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Innovative Payment for Care Coordination for High-Need, High-Cost Patients

A Perspective from the Health Care Transformation Task Force

April 25, 2016

1. The highest need, highest-cost population is ever-changing
2. Providers must be responsible for identifying patients for whom they can have the most impact
3. Providers face financial “barriers to entry” to make initial programmatic and infrastructure investments
4. Incorporate protection from insurance risk

APMS that work:

- *Population-Level Risk-based Care Management fee* is a per-member-per-month care management fee based on triple aim outcomes for high risk patients, plus shared savings
- *Full-risk Capitation* is preferred by many providers

Payment Models that don't:

- Traditional fee-for-service payment systems do not reimburse for these services when furnished
- *Patient-Level* CPT-based care management fees are insufficient to advance adoption of programs for high-need, high-cost patients

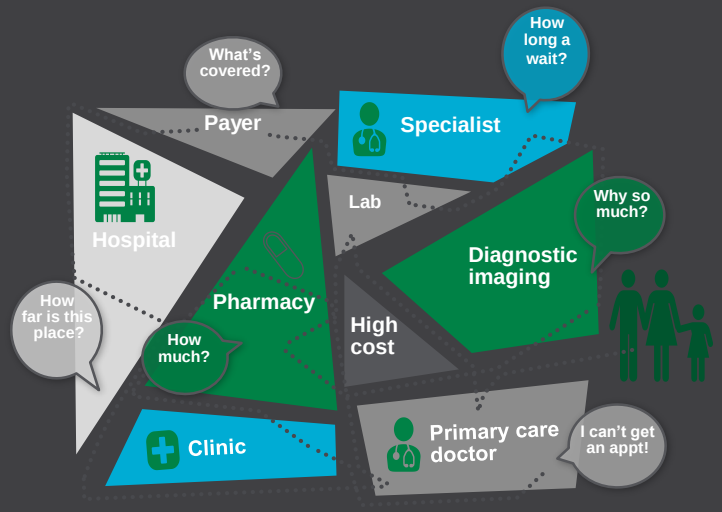
Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Presentation to the LAN Summit – April 2016

- Greg A. Jones
- Government Affairs

Aetna’s Mission: Build a Healthier World

The “Old Model”



- Complex products
- Confusing to access
- Limited price discovery
- Uncoordinated care
- Varied outcomes

The “New Model”

- Simple products
- Engaging technology
- Price & quality transparen
- Coordinated care
- Better outcomes

Aetna's Vision for Improving Care for High-Need, High-Cost Medicare Beneficiaries

Target Population	• Beneficiaries with advanced illness, persistently high spending and multiple chronic conditions • Beneficiaries with spending in the top 10 percent of fee-for-service, regardless of condition • Passive enrollment with opt-out
Care Coordination	• Dedicated nurse or care managers to improve care coordination and help beneficiaries get the right care at the right time
Care Model	• Program through high value networks including best in class providers or centers of excellence • Risk based contracting between MA plans and providers • Aligned incentives based on quality
Financing	• Guaranteed savings to the Medicare Trust Fund through fully capitated payments to high quality (4/5 Star) MA plans • 10 year savings estimate ranges from $16B to $80B*

*Avalere Analysis Performed on Behalf of Aetna, November 19, 2013.

Overview of Current Medicare Legislation

H.R. 3244- House Proposal

Providing Innovative Care for Complex Cases Demonstration Act of 2015

- Target Population: Medicare FFS Beneficiaries with **highest 10th percentile** of all FFS costs
- Eligible Organizations: MA plans or ACOs

S. 2498 – Senate Proposal

Medicare Program Linking Uncoordinated Services (PLUS) Act

- Target Population: Medicare FFS Beneficiaries with **highest 15th percentile** of all FFS costs
- Eligible Organizations: MA plans or ACOs

Both Bills Establish:

- Three year pilot program
- Conducted in at least four service areas
- Up to 2 organizations per service area
- HHS can extend duration and expand pilot to additional areas if quality and savings targets are achieved

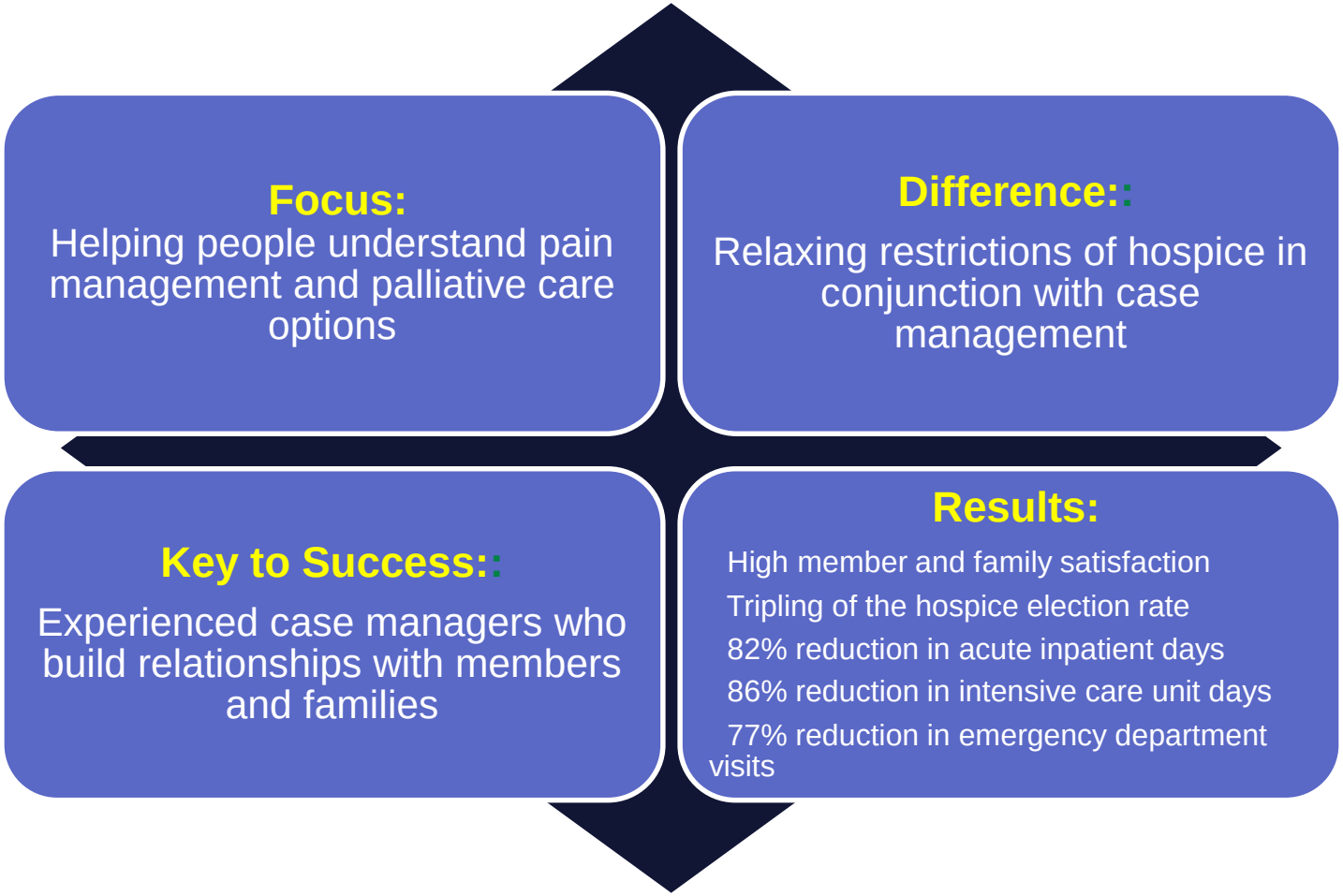
Additional Provisions:

- **More Benefits:** Enhanced benefits such as transportation, meals, and personal care
- **Lower Out-of-Pocket Costs:** VBID component allowing reduced or eliminated cost sharing
- **Integrated Care Model:** Includes best-in-class providers and mandatory health risk assessment/care plan
- **Risk Adjusted Payments:** Risk adjusted capitated payment set at 98 percent of Medicare FFS program
- **Preserves Part D** - Preserves Part D payment, benefits, beneficiary protections and non-interference

Successful Model of Care Requires Regulatory Flexibility

Value Based Insurance Design	• Patient-centered approach based on individual health conditions and needs • Reduced or eliminate cost sharing to remove barriers and improve health outcomes
Waiver of Network Requirements	• High-value provider networks allow for greater collaboration between plans and providers • Enhanced HIT with ACO partners
Ability to Provide Additional Benefits	• Care management, custodial care, transportation, or other services not available under Medicare Parts A or B

Case Study: Aetna Compassionate Care Program for Advanced Illness



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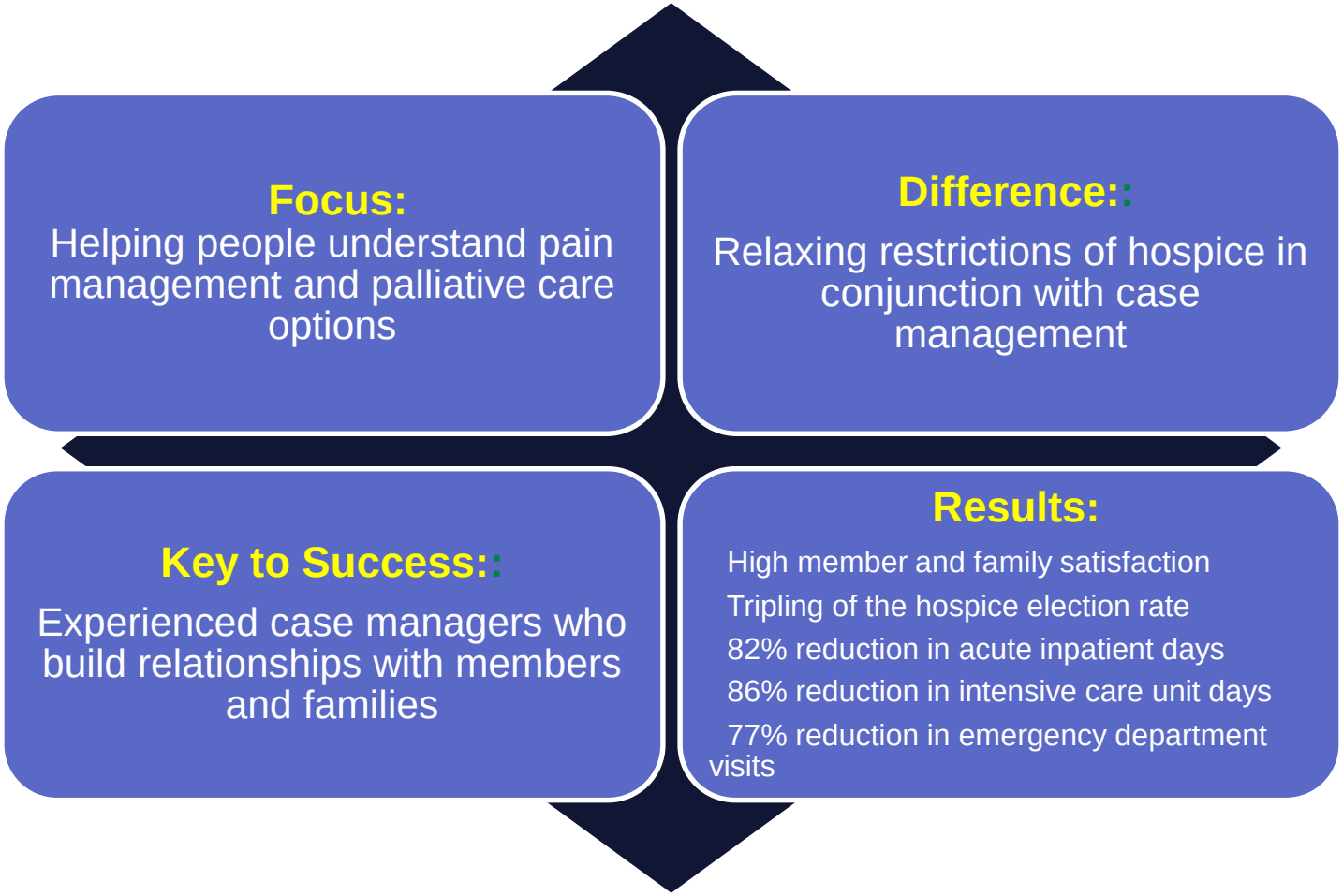

HRHCare: Community Health & Alternative Payment Models

April 25, 2016

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Federally Qualified Health Center Model

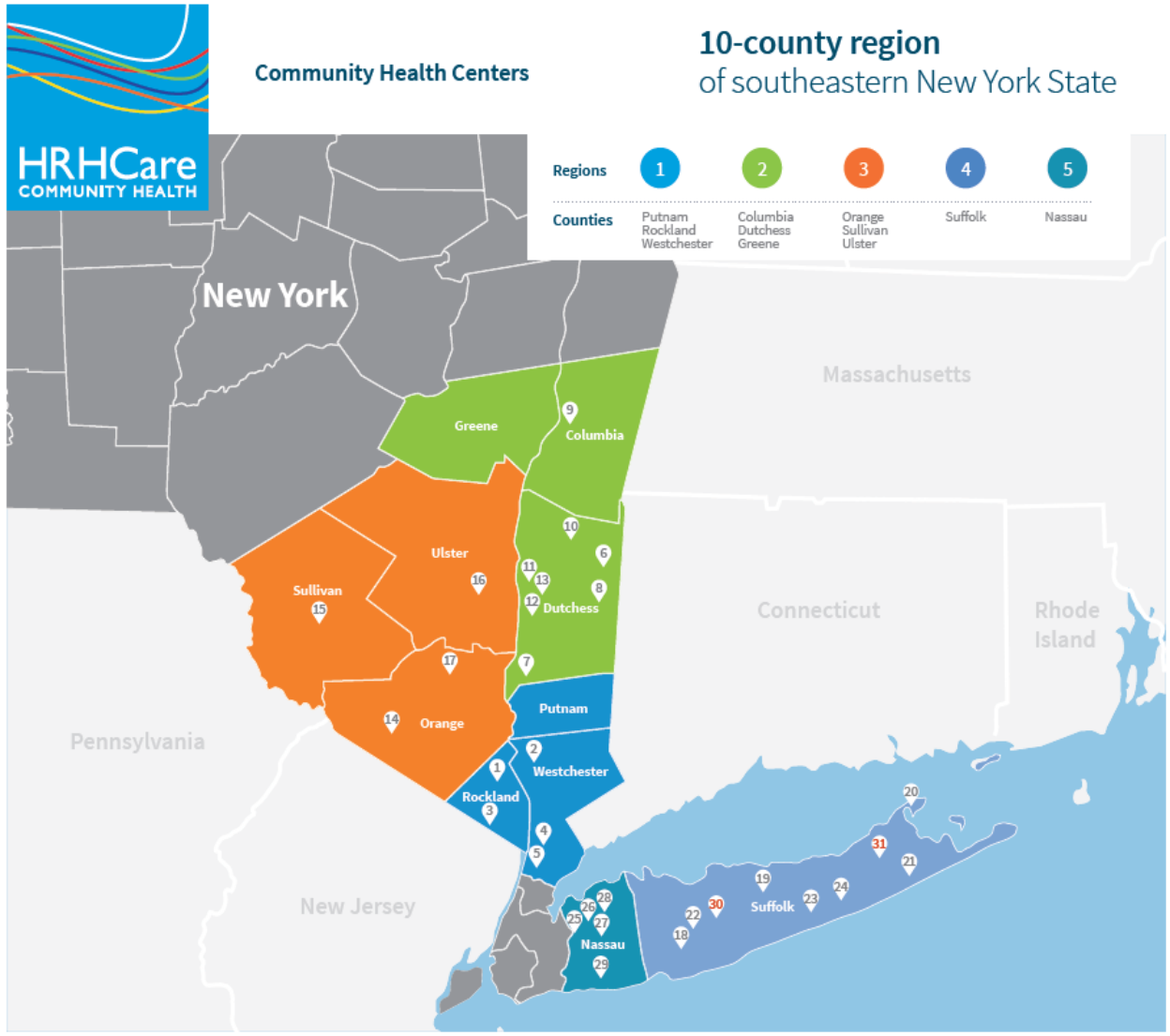
- Not-for-profit organization
- Governed by a Board of Directors controlled by patients of the center
- Serve a Medically Underserved Area or Population
- Provide comprehensive preventive and primary care
- Assure that care is accessible
- Provide care regardless of ability to pay
  - Services offered on sliding fee scale for those without insurance

History: HRHCare

From Left to Right: Willie Mae Jackson, Pearl Woods, Rev. Jeannette Phillips, Anne K. Nolon, Mary Woods.

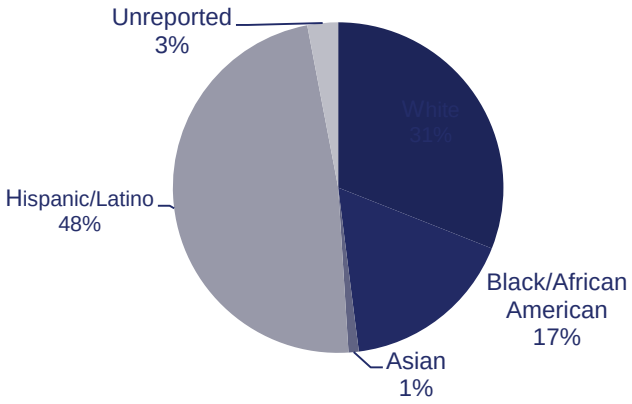
In the early 1970s, a group of four women, fondly referred to as the Founding Mothers, spearheaded the efforts of fellow community members and religious leaders to address the lack of accessible and affordable health care services in Peekskill, one of the Hudson River Region's poorest cities. With a small federal grant, the Peekskill Area Ambulatory Health Center. In the 40 years since then, the Health Center, now known as HRHCare, has grown into a network of 30+ health centers.

HRHCare Service Area

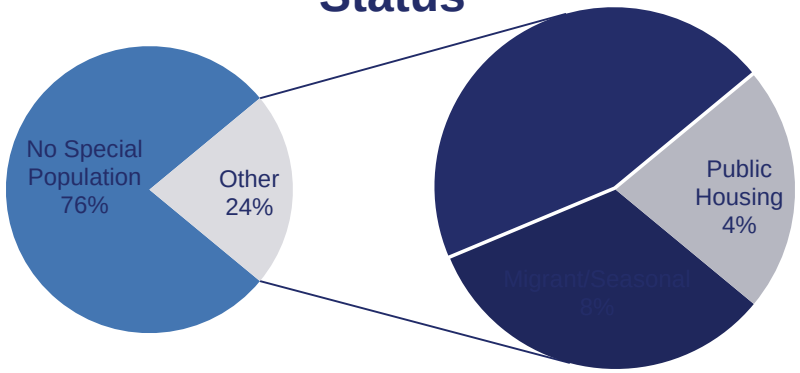


Patient Snapshot

Patients by Race



Patients with Special Population* Status



*As designated by the Health Resources and Services Administration

Of the patients with documented income status in 2015, 77% were at or below federal poverty level (FPL) with 98% at or below 200% FPL.

In 2015, 34% of patients were uninsured; 43% Medicaid or Medicaid Managed Care; 8% Medicare; 12% private insurance; 3% CHIP.

Our Approach: Services & Model

Medicine

- Family Practice
- Pediatrics
- Internal Medicine
- Prenatal and OB
- Gynecology
- Family Planning
- HIV Primary Care
- Immunizations
- Well Child Visits
- Cancer Screening
- Lab Services

Specialty

- Podiatry
- Optometry
- Cardiology
- Telederm

Behavioral Health

- Counseling
- Substance Use Disorder Treatment
- Suboxone Treatment

*Dentistry**

Our Approach: Care Management Initiatives

- Wagner/Stanford Model: diabetes, CVD, Hep C, Asthma, Obesity, HIV/AIDS, depression
- NYS FQHC Pilot: Hypertension and Diabetes Management
- Genesis HIV treatment
- Anoscopy
- Buprenorphine/Suboxone Program
- Addressing Childhood Trauma Together in Our Neighborhoods

Enabling Reimbursement Activities: Weaving it all Together

- Largest Medicaid Health Home in New York state
- MSSP Program
  - only FQHC-led Medicare ACO in NYS
- Founding member of Behavioral Health/Primary Care Jointly led IPAs
- Participant in multiple DSRIP Performing Provider Systems

Challenges and Questions

- Aligning APM frameworks (state v. federal)
- Barriers to entry:
  - Upfront investment outside of reimbursement
  - Using existing care management programs for high-cost, high-need populations as platform
- Reaching highest levels of APM
  - How should reimbursement models incentivize increases in primary care while enabling access to reduced downstream costs?
  - Circumstances for specialized reimbursement models vs. total cost of care through provider partnership

Health Care Transformation Task Force
Recommendations for Public Purchasers and Policy Makers

1. Promote movement toward APMs under MACRA; MIPS unlikely to adequately support care management programs for this patient population.
2. Allow value-based insurance design in Medicare Advantage products.
3. Align with commercial APMs around quality measurement, risk adjustment and budget setting methodologies.
4. Link mental health care services and social services to promote broad patient-centered care delivery.

Thanks!

Questions?