

Implementing Medicaid Value-Based Purchasing Initiatives with Federally Qualified Health Centers

Beth Waldman, JD, MPH

June 14, 2016

Presentation Overview

1. Brief overview of payment reform strategies
2. How payment reform activities interact with the Prospective Payment System
3. Impact of payment reform activities on day-to-day operations of CHCs
4. Lessons learned from activities in other states

Brief Overview of Options

PAYMENT REFORM STRATEGIES

Delivery System and Payment Reform Strategies That May Include FQHCs

- Pay for Performance
- Supplemental Payments for Care Coordination or Transformation
- Shared Savings
- Accountable Care Organizations (ACOs)
 - Groups of providers that come together to transform care
 - Responsible for coordinating a comprehensive set of services for a population
 - Evaluated for performance relative to expected vs. actual costs as well as quality
 - Potential to share in savings (and accept risk) based on performance

Pay for Performance

- P4P associated with meeting performance targets on specific quality measures
- In **Colorado**, FQHCs participate as part of Accountable Care Collaborative and are eligible to receive P4P based on quality performance for:
 - Reduced ED visits
 - Increased post-partum visits
 - Increased well-child visits

Patient Centered Medical Home (PCMH)

- Supplemental Payment for Care Coordination and Transformation:
 - Financial support for primary care provider efforts to transform practices
 - Increased care coordination and team-based care
 - Increased focus on addressing gaps in care
 - Increased patient engagement in care
- Nationally, health centers have been a leader in transforming practices to be PCMHs
 - Builds on core competencies of CHCs – focus on whole person care, coordination, social determinants
- All FQHCs are encouraged by HRSA to be recognized or certified

- Some states have developed their own certification process for PCMH, others rely on NCQA and/or other national accrediting bodies
- States also utilize FQHCs for health home programs
- ***Connecticut, Missouri and Oregon*** FQHCs are eligible to receive supplemental payments for care management

Accountable Care Organizations (ACOs)

- ACOs are groups of providers that come together to transform care
 - Responsible for coordinating a comprehensive set of services for a population
 - Evaluated for performance relative to expected vs. actual costs as well as quality
- Payment options for ACOs:
 - Potential to share in savings (and accept risk) based on performance; built on top of a fee-for-service system
 - Global payment or capitation

Shared Savings Through ACOs

- Several examples of FQHCs participating as part of an ACO with a group of providers or forming their own organization:
 - **Minnesota** – FQHC Urban Health Network (FUHN) participates in model as a virtual Integrated Health Partnership; includes 10 FQHCs in the Minneapolis/St. Paul Area
 - **Rhode Island** – Three FQHCs individually certified as Accountable Entities (AE); will have potential to share in savings

Primary Care Capitation

- Initiatives allow FQHCs to provide services that are beneficial, but not traditionally reimbursable because can share in the savings.
 - Primary Care Capitation:
 - Model provides both flexibility and predictable flow of funds to FQHCs
 - In **Massachusetts**, CHCs actively participate in model; leverages PCMH as foundation. Majority are only eligible for shared savings based on size of patient panel.
 - **Oregon** and **California** have specific FQHC payment reform initiatives that provide PMPM based on expected spending

Traditional FQHC Payment Strategies

PROSPECTIVE PAYMENT SYSTEM

FQHC's Prospective Payment System (PPS)

- **Statutory payment structure for PCMHs**
 - Ensures minimum payment rate based on individual costs to provide services
 - Annual adjustment based on Medicare Economic Index
 - Alternative Payment Methodology option
 - Allows for use of different methodology as long no lower than what would have been paid under the PPS

- **Some flexibility provided within PPS**
 - Can set different rates for services provided
 - Medical
 - Behavioral Health
 - Dental
 - Can offer option for blended or separate rates

Operational Activities Associated with the PPS

- Payment through the PPS or an APM can be operationally burdensome to both FQHCs and Medicaid agencies
 - Submission of annual cost reports by FQHCs
 - Need to ensure the cost reports accurately captures all costs
 - Training to FQHCs on appropriately completing reports
 - States must adequately review to identify any inconsistencies or data errors
 - If states contract with managed care organizations (MCOs)
 - Either require MCOs to pay PPS rates, or
 - State reconciles MCO payment to PPS and makes a supplemental payment to FQHC

How Can Payment Reform and PPS Co-exist?

- There is potential for direct conflict between PPS and value-based purchasing
 - PPS guarantees FQHCs a minimum payment based on cost
 - Value-based payment provides FQHCs the ability to have more flexibility in how provide services, but also adds potential that alternative payment is less than what would have received under PPS; and ties payment directly to meeting quality standards
- Most models involving FQHCs today address this conflict by reconciling to PPS rate
 - But this can be burdensome for both providers and states
 - **California** looking to bypass PPS reconciliation

Developing and Implementing Value-Based Purchasing

STATE POLICY DECISIONS

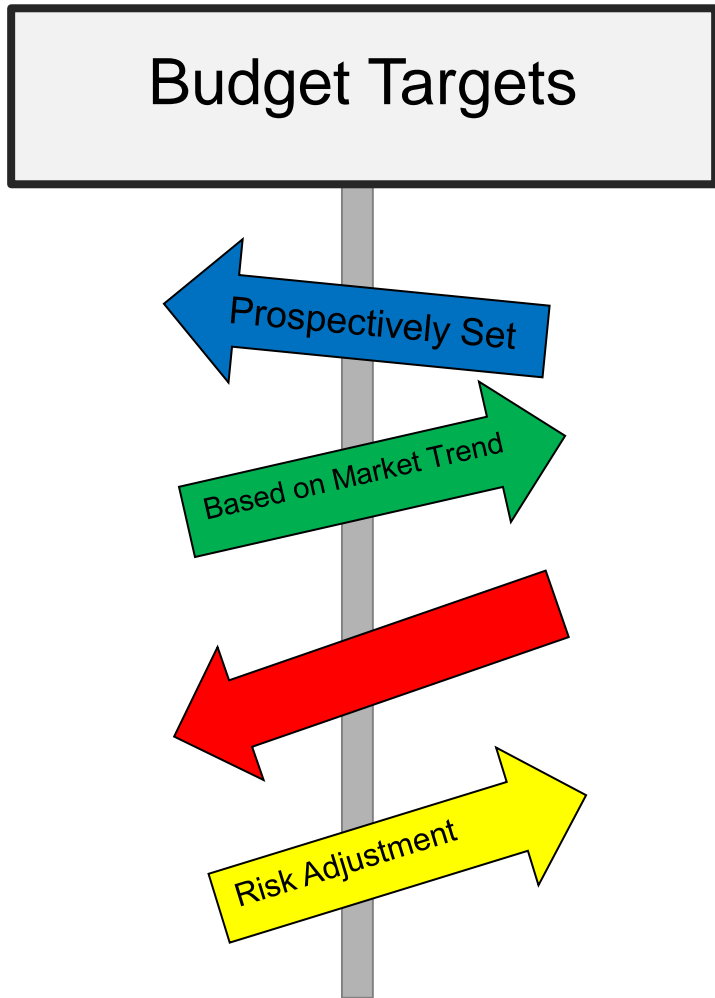
Development of Total Cost of Care Methodology

Included Services



- Total cost of care methodology will include an estimate cost for a comprehensive set of services for which the PCMH and/or ACO will be responsible.
- At a minimum, services will include preventive care, chronic illness and acute medical care
- Recommend that also include Behavioral Health and LTSS if possible.
- Potential for some outlier services to be excluded (e.g., emergency out-of-area services and transplants)

Setting Budget Targets for Providers



- In developing programs, states will set a TCOC for the particular population.
- States set a prospective budget estimate based on historical spending and forecasted growth
- TCOC budgets will be risk-adjusted based on population
- Financial performance will be reconciled retrospectively

Required Population Size for Sharing in Savings/Risk

- In order to be confident any observed savings or losses are significant, **it's important to have a population sizeable enough** to reduce the impact of random variation.
- See recent brief on issue from Mathematica:
 - <http://statenetwork.org/wp-content/uploads/2016/04/SHVS-Mathematica-Tricky-Problems-with-Small-Numbers-April-2016.pdf>
- Particular issue where states contract through multiple health plans



Member Attribution

- Key to the model is attributing members to appropriate FQHCs
 - Based on PCP being associated with FQHC
 - Visits to practice over period of time
- Depending on data available at state, health plans or FQHCs, list of attributed members can originate from any of them
 - Need to ensure that members are attributed only to one FQHC
 - Need to ensure that there is an appeals mechanism for the FQHC to challenge attribution of particular member where no interaction with member

Member Attribution (2 of 2)

- Need process to add/remove members:
 - How quickly do new members get attributed to an FQHC?
 - What process is in place to remove members when Medicaid eligibility ends? When they switch providers?

What Payment Reform Means for FQHC Operations

PRACTICE TRANSFORMATION

Practice Transformation is Hard Work

- FQHCs are complex, adaptive systems with interdependent and interacting processes and systems
 - Operating successfully as a PCMH [or within an ACO] requires a change to the roles and identities of all staff within the FQHC, not just the physicians
 - A change to one aspect (e.g., a staff role) affects other staff and practice processes.
 - Important to establish new workflows to replace currently established routines and patterns to limit provider stress with the new system.

Source: Nutting et al. *Ann Fam Med.* 2009; 7:254-260

Required Capacity to Assume Clinical and Financial Accountability



Required Capacity to Assume Clinical and Financial Accountability

**1**

Under both ACO and PCMH model, the underlying payment in most initiatives remain the same as today.

FQHCs will need to have capacity to monitor its actual vs. estimated financial performance, to understand performance relative to the TCOC

Required Capacity to Assume Clinical and Financial Accountability



2

Within the PCMH model, providers may have opportunity for shared savings.

Within ACO model, there is potential for both shared savings and shared-risk. There are examples of FQHCs taking on risk despite PPS (MA).

Required Capacity to Assume Clinical and Financial Accountability



2 If contracting with a shared-risk model, a financial strategy will be necessary in the event the providers within the ACO network exceed the budget.

Sufficient cash reserves are required, and in some states, regulated. This may include the need for capitalization. It may also require state actuarial certification of the ACO. *Other tools:* withhold, risk delegation, reinsurance, risk adj. and outlier protection

Required Capacity to Assume Clinical and Financial Accountability



3

Whether operating as a PCMH or as part of an ACO, FQHCs will need to continue to evolve their care management and care coordination programs.

FQHCs may want to enhance resources for community health workers and nurse case managers.

Greater focus on tying data analytics to care management/care coordination is one way to target efforts to improve health outcomes.

Required Capacity to Assume Clinical and Financial Accountability



3 One benefit to an integrated approach is the ability to coordinate and manage care across multiple providers – coordinating care across settings and providers (e.g., primary care and behavioral health) and managing care for those at greatest risk for near-term health decline and acute service use.

A systemized approach to these activities can serve patient needs and prevent use of duplicative and avoidable services.

Required Capacity to Assume Clinical and Financial Accountability



4

To operate most effectively as an ACO (and to some extent as a PCMH), the FQHC will need real-time data analytic resources and population-based management tools that leverage an integrated multi-payer claims database, ideally integrated with clinical data - *and be able to translate this data to action.*

FQHCs will need to be connected to interoperable EHRs & patient disease registries to identify high-risk populations.

Required Capacity to Assume Clinical and Financial Accountability



4

Practices need data to:

- 1) Avoid hospitalizations: need to know which patients are at high risk
- 2) Avoid readmissions: need to know which patients have been hospitalized
- 3) Avoid unnecessary ER visits: need to know when and how often patients are in ER
- 4) Avoid use of high cost setting: need to know relative costs of different referral providers

Required Capacity to Assume Clinical and Financial Accountability



4

Sophisticated analytic tools should assess quality, cost, utilization, patient experience and resource use efficiency.

They should review episodes of care, predictively model, and identify provider performance variation.

Required Capacity to Assume Clinical and Financial Accountability



4

Depending on current capabilities, additional resources may be needed to:

- Hire staff with expertise in IT, finance and analysis
- Upgrade IT systems – data warehouses and electronic health records
- Educate and train staff on e-record input

FQHCs may decide to “make” or “buy” data capacity; but need to have ready access to data either way. **Don't underestimate the critical nature of this capacity.**

Required Capacity to Assume Clinical and Financial Accountability

**5**

In order to be successful under accountable payment structures, participating providers must be engaged. This means increased provider attention to priority goals, use of and response to provided performance data, implementation of clinical pathways and aligned financial incentives.

Required Capacity to Assume Clinical and Financial Accountability



6

Assessing provider performance relative to performance expectations is essential. Doing so will allow for identification of providers and processes needing attention.

Since quality performance will be required to share in savings under both PCMH and ACO models, an infrastructure in place to monitor performance is required capacity.

Required Capacity to Assume Clinical and Financial Accountability



7

Resources to promote quality improvement among participating providers, and specifically a system to teach, share and implement best practices, will increase likelihood of VBP success.

Efforts should focus on a) measures integrated into the contractual VBP terms, and b) opportunities for improvement identified by the data analytics function, including reduction of misuse and overuse.

Characteristics of Practices that are Successful at Transformation

- Stable, strong and facilitative leadership
- A learning culture
- Organized business and financial systems
- Low staff turnover; high employee satisfaction
- Two-way communication and collaborative relationships between physicians and staff
- Stable IT systems, including effective implementation and use of an EHR

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Strong visionary leadership at all levels is critical.

Organizations need to make very difficult decisions and affect fundamental change to successfully operate as an ACO.

- Getting competitors to be collaborators.
- Finding a way for everyone to win.
- Persevering through initial periods without financial success.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Adequate population size is critical.

Providers should not reasonably accept financial responsibility for a patient population without enough patients. Otherwise, random variation will drive results.

- Medicaid: 5K – if including persons eligible due to disability (would need more if women and kids only)
- Medicare: new Next Gen ACO model requires 10K, while MSSP required only 5K
- Commercial: 15K-20K



Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Adequate population size is critical.

This begs the question – what are independent FQHCs to do if they are not big enough?

- participate in shared savings-only models
- affiliate with a larger health system or ACO (CHA)
- partner with other similar providers to create a bigger network (FUHN)



Probability of Achieving Shared Savings as a Result of Chance (MassHealth PCC Plan & MCO Data)

| Savings % | 5,000 attributed patients | 10,000 attributed patients | 20,000 attributed patients |
|-----------|---------------------------|----------------------------|----------------------------|
| 1% | 27% | 21% | 11% |
| 2% | 18% | 8% | 3% |
| 3% | 9% | 3% | 1% |
| 4% | 5% | 1% | 0% |
| 5% | 2% | 0% | 0% |
| 6% | 1% | 0% | 0% |

Source: Weissman J, Bailit MH, D'Andrea G, Rosenthal MB. ["The Design And Application Of Shared Savings Programs: Lessons From Early Adopters"](#), *Health Affairs*, September 2012.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Health informatics capacity is essential.

Management of population health and cost needs to be data driven. Analysis is required to assess:

- High risk patients amenable to intervention
- Quality gaps in care
- Variation in treatment patterns and resource use
- Quality and cost of referral providers
- States and trends in access, patient experience, quality, utilization and cost

States and/or MCOs need to provide data.

Providers need to determine whether to develop capacity, outsource to a vendor, or use a combination approach

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Care management is a key tool for cost reduction, but is not easily executed.

- It appears clear that reducing avoidable hospital utilization by high risk patients can produce savings.
- Every studied safety net ACO made care management a primary (and often the primary) cost management strategy.
- Determining which patients to target, with what kinds of staff, with what training and supervision, and whether centralized or embedded, is less clear.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

High risk care management is not enough.

Successful operation of an ACO needs to be a lot more than high risk patient care management. Why?

- Shared savings is tied to quality improvement, and moving quality measures requires a population health approach.
- There are other drivers of cost aside from high risk patients
 - Savings may be created by changes in site of care for all patients.
- One safety net ACO put “performance improvement advisors” at FQHC sites to support care transformation and improved operations.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Communication of information across partners is essential – and often lacking.

- With HIEs not close to realizing their promise most everywhere, safety net ACOs have worked to find ways to get the most critical information, such as inpatient ADT notification.
- Communication of behavioral health data is also a challenge, with state laws and inconsistent provider and insurer understanding of legal requirements creating barriers.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Social and economic determinants of health influence health care utilization by the safety net population.

- Housing, nutrition, employment, stress, transportation and other non-medical factors profoundly influence health status and health services utilization.
- Safety net ACOs target those factors, partnering with community agency partners to do so.
 - e.g., Hennepin Health (MN): leases transitional housing for homeless adults post-discharge, piloting employment placement assistance as a means to improve health status

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Behavioral health is a major cost driver.

- Behavioral health plays a large role in health status and cost in ways that only partially appears through behavioral health service utilization.
- Safety net providers are rapidly co-locating and integrating care, but physical plant constraints and provider training and experience with the model creates challenges.
- Closer relationships with referral providers are also important.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

Real change in care delivery takes time.

While it is possible to see some “quick hit” savings through targeted successful interventions (care mgt for selected highest utilizers), systemic change does not happen quickly.

- Even organizations that have been contracting on a risk basis for 10+ years are still developing key processes.

Relevant Lessons for Successful Delivery System Transformation and Payment Reform

The finance function plays an active role.

- Finance professionals manage both revenue and expense in a manner distinct from their traditional roles, as population-based contracts create different incentives and demands than traditional contracts.
- The question of making vs. buying for key ACO functions also requires significant finance input.
- Means for securing the funds for large staff and systems investments requires creativity.
 - Some observed approaches: health insurer contribution, analytics vendor investment, capitation payment to help with cash flow, affiliation with an MSO

Discussion and Questions

- My contact information:

Beth Waldman, JD, MPH

Senior Consultant

bwaldman@bailit-health.com

781-559-4705