OPCA

Oregon Primary Care Association

APCM 2.0 Informational Sessions

April 13, 14 and 19, 2022

Welcome!

- In the chat box, please introduce yourself:
  - » Your name
  - » Health center
  - » Role and,

  - » Either what your favorite CareSTEP is (to bill or do) or,

  your favorite memory/experience in the APCM program…

< 10 years of APCM in Oregon

2011 – 2022

8 Years of Growth: 20 CHCs + 2 RHCs Participate in Oregon's APCM

Phase 1 (2013)	Phase 2 (2014)	Phase 3 (2015)	Phase 4 (2016)	Phase 5 (2017)	Phase 6 (2018)	Phase 7 (2019)	Phase 8 (2020)
Mosaic Medical	Benton County	Clackamas County	Neighbor-hood Health	La Clinica	Lane County	ADAPT	Aviva
OHSU-Richmond	Multnomah County	Rinehart Clinic	Northwest Human Services	Wallace Medical Concern	Valley Family	Waterfall Clinic	One Community Health
Virginia Garcia	OHSU-Scappoose	Rogue Community	Winding Waters		Orchid Health		
	Yakima Valley						

Behind the Scenes

- OCPA Staff
  - Danielle Sobel, Sr. Director of Policy and Government Affairs
  - Torie Baldwin, APCM Specialist
  - VBP Strategies Director, TBD
  - Simon Parker Shames, Data Director
  - Brandon Lane, Data Analyst
  - Brooke Linn, Transformation Director
  - Stephanie Castano, Transformation Sr. Manager
  - Marty Carty, Government Affairs Director
  - Jason Bell, Quality Improvement Manager
- Members + Consultants
  - APCM Steering Committee, 7 members
  - Value-Based Pay Committee (Board)
  - CedarBridge Consulting
  - Curt Degenfelder
  - Hostetler Group
  - Community Health Center Network of Oregon (CHCNO)
- OHA
  - Donald Jardine
  - Jennifer Smith
  - Adrienne Cook

Founding Principles

OHA Guideposts

1. **Accountability for Outcomes**: OHA's goal, aligned with their vision for health reform that established the CCO model, was to move towards increased accountability for Triple Aim outcomes - Improved quality, improved patient experience and reduced cost. It was particularly appealing to OHA that under a new methodology they would reports tracking quality outcomes when heretofore they had not received any such data from health centers.

2. **No Additional Funding**: OHA stated explicitly that they were unwilling to pay *more* for health center services, but they were willing to pay differently. OPCA found common ground in the ask of Health Centers, which proposed equal payment on a per patient basis, with flexibility to serve those patients differently.

3. **Maintain Access**: OHA's biggest concern about unintended consequences was that patients would see constricted access. This concern was primary for OHA because of their required accountability for Medicaid access and the experience that many had under Medicaid managed care models during the 90's.

Founding Principles

OPCA and CHCs

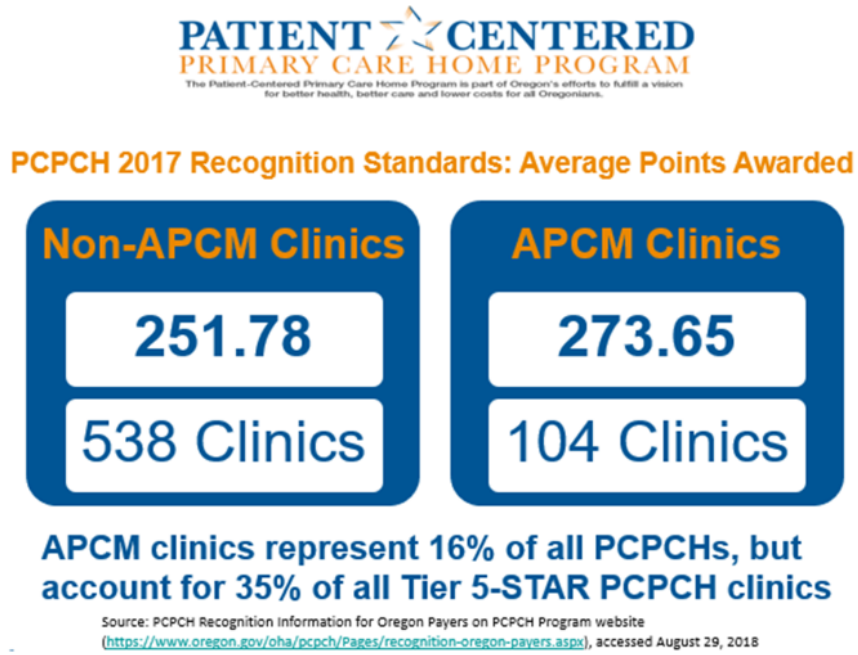
1. **Off the Face-to-Face Visit**: The foundation of health center's ask was to create a methodology that would maintain their level of payment on a per patient basis and allow them to move off of the face-to-face visit with a billable provider.

2. **Formal APM**: OPCA required that the methodology be established as a formal Alternative Payment Methodology (APM), allowed for under federal PPS law. OPCA saw the PPS law as both protective of health centers by limiting the potential downside to the model as well as addressing concern that the APM would set a PPS-damaging precedent.

3. **Bridge to Value Based Payment**: Health centers were willing to share quality and access data for maintaining or improving outcomes but were not willing at the outset to put money at risk for improving outcomes. In particular, OPCA cautioned that until adequate social risk adjustment would become a reality, the playing field between providers is not level. The payment methodology was intended to "bridge to value-based payment", because CHCs were not willing to go fully at risk for outcomes without improved medical and social risk adjustment.

APCM Program Successes

- Highest performing PCPCHs
- Significant and measurable increases in CareSTEPs
- Improvements in quality metric performance
- Cost savings demonstrated through reductions in hospital/ER utilization
- Countless local level clinical and community health innovations enabled by movement to population-health payment



APCM Challenges

- Limited staffing at OHA to administer APCM
- Increased complexities with new and existing reporting requirements
- APCM focus shifted to reporting requirements instead of original intent (care model advancements and innovations)
- Scaling up to meet need of larger number of FQHCs on the model is a major challenge
- Lack of automated operations/staffing stretches OHA, OPCA resources; FQHCs experience significant delays

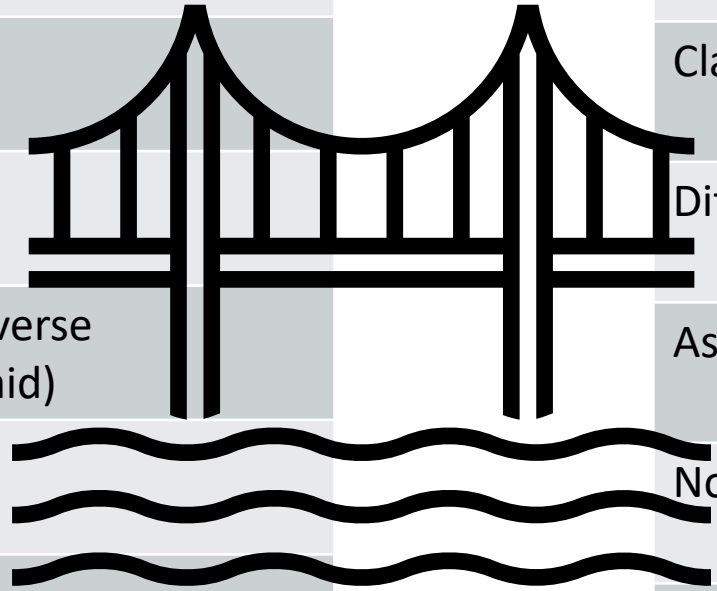
Opportunities

Equity and Payment landscape

1. OHA strategic goal: Eliminating health inequities by the year 2030
2. CCO incentive metric: 70% of all primary care payment in VBP model by 2024 (LAN category 2C)
3. SDoH Incentive Metric (2023 planned)
4. CMMI and future of APMs (2026)

VBP Bridge(s)

Element	FFS	APCM	VBP
Attribution	Visit-based	Services-based	Annual assignment + patient preference
Accountability	Documentation	CareSTEPs	Outcomes: Total cost + quality
Risk Adjustment	None	None	Claims-based
Risk Stratification	None	None	Different levels of intensity
Quality	In-patient Universe (UDS)	In-patient Universe (UDS + Medicaid)	Assigned patient universe (CCO)
Race Adjustment	None	None	None
SDoH Adjustment	None	Nonne	None



Setting the stage: Priorities

- Leverage the current state environment without jeopardizing program gains though:
  1. Risk adjustment includes: SDoH adjustment and race adjustment
  2. Streamline and automate data collection and evaluate outcomes
  3. Promote and be recognized as trainers in care model transformation and transitional mindset

- We can do this by iterating the following areas of APCM:
  - » Accountability: Quality outcomes, Total Cost of Care analysis, assess current accountabilities
  - » Attribution: align with CCO attribution?
  - » Quality: CCO metrics, attributed universe of claims-based
  - » SDoH: Z-codes collaborative
  - » Technology: new platforms/modules at OPCA and OHA

The Vision for APCM 2.0

DRAFT
APCM 2.0 Framework

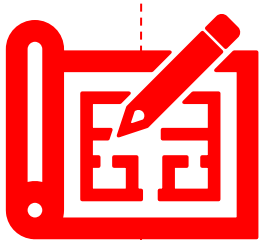
Reengineered for equity and innovation

APCM 2.0 Consensus Building Timeline

Re-engineered for equity and innovation

Q4 2021

OPCA develops draft framework for evolving APCM program



Q1 2022

Draft framework reviewed by APCM Steering Committee in **January**. Presented at APCM forum in **February,** with focus groups through **April**, for clinic feedback**.**

Q2 2022

OPCA and FQHC champions meet with OHA to gain buy-in on APCM 2.0 in **May and June**. New participation agreements signed in **June/July**.

Q3 2022

APCM 2.0 launches in July

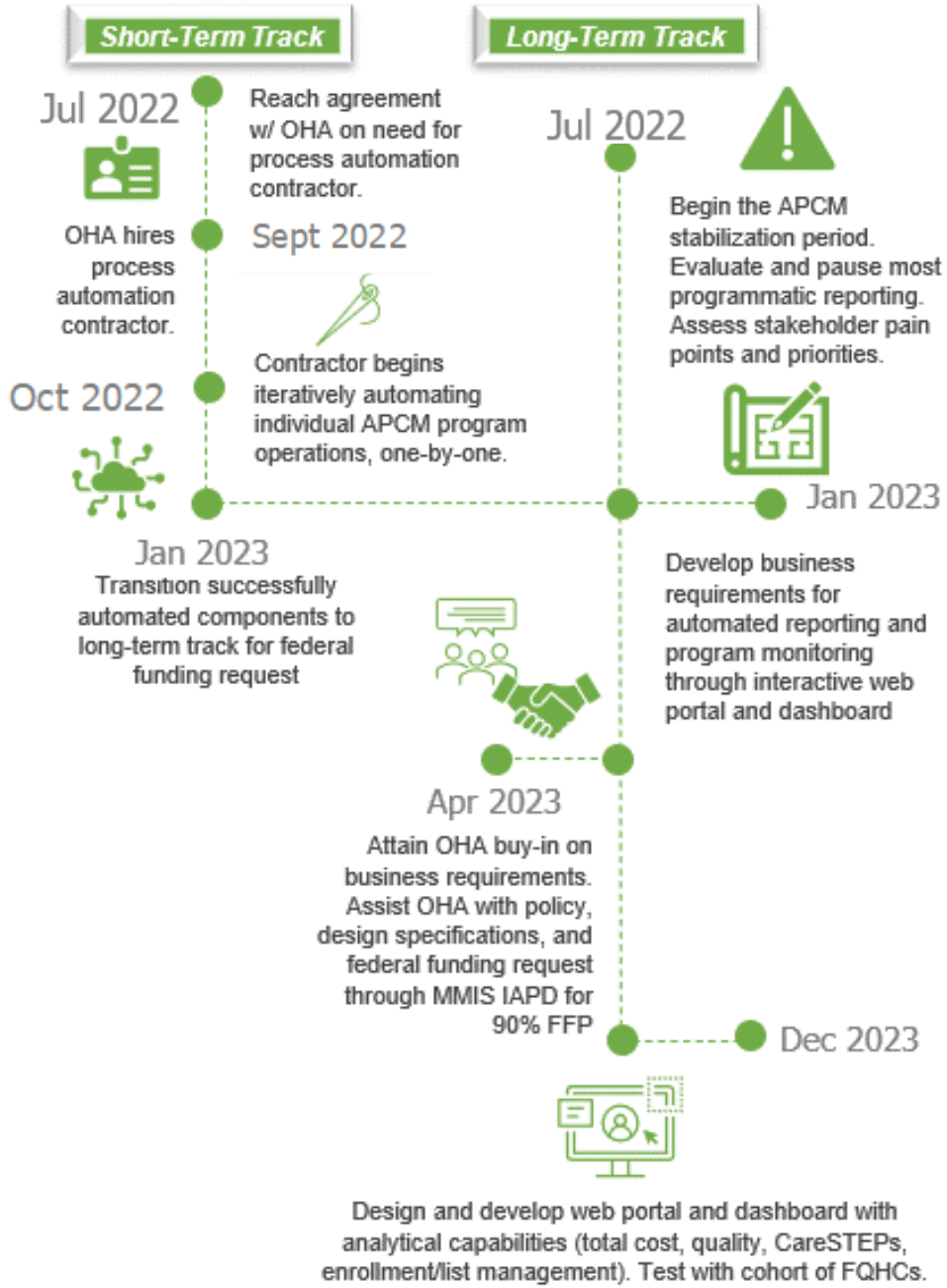
Structure of APCM 2.0 Framework

Goal 1	***Renovate and redesign APCM operations*** to promote efficiencies through automated data exchange and reporting requirements
Goal 2	***Maximize interoperability*** using federal funds to advance Medicaid systems and promote sharing of health and community information
Goal 3	***Accelerate health equity*** by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions
Goal 4	***Bridge to value-based care*** through alignment with CCOs and exploration of new innovative performance incentives

- Including:
  - ✓ Timelines
  - ✓ Milestones
  - ✓ Cost Estimates
  - ✓ Success Metrics

Goal 1	***Renovate and redesign APCM operations*** to promote efficiencies through automated data exchange and reporting requirements

Implementation Timeline & Milestones



Goal 1

Renovate and redesign APCM operations to promote efficiencies through automated data exchange and reporting requirements

Success Metrics

- ✓ List management reporting and operations paused by September 2022
- ✓ Business requirements document produced by January 2023 for automated reporting and dashboard
- ✓ MMIS IAPD approved by CMS by July 2023
- ✓ Web portal and dashboard with advanced analytics implemented by December 2023

Cost Estimate*

$910K

*Estimate of state general fund required for 10% portion of $1.1 million cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities (FFY 23-24). Add $400,000 annually for process automation contractor over 2 years ($800,000 total)

Goal 2

Maximize interoperability using federal funds to advance Medicaid systems and promote sharing of health and community information

Implementation Timeline & Milestones

Jan 2023

Evaluate existing systems and initiatives for health and community information exchange in Oregon. Assess data sources OHA / DHS that may assist with client care.

Aug 2023

Pilot workflows for utilizing community information exchange (CIE) to screen for patients' social risk factors, query for social risks, refer to community-based organizations, track and monitor the status of referrals, and/or analyze population data on social risk factors at the community-level

Oct 2023

In accordance with the MMIS IAPD in Goal 1, include funding for OHA to support FQHCs with onboarding and technical assistance to CIE technology infrastructures

Aug 2024

Publish an annual report on FQHC CIE pilot activities with measurable outcomes and preliminary findings

Goal 2

Maximize interoperability using federal funds to advance Medicaid systems and promote sharing of health and community information

Success Metrics

- ✓ Assessment of FQHCs data infrastructure and community landscape for health and community information sharing by March 2023
- ✓ Each FQHC implements a pilot for CIE-type activities by August 2023
- ✓ OHA begins support for CIE activities by March 2024
- ✓ Report on FQHC CIE pilots including preliminary findings and community health outcomes by August 2024

Cost Estimate*

$50K

*Estimate of state general fund required for 10% portion of $500,000 cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities.

Goal 3

Accelerate health equity by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions

Implementation Timeline & Milestones

Jan 2023

Confirm capabilities for analyzing and integrating REALD and SOGI data. Combine aggregate data with clinical and social risk data. Identify health disparities at community level.

Jun 2023

Evaluate best practices for reducing specific health disparities. Confirm disparities FQHC will focus on. Identify and partner will relevant community-based organizations.

Dec 2023

Design and implement a community health intervention pilot. Establish clear metrics for success. Create monitoring capabilities to analyze data and evaluate success of interventions.

Dec 2024

Implement pilots. Monitor and report progress. Showcase community health intervention success stories

Goal 3

Accelerate health equity by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions

Success Metrics

- ✓ FQHCs report predominant health disparities identified by June 2023
- ✓ FQHCs focus disparities and intervention methods by December 2023
- ✓ FQHCs design and implement the community health intervention(s) by Mar 2024
- ✓ Report progress and success stories by December 2024

Cost Estimate*

$0

*Scope proposed does not impact state general fund budget.

Goal 4

Bridge to value-based care through alignment with CCOs and exploration of new innovative performance incentives

Goal 4

Bridge to value-based care through alignment with CCOs and exploration of new innovative performance incentives

Jul 2022

Pause and remove previous VBP attempts (accountability plan and non-engaged closure report). Engage FQHCs, OHA, and CCOs on menu of HCP-LAN VBPs methods. Explore new risk scoring based on REALD, SOGI, and social risk data.

Oct 2022

Reach agreement with FQHCs. Present a proposal to OHA to get buy-in. Assist OHA with applying for necessary federal authority to introduce new risk and/or reward components to APCM. Prioritize shared savings from total cost of care measure.

Jan 2023

Plan and design Medicaid system changes necessary to efficiently administer VBP, including savings from aggregate total cost of care measurement. Assist OHA with design and development discussions with MMIS VBP vendor.

Dec 2023

Launch the new VBP component of APCM 2.0. Facilitate engagement and technical assistance for participating FQHCs. Implement capabilities to monitor shared savings accrual in near real-time.

Success Metrics

- ✓ Reach agreement with FQHCs on preferred HCP-LAN VBP components by Jan 2023.
- ✓ UAT testing of new Medicaid VBP module by Oct 2023.
- ✓ Launch the new APCM 2.0 VBP (risk adjusted for REALD, SOGI, and SDoH) shared savings model using total cost of care by Dec 2023.

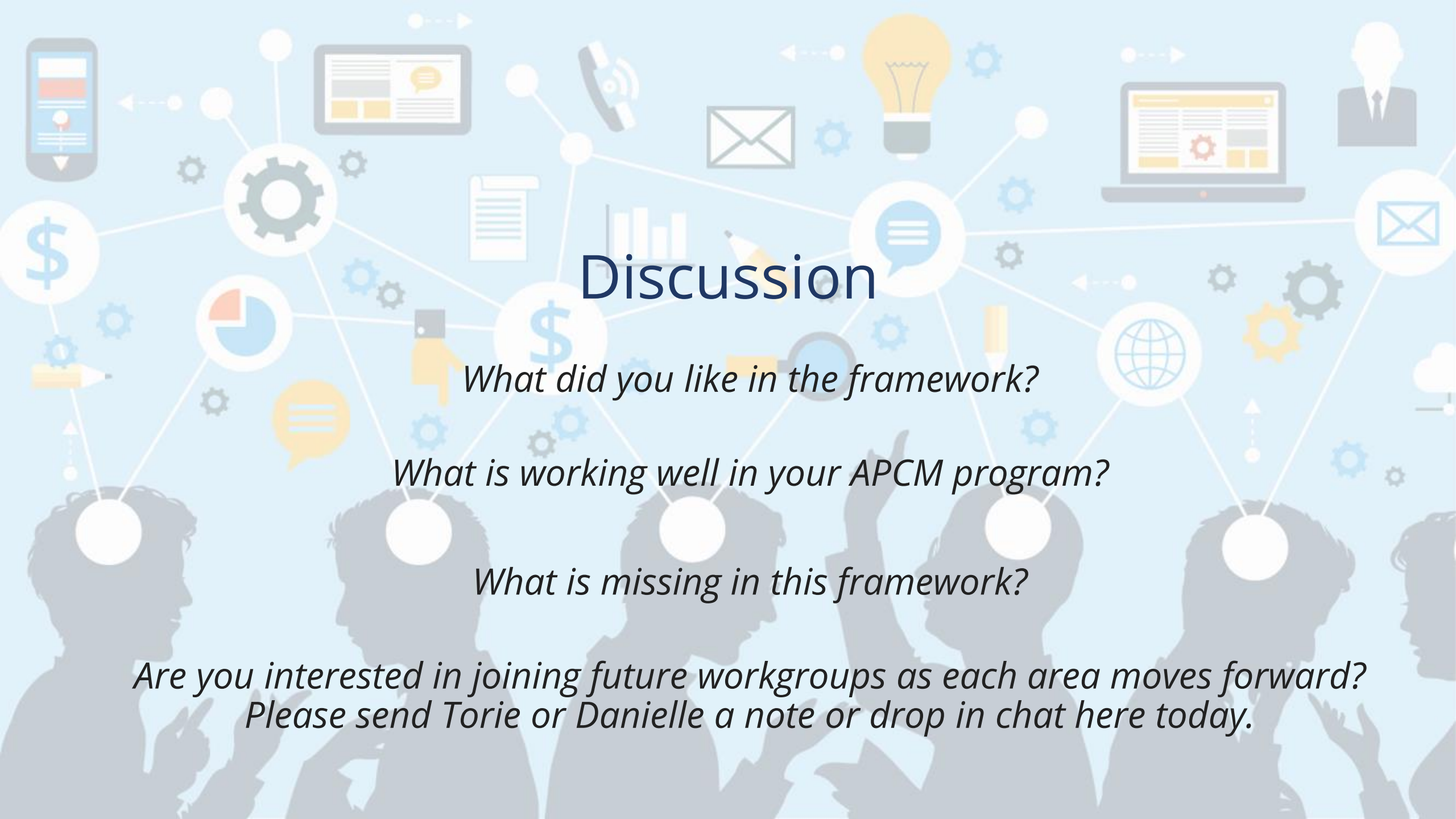
Cost Estimate

$250K

*Estimate of state general fund required for 10% portion of $2.5 million cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities (FFY 23-24).

REMEMBER…

- This is a **DRAFT** framework…with planned implementation over next 2 years
- Your feedback matters and will improve the proposal
- OHA's continued partnership is key
- Framework agreed upon will remain iterative and will build upon current successes



Discussion

What did you like in the framework?

What is working well in your APCM program?

What is missing in this framework?

Are you interested in joining future workgroups as each area moves forward? Please send Torie or Danielle a note or drop in chat here today.

Thank you!

Danielle Sobel, dsobel@orpca.org
Torie Baldwin, tbaldwin@orpca.org

Next steps for this group

Next Forum will be in Summer 2022 (July-August)

In-person networking event TBD (and as gatherings resume)

Workgroups/feedback opportunities on APCM 2.0

If you have questions or want to connect about anything APCM, please contact us anytime!

Torie (tbaldwin@orpca.org) or

Danielle (dsobel@orpca.org)

Thanks very much!

Hang in there!