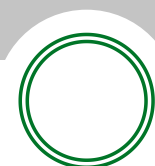




Value-Based Alternative Payment Methodologies for Federally Qualified Health Centers: Lessons from Colorado and Minnesota



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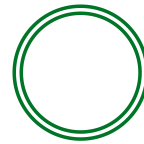
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AUGUST 24, 2017

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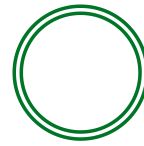
This work is supported through NASHP's Cooperative Agreement with the Health Resources and Services Administration (HRSA), grant #UD3OA22891

LOGISTICS



- Lines will be on mute for the duration of today's webinar
- Use the chat box on your screen to ask a question or leave a comment
 - Note: chat box will not be seen if you are in “full screen” mode
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Today's Presentations



The State of FQHC Value-Based Payment Reform: Lessons from NASHP's Value-Based Payment Reform Academy

Health First Colorado FQHC Payment Reform, **Shane Mofford**, Director of Rates and Payment Reform, Colorado Department of Health Care Policy and Financing

FUHN's Journey: Minnesota DHS's Integrated Health Partnership, **Deanna Mills**, Director, Federally Qualified Health Center Urban Health Network



Value-Based Payment Reform Academy



National Academy for State Health Policy Value-Based Payment Reform Academy

Advancing Value-Based Payment Methodologies for Federally Qualified
Health Centers and Rural Health Clinics
2016 – 2017

Request for Applications for Technical Assistance

Through a cooperative agreement with the Health Resources and Services Administration (HRSA),¹ the National Academy for State Health Policy (NASHP) is pleased to announce a new technical assistance opportunity for states interested in advancing value-based approaches to Medicaid reimbursement for federally qualified health centers (FQHCs) and rural health clinics (RHCs).

States selected to participate in NASHP's Value-Based Payment Reform Academy will receive 12 months of targeted technical assistance to support the development and/or implementation of value-based alternative payment methodologies (APMs). Technical assistance will include individual learning opportunities tailored to each state's specific goals, group activities designed to promote state-to-state learning, as well as ongoing access to expert faculty, including state and federal officials, national leaders, and NASHP staff (for more information on expert faculty, please see both page 3 and Appendix A of this RFA).

This Academy will work with states to develop and/or implement value-based APMs for FQHCs and RHCs that support their goals for transforming how care is paid for and delivered. For the purposes of this Academy, NASHP defines value-based APMs as those that incentivize value over volume, promote the delivery of comprehensive, coordinated, and patient-centered care, are tied to quality and efficiency, and meet the requirements for FQHC and RHC reimbursement under current federal law.²

Through this request for applications (RFA), NASHP will select up to six (6) states to join this Academy. Applicants will name a core team of four to six members, including a senior Medicaid official, a senior representative from the state's primary care association, a FQHC or RHC provider representative, and others as identified by the state. NASHP is seeking applications from states with diverse geographies, political compositions, and Medicaid delivery systems. States may have an array of experiences with and readiness for payment reform for FQHCs

Key Value-Based Payment Reform Academy Dates in 2016:

March 10: RFA Informational
Webinar

April 1: Application due to
NASHP

April 21: Notification of selection
to states

Early May: Technical assistance
period begins

June 14-15 or June 23-24: Kick-
Off Meeting, *location TBD*

- **Goal:** Support states to develop and/or implement value-based alternative payment models (APMs) for FQHCs within Medicaid
- Six states competitively selected to participate
- Received 15 months of technical assistance
- Supported through cooperative agreement with HRSA

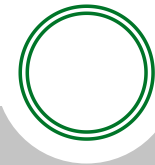


Payment Incentivizes Delivery System and Practice Transformation

- First, identify the **vision** and goals for how you want to **improve** the delivery of care
- As we change how care is delivered, providers and their care teams are being asked to:
 - provide additional services (such as care coordination) which are traditionally not billable under volume-based payment models
 - Employ a larger staff with wider range of competencies (e.g., data analysts)

In summary: we need to implement value-based payment models that will compliment how we want care to be delivered!

A Time of Opportunity



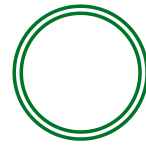
Why include FQHCs in VBP?

- FQHCs have experience working with and engaging vulnerable populations
- Primary care focused
- FQHCs are sometimes the only provider or only Medicaid provider in communities
- Many FQHCs are recognized patient-centered medical homes and already provide a wide range of services (e.g., physical health; behavioral health) and supports (e.g., WIC, care coordination, patient education)

Why would FQHCs want to participate in VBP?

- Opportunity for increased flexibility to support care team model:
 - Workforce
 - Practice transformation
 - Ancillary support services and staff (e.g., care coordination, community health workers) to address upstream social determinants
- Increase capacity to catalogue and use clinical data → improved quality
- Experience with VBP can help with MCO contracting

Unique Criteria for FQHC Payment



- The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 requires that FQHCs be reimbursed through the prospective payment system, or an alternative payment model (APM) as long as:
 - Individual FQHCs agree to be reimbursed by that APM; and
 - Each clinic's total payments are equivalent to or higher than the total payments they would have received through PPS.

Full text of the Act can be found here: <https://www.govtrack.us/congress/bills/106/hr5661/text>



VBP: Payment Models

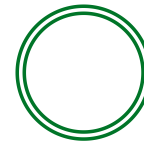
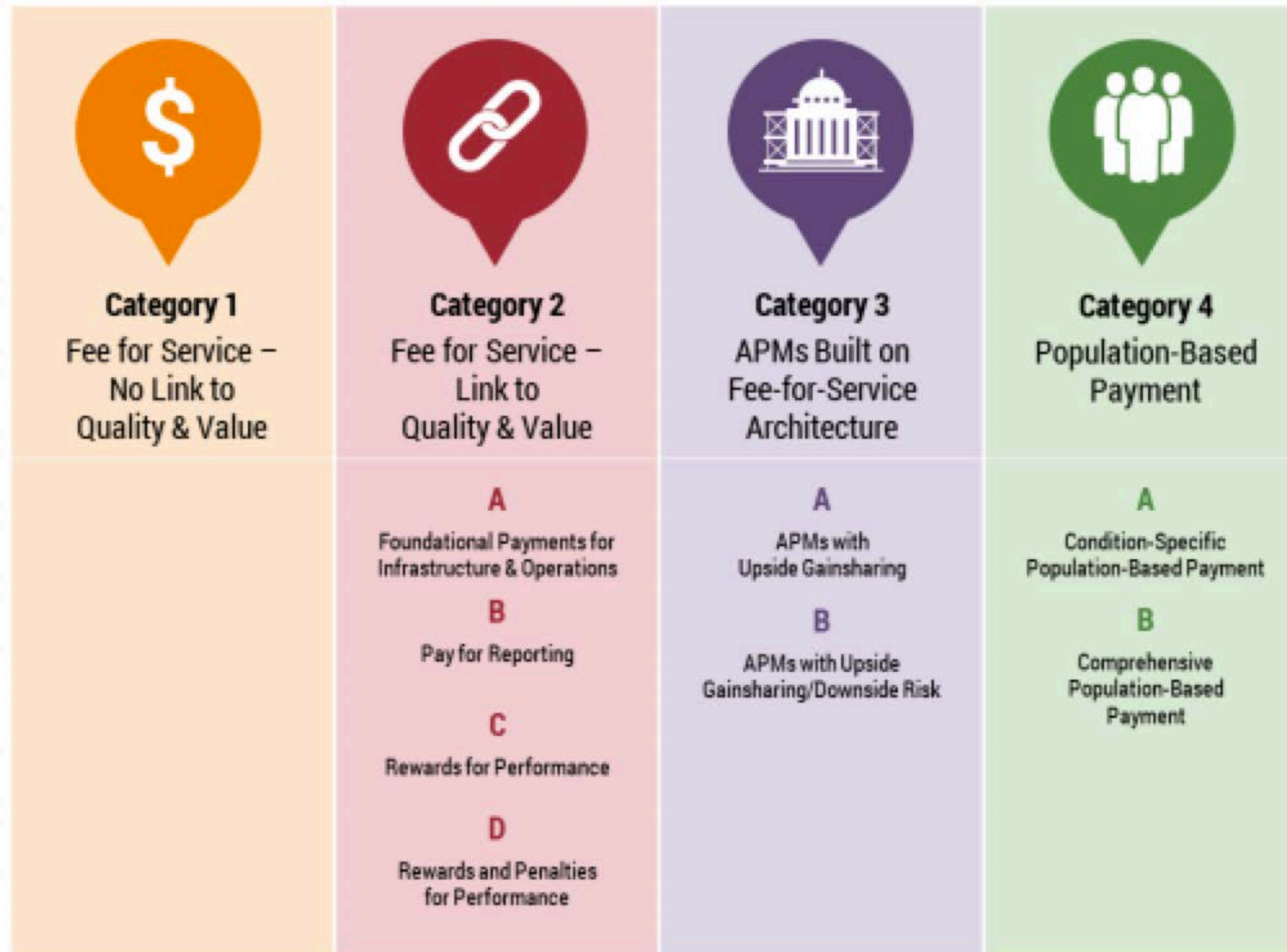
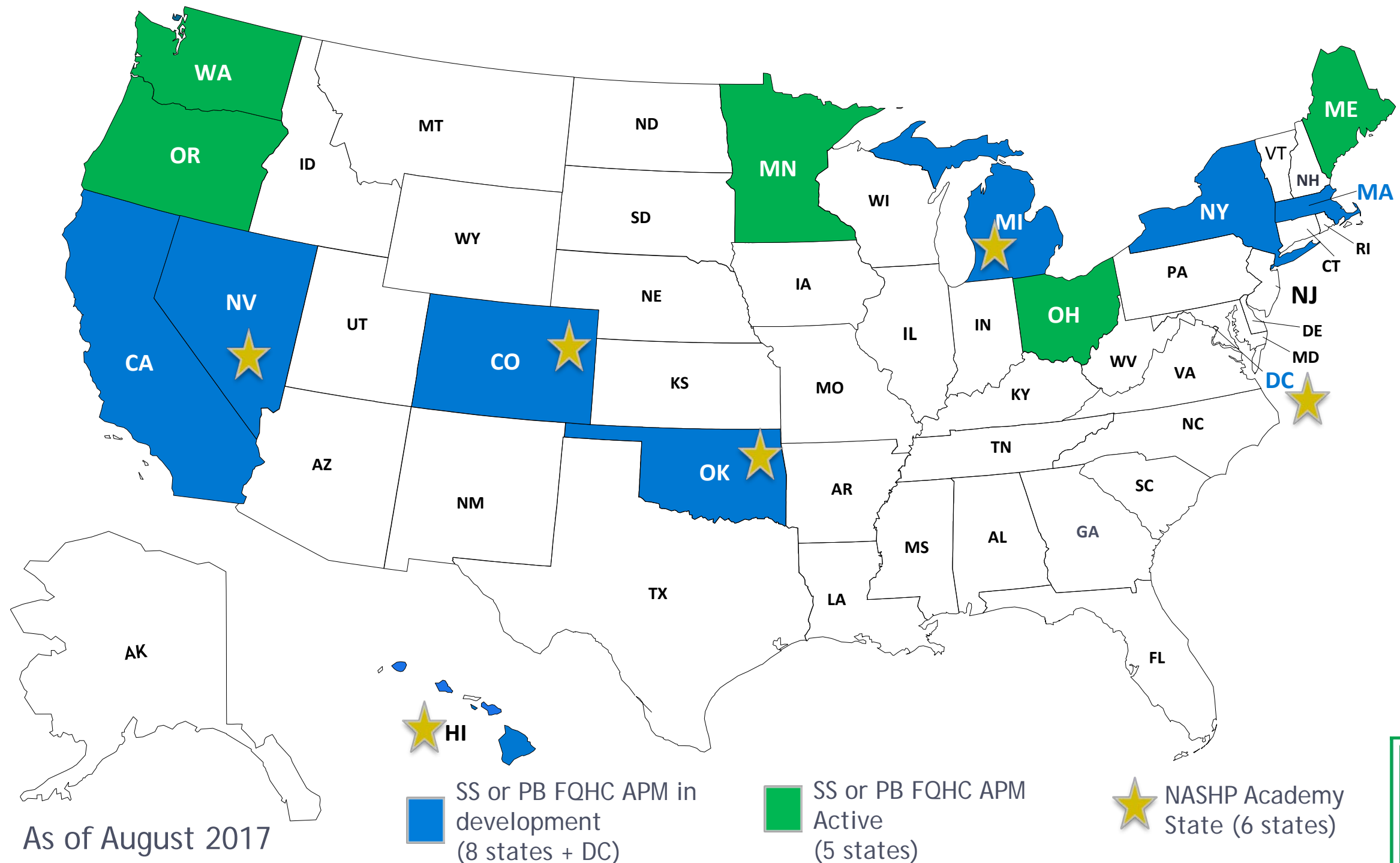


Figure 1. APM Framework (At-A-Glance)

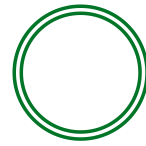


Source: Healthcare
Payment Learning and
Action Network;
<https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

Shared Savings (SS) and Population-Based (PB) APMs Underway for FQHCs

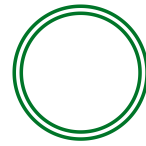


Lessons Learned from Academy States



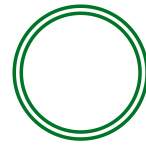
- Start by identifying vision and shared goals for how care should be delivered
 - Then what needs to change about payment to support providers to achieve that vision
- Critical to foster trust and transparency among state agencies and organizations involved in model development
- Consider state agency bandwidth, and opportunities to align FQHC payment reform with broader Medicaid initiatives

Lessons Learned, Continued



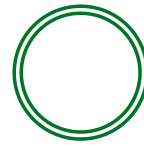
- State should work with primary care association to assess FQHC readiness
 - Remember: APMs are opt-in; not all health centers need to be ready at launch
- Among Academy states, PPS→PMPPM was of most interest due to opportunity for greatest flexibility for providers
- APM development takes time!

Forthcoming NASHP Resources



- *Blog Series on FQHC Payment Reform*
 - Stay tuned to www.nashp.org and our weekly e-newsletter for blogs throughout the late summer and fall.
- *Toolkit for states on key considerations and lessons learned for FQHC payment reform*
 - Anticipated release: October 2017

Thank You!



For questions or more information, please
contact Rachel Yalowich
(ryalowich@nashp.org)



Health First Colorado FQHC Payment Reform

Shane Mofford

08/23/2017



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Department of Health Care
Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**



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Context

- Lay of the land – the changing national framework of payment reform
- Colorado Specific Payment and Delivery System Reform
- Why FQHC Reform?
- What we're doing.

National Drive to Value-Based Purchasing and Integrate Care

- Health Care Payment Learning Action Network Framework
 - How you pay matters, not just how much
 - Public commitment from CMS and Colorado
- MACRA - Medicare primary care payment reform
- CPCi/CPC+/TCPi - multipayer primary and specialty care reforms
- State Innovation Model - large federal investment in integrated care and public health policy at the state level



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Colorado Payment Reform

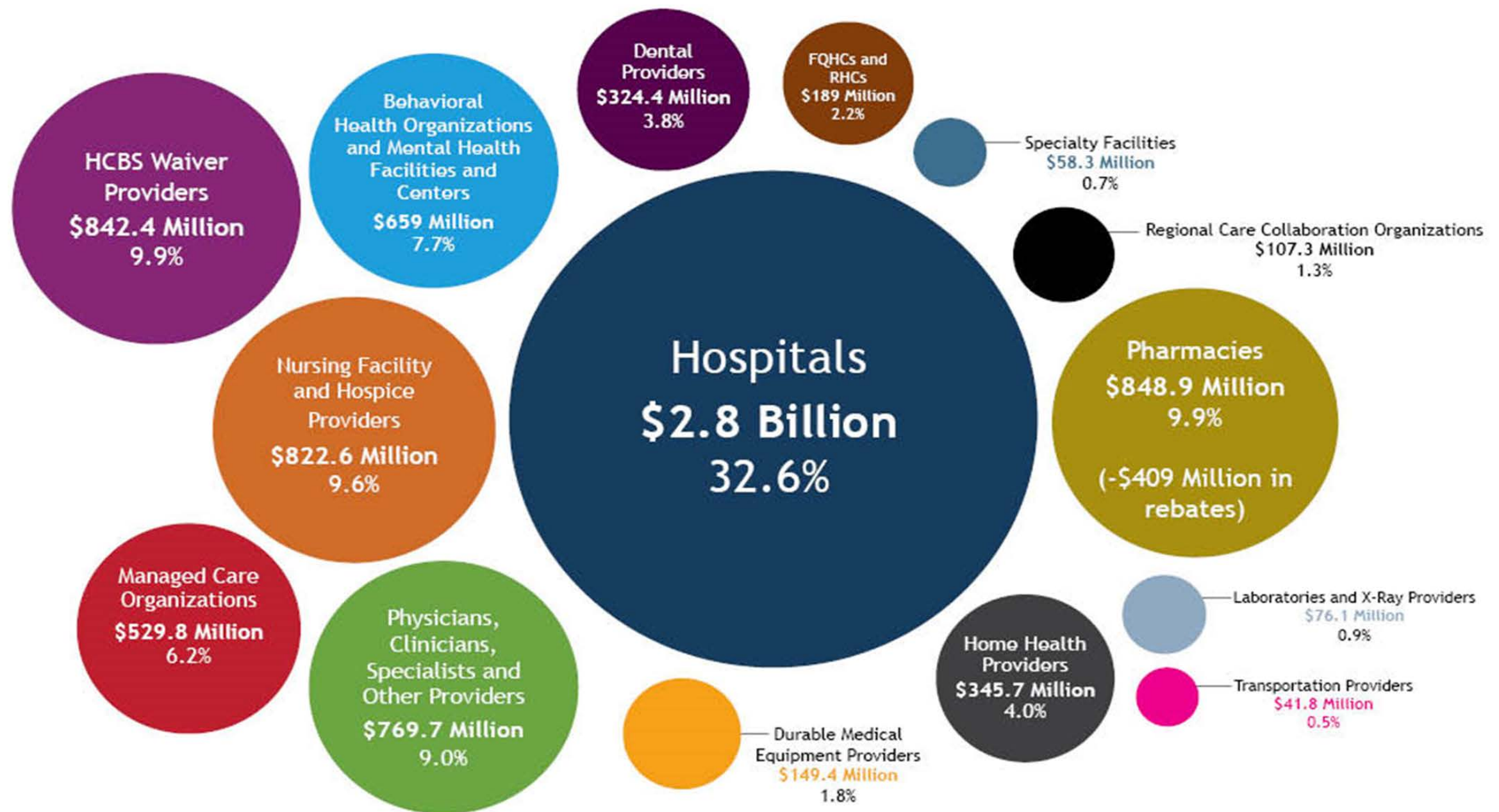
- Time of change for all providers
 - The Accountable Care Collaborative
 - Behavioral Health Reform
 - Integrated Care - SIM
 - CPCi/CPC+ and TCPI
 - Managed Care Reforms
 - Hospital Reforms - DSRIP/Hospital Transformation/Enterprise
 - LTSS/PACE
 - Primary Care



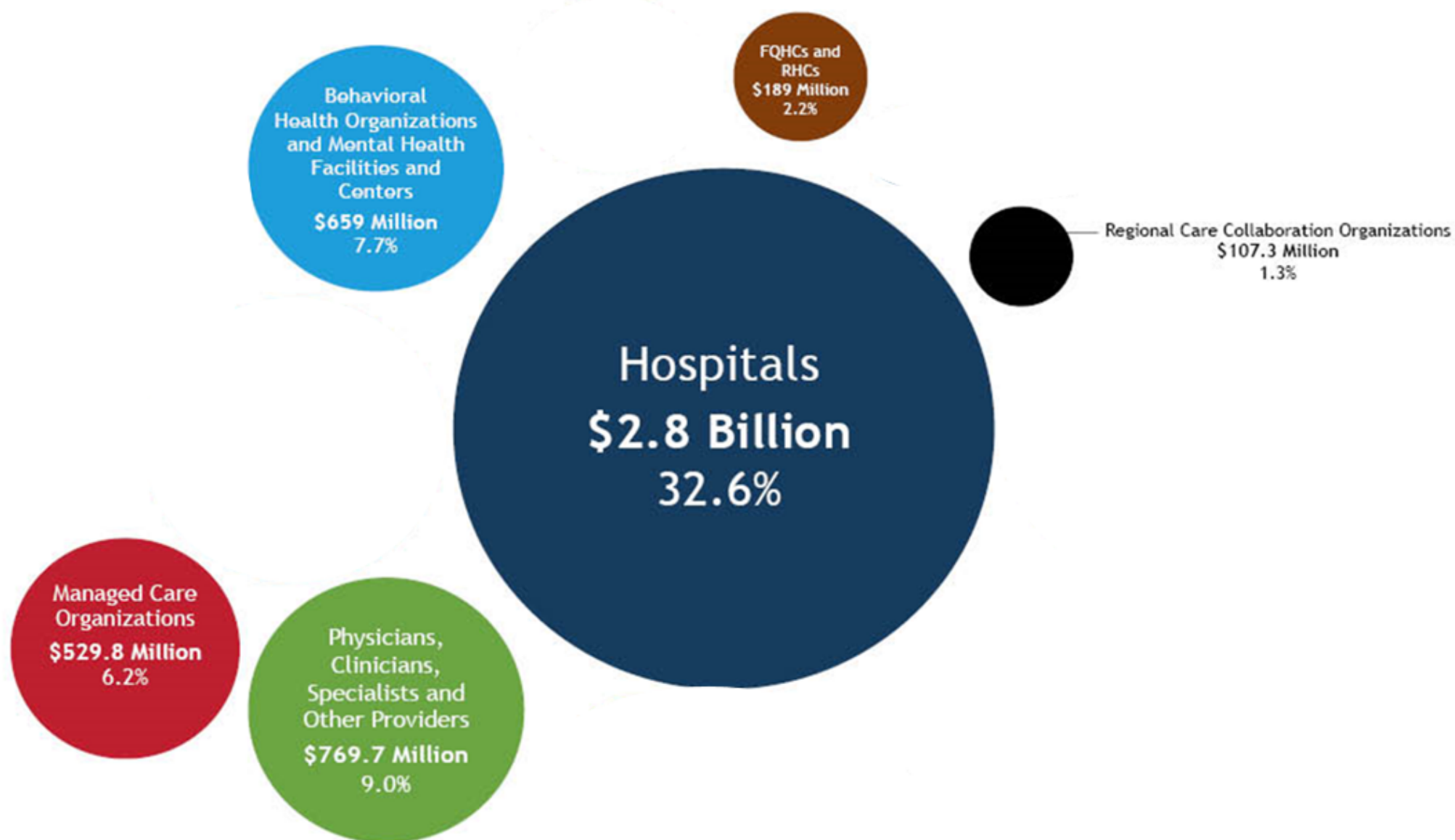
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Colorado Medicaid Expenditures



Payment Reform Initiatives Currently Under Way



Regional Care Collaborative Organizations:
 *Merged with Behavioral Health Organizations into Regional Accountable Entities.
 *Payment tied to performance on Key Performance Indicators

FQHCs:
 *2 payment models - both tied to quality, one providing greater financial flexibility

Physicians:
 *2 payment models - both tied to quality, one providing greater financial flexibility.

Managed Care Organizations:
 *Performance on quality impacts rates and Medical Loss Ratio

Behavioral Health Program:
 *Incentive program to ensure access, quality, and continuity of care

Hospitals:
 *Implementation of EAPG for outpatient
 *Inpatient reforms underway
 *Hospital Quality Incentive Payment Program
 *Transformation of supplemental payments underway

FQHC Reforms – Why?

- Primary care investments can reduce downstream costs. (Remember the giant blue circle on the last slide?)
- 40% of clients in Colorado Medicaid's Accountable Care Collaborative Program utilize FQHCs.
- The PPS model is antiquated and has strong perverse financial incentives.
- The delivery model enforced under PPS is inefficient.



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FQHC Reforms - What We're Doing

- NASHP Technical Assistance Grant
 - Collaborative partnership between state, providers, and professional organization to change how FQHCs are paid
- Goal 1: Implement primary care limited risk capitation with tie to quality for FQHCs by 7/1/2018 – On Track!
- Goal 2: Implement quality incentives that tie FQHC encounter rate to value/performance for those not under monthly cap by 7/1/2018 – On Track!



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Four Key Bodies of Work and Critical Lessons Learned

- Stakeholder engagement
- Program Design
 - Clean up of current state
 - Building future state
- Authority
 - Federal – State Plan Amendment
 - State – Statute, Rules
- Operational Strategy – death by 1,000 cuts

~~Stakeholder Engagement~~ *Partnership - Priority #1*

- FQHC Alternative Payment Methodologies require FQHC consent to implement.
- Building and operationalizing new payment models that are sustainable and drive real change requires 'boots on the ground' insight
- Reform is hard and resource intensive. State Medicaid programs are not overflowing with administrative resources. You will need your professional association and providers' support.

Program Design

- Resource constraints are real and always have been.
- When you look at your current program to prepare for reforms, you will find things you need to fix before progressing – maybe a lot of things. Plan for it. (Change in scope process, for example)
- Look to other examples – a lot of work has already been done. You don't need to solve every problem on your own.

Authority

- Navigating CMS approval.
 - Understand BIPA
 - Whatever you design must still comply unless you get an 1115 waiver
 - APMs can be approved through a State Plan Amendment
 - Lean on precedent (Thanks Oregon!)
 - Engage CMS early and often



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Operational Strategy

- Again, reform is hard.
 - Systems changes, rule changes, documentation changes, communication strategies, authority, etc.
 - If any piece fails, the program fails.
 - Give yourself enough time!
- Investment in upfront, detailed planning is time well spent.
- Internal engagement is as critical as external engagement. This is fun stuff and important work – get people excited about it.

Contact Information

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FUHN's Journey: MN DHS's Integrated Health Partnership



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Deanna Mills, MPH
FUHN Program Director
August 2017



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What is FUHN?

Federally Qualified Health Center Urban Health Network

- Collaborative partnership of 10 Mpls./St. Paul Federally Qualified Health Centers (FQHC)
- Nation's first FQHC-only Safety Net Medicaid Accountable Care Organization.





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What is FUHN? cont....

- Member clinics serve 110,000 patients in the Twin Cities area
- Very Diverse 91%; 41% best served in a language other than English
- Very Poor 95% under 200% FPL
- 50% Medicaid, 28% uninsured, 15% commercial, 7% Medicare
- 40 unique service sites
- Services include medical, dental, mental health, substance abuse, vision and enabling; also Variety of special programming – homeless, public housing, schools, HIV/AIDS, legal, case management, mobile, community education & outreach, enrollment in public programs, exercise, community gardens and farmers markets, domestic violence, etc.



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Topics

- FUHN's participation in the MN DHS Medicaid Program IHP
- Why we did what we did
- Results we've achieved
- Resources FQHCs need to succeed

Disclaimer: I don't represent MN DHS Medicaid/IHP Staff; they are great people and partners, but I can't represent their perspectives in this presentation



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FUHN/DHS IHP Project Overview

- FUHN's 10 member health centers are working together with MN Department of Human Services on Medicaid health care reform to further enhance the health care provided to our Medicaid patients through Value Based Purchasing called the "Integrated Health Partnership" (IHP).
- The overall goals of the FUHN's IHP project is to demonstrate our ability accomplish the Triple Aim +1
 - Reduce Total Cost Of Care
 - Improve Clinical Quality
 - Improve the Patient Experience
 - Improve **PRIMARY CARE ACCESS** for vulnerable populations



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Why did the FQHCs choose to participate in this Medicaid ACO Project?

- MN Health Reform Legislation in 2010 allowed for ACO Medicaid Demonstration
- FUHN viewed Demonstration as
 - Opportunity: leverage resources, foster collaboration, learn together
 - Threat: survival in a quickly reforming health environment
- ?Join larger systems to gain access to resources OR take a leap of faith to transform our clinical practices?
- FQHC Mission
 - Community based, governed by patients, economic engine in urban core, tailored service delivery, social justice
 - 10 independent FQHC Boards' support (51% patients)



Why did the FQHC's choose to participate in this Medicaid ACO Project? cont...

- Health Reform was taking shape
 - Our Clinics needed to complete a **significant operational transformation** in order to be relevant in this new environment.
- FQHC's are the **model for this population**:
 - Health reform trends place importance on primary care health care homes that focus on the health of patients and address social determinants.



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Challenge for FQHCs

Shifting sands of the environment where FQHCs must

**Play Checkers –
Maintain mission to
serving underserved**



**Play 3D Chess –
Participate in
“reform/evolving”
marketplace**





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Recognizing our need to respond to this new VBP market, what did the FUHN Clinics need to do?

Clinical Practice Transformation

- ✓ People
- ✓ Process
- ✓ Technology



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Clinical Practice Transformation

- Infuse Change Management Techniques – change culture
- Achieve Health Care Home Certification as building block to establish policies/protocols/process
- Use of e-health technologies and data analytics
 - Predictive modeling for higher cost patient costs
 - ID/Stratification for gaps in care leading to higher costs
 - eHealth Exchange for more comprehensive view of care
- Design new and more effective clinical interventions with standardized medical protocols, workflow and processes and associated workforce training
- Example: Avoidable ED utilization



Clinical Practice Transformation cont...

- Re-invigorate care coordination
 - Motivational interviewing
 - LEAN process improvement
 - Utilization of population health analytics data
 - Team-based care
 - Pre-visit Planning
 - Daily Team Huddles
 - Referral management
- Understand new payment models
 - Responsibility for total care received outside our 4 walls
 - Gain/risk-sharing around TCOC, quality and patient satisfaction



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FUHN Results: Attribution

- 2013: approx. 24,000
- 2015: approx. 32,000
 - Medicaid expansion
 - Move from 12 months to 24 months attribution period
- This represents roughly 55% of the MA patient population served by our 10 FUHN Member Clinics (remaining did not meet eligibility of enrollment time)



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FUHN Results: TCOC Summary

Annually, approx. \$175,000,000 TCOC - excluded Medicaid services resulted in approx. **\$140,000,000** TCOC was FUHN's responsibility or 80%

- | | |
|----------------|------|
| • Pharmacy | 100% |
| • Outpatient | 99% |
| • Professional | 99% |
| • Inpatient | 97% |
| • MH/CD | 43% |



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FUHN Results: Shared Savings Over 3 Years

	2013	2014	2015	
Savings %	-3.10%	-4.60%	-5.90%	
MN State Savings				\$17+M State retains 50% each year
Shared Savings FUHN	\$1,823,769	\$2,984,751	\$3,853,185	\$8,661,705 *73% of the savings achieved by FUHN were used reimburse our administrative partner for their investment



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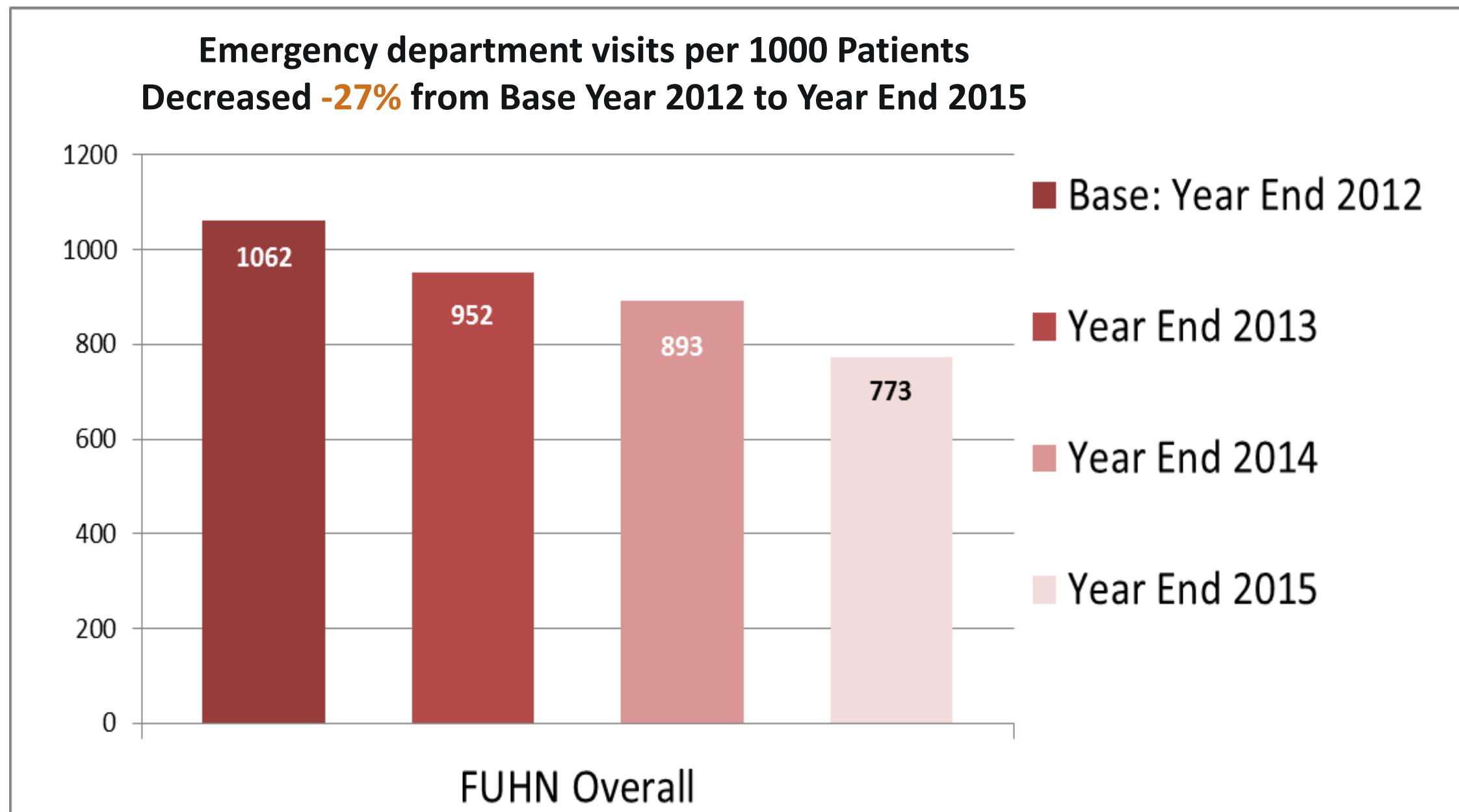
Quality and Patient Satisfaction

- Savings dependent on achievement
 - 2013 no withhold but required to report quality outcomes
 - 2014 25% withheld
 - 2015 50% withheld
- >5% relative improvement
 - Vascular & diabetic care, child & adult asthma, depression remission
- >90% on excellent/good
 - Able to get appointment for checkups
 - Your provider gives you good advice
 - Send your family and friends to us



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FUHN Results: ED utilization reduction graph 2013-2015

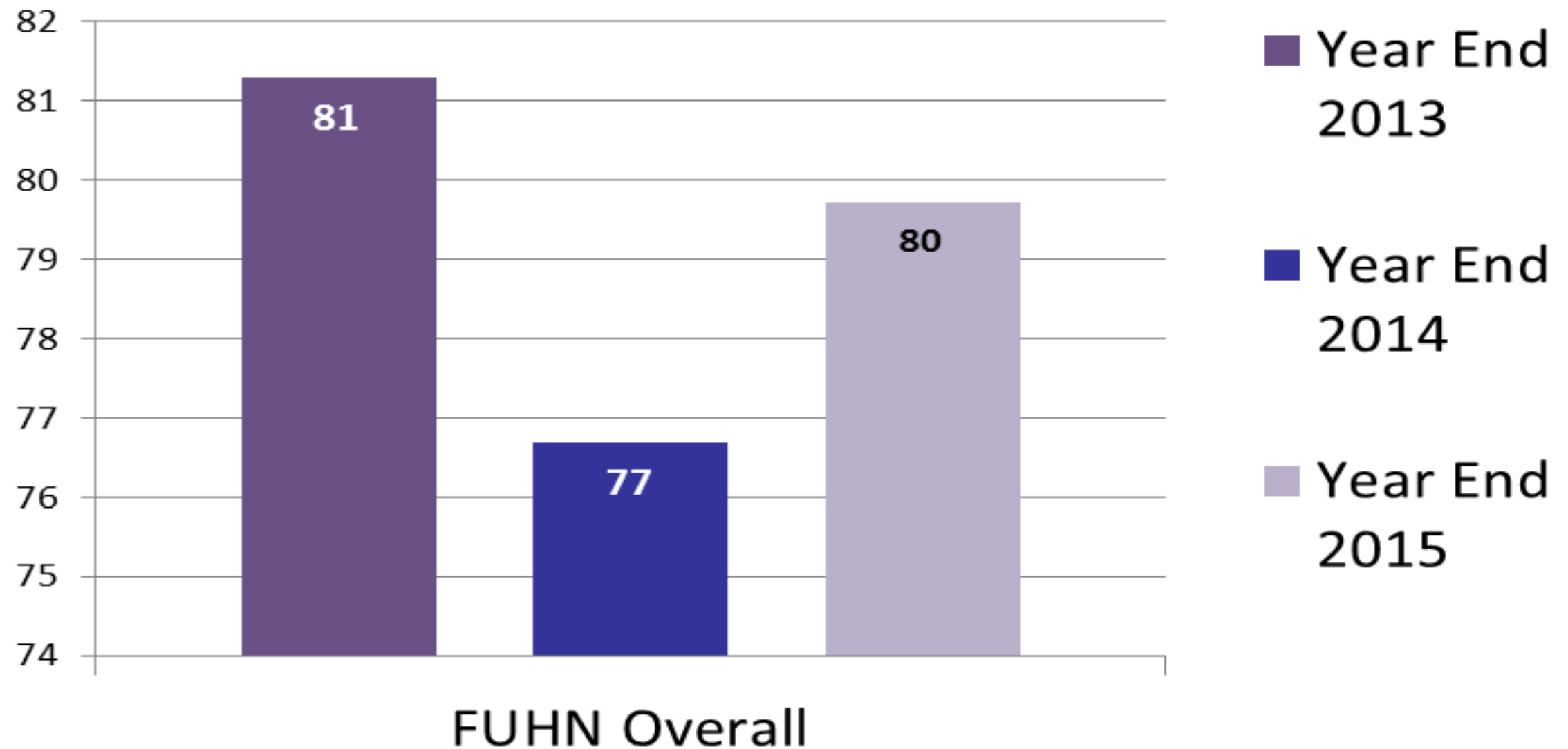




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FUHN Results: Inpatient admissions reduction graph

Inpatient admissions per 1000 Patients
Decreased -2% from 2013 to 2015



How did FUHN achieve these results?

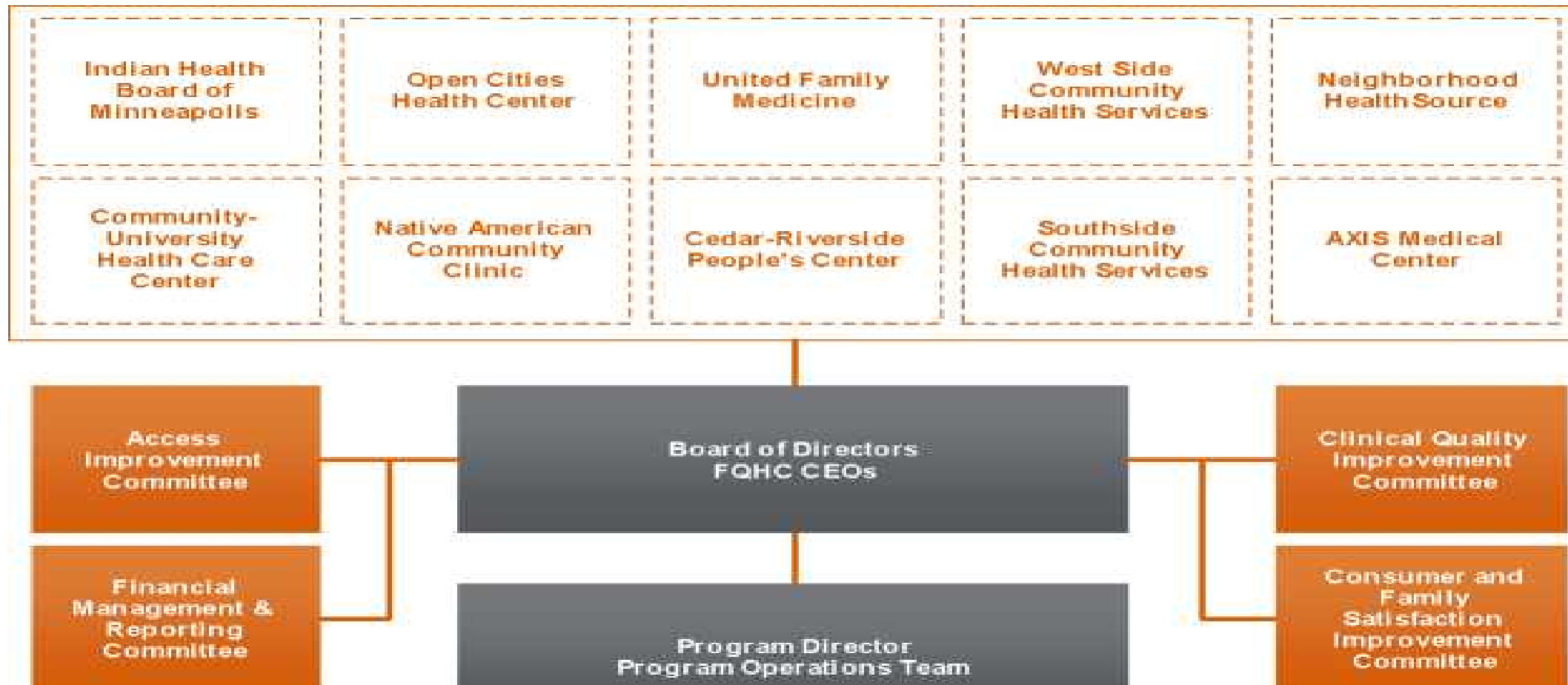
“Fierce competitors to extreme collaborators”





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FUHN's Structure Fosters Collaboration & Consensus Decision Making





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How did FUHN achieve these results? cont..

- Implementation of a Care Coordination Program comprised of two essential components designed to put **ACTIONABLE** data in the hands of our Primary Care Providers:
 - **Robust Data Analytics** infrastructure using claims utilization and real-time clinical data.
 - **Dedicated personnel** in our clinic sites using this new data analytics to implement patient interventions designed to drive cost and quality improvements.
- This capability gave our providers a sight line to patient utilization occurring **OUTSIDE** of the Primary Care office.



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How did FUHN achieve these results? cont..

- The implementation of this Care Coordination Program required a **significant upfront investment** ... *an investment that our FQHCs could not possibly make:*
 - FUHN relied on an administrative partner (Optum) to provide the initial upfront funding necessary to acquire the data infrastructure and dedicated personnel required by our Care Coordination Program.



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How did FUHN achieve these results? cont..

- Using **ID/Stratification** Tool
 - Emergency Department Reduction (minor conditions)
 - Asthma Management
 - Diabetes Management
 - Pain Management/Opioid RX
- **Standardized clinical policy** throughout the Network – Getting to the power of 10
- Work flow – Proliferation of **LEAN**



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Health Information Technology Initiative

- FUHN, using approx. **\$1.5M grants** received through MDH, DHS and the BPHC, is building the data analytics infrastructure and capability needed to manage VBP arrangements – *this will replace current “expensive” administrative partner.*
- A **data warehouse** that will receive real time data feeds from:
 - FQHC’s EMR clinical data
 - Payer claims data
 - Available admit, discharge and transfer data provided by selected hospital care partners
- A **robust data reporting and analytics capabilities** for use by our Care Coordinators.
 - Future gain savings are expected to partially sustain the ongoing operating costs with this new infrastructure.



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Sustainability Through Federal Grant

- In August 2016 FUHN was informed that it was one of 51 HRSA Grant Recipients for **Health Center Controlled Networks**.
 - This three-year, \$1.5M Grant award provides FUHN and its members funding to continue our organizational transformation by securing ongoing staffing.
 - Will help FUHN Clinics fund the automation of data reporting obligations from our annual Federal Uniform Data System, State MNMCM Submissions and VBP Reporting obligations.



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Lessons Learned

- Moving to VBP requires **clinical practice transformation**
- Upfront **capital for technology** is very expensive
 - *Caution: Risk Partners that take most of the risk & will take most of the money.*
- Investing in **staff re-training** is essential & takes times – LOTS OF IT
- **FQHCs are the model** for serving the Medicaid population who experience social inequities
- **TCOC reduction and improved health outcomes** are possible

THANKS!



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Resources

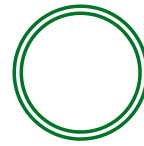


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Minnesota Statutes, section 256B.0755 Health Care Delivery Systems Demonstration
<https://www.revisor.mn.gov/statutes/?id=256B.0755&year=2010>

Thank You!



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