



OPCA
Oregon Primary
Care Association

Advanced Care Learning Community

Care Model Connection Webinar:

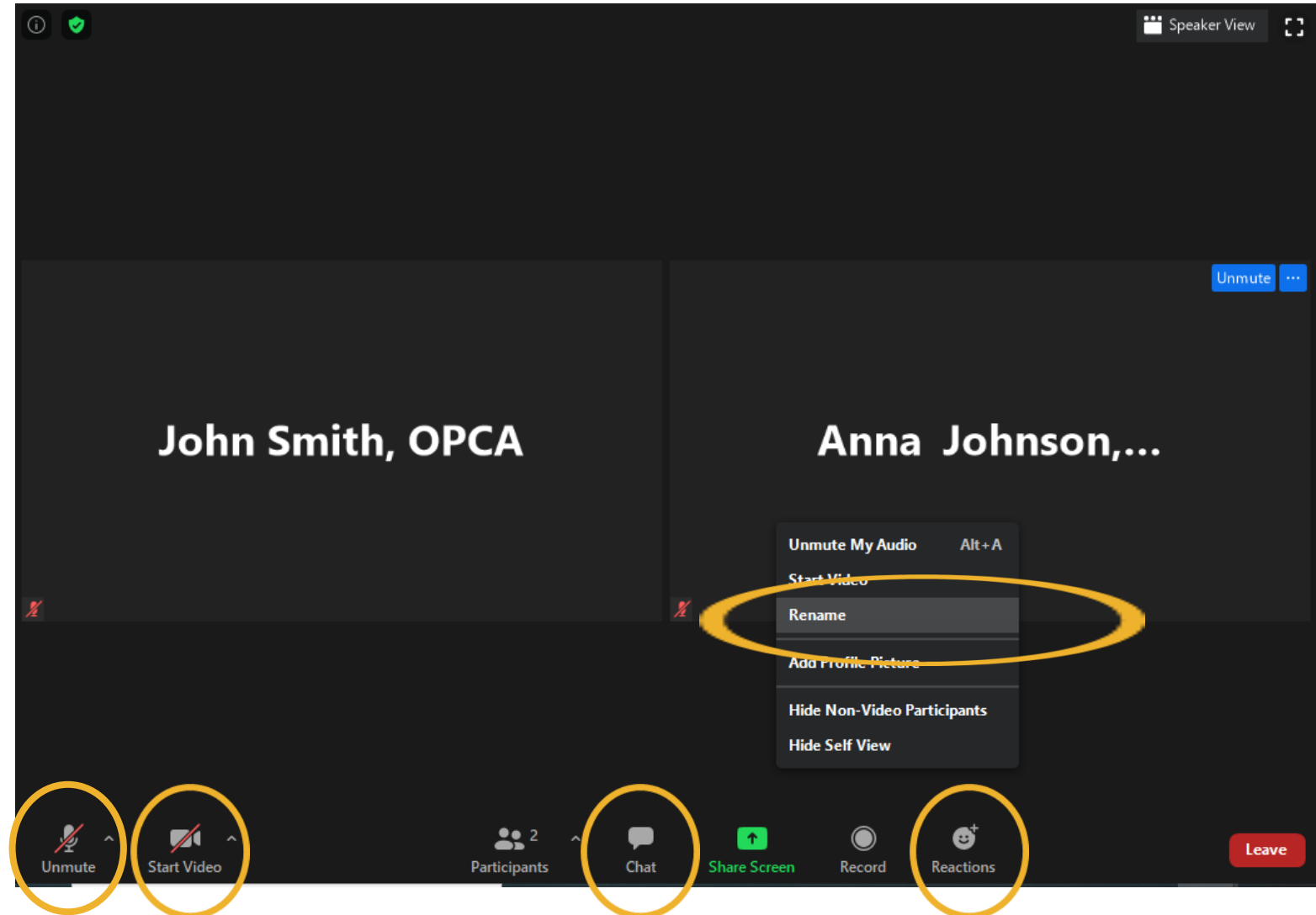
April 21, 2022

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This webinar will be recorded

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- Use the chat freely! Send kudos, ask questions, and connect with peers
- Feeling a sort of way? Express yourself with the 'Reactions' feature!



- Quality Improvement
- Advanced Care Model
- Social Needs Screening
- Patient-Centered Care
- UDS Data and Metric Focus
- Patient Engagement

Transformation Team



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Who's joined us?



In the chat box, type your:

- Name
- Role
- Organization

Today...

What: review and learn about foundational Oregon value-based pay and care model transformation elements and the opportunities Oregon health centers have available to be successful

Objectives:

1. Review the history and opportunities of value-based pay & care for Oregon health centers
2. Gain foundational understanding of how health care payment change will impact care model infrastructure
3. Learn lessons learned and recommendation from an expert and health center of how to be successful in future value-based health care environment

Questions to consider:

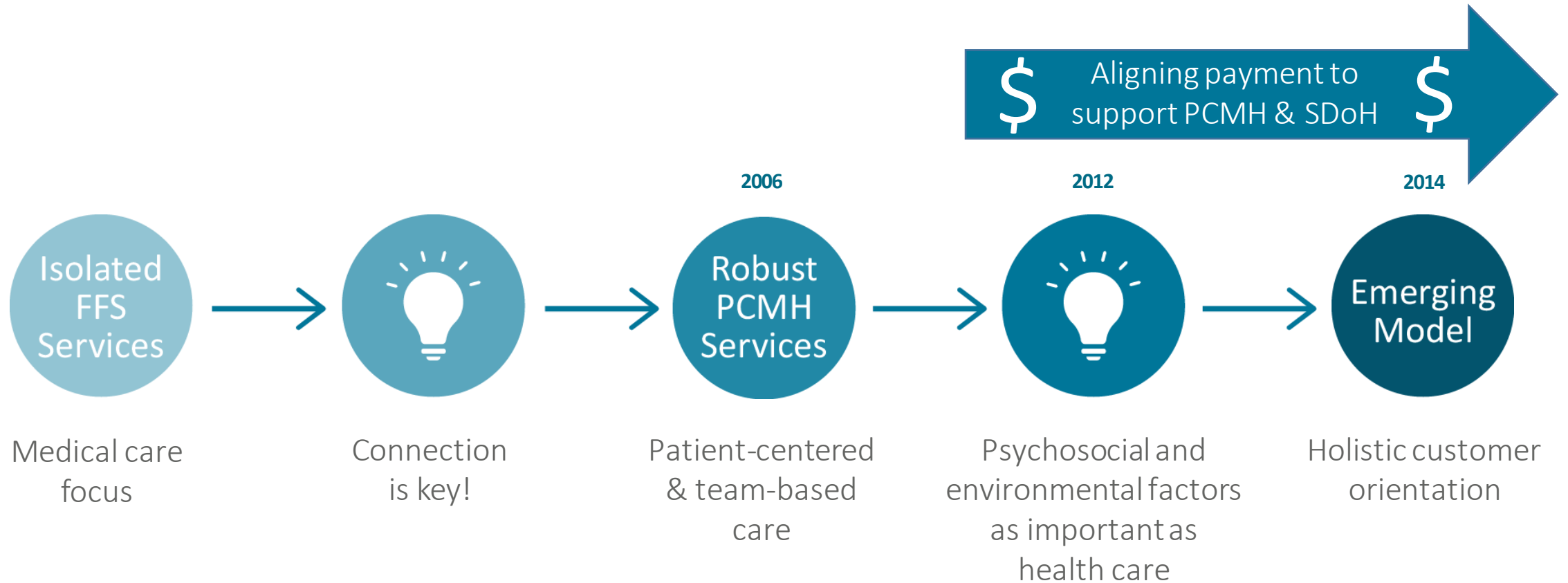
- What are you working on now re: VBP and/or care model transformation?
- What are you struggling with? What's going well?
- What do you plan to focus on in the future for VBP and/or care model transformation?

Why Did We Implement APCM & How Can It Prepare Us for What's Next?

Oregon PCA
April 21, 2022

Why We Implemented APCM

EVOLUTION OF APPROACH



IT WAS ABOUT THE CARE MODEL

- In 2008, we joined the Safety Net Medical Home Initiative to implement comprehensive, team-based care.
- Payment was a barrier since revenue relied on a F2F visit with a billable provider.
- We started developing the APCM concept and aligning stakeholders in 2011.
- Became the first state in the country to implement a statewide capitated APM for FQHCs with Medicaid in March 2013.
- It was meant to be a bridge to value-based pay (VBP).
- *Side note: other states are interested in hearing from you.*

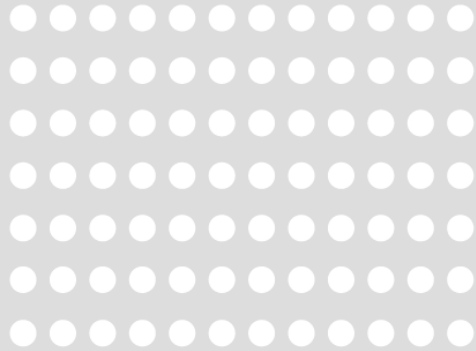
A starry night sky with a prominent star and a faint constellation line.

Know your North Star

**Lead the transformation of
primary care to achieve
health equity for all**

Listen to your data.

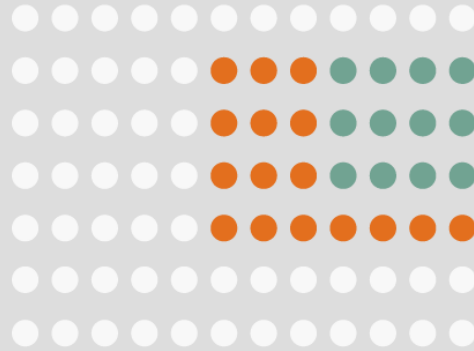
10,000 PEOPLE POPULATION



Use analytics to piece together target population characteristics.

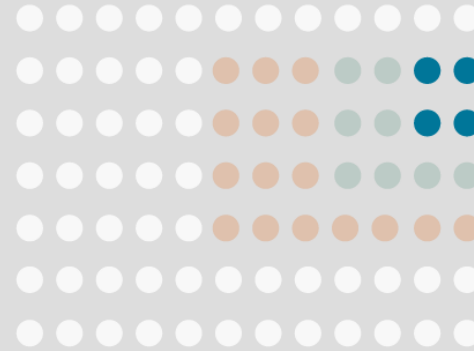
May require multiple data sources and analytic processes.

SUB-POPULATION(S)



- 834 diabetics
- 223 with HbA1c >9

TARGET POPULATION



- 56 out of the 223 diabetics with HbA1c >9 who also:
 - Missed 2 appointments in the last 6 months
 - Live below 100% FPL
 - Are non-native English speaker
 - Have a co-occurring mental health diagnosis
 - Did not graduate from high school

Understanding Their Needs

- Empathic inquiry and community data (*PRAPARE*)

Responding to Their Needs

- Redesigning care teams
- Developing strong community partnerships
- Expanding social determinants of health/upstream interventions

Demonstrating Impact

- Metrics of success
- Understanding cost and ROI

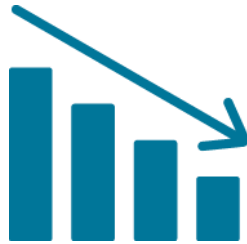
Change care and listen for the effects.



PRESSURE ON THE SYSTEM



Cost increases



Budget deficit



System reform



Need to
show value

Capitated APM Increasing Popularity

- Started in Oregon (first statewide), then WA, then CO.
- NACHC APM Academy – IA, LA, MT, TN, NY
- NACHC APM Academy 2 – AK, DC, FL, IN, ME
- Several other states are actively pursuing or have actively pursued: CA, CT, HI, IL, MI, MO, NV, OK
- That's 20 total, I'm sure there are others I've missed.



COMMON PURPOSES OF FQHC CAPITATED APMs





- Remove the incentive to produce billable visits.
- Provide flexibility to implement robust team-based care, including SDoH interventions.
- Providers are getting harder to recruit.
- Increase focus on care coordination.
- Integration of services
- Improve health equity.
- Predictable cash flow – state, CHCs
- Control destiny on state VBP efforts.

The VBP Environment is Evolving



FEE-FOR-SERVICE FLAWS

- Rewards volume without accountability to quality or cost.
- Focuses work on the billable provider instead of the work of the team.
- Doesn't reward continuity between the patient and provider.
- Doesn't incentivize proactively managing patients.
- Doesn't support improving care through risk stratification.
- Doesn't incentivize provider organizations to work together.
- Doesn't incentivize efficiencies in the health care system.
- Hasn't sufficiently supported primary care and behavioral health integration.
- However, FFS does track access to services and will have a role in VBP/VBC.

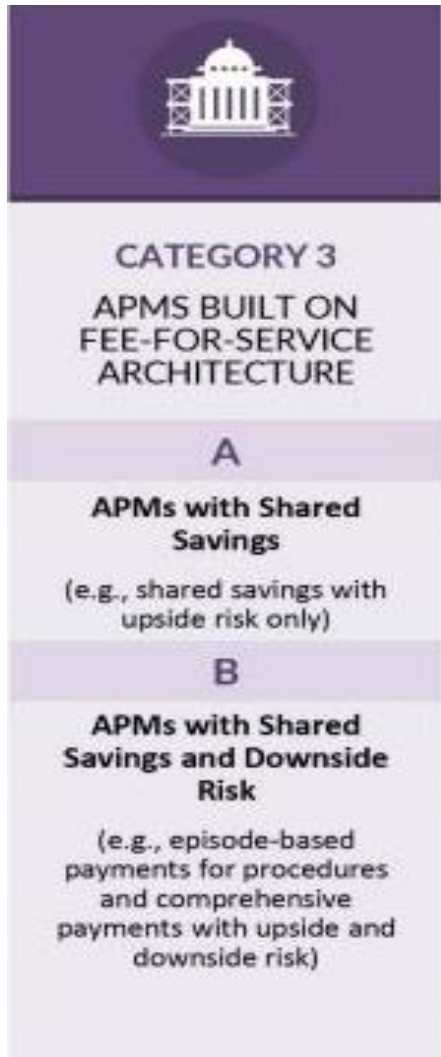
			
<p>CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE</p>	<p>CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE</p> <p>A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)</p> <p>B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p> <p>C Pay-for-Performance (e.g., bonuses for quality performance)</p>	<p>CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</p> <p>A APMs with Shared Savings (e.g., shared savings with upside risk only)</p> <p>B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>CATEGORY 4 POPULATION – BASED PAYMENT</p> <p>A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</p> <p>B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</p> <p>C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk Based Payments NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

FFS with Link to Quality and Capabilities Needed



- 2A • **Time to play:** build PCMH & BHH capabilities, like care coordination, IT capabilities, data & analytics, leadership
- 2B • Ability to capture and report data, usually quality metrics. SDoH is important for vulnerable populations, think about data for risk adjustment
- 2C • QI & chronic disease management programs
 - Registries and performance dashboards
 - Patient experience performance reporting
 - Data security infrastructure
 - Financial and payment performance modelling
 - Aligned incentive performance payment programs
 - Cultural alignment with quality
 - Change management expertise
 - Adaptive reserve

APMs Built on FFS Architecture and Capabilities Needed



- 3A
 - Master care coordination
 - Set quality and utilization benchmarks and standards
 - Establish clinical protocols and coordinated workflow processes
 - Population health capabilities (e.g., risk stratification)
 - Alternative visits
- 3B
 - Care management capabilities, especially high risk
 - Targeted disease management
 - Medical oversight of coordinated care and disease management programs

Population-Based Payment and Capabilities Needed



In 4A, for primary care cap

- Need to know your costs
- Rates should reflect costs and stable utilization
- Analyze risks associated with quality requirements

In 4B & 4C, you need

- Utilization management and review
- Pharmacy benefits management
- Prevention and wellness programs
- Actuarial analytics & predictive modelling
- Payment processing and claims adjudication
- Underwriting, Reinsurance
- Reserves maintenance

4N isn't VBP, but can offer flexibility to evolve care transformation.
Need to know your costs.

HOW COVID IMPACTED VBP

- Accelerated VBP
 - ✓ Flexibility for FQHCs getting paid for alternative visits - telehealth video visits and telephone visits.
 - ✓ CMS flexibility, CMS letter to Medicaid Directors in 2020 and State FFS views could lead to acceleration of VBP.
 - ✓ LAN HEAT recommendations to support health equity.
 - ✓ CMMI interest in safety net participation in VBP.
- Slowed VBP efforts
 - ☹ Focus on the pandemic and fiscal impact on the State/providers & quality and cost metrics were skewed in 2020 & 2021.

CMS Payment Reform Letter 9-15-20

- Promotes use of capitated payments, citing this shift during the pandemic.
- Providers taking on down-side risk is critical, although CMS was concerned that some providers didn't have the capacity to take on risk.
- Encouraged states to shift from voluntary to mandatory VBP models.
- Used HCP-LAN definitions.
- CMS acknowledged that what works for one state doesn't necessarily work for another.
- CMS will ensure that any APMs with FQHCs are voluntary and pay no less than the FQHC would have received under PPS.

LAN HEAT CALL TO ACTION

The disparate outcomes during COVID has increased health care's focus on decreasing health disparities.

APMs (CMS definition) present a significant opportunity to reduce inequities in care and outcomes.

LAN launched the Health Equity Advisory Team.

FEATURES
IMPORTANT TO
ADVANCING
HEALTH
EQUITY

Hold providers accountable for delivering better care and achieving better health outcomes for all people.

Give providers greater flexibility to deliver whole-person care, consistent with each individual's community, culture, and identity.

Increase accessibility and use of effective, appropriate, and affordable care and services.



CARE
DELIVERY
DESIGN
ELEMENTS

- Partnership with CBOs and social service agencies.
- Partner with patients to drive decision-making and investments.
- Provide person centered, culturally and linguistically appropriate care.
- Integrate care to address medical, BH and health-related social needs.



PAYMENT
INCENTIVES
AND
STRUCTURES

- Multi-payer alignment is needed.
- Population-based models with prospective cash flows.
- One-time infrastructure payments for care delivery transformation.
- Payments focused on populations historically harmed or underserved.
- Payment incentives to reduce health disparities in quality, outcomes, and patient experience.
- Clinical and social risk adjustment for payment.
- Payments to CBOs to fund collaborative partnerships.



PERFORMANCE
MEASUREMENT

- Collect data related to health disparities.
- Stratify and risk-adjust performance measures.
- Integration of state, public health, social services, and community-level data.

DESIGNING PAYMENT INCENTIVES

- Acknowledgements
 - In some instances, APMs have increased health disparities.
 - The LAN recognizes that organizations delivering care to the underserved are often underfunded.
- Health equity performance is a significant % of quality score, at least 20%.
- Prospectively paid primary care/population health APMs, shared savings rates, and other performance-based payments adjusted based on health equity.
- An additional equity pool is available to historically underfunded providers serving vulnerable populations.
- Time-limited, upfront payment to support capacity building and practice transformation.
- Ensure payments adequately cover patient care costs.

OVERARCHING GUIDANCE

- Align around a common definition and shared understanding of health equity.
- Partner with communities to understand the root causes of health equity.
- Support providers to understand and address health disparities.
- Payer and provider contracts reflect expectations for tracking and incentivizing health equity performance.
- Monitor and address unintended negative consequences.
- Develop transparency to assess impact on populations experiencing health disparities and under-resourced providers.

EXAMPLES

- Health home payments for integrating physical, behavioral, and social health for patients with serious mental illness and complex health histories.
- Cover services for doulas, personal health navigators, peer support specialists, and community health workers.
- Pay for reporting incentive to support data collection and analysis.
- Provide upfront care transformation payment and guardrails for acceptable use of payment.
- Reward meaningful reduction in health disparities. Increase performance benchmarks over time as provider capacity to address health inequities grows.

LAN HEALTH EQUITY ADVISORY TEAM RECOMMENDATIONS

- Need risk adjustment to account for the social risk of populations served.
- Support efforts to address health related social needs.
- Need multi-payer alignment.
- Provide one-time infrastructure payments to support care delivery transformation.
- Support data collection and analysis related to health disparities.
- Need population-based models with prospective cash flow.
- CBOs should be funded to support collaborative partnerships.
- Health equity performance should be at least 20% of the quality score.
- Adjust VBP models to reward health equity.
- Provide an equity pool to historically underfunded providers serving vulnerable populations.
- Payer and provider contracts should have expectations for tracking and incentivizing health equity performance.

WHAT DOES THIS
MEAN FOR
HEALTH
CENTERS?

Payment should support data, analytics, and care model changes that improve health equity.

Identifying and addressing SDoH barriers will be a competitive edge.

Payment should support interdisciplinary teams, including CHWs.

Seeing patients that others won't see should not be a disadvantage in APMs.

Risk adjustment for behavioral and SDoH will be required.

Payment should support closed loop referrals to social service agencies.

NASEM

- Committee on Implementing High-Quality Primary Care
- High-value primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

NASEM

- Takeaways

- Payment should focus on supporting high-value primary care, not short-term costs savings.
- Payers should not focus on LAN%.
- Shift to hybrid pay - FFS and capitated.
- Invest in practice transformation.
- Risk adjust for medical and social complexity.
- Effective measurement that's not onerous.
- Increase the portion of health care spending on primary care.
- Target sustained investment in the creation of new health centers.
- Partner with CBOs.
- Support alternative visits.
- Expand and diversify the primary care workforce.
- HHS should establish a Secretary's Council on Primary Care.

COMMONWEALTH FUND & FQHCs

- FQHCs have been left out of CMS APMs.
- PPS was designed to pay for additional services FQHCs provide to high need populations.
- PPS is no longer sufficient because it hasn't kept up with HC costs or the patient's complexity, including the roles of trauma and SDoH.
- Profiles FQHCs participating in APMs: FQHC capitated APMs, quality incentives, shared savings with up and downside risk, creating IPAs, forming ACOs, partnering to build data warehouses and utilize population health tools, and leveraging DSRIP payments,

COMMONWEALTH FUND & FQHCS

- Shifting more FQHCs to APMs will require technical assistance, culture change, collaboration, and customized payment models.
- External support may be needed to develop data analytics and financial forecasting tools.
- APMs may require upfront funding for smaller health centers and more flexibility for advanced FQHCs.
- Effective partnerships between health plans and health centers are essential.
- Health centers need to collaborate with other health care providers, including specialists and hospitals.
- Payment models must cover all patients.

Opportunity

- VBP seems to be here to stay. However, VBP is evolving.
- The environment is right to align VBP models to support the evolving care model.
- FQHCs have an opportunity to lead the alignment of VBP effort for vulnerable populations.



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Questions for You

- What are you working on now re: VBP and/or care model transformation?
 - What are you struggling with?
 - What's going well?
- What do you plan to focus on in the future for VBP and/or care model transformation?

Wrap-up & Evaluation



Upcoming Transformation Event

Save-the-date! ACLIC Virtual Conference

- Dates: June 6 & 7, 9am – 12:15pm PST
- Objectives:
 - » Network and learn from peers about their strategies and lessons learned for population health .
 - » Learn and discuss sustainability strategies for health care transformation within an evolving environment.
 - » Discuss measures used to obtain and practice transformation and quality improvement.
- Registration will open in May



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