CASE STUDY

Partnering with Health Plans to Improve Financial Solvency, Organizational Autonomy, and Patient Care: Community Health Network of Washington

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The Community Health Network of Washington is comprised of federally qualified health centers that govern and operate their own health plan, the Community Health Plan of Washington. Formed in the early 1990s during the rise of managed care, it is one of the first health center-governed health plans in the country.

The Community Health Network of Washington serves a patient population that is mainly low-income. In 2014, almost a quarter of its patients were uninsured and more than half were on Medicaid. The Community Health Plan of Washington is one of five Medicaid Managed Care Organizations (MCOs) that contracts with the State to deliver physical health and mild to moderate behavioral health services on a county basis.[1]

In this case study, we will examine how the Community Health Network of Washington (CHNW, or the Network) formed the Community Health Plan of Washington (CHPW, or the Plan), what the governance structure is of the managed care network and the health plan, and how the Network operates to deliver care to Washington's Medicaid population. Throughout the study, we dedicate particular attention to the Yakima Valley Farm Worker's Clinic and its unique experience, including its leadership role in the founding of both the Network and the Plan, its participation in risk-based payment arrangements, and the delivery system changes it has consequently implemented. This study highlights how health center participation in a managed care network can better position health centers to partake in other accountable care strategies. We conclude with lessons for other health centers seeking greater financial solvency, organizational autonomy, and improved patient care in an era of value-based payment reform.

Community Health Network of Washington

Location: 19 health centers across Washington

Patients served: 300,000

% Medicaid paitents: 83%

Motivation for Organizational Innovation

During the Clinton Administration's effort to reform healthcare in the 1990s, Washington State underwent its own healthcare reform that focused on moving most of the fee-for-service Medicaid population into managed care. At the time, health centers had a robust network of primary care providers that managed over half of the Medicaid population in Washington. Because these patients had stronger personal connections with their providers than with their health plans, health center leaders realized they held a position of strength for negotiating greater control in managed care. Rather than ceding it to the twelve health plans competing in the state at that time, these leaders were confident that their intimate

> "If Molina or Group Health or Kaiser could take risk on the Medicaid population, there would be no reason at all why we, who have been treating this community, should not be able to take the same type of risk."
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> **Carlos Olivares,**
> CEO of Yakima Valley Farm Workers Clinic

understanding and experience with Medicaid patients meant they could manage patients more effectively than could health plans, and could participate in managed care successfully by taking on risk directly.[2]

One of these health centers was the Yakima Valley Farm Workers Clinic (YVFWC), which began their foray into value-based payment by renting a managed care license from Blue Cross Blue Shield (BCBS). BCBS provided YVFWC with backup financial reserves and claims processing; YVFWC paid BCBS a small fee of $5 per member per month (PMPM) to then manage and take on the risk of patients' primary and specialty care. By renting the license, YVFWC leadership were able to learn about managing risk themselves and YVFWC was able to build its own reserves. YVFWC hired staff to build the internal capacity to analyze their data and negotiate with BCBS as well as with other health plans, which gave them greater control over pursuing value-based payment in ways that would be most beneficial to YVFWC.

The Yakima Valley Farm Workers Clinic was also able to persuade several of the other larger health centers in Washington to cooperate for greater gains by pursuing risk-based contracts together, leading to the formation of the Community Health Network of Washington and its subsidiary non-profit managed care plan, the Community Health Plan of Washington. Carlos Olivares, the CEO of YVFWC, was a founding board member and chairman of the Network and the Plan for the first five years. Offering options to smaller health centers to take on their preferred level of risk made it easier for them to join the Network. Health centers in the Community Health Network of Washington were able to terminate their agreement with other health plans and began to contract with the State directly for Medicaid patients. The model was highly financially successful, earning over $11 million in the first few years.

> "My thinking is, if somebody else is doing something, so can we. You can always find the people that know how to do this. You can do this is you have the volume and the courage to do this."
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> **Carlos Olivares,**
> CEO of Yakima Valley Farm Workers Clinic

Governance and Management Structure

Both the Community Health Network of Washington and its subsidiary, the Community Health Plan of Washington, are structured as 501c4 non-profit organizations. These two entities have legally separate boards that are staffed by the same executive leadership, who split their time between the two groups. The Network board focuses on improving the care environment, including public policy, risk sharing, and quality incentive programs, whereas the Health Plan board focuses on health plan functions as they relate to state regulators.[3] Although the board members are the same, the Network board focuses on quality, policy, and the care environment, while the Plan board focuses on Plan-specific issues, Plan strategy, financial performance, product performance, and other related activities.

Payment Model

As the Community Health Plan of Washington grew, the revenues generated went towards 1) continuing to build financial reserve infrastructure that would allow the plan to take on more risk for more patients, and 2) creating significant financial distributions to the member clinics to allow them to improve their access and care systems.

The Community Health Network of Washington has been engaged in a shared risk agreement for over 20 years, predating the more recent accountable care efforts by the State. From its inception, the Plan globally capitated the Network for its assigned members. At the Network level, there are funding pools that are risk adjusted for each center's population and there is shared risk amongst them. Centers can determine the level of risk based on their risk appetite and other related factors. The Network provides stop-loss coverage for every center in the Network in order to protect some of the smaller health centers with less sophisticated financial management from catastrophic

risk, and some of larger centers that are risk averse as well. However, some of the larger, more sophisticated health centers would rather take on full risk without stop-loss coverage, an arrangement not currently possible through Network. As a result, a few health centers have left the Network because of the shared risk and their perception of the overall performance of others, though a number of these health centers have since returned. As of August 2017, nineteen out of Washington's twenty-seven health centers participated in the Network.[4] The Network's payment model has enabled its health centers to participate in payment arrangements that best strengthen their financial situation. As revenues increase, the health centers have been able to invest in improving care delivery services.

Following Medicaid expansion under the Affordable Care Act, the Community Health Plan of Washington gave health centers a choice of three contracting options for the expansion population. The first is a straight fee-for-service (FFS) contracting option with no risk involved. The second option is a shared-risk agreement, with health centers deciding the level of risk they want to assume. Within this arrangement, risk is pooled across the participating health centers, although health centers can choose their own level of stop-loss coverage. The third option involves health centers assuming their own risk, and choosing the attachment point for stop-loss coverage individually. The vast majority of health centers in the Network participate in the second option, with only a few participating in the first and third options. In addition, the Plan allows health centers the opportunity to partake in risk-based contracts for their Medicare populations, and choose to participate in either a special-needs plan for the dually eligible, or in a Medicare Advantage plan.

Yakima Valley Farm Worker's Clinic provides an example of a large health center that has taken advantage of this opportunity to negotiate risk structures that are complementary to its primary care capitated risk payments. YVFWC leadership emphasizes that these new risk structures do not inherently prevent Prospective Payment System (PPS) or alternative payment methodology (APM) payments. For example, the clinic negotiated a contract for 340B medication dispensing within the managed care structure. Furthermore, other health centers looking to learn from YVFWC's experience do not need to assume full risk in order to benefit from this structure; they can take on varying amounts of risk and still see financial benefits. These financial gains have allowed YVFWC to expand its services to new geographic regions in both Washington and Oregon. These geographic expansions have further strengthened the YVFWC's financial situation and was facilitated by the clinic's participation in other IPAs.

As of 2017, in addition to health plan payments to the individual health centers, the health centers in the Community Health Network of Washington have an alternative payment methodology (specifically, APM4) with the State that replaces the traditional PPS payment system to health centers. Similar to the health center payment reforms in Oregon, health centers receive PMPM payment based on historical PPS payments. The baseline PMPM rate is carried forward in future years and updated by trends in the Medical Expense Index (MEI). The PMPM rates are linked to quality improvement, based on a subset of the Washington State Common Measure Set. Attribution of patients to health centers are based on reported beneficiary rosters from Medicaid MCOs, which are then reported to Medicaid.[5] The new APM4 system is designed to allow health centers to bill for services that do not fit into traditional PPS billing.

> "Each of these health centers saw it in their business interest to freely contract in an advantageous way, for the population health and financial aspects, with another managed care entity besides the Community Health Plan of Washington."
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> **Bob Marsalli,**
> CEO of Washington Association for Community Health

"It is important to develop strong partnerships with health plans so that the health center's efforts to improve patient outcomes and lower the total costs of care benefit both the health centers and the health plans through shared savings."

Patrick Bucknum,
CEO of Community Clinic Contracting Network

As a result of their experience in the Community Health Plan of Washington, five of the participating health centers decided to create a separate independent provider association (IPA), Community Clinic Contracting Network, to contract with Washington's other Medicaid health plans. The impetus for this grew out of the health centers' desire to participate in risk-based contracts with payers other than the Community Health Plan of Washington. From 2000-2010, Washington clinics and health centers were moving from having all their managed care and Medicaid patients exclusively with the Plan to the majority of their patients enrolled in other Medicaid managed care plans. An increasing number of Medicaid patients were not associated with the Plan, health centers needed a strategy to participate in risk-based contracts with these other payers, which led to the creation of the IPA. Seven health centers are now members of the IPA; each of the health centers for which contracting is performed are members of the organization, and constitutes its governing board.[6]

The IPA's payment model is similar to that of the Community Health Network of Washington, in that it globally capitates its health centers for their assigned members enrolled in Medicaid contracts. The IPA also has a limited number of risk-based contracts for exchange and foster care patients. Unlike CHPW, the IPA has yet to participate in risk-based contracts for Medicare or Medicare-Medicaid duals populations. The IPA is both financially and clinically integrated, and has other services aimed at processing gaps in care and information. By participating in both CHPW and Community Clinic Contracting Network, these health centers now have the ability to foster strong partnerships with multiple health plans.

Members of the Community Health Network of Washington anticipate that future Medicaid reimbursements will be based on some type of direct, risk-based contracting, whether through an IPA, managed care system, accountable care organization (ACO), or other structure. Health centers, which are integral to the primary care delivery network due to their large numbers of enrollees, are well-positioned to negotiate for advantageous risk structures.

Delivery System Improvements

The Community Health Network of Washington's health centers, in line with their missions, provide a wide array of services including primary, dental, preventative screening services, and wraparound services like case management, eligibility assistance, and transportation. The individual centers have built these services into their activities, and the Plan has supplemented this work by developing partnerships with other community-based organizations to fill in the gaps and meet other needs. Although the Network is not an ACO, insofar as they allocate revenue towards improving care, they act like a 'virtual ACO.' The health centers in the Network have been able to use their increased revenue to enhance the wide array of services offered, such as improving behavioral health integration, investing in a data warehouse, and building a mail order pharmacy center.

"It's interesting when I hear the conversation about social determinants of health. We've been dealing with that since day one. These are elements of our everyday thinking in our work and have been incredibly helpful for our work."

Carlos Olivares,
CEO of Yakima Valley Farm Workers Clinic

The Community Health Plan of Washington's Mental Health Integration Program, implemented in 2009, provides funding and training to support integrated behavioral health in the health centers through a licensed mental health professional who serves as an onsite behavioral health care manager. This care manager acts as the primary linkage in care coordination between primary care and behavioral health providers. Behavioral health integration occurs via the support of a web-based registry known as the Mental Health Integrated Tracking System (MHITS) available through the Care Management Tracking System (CMTS) hosted by the University of Washington. The CMTS is not linked to a specific EMR system. As a freestanding, centralized registry, the CMTS provides psychiatrists all of the relevant information that guides consultation with the care coordinator, regardless of the EMR used by each clinic.[7]

The Community Health Plan of Washington has made a major investment in clinical information systems to improve population health. The Plan's system combines claims information with EMR information to identify gaps or problems in care. The system also provides daily, weekly, or monthly alerts when patients are due to visit the health center for care. The Plan works with individual health centers in adapting their patient workflow and clinic design with input from this clinical information system.

Additionally, through the State's health home initiative, the health centers have access to the Predictive Risk Intelligence System (PRISM), which is a secure, web-based clinical support tool that uses predictive modeling to help identify patients most in need of care coordination. PRISM is intended to complement provider electronic health records and the state's health information exchange, OneHealthPort.[8] Like in many other states, Washington's state policies not only incentivize the delivery system's movement towards accountable care, but also foster broader efforts that support providers' ability to deliver whole person care.

To have a data-informed understanding of utilization and risk to meet their contracts, YVFWC chose to invest in a data warehouse to combine its EMR and claims data, rather than relying on claims data from an outside party that could not be linked to its EMR. YVFWC's internal informatics department partners with an external group to increase its capabilities. The department standardized the denominators (e.g., all patients assigned, all patients seen) on their patient metrics, such as cancer screening rates, to allow for comparability across clinics. Through iterative learning, YVFWC is now able to make operational and clinical decisions by using its data on such variables as availability, access, and utilization costs for the emergency department and inpatient visits. All the data are fully transparent, such that staff can pull productivity and patient metrics for any site. As of August 2017, providers dedicated two hours twice a week to review their data, with a goal to move towards two hours four times a week.

> "We have invested a lot into a clinical information system that integrates our claims data with the FQHCs electronic medical record data to provide a full picture of their members. Having data is key to being able to support taking risk with new arrangements."
>
> **Alan Lederman,**
> COO of the Community Health Plan of Washington

Finally, as an example of the efficiencies gained through its greater population served and ability to re-invest its revenue, YVFWC was able to improve how patients received their medication. With its pharmacies dispensing close to one million prescriptions a year, YVFWC invested in building a mail order distribution center, with equipment, phone and computer management, and a pharmacy staff to mail medication directly to patients. YVFWC pharmacies will deliver 40% of medications by mail order by the end of 2019. The reduction in utilization allowed YVFWC to integrate

pharmacists into primary care clinics to be part of care management, which reduced medication errors. YVFWC's spending on pharmacies decreased from $35 PMPM to $15 PMPM through a combination of enforcement of a generic formulary for most of their patients, and improving medication management by the primary care providers in partnership with pharmacists in the system.

Conclusion and Implications for Other Health Centers

Unlike other health center alliances that formed as a response to health reform, the Community Health Network of Washington formed over twenty years ago because its members recognized the advantages of founding their own health plan. Because they founded the plan instead of contracting with a third party, the Network was able to build capacity to gain greater leverage with health plans. As a result of this alliance, a subset of members of the Network established its own IPA in order to contract with other Medicaid health plans in the state.

As a member of the Community Health Network of Washington and the Community Health Plan of Washington, the Yakima Valley Farm Workers Clinic was able to develop significant expertise related to risk-based contracting and contract negotiations. Being directly involved in these negotiations deepened this expertise and enabled YVFWC leadership to expand its clinic and participation in various payment reforms. By enhancing this expertise and improving payment understanding, the leadership was also able to transform its care delivery system.
The health centers' experience in The Community Health Plan of Washington offers important lessons for other health centers interested in pursuing accountable care strategies:

1. Health centers that have yet to pursue risk-based contracting may be missing out on important opportunities for financial solvency, organizational autonomy, and improving care for their patients.
2. Because health plans often have few alternatives to serve the large proportion of Medicaid patients that health centers serve, and patients are loyal to their providers over their plans, health centers have a strong position from which to negotiate with health plans if the health centers band together in IPAs or other networks.
3. By working together through IPAs or other networks, health centers may also be in a stronger position to take advantage of broader state efforts and policies to move towards improving care and population health management as part of their accountable care strategy.
4. Cooperating with, rather than competing against, other health centers may require a cultural shift that places a high value on participation of most health centers in a network. Network leadership must work to ensure that the payment model is beneficial to both large and small health centers to maintain their commitment of working together.
5. Hiring internal staff to analyze data and negotiate with other health plans can offer greater control over pursuing value-based payment in ways that would be most beneficial to health centers.
6. Having data is key to being able to support taking risk with new arrangements, as data allow networks to identify opportunities for revenue enhancement and better care (e.g. PRISM).

Endnotes

1. Interview with Alan Lederman, COO, Community Health Plan of Washington.
2. Interview with Carlos Olivares, CEO, Yakima Valley Farm Workers Clinic.
3. Interview with Alan Lederman.
4. Interview with Alan Lederman.
5. National Association of State Health Policy. Comparison of Oregon and Washington's Medicaid Alternative Payment Methodologies for FQHCs. Available at: https://nashp.org/wp-content/uploads/2017/11/NASHP-PR-Academy_OR-WA-Comparison-Chart.pdf
6. Interview with Patrick Bucknum, CEO, Community Clinic Contracting Network.
7. Interview with Patrick Bucknum.
8. Agency for Healthcare Research and Quality. Integrating Behavioral Health and Primary Care: Community Health Plan of Washington. Available at: https://integrationacademy.ahrq.gov/health-it/case-studies/community-health-plan-washington
9. Kaiser Family Foundation. The Washington State Health Care Landscape. 2014 Jun 03. Available at: http://kff.org/health-reform/fact-sheet/the-washington-state-health-care-landscape/