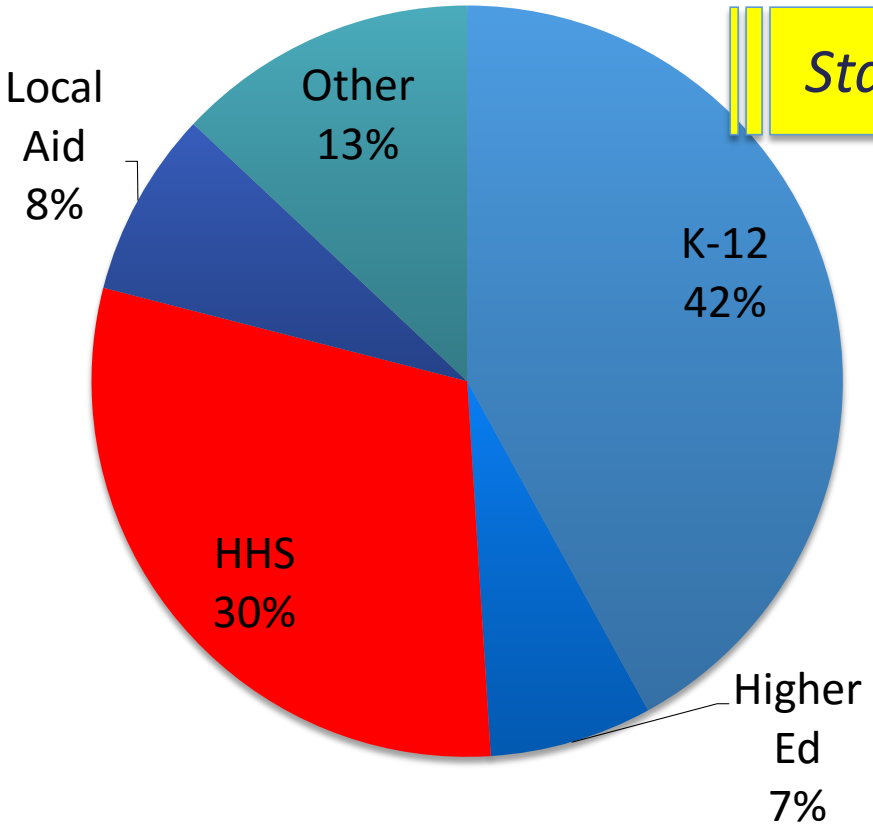


Lake Wobegon

- ***2008 MN Session***
  - **Health Care Homes** – team-based, patient centered care
  - **Measurement –** Statewide Quality Reporting Measurement System (SQRMS)
  - **Quality Incentive Payments**
  - **Peer Grouping (suspended)**
- ***2010 MN Session***
  - Integrated Health Partnerships to test innovative delivery care systems for Medicaid enrollees.

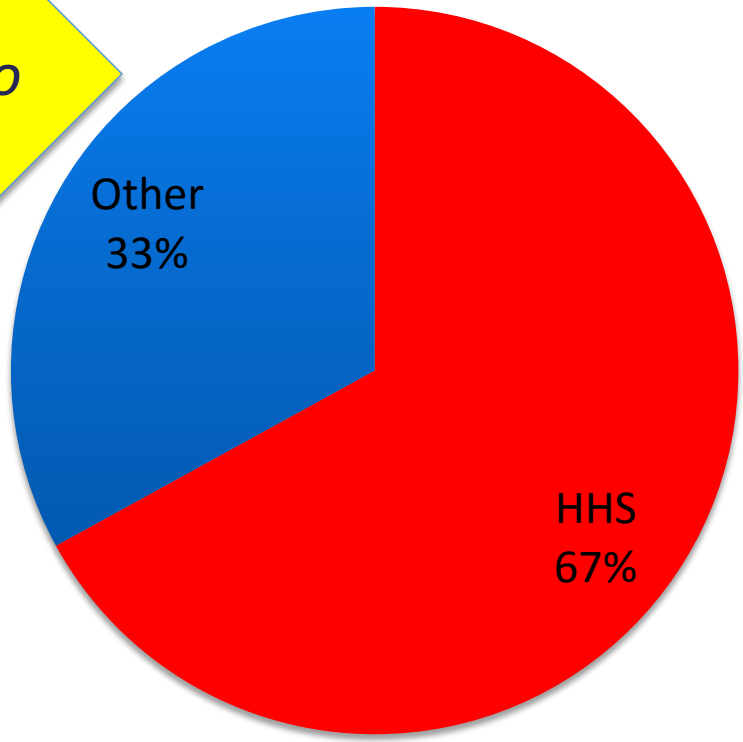
Unsustainable Spending Growth

CHART 1| FY2014-15 STATE SPENDING



Status Quo

CHART 2 | PROJECTED 2033 STATE SPENDING



MN's Medicaid ACO Integrated Health Partnership

- The Minnesota Department of Human Services (Medicaid Agency) shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."
  - Minnesota Statutes, 256B.0755 (2010, 1st Special Session, Chapter 1, Article 16, Section 19)
  - Demonstration original named Health Care Delivery System Demonstration and subsequently renamed Integrated Health Partnership (IHP)

Model Options & Framework

- IHPs contract with DHS under two options:
  - **Virtual IHP** – primary care organizations, no affiliation with hospital or health care system
  - **Integrated IHP** – providing a broad spectrum of care as a common entity
- Same framework, but different financial arrangements
  - **Virtual IHP** – No Downside Risk, Upside Only
  - **Integrated IHP** – Both Upside and Downside Risk
  - 2% “threshold” for both Virtual and Integrated
- Agreements are 1-year contracts that renew annually for the 3-year demonstration period.

Attribution

- Patient attribution is based on where the patient had the most visits using health care claims data
  - Based on enrollment tenure in Medicaid, enrollment in state certified Health Care Homes and Primary Care Provider relationships (preponderance of E&M visits)
  - Patients maintain freedom of choice
  - IHP receives monthly attribution roster for whom they are accountable
- Exclusions: Dual Eligibles and enrollees with less than 6 months of Medicaid eligibility

Total Cost of Care

- Medicaid enrollees attributed to IHP in TCOC calculation include both fee-for-service (FFS) and Managed Care (MCO)
- Defined core set of MA services
  - Excludes dental, transportation, long term care and residential mental health)
  - Roughly 2/3rds of total patient services
- Existing payment methodologies remain in place during demonstration

Quality Measures

- IHPs must meet quality measures in addition to TCOC benchmarks.
- 36 clinical quality and patient experience metrics
  - Statewide Quality Reporting Measurement System (SQRMS)
- Allowance for negotiation between IHPs and DHS

IHP Quality Measures

Clinical Quality	Clinical Patient Experience
Depression Remission at 6 months (patients with major depression and initial PHQ9 score > 9 whose score at six months <5)	**Timely Appointments**
Optimal Diabetes Care (COMPOSITE MEASURE)	**Provider Communication**
- HbA1c<8, BP<140/90 mm Hg, Daily aspirin use, tobacco free, statin use	**Helpful/Courteous Office Staff**
Optimal Vascular Care (COMPOSITE MEASURE)	**Provider Rating of 9 or 10**
- BP<140/90 mm Hg, Daily Aspirin Use, tobacco free, statin use	
Optimal Asthma Care (Adults, 18-50)	
- Asthma well-controlled and patient reports less than two total ER visits/hospitalizations during previous 12 months.	
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FQHC Call to Innovate in 2011!

vs.

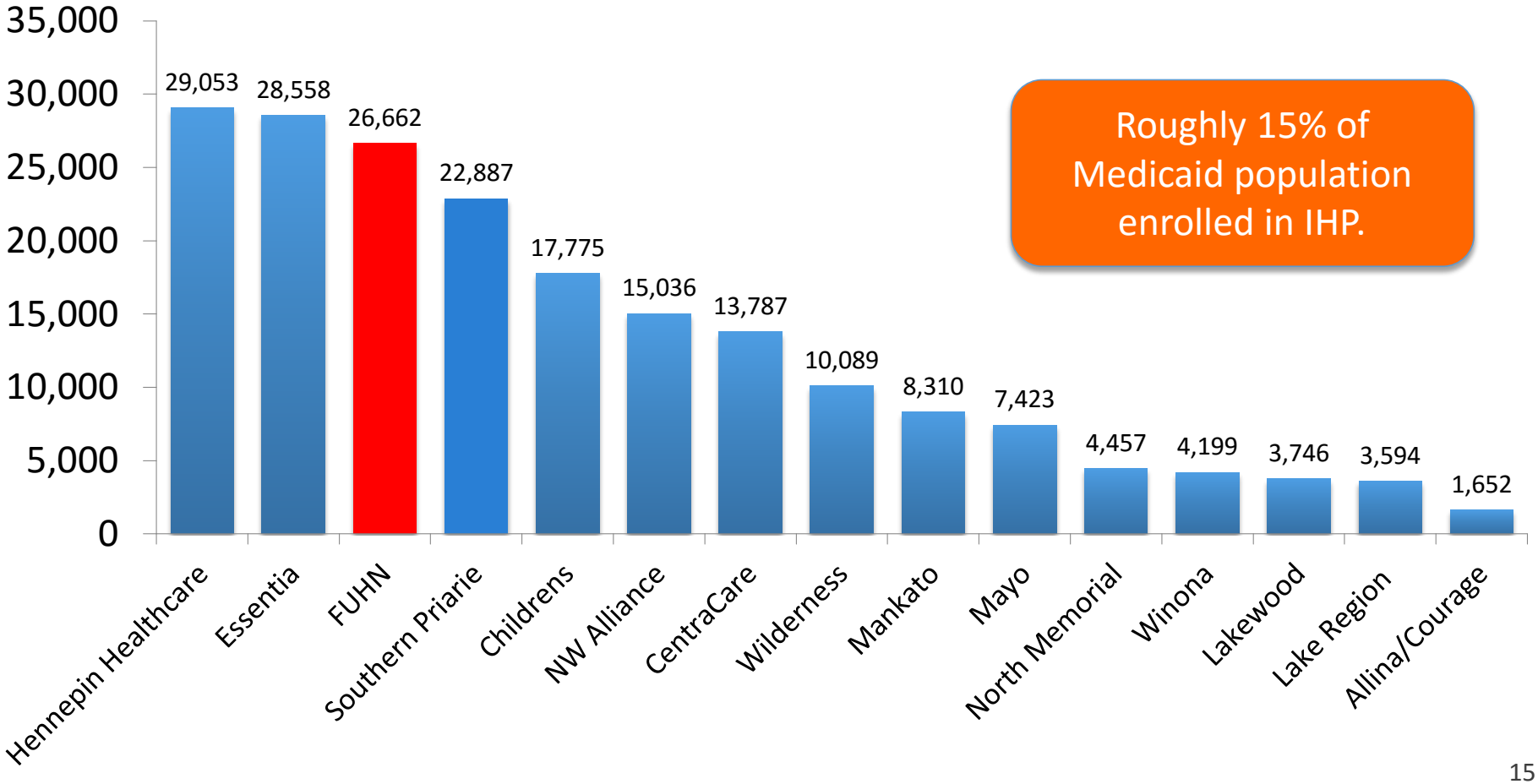
IHPs in Minnesota

- **2013 – 6 organizations**
  - Children's Hospitals & Clinics
  - CentraCare Health System
  - Essentia Health
  - **FUHN**
  - North Memorial
  - Northwest Metro Alliance (Allina & HealthPartners)
- **2014 – 3 organizations**
  - Hennepin Health Care System (HCMC)
  - Mayo Clinic
  - Southern Prairie Community Care (**includes FQHC**)
- **2015 – 7 organizations**
  - Bluestone Physician
  - Lake Region
  - Lakewood Health Systems
  - Mankato Clinic
  - Wilderness Health
  - Winona Health
  - Courage Kenny

16 IHPs serving 176,000 Minnesotans enrolled in Medical Assistance (FFS Medicaid and MCO Medicaid)

IHP Enrollment

Chart 6 | April 2015 IHPs – 197,300 MA Enrollees



FQHC Urban Healthcare Network

- Decades long service and keen understanding of socio-economic, social and cultural barriers to care.

- Access to data “beyond 4 walls” of FQHC (pharmacy, specialty, hospital/ED
- Data analytics to imbed new information into care processes

What is FUHN?

- **F**QHC **U**rban **H**ealthcare **N**etwork
- Collaboration of 10 FQHCs in the Twin Cities (Minneapolis/Saint Paul).
- Repurposed under an existing non-profit corporation (Neighborhood Health Care Network)
- Not part of MNACHC (State Primary Care Association)
- First FQHC-Only Medicaid ACO in the United States
  - One of two currently - Vermont

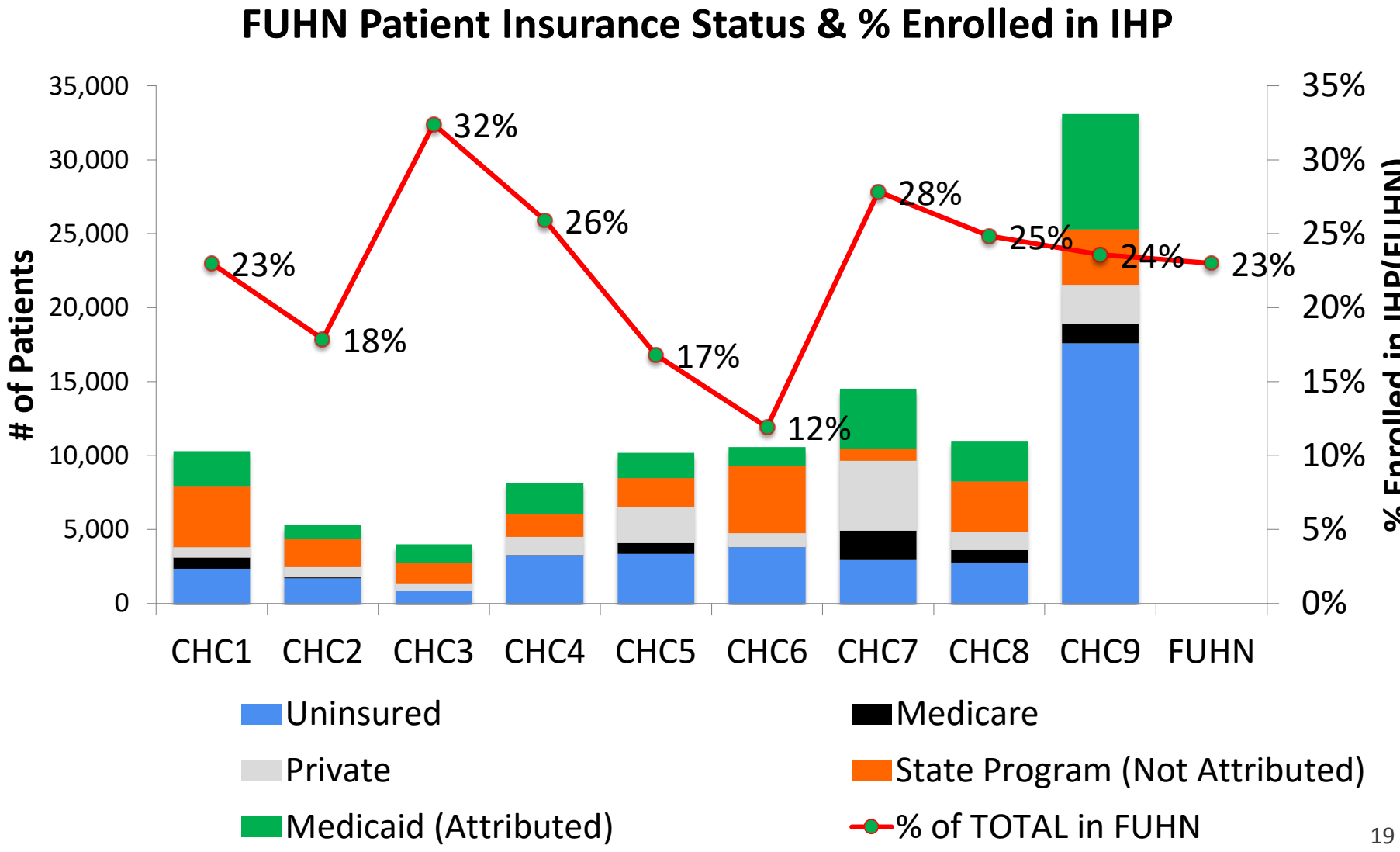
FUHN Hypothesis

Carefully targeted increases in funding for primary care, care coordination and enabling services for an identified set of patients will produce an overall decrease in the total cost of care, whilst improving clinical outcomes for these patients.

Who is FUHN?

- Nine FQHCs and one FQHC Look-Alike located in Minnesota's Twin Cities – 7 in Minneapolis and 3 in Saint Paul serving approximately 122,000 Minnesotans across 40 sites.

FUHN Patients



Evolution of FUHN

- Best offense is a good defense…

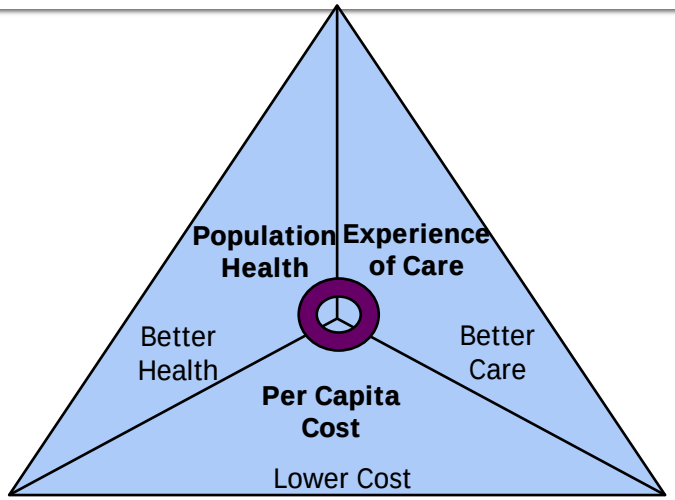
- Bringing value to the market…

- Improved quality of care

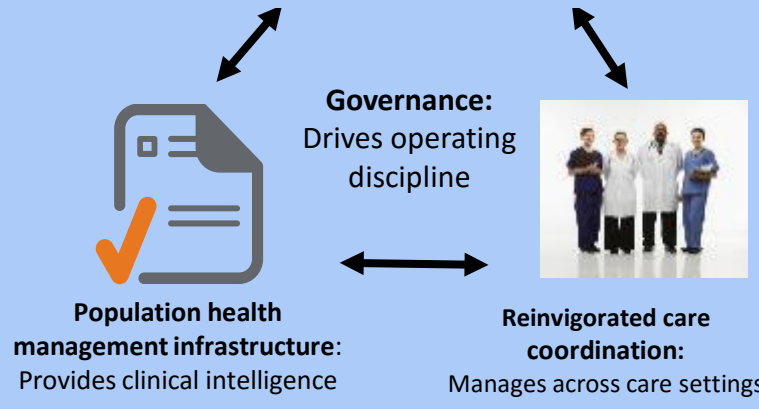
FUHN Program Goals and Elements

Triple Aim + 1:

1. Reduced total cost of care
2. Improved clinical quality
3. Improved patient and family satisfaction
4. Emphasis on primary care services and relationship

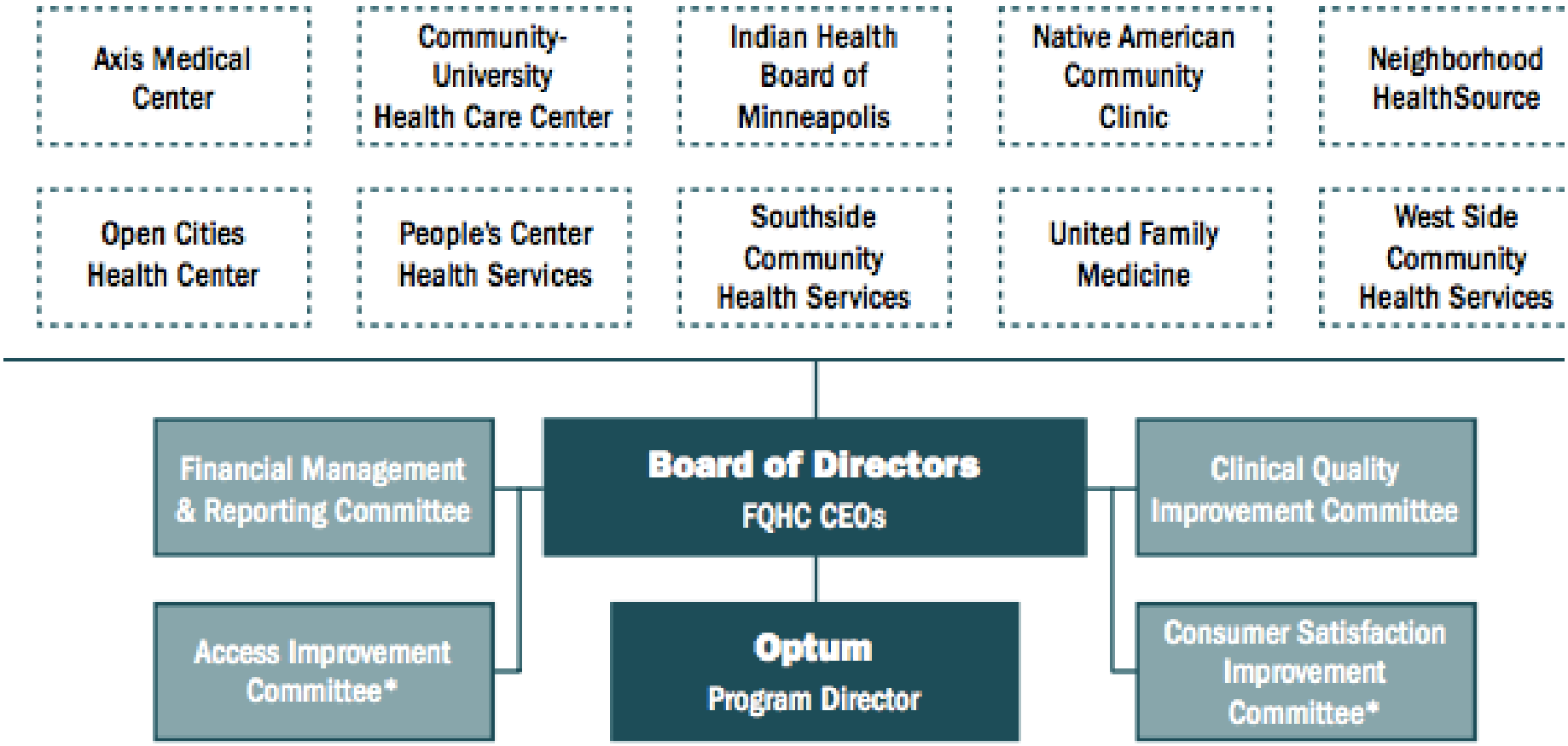


- **Element #1: Population health management infrastructure**
- **Element #2: Program governance**
- **Element #3: Performance improvement & clinical transformation**
- **Element #4: Care coordination across care settings**



Governance Structure

Exhibit 3. Governance Structure of the FQHC Urban Health Network (FUHN)

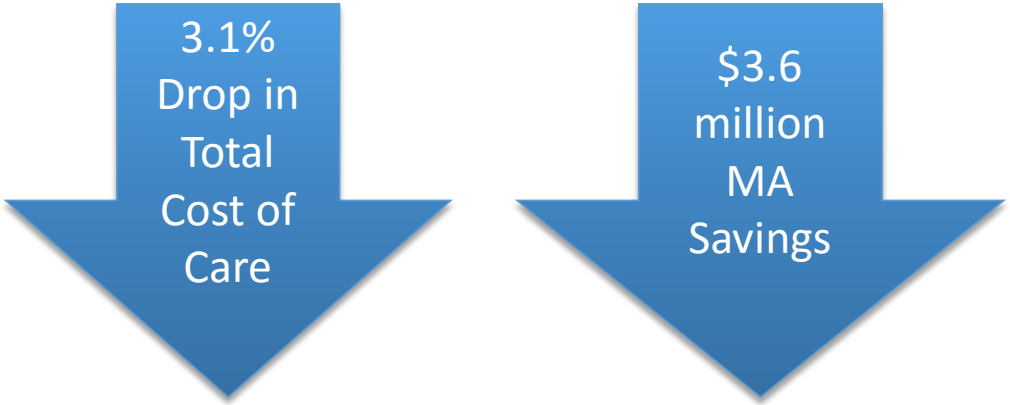


Initiatives "In Flight"

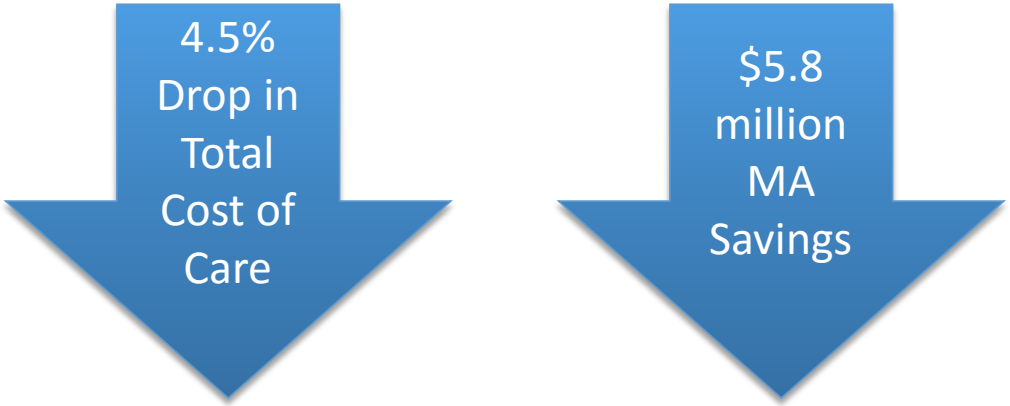
- Enhancing care coordination resources and work flow development at Network level
- Standardizing rooming procedures and pre-visit planning for highest-risk patients across disparate service delivery sites
- ED and Discharge notification and follow up processes including patient activation
- Tracking avoidable inpatient admissions and readmissions with emphasis on dental, depression, and substance use disorders
- Leveraging integrative and collaborative care models
- Targeting high cost pharmaceutics and patient restriction when needed
- Integrating EMR & Claims Data
- Health care home billing and greater coding specificity to ensure efforts and intensity are maximally recognized

FUHN - TCOC Results from First 2 Years

Year One (CY 2013)

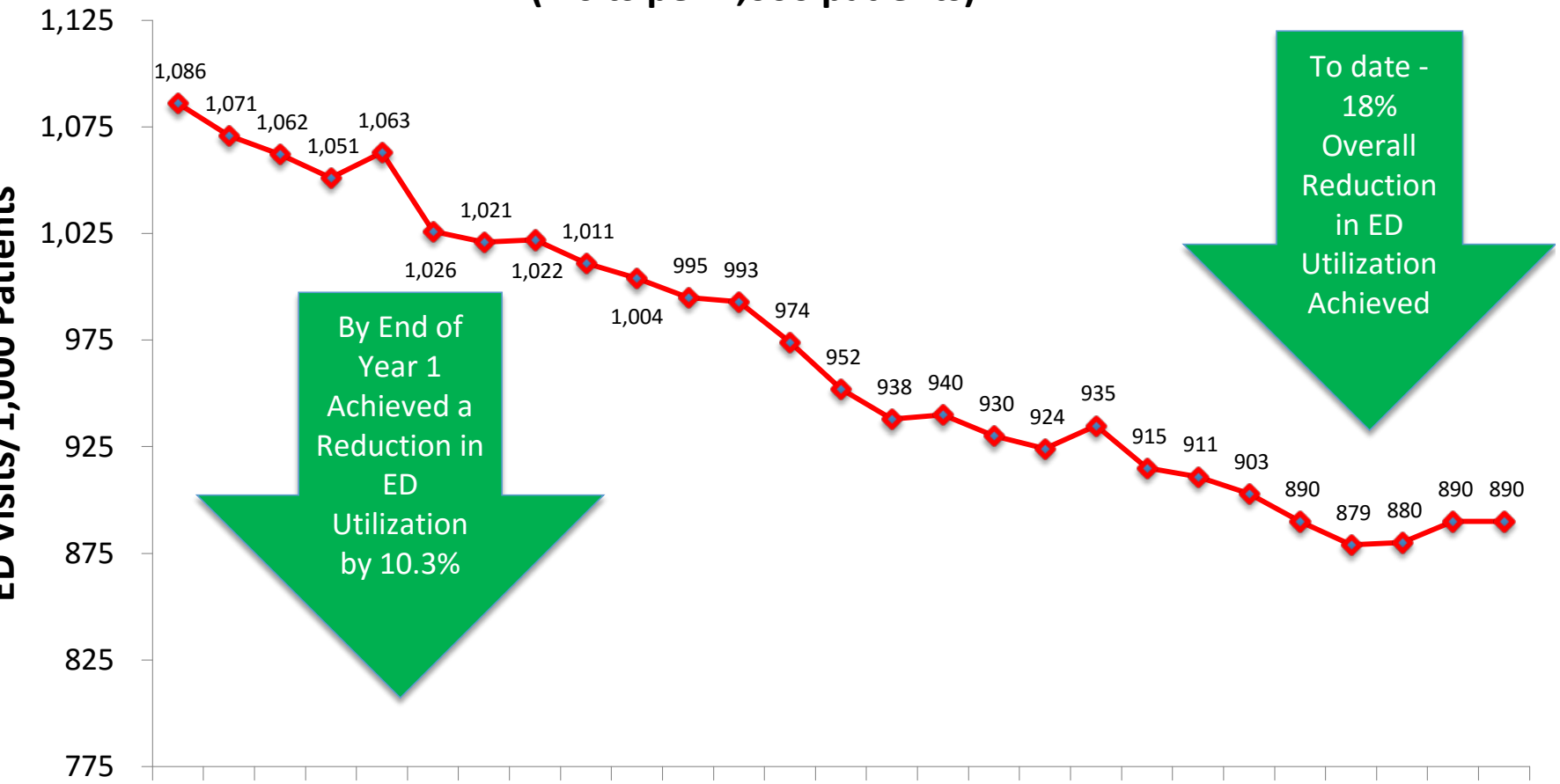


Preliminary Year Two (CY 2014)

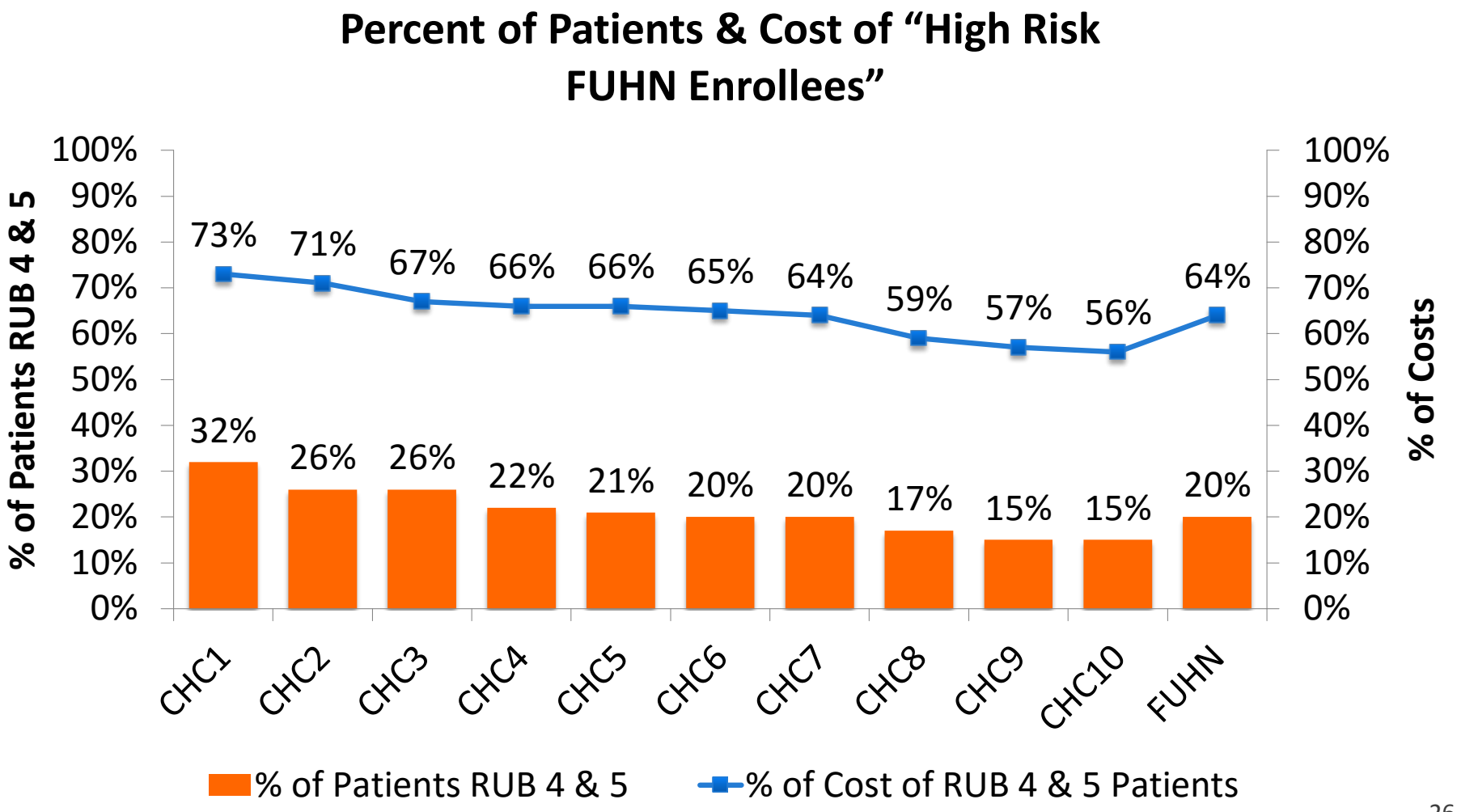


- Savings split 50/50 between FUHN and State of MN after 2% threshold achieved.
- FUHN portion of savings distributed between
  - Administrative services partner
  - FUHN organization
  - 10 FQHCs

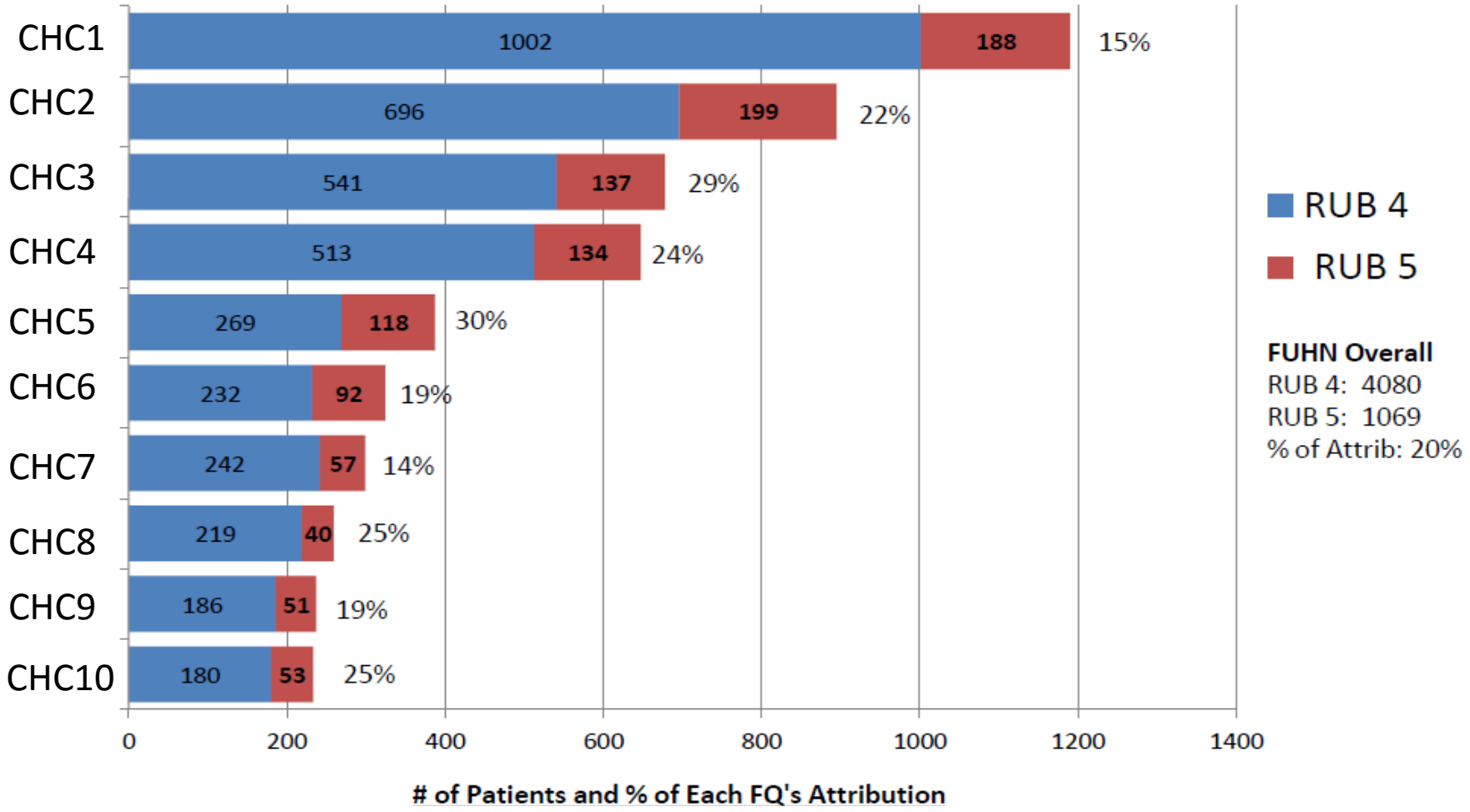
FUHN – Clinical Successes
Significant Reduction in ED Use



"High Risk" Patients and Cost



Identifying High Risk Patients



Identifying Utilization Trends at the Patient Level

ED Utilization by Patient

Select FQHC(s): (All)

HCDS Clinic Site Name: (All)

Select Minimum Number of ED Visits: 0 — 27

Select Condition(s)
Select Potentialy Avoidable Conditions,
OR select ALL to include "Non-Avoidables"
(All)

Select one or more FQHCs
Select the minimum number of ED visits by moving the slider left and right
Select the Avoidable ED conditions.
This page also allows you to select non-avoidable ED visits. Selecting "ALL" will include every ED visit in the count regardless of cause. Alternately, users can select multiple individual avoidable ED visits.

ED Frequent Visitors
West Side FQHC(s)

PatientID	Full Name	Month, Day, Year of Birthdate	FQHC Name	Visits
02737610	[redacted]	November 23, 1986	West Side	27
02378209		July 19, 1992	West Side	23
02122682		October 9, 1987	West Side	16
02967361		September 14, 1955	West Side	15
00609840		December 29, 1987	West Side	15
03020595		September 30, 1968	West Side	14
04264284		November 4, 2012	West Side	7
04265470		November 4, 2012	West Side	4
04280224		November 4, 2012	West Side	3
00052288		April 13, 1982	West Side	13
00307838		September 22, 1984	West Side	12
00322181		September 22, 1984	West Side	1
01175156		July 11, 1955	West Side	11
01398699		June 24, 1959	West Side	11
01614038		April 22, 1977	West Side	11
00560523		May 27, 1990	West Side	11
02127790		September 17, 1969	West Side	10
03969704		September 27, 1984	West Side	10
02082053		June 10, 1998	West Side	3
02090303		June 10, 1998	West Side	7
01146902		February 9, 1961	West Side	9
00386666		February 21, 1964	West Side	4
04162366		February 21, 1964	West Side	6

This sheet provides information on frequent ED utilizers.
Users may filter by the minimum number of ED visits using the slider at top middle.
The drop down list at the upper right allows users to identify individuals with ED visits for specific avoidable reasons or ED visits for any reason (i.e., including non-avoidable)
Of note, members with numerous ED visits for "non-avoidable" conditions may include individiduals with highly complex conditions (e.g., cancer, dialysis) who are requiring frequent ED utilizers.

Lessons Learned

1. Upfront investments are steep – both operational and time
   - State upfront Investment/Contribution = $0
2. High Level of collaboration and commitment amongst ACO participating organization is a must.
   - "From extreme competitors, to extreme collaborators"
3. Sharing clinical practices to improve care/services through strong clinical and quality improvement leadership

Lessons Learned

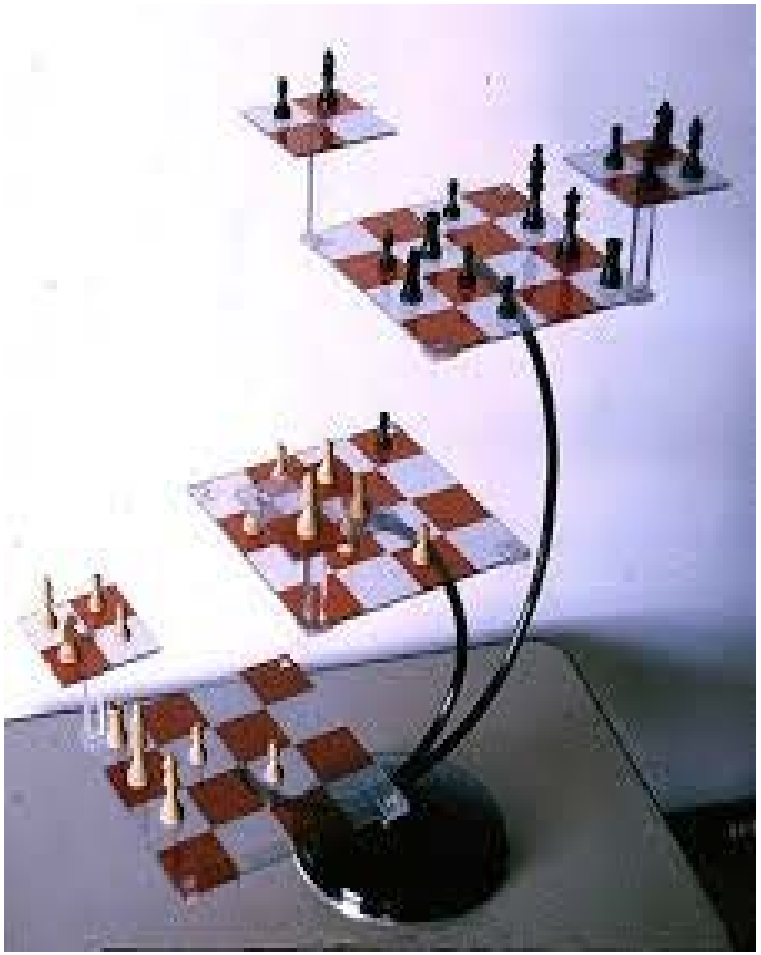
4. Data informing clinical care initiatives must be actionable and timely and ACO must prevent "tsunami" of data.
   - Dependent on analytic capabilities to identify at-risk/soon-to-be at-risk patients
   - Dependent on interoperability with external (non-ACO) providers
5. Culture and process change at FQHCs takes time – people like innovation, but they don't like change.
6. Care coordination is the heart of payment reform success – both in terms of financial and clinical outcomes. This is also the area that is underfunded.

FUHN's new motto: Triple Aim Plus Two – emphasis on Primary Care and Care Coordination

Some Global Lessons for All ACOs

- No need to do everything at once, but steady commitment is needed
- Take a broader perspective than illness
- Must seek pay for outcomes, not just TCOC arrangements
- Foster continuous learning environment that assures strong collaboration amongst clinical and managerial leadership
- Encourage inter-operable data systems integrated into the clinical workflow

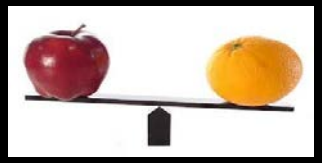
FQHC Challenge Under Payment Reform



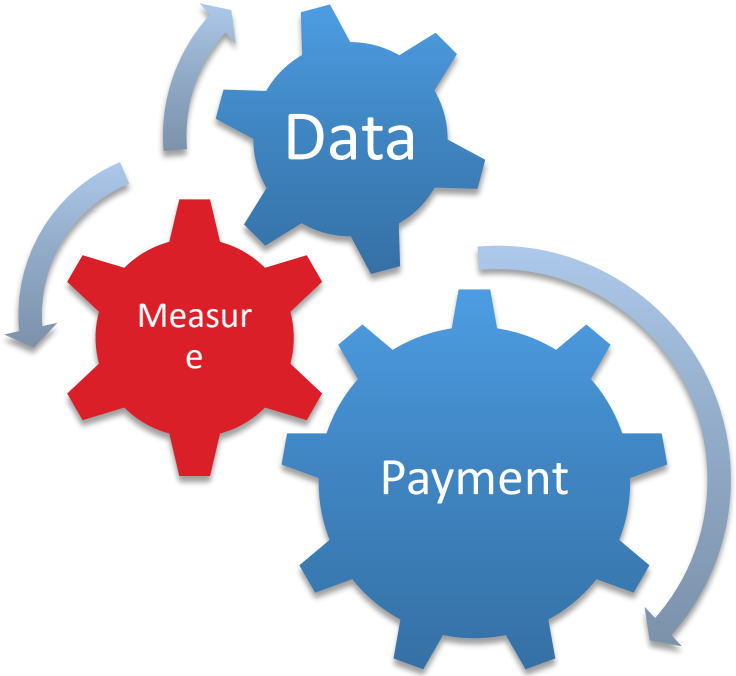
Challenges

1. Lack of “start-up” investment
2. Data Quality and Timeliness
3. Lack of metro/state-wide Health Information Exchange – lack of interoperability
4. Lack of resources at FQHCs
5. Enhance collaboration with hospitals and specialists – coordinate transitions.
6. Enhance relationships with MCOs – eliminate redundant efforts
7. Resetting the baseline without recognition of investment needed to sustain progress achieved – both clinically and financially.

Key Change Still Needed in MN



- Existing Minnesota measures (SQRMS) "risk adjusted" only for insurance status, age and gender.
- **PAYMENT REFORM MUST RISK ADJUST** additional "social determinants" to truly reflect quality of care (and also dis-incent providers from "cherry picking" patients).



The Future

- 70% of MA & MinnesotaCare enrollees into an IHP in Minnesota – currently at 15%
  - "2017 Waiver"
  - 30% excluded due to dual eligible, <6 months enrollment, EMA, refugee
- Movement from ACOs to Accountable Communities for Health (ACHs)
  - Connecting with social service needs of your patients.
- Sustainability of model in future years?

Are FQHC-Led Medicaid ACOs Realistic?

- FUHN believes its ACO project is repeatable and scalable.
- FUHN is a critical model for Medicaid programs throughout the US based on:
  - Primary care capacity is shrinking
  - Medicaid expansion puts more pressure on safety net providers/FQHCs in particular
  - Enrollee complexity demands better coordination
  - FQHCs are ideally situated to succeed, with modest investment
  - Place the focus on **community based primary care**

What to Celebrate

- FUHN is…
  - …the first FQHC-led Medicaid ACO in the United States
  - …saving Minnesota taxpayers
  - …one of two FQHC-led Medicaid ACO (VT)
  - …recognized as being on the cutting (bleeding) edge
  - …collaborative effort of 10 FQHCs (“from extreme competitors, to extreme collaborators”)
  - …bringing elements of reform to underserved communities (learning lessons for the 30% the remain uninsured!)

Contact Information

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FUHN
Leading your community-based health care in the Twin Cities

West Side
Community Health Services

Minnesota Association of
COMMUNITY HEALTH CENTERS