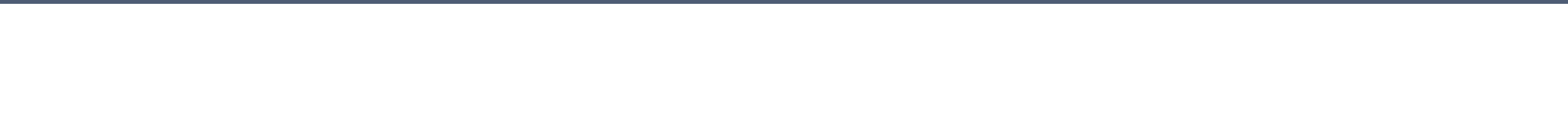
Update on Payment Reform Trends

Implications for California Community Health Centers

January 2013

Prepared by JSI for the California Family Health Council and the Regional Associations of California

JSI



Introduction

John Snow, Inc. (JSI), a public health research and consulting organization with a focus on underserved populations, prepared the following report for the California Family Health Council on behalf of the Regional Associations of California, representing California's community health centers and clinics (CCHCs).

The report is composed of three sections. The report is meant to serve as a resource for CCHC leaders and does not need to be read in its entirety.

Section 1: The Executive Summary is an overview of the whole report and is designed to be used as a stand-alone document to communicate high-level messages regarding payment reform trends and their implications for California community health centers.
Section 2: The national trends section provides bulleted high-level takeaways followed by more detailed supporting commentary.
Section 3: The third section contains five case studies, each highlighting key trends.

JSI was selected for this work to build upon the CPCA-supported JSI January 2012 report, *Building a Foundation for Payment Reform for Community Health Centers in California*; the March - December 2012 "Tides CCI-supported Payment Reform Roadshow" presentations to 21 audiences statewide, including 19 CHC audiences, the Blue Shield Foundation of California, the California Association of Public Hospitals and the Department of Health Care Services; and the JSI project management and consulting support for three CPCA payment reform work groups pursuing specific payment reform models.

Sincerely,
Your JSI Team

Rachel Tobey, MPA
Jim Maxwell, PhD
Elena Thomas Faulkner, MA
Clancey Bateman, MS, MPH

January 18, 2013

Section 1: Executive Summary

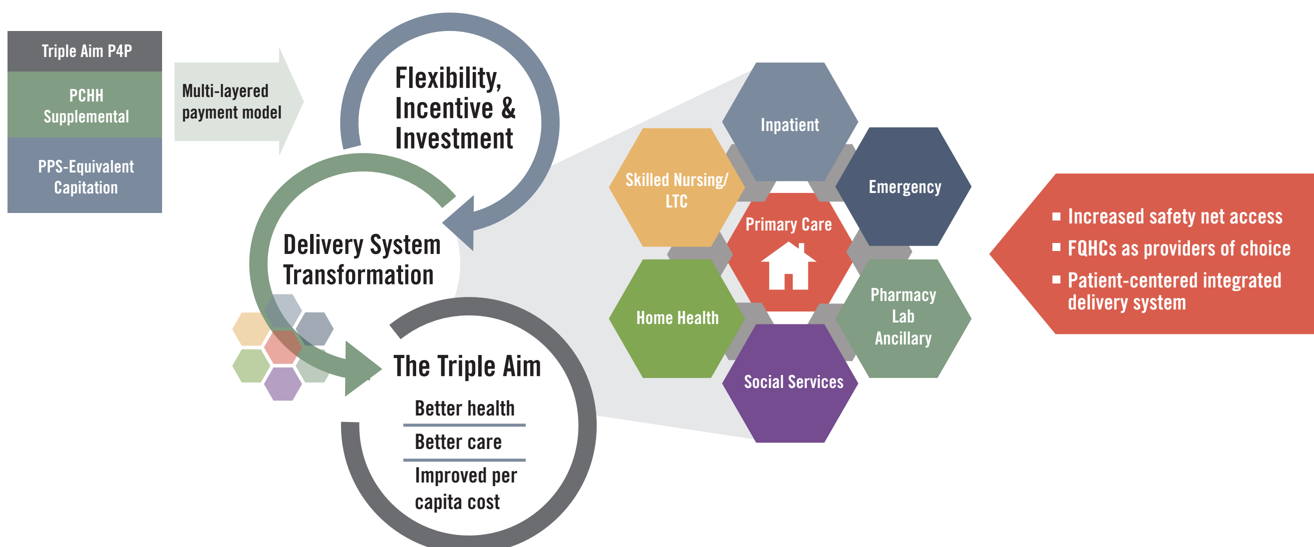
The Regional Associations of California (RAC), in collaboration with the California Primary Care Association (CPCA), recognize that payment reform is a critical ingredient for catalyzing and sustaining a transformed delivery system—a system that can realize the IHI's Triple Aim goals of better health, better care, and reduced per capita costs.[1] They also recognize that payment reform is evolving rapidly as health centers, health system stakeholders, researchers, and policymakers design, pilot, and implement new payment systems and innovative care models. Indeed, the field of payment reform and delivery system transformation is exploding with interest and activity, as evidenced by entire recent issues of the *Journal of the American Medical Association* and *Health Affairs* and significant foundation-supported literature dedicated to payment reform in the past year.

RAC strives to ensure that California health centers' state-level and local efforts in payment reform and delivery system transformation are informed by the most up-to-date information. In September 2012, RAC engaged John Snow, Inc. (JSI) to conduct a Payment Reform Research Update that included: a literature scan of key publications released over the recent 18 months on payment reform and delivery system transformation; interviews with 18 national experts and representatives from cutting-edge efforts in Medicaid payment reform in other states; and identification by RAC leaders of key questions regarding payment reform efforts.

This report presents the findings of the Payment Reform Research Update and includes:

- Key messages for CCHC leaders as they engage in payment and delivery system reform efforts;
- A summary of current and emerging trends with a focus on how they apply to FQHCs and the safety-net; and
- Five case studies that highlight national trends with specific examples from innovative efforts in Minnesota, Hawaii, Massachusetts, and Colorado.

Figure 1. Payment Reform and Delivery System Transformation



Key Messages for CCHC Leaders Looking Ahead

Public and private sectors across the nation are increasingly investing in primary care and patient-centered health home (PCHH) as core strategies to achieve the Triple Aim and lay the foundation for a transformed delivery system. At the same time, there is increased recognition of the importance of increased coordination and transformation at all levels in the system, and that payment reform is both a prerequisite for and a core element of a transformed system. California CCHCs have begun to embrace a phased and layered approach to payment reform that will allow primary care to transform as part of a larger, more coordinated and integrated delivery system within the uniquely budget-constrained state context. CCHC leaders should consider the following key messages as they work toward a transformed delivery system and payment reforms to support the new system.

1. **A robust primary care patient-centered medical home (PCMH) must be the first focus of delivery system transformation.** Transformation to a robust PCMH-based model of care can be achieved through a phased approach involving the following:

    - **Transformation of base payment to primary care capitation for increased flexibility and upfront, predictable revenue.** Primary care capitation is emerging as a key strategy for moving away from volume-based payment towards delivering more effective, coordinated care, including care provided outside of the clinic and using novel modes of practice to supplement face-to-face visits. Primary care capitation has also gained increased traction and interest as part of a broader trend in delegating financial risk and granting flexibility and ensuring a predictable cash flow to providers. In two vanguard states, primary care capitation is being pursued as an overall strategy for Medicaid [See Case Study - MA Primary Care Payment Reform] as well as specifically for health centers under an alternative payment methodology (APM) (Oregon).

    - **Supplemental payments for PCMH to support care coordination and case management at the primary care provider level.** PCMH and PCHH supplemental payments have continued to proliferate nationwide [See National Trend 2], and a growing number of PCMH programs in public and private sectors are reporting positive clinical results and favorable return on investments in health home activities.[2] California CCHCs have continued interest in becoming PCMHs and have advocated with the State to pursue Affordable Care Act Section 2703 federal funding for chronic care health homes. Even though California Department of Health Care Services (DHCS) has not yet expressed interest in pursuing 2703 at this stage, CCHCs should continue to advocate to stakeholders such as health plans the merits and cost benefits of PCHH investment.

- **Value-based Pay-for-Performance (P4P) to reward Triple Aim outcomes.** Existing and emerging value-based pay-for-performance programs can provide financial incentives for improving health outcomes and patient experience, and also controlling costs of the overall health system. Health plans are expected to increase use of such programs in contracts with health centers to promote the desired outcomes of delivery system transformation. Health centers can also advocate for value-based P4P as a strategy for being financially rewarded for influencing cost and quality outcomes both within primary care and within the broader health system.

2. **Transformation cannot stop with primary care.** Payment reform must also support a more coordinated and integrated delivery system able to focus on the most high-risk and high-cost individuals. While investment in PCHH and support for primary care can be the cornerstone of a more affordable, patient-centered and high-quality delivery system, payers are also building incentives for a more integrated system overall. States are layering payment models and promoting Medicaid accountable care organizations (ACOs) to support integration [See National Trend 4]. Many of the underlying tenets of the ACO model are spreading across the delivery system and impacting payment models, even where ACOs themselves are not emerging. These tenets include: patient-centered health home, mechanisms for broader integration of services across the health delivery system, robust health information technology systems, provider access to shared savings for a defined patient population, and shared data and communication between hospitals, health plans, providers, and patients [See Case Study - Accountable Healthcare Alliance of Rural Oahu]. Other states are aligning delivery system transformation and payment reform strategies, and health centers can encourage California to do the same, especially with programs such as dual eligible demonstrations [See National Trend 5].

3. **The payment system is evolving to reward providers for achieving the Triple Aim of improved patient care, improved population health and reduced overall health costs as well as reducing health inequalities.** Key characteristics of emerging payment models that support delivery system transformation include:

   - **Increasing reliance on risk - upside at first and eventual downside**
     Medicaid and private payers are increasingly relying on risk-based contracts. Most risk arrangements FQHCs have today provide upside-only incentives, but there are increasing payment arrangements that include downside risk.

     Current downside risk strategies include primary care capitation for FQHCs, professional services capitation, and Medicaid program capitation of health plans. Emerging downside risk strategies include Medicaid withholds for health plans for quality outcomes and health

plan establishment of global budgets for provider groups in which the provider is financially responsible for budget overruns for a defined patient population [See National Trend 1 and Case Study - Alternative Quality Contract].[3]

A final manner in which risk is being delegated away from Medicaid programs is via states asking health plans to administer PPS payments to health centers [See Case Study - Delegation of PPS Payment to Health Plans].

- **Preliminary focus on total costs leading to subsequent focus on prices**
  Many payment reform efforts have focused on reducing total cost of care through reduced inpatient utilization. However, the effectiveness of this strategy is limited if the price of services (especially inpatient services) continues to escalate. As a result, some states—most notably, Massachusetts and Vermont—are instituting global budgeting programs that will force providers to operate within fixed price and/or fixed cost contracts. In the future, these types of strategies will likely become more common [See Case Study - MA Primary Care Payment Reform].

  Additionally, because health centers can influence inpatient utilization but not the price of inpatient services, health centers could also benefit from negotiating for shared savings based on decreases in inpatient utilization as a proxy for total cost of care.

- **Layering of payment models**
  One of the initial conclusions of our January 2012 report, *Building a Foundation for Payment Reform for Community Health Centers in California,* was that no single payment arrangement was emerging as an alternative to FFS, but that there are multiple methods that can and are being used together in complementary ways. This layering approach of payment models is increasingly being relied upon among both public and private payers across the country. The layers most often include a base payment (either capitation or fee-for-service), a PMPM supplemental PCHH payment, and value-based P4P most often financed with overall health system savings.

CPCA Explores Multiple Payment Reform Models

CPCA has engaged workgroups to explore pilots of both a PPS-equivalent capitation model meeting APM requirements and a PCHH supplemental payment while acknowledging that most health centers in managed care will continue to arrange P4P contracts in collaboration with their health plan partners. The CPCA Capitation Workgroup has gained the interest and attention from California's Department of Health Care Services, and CPCA, in collaboration with the California Association of Public Hospitals, submitted a proposal of key elements of a PPS-equivalent capitation pilot for FQHCs to DHCS in December 2012. The PCHH workgroup also submitted a formal response to a California State solicitation of stakeholder input on payment reform as part of a State Innovations Model grant in December 2012.

4. **Health centers must take a strong leadership role to ensure payment reform and delivery system transformation is beneficial to them and their patients.** Health centers are at a critical juncture with respect to payment reform and cannot afford to allow the terms of participation to be dictated by other entities, or to miss the opportunity to shape payment reform. Key leadership strategies should include:

   - **Building capacity to negotiate terms of contracts.** Health centers will need to have strong relationships with safety-net health plans, and will need to work in partnership with the health plans if they are to increase their ability to take on risk and potentially share savings over time. They will also need to be savvy and active in setting the terms of FQHC payment methodologies in order to achieve favorable and beneficial payment arrangements. Health centers will need access to sample contracting language to use in negotiation with health plans, especially in areas where FQHCs will be negotiating with health plans for the first time under managed care expansion. In areas where health centers are critical safety-net providers (i.e. have market power), they should have tools that support negotiating for PCMH supplemental payments, Value-Based P4P, and accountability for receiving timely and accurate total health system data from health plan partners for their assigned patient population.

   - **Maintain a focus on delivery system transformation as the primary goal.** Health center leadership will need to continually remind stakeholders to think beyond the payment changes themselves to consider how payment reforms should support changes in workforce capacity, staff training, and clinical infrastructure to achieve a more coordinated and patient-centered delivery system.

   - **Promote development of data infrastructure.** The January 2012 report, *Building a Foundation for Payment Reform for Community Health Centers in California,* emphasized the critical role of transparent and accessible data for all payment reform efforts to facilitate retrospective evaluation and pay for performance. In innovative states, an emerging trend is that health centers and other stakeholder partners are not only using data for retrospective analysis. Data is increasingly being viewed as a tool for business intelligence to prospectively manage the health of populations in real time, with the intent to intervene with high-risk patients before they require more intense and costly intervention [See National Trend 3].

5. **Health centers are uniquely positioned to move towards a delivery system that incorporates social determinants of health.** The delivery system is becoming more integrated and patient-centered, but has thus far struggled to address the social determinants of health in socioeconomically disadvantaged populations. A key challenge is how to design and pay for integrated approaches that incorporate social and community-based services and can account for social determinants of health. Health centers recognize that many of their patients have a multitude of intersecting economic, psychosocial and health problems, only some of which are addressed in the current healthcare system. Many CCHCs already provide enabling and integrated services such as insurance eligibility assistance, behavioral health, translation, and transportation. A few vanguard health centers are leading efforts to join with social service agencies to reduce duplication of case management services and provide the full spectrum of social and health services that vulnerable patient populations receive in a more coordinated and cost effective manner [See Case Study - Hennepin Health]. This model may be of particular interest and relevance in County Operated Health System counties in California.

   Health centers can lead the conversation about the need to account for social acuity in data tracking, risk adjustment, care delivery and payment. Specifically, measurement of and eventual risk adjustment for social acuity factors can become part of a whole-person, patient-centered strategy that addresses the unique psychosocial and economic factors that affect vulnerable and underserved populations.

FQHC Payment Reform Measures of Success

The State of California's Department of Health Care Services articulated four key measures of success for payment reform in health centers.[4] It will be key to be able to demonstrate movement in all these areas.

1. Increased primary care capacity—care for more patients with same number of providers
2. Truly delivering care differently
3. Bending the cost trend (longer term)
4. Improved health outcomes (longer term)

Conclusion

Over the last year, a groundswell of theory and rhetoric on payment reform and delivery system transformation has become a tide of change. Health plans, state governments, CMS, thought-leaders and providers, including FQHCs, will need to collaborate to find new ways to pay for health services in a manner that provides increased flexibility in delivering care to a growing Medi-Cal population, investment in increased care coordination and integration of services across the system, and rewards providers for achieving Triple Aim goals.

National Trend 1: Performance Incentives, Shared Savings and Pushing Risk Toward Providers

- Most payment reform arrangements that FQHCs have today are still upside risk only or "PPS Plus." PPS-Plus includes both incentive payments for performance and incentive payments for transformation or processes (PCMH supplemental is discussed in National Trend 2). Performance-based incentive payments can be for achieving process and/or outcome measures in cost, quality and patient experience for a defined patient population.
- Increasingly, metrics from all three realms of the Triple Aim—health outcomes, patient experience and total cost per capita—are being employed in "value-based" P4P programs.
- Some clinics are also pursuing risk-based contracts with health plans and managed care organizations, or via participation in an IPA, as a strategy to share in savings that result from reduced total costs in the system, often being driven by reduced hospital utilization.
- Nationally, both the public and private sectors are moving toward introducing more risk to providers [See Case Study - AQC].[5] This increased risk tends to start with payers making supplemental incentive payments for PCMH or network services contingent on achievement of higher performance standards.
- The concept of downside risk for health plans is already being explored in dual demonstration projects and in the private sector. Health centers should be prepared for downside risk conversations in the future.
- Shared savings can be thought of as a performance-based payment resulting from and financed by reduction in total cost of care for a defined patient population.[6,7] There is also a trend toward using shared savings as the financing for performance incentives, making the incentives "cost neutral," for states.
- Capitation of providers is a key way in which risk is being pushed toward providers, and abiding by APM requirements [See Sidebar - PPS and APM] and risk-adjustment of capitation rates is a strategy for mitigating the risk FQHC providers bear.

FQHC Participation in Risk Contracts

Most CCHCs in managed care are already participating in upside P4P payments funded either through a set-aside risk pool and/or shared savings. Some CCHCs are also participating in risk-based capitation contracts for specific sets of services, such as the Program of All-Inclusive Care for the Elderly (PACE) and special needs plans (SNPs) under Medicare. In both instances, CCHCs have maintained the ability to receive volume-based PPS payments for health center services. In the few examples where FQHCs are in risk-based contracts with downside risk, APM requirements still protect FQHC total revenue per visit, and there are no examples to date where FQHC providers were asked to return dollars as part of a risk-sharing arrangement. In Oregon and California, CCHCs are proposing PPS-equivalent primary care capitation, thus accepting some risk under capitated contracts that will facilitate replacing some face-to-face utilization with novel modes of care.

In some states such as Colorado, the “downside” risk to health centers in Medicaid ACOs will emerge over time as supplemental payments are becoming contingent on performance, even though PPS base payments remain intact. As the State and CMS give health plans in duals demonstrations downside risk through withholds, it can be expected that health plans will desire to push this risk to providers in some form.

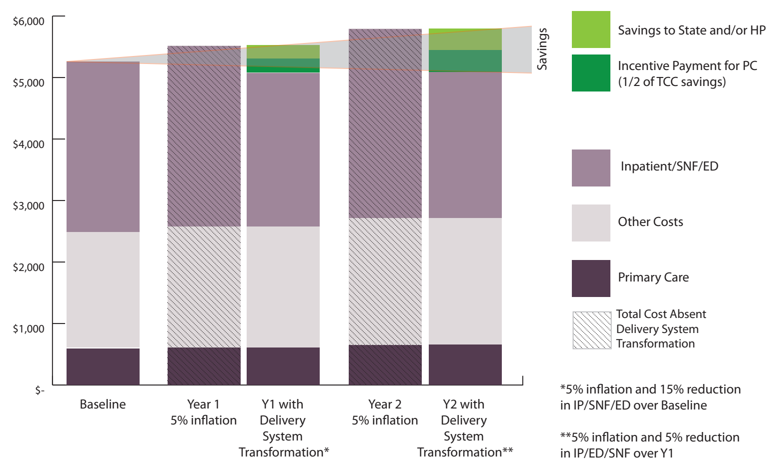
Shared Savings

If providers can reduce total spending for their patients below an expected level, the providers are rewarded with a portion of the savings. Thus, shared savings can be thought of as a “performance payment” for achieving a total cost of care reduction where investments in PCMH are netted out before calculation of savings. Shared savings is upside reward only for the provider that is sometimes capped at maximum percentage of total cost (e.g., no more than 20% of total cost of care reduction will be shared in the Medicare ACO). Shared savings exposes the payer to downside risk in the form of probability that savings were due to chance rather than action on the part of providers in the system. For this reason, some shared savings arrangements only share savings with providers beyond a certain percentage (e.g., 2%) while others take more sophisticated approaches of mathematically incorporating the probability that savings were due to chance in the shared savings formula.[8] Some key critiques of shared savings are:

- They can exist even though a volume-based system remains the basis for most revenue
- Asymptotic—savings will eventually be exhausted
- Many entities want to share savings
- Transparent data, especially on specialist and hospital cost and utilization, are critical and not always available to CCHCs

One caution for health centers to be aware of with shared savings is that **it is important to agree with payer partners on the expected trajectory of costs for the patient population to which actual costs will be compared for the calculation of shared savings.** Without these agreements, health centers have reported that the potential for shared savings can be quickly exhausted, especially in mature managed care environments where many cost-saving opportunities have already been explored. In such cases, comparing a health center’s patient population to a risk-adjusted regional average may be more advantageous than comparing to a projection of the health center’s already well-managed population.

Figure 2. Total Cost of Care Trajectory (Per Member Per Year)



National Trend 2: Investment in Patient-Centered Medical Home (PCMH) and Patient-Centered Health Home (PCHH)

Patient-Centered Medical Home

- Payment for PCMH continues as the most active form of payment reform for CHCs to date.
- Approximately half of states have implemented PCMH initiatives for the general Medicaid population. FQHCs are largely receiving supplemental per-member-per-month payments (PMPM) for PCMH or components of PCMH (e.g., case management) on top of PPS rates.
- PCMH payments are increasingly being tied to performance on Triple Aim outcomes.
- Evidence to support PCMH has been increasingly emerging over last year and early findings show that PCMH has the potential to achieve Triple Aim goals.
- PCMH is serving as a cornerstone building block for broader delivery system reforms such as integrating care across the continuum of care.

The goal of the patient-centered medical home is improved outcomes resulting from coordinated, patient-centered care provided by a multidisciplinary care team. The concept of the patient-centered medical home has continued to gain significant traction across the states. Twenty-five states now have PCMH initiatives specifically for the Medicaid population.[9] Health centers are also participating in multi-payer PCMH initiatives in more than 32 states [See Table 1 below].[10]

Within Medicaid PCMH initiatives, a diversity of payment models are used, but the most pervasive model is a supplemental PMPM payment on top of existing payment arrangements. These supplemental payments range from $1.20-8.66 PMPM and are often paid as fees for care management services. PCMH supplemental payments can be tied to infrastructure/transformation, services, and/or performance. Five states are providing funding for the costs associated with transformation to a PCMH, and 19 states are paying PMPM fees for care management. While early PCMH efforts, such as Oregon's program, tended to link payment to a package of services endorsed by a level of recognition (e.g., NCQA recognition or state-developed PCMH standards), more initiatives are emerging that emphasize the value of specific components of PCMH, such as case management of high-cost, chronically ill individuals.

In their initiatives, states have recognized the need to help practices by providing funding or technical assistance for infrastructure changes related to PCMH transformation. The majority of states provide either up-front payments or technical assistance through learning collaboratives or training as a way to support system transformation at the provider level.

PCMH dollars are often required to be spent on specific services or for personnel costs. For example, Rhode Island's program requires that part of payments is used to hire a care manager.[11] Many states also pair PCMH payments with P4P payments for meeting cost or quality targets or an opportunity to share in savings. Table 1 below lists various payment structures employed across multi-payer and Medicaid PCMH programs.

Table 1. PCMH Supplemental Payment Types in State Medicaid and Multi-Payer Programs

Payment Incentive Structure (# of states)	**States with established or pilot PCMH programs**
Supplemental PMPM for care coordination or case management (21)	AL, CT, IA, ID, IL, ME, MA, MD, MI, MN, MO, NE, NC, NY, OK, OR, PA, RI, SC, VT, WA
Supplemental PMPM per visit on top of PPS/FFS (15)	AL, CT, IL, IA, MD, MA, MI, NE, NY, NC, OR, OK, SC, TN, VT
Performance-based payments for outcomes (10)	CT, IL, IA, MA, MI, NJ, OR, OK, PA, SC
Shared savings based on performance or improvement (8)	AL, ME, MD, MA, SC, PA, WA, WV
Lump sum payments for transformation (5)	CO, CT, MA, PA, WV
Network payments (3)	AL, OK, NC

Source: Medical Home & Patient Centered Care. National Academy for State Health Policy. Available at: http://www.nashp.org/med-home-map. 2012. Accessed December 18, 2012.

There is increasing evidence that PCMH is effective in achieving the Triple Aim goals of better care, better health outcomes, and reduced per capita costs. A recent report by the Patient-Centered Primary Care Collaborative reviewed the latest cost and quality data from PCMH initiatives across the nation, drawing on a mix of early findings from peer-reviewed and industry sources.[12] The report found substantial support for transformation to PCMH, showing that initiatives were often associated with a reduction in expensive care such as hospital readmissions and inpatient stays, allowing for PCMH to generate both short and long-term savings.

Section 2703 Health Homes State Plan Option

While PCMH programs continue to be part of the payment reform landscape, the newer and related concept of "health homes" for chronically ill patients is emerging out of provisions made in Section 2703 of the Patient Protection & Affordable Care Act. Under a state plan amendment (SPA), Section 2703 allows for states to receive a 90-10 match from CMS for up to eight quarters to provide health home services to Medicaid and dually eligible populations with qualifying chronic conditions, who have greater needs for care coordination. Section 2703 provides guidance that "health homes must coordinate and provide access to preventive services, mental health and substance abuse services, comprehensive care management and care coordination, disease management, and long-term care supports and services."[13] Health homes may also link with community and social support services.

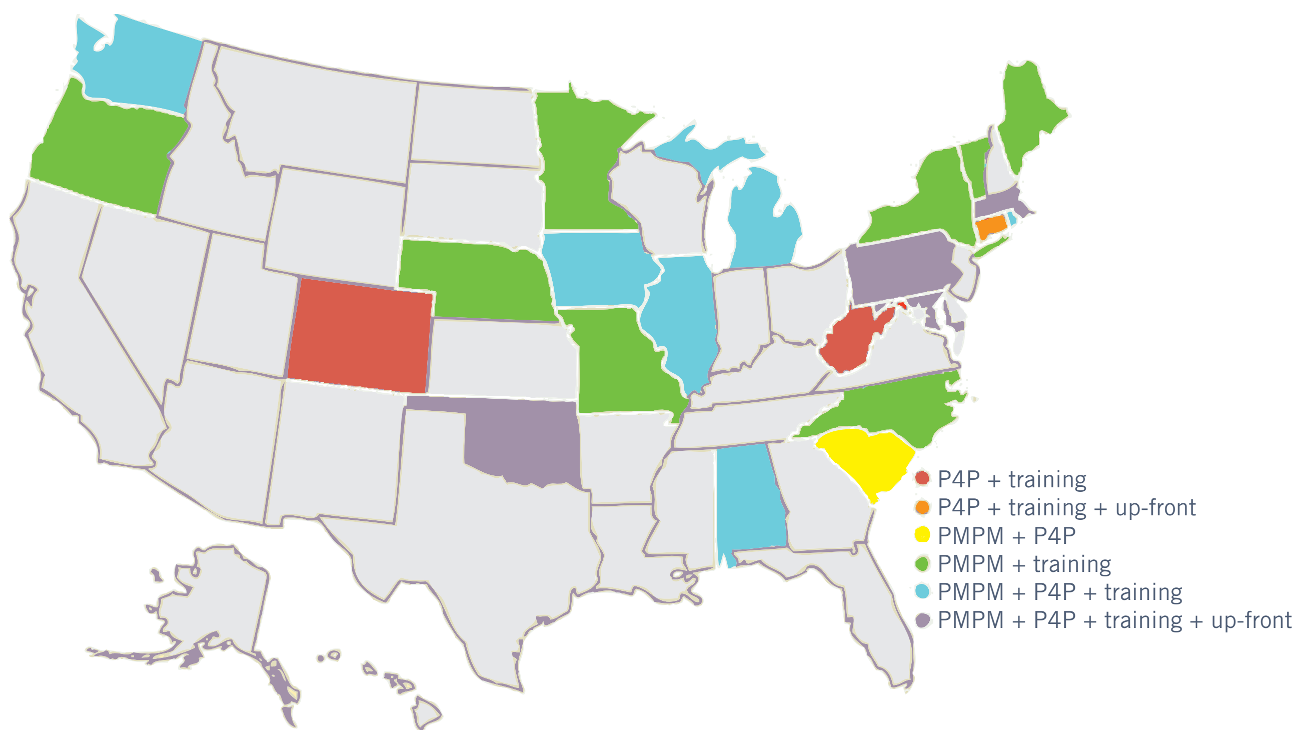
- Eight states[i] have approved 2703 SPAs, and three others[ii] are pending approval from CMS. Twenty-five states have plans to implement 2703 health homes and are engaged in the planning process.[14]
- Implementing health homes allows states to focus on a high-risk group that needs a greater level of care coordination, and a 2703 SPA provides a way to utilize federal dollars to pay for services.
- Several states, like New York and Rhode Island, have re-matched existing Medicaid dollars by reconfiguring existing programs (e.g., targeted case management) as health homes. States often started by mapping the services already provided against health home services. Oregon and New York are passing health home payments through MCOs.[15]
- States have specifically incorporated FQHCs as health home providers. In Missouri, health centers were particularly active in planning a 2703 SPA with a safety-net focus.
- Several states are using the enhanced FMAP provided for eight quarters under 2703 SPAs as a strategy to fund demonstrations for the dual eligible population.

Approved SPAs include substantial PMPM payments for health home providers for case management, care coordination, and data management and can be paid based on qualifying tiers. Supplemental payments range from $10-281 PMPM, substantially larger than PCMH payments. For example, Missouri pays $58.47 PMPM for PCHH for individuals with qualifying chronic medical conditions and $78.74 PMPM for patients with serious and persistent mental illness on top of PPS rates.[16] New York pays providers $141-281 PMPM based on acuity level, and Oregon primary care providers are paid $10, 15 or $24 based on three PCMH tiers.[17] To date, payments are not contingent on cost or quality outcomes.

Some states have viewed 2703 as an opportunity to build upon existing programs and to leverage existing payments to draw down the 90% match from CMS. For example, Rhode Island built its SPA off of its existing CEDARR Family Centers program for children with special needs. North Carolina took a similar approach in implementing health homes within its long-running community network model. New York, which is implementing health homes in three regional phases, is leveraging its existing targeted case management (TCM) program by transitioning TCM providers into health homes.[18] In doing so, the 90% match can be used to pay for care coordination services within the TCM program.

[i] Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island
[ii] Alabama, Maine, New York (phase II), Wisconsin

Figure 3. Medicaid Patient-Centered Medical Home Practice Payment Initiatives, June 2012



Takach M Health Aff 2012;31:2432-2440

National Trend 3: The Critical Role of Health Information Technology in Payment and System Reform

- Health information technology (HIT) is an important facilitator of current and emerging payment and system reform efforts.
- The emergence of payment reform models that include P4P and/or shared savings based on demonstration of higher quality and lower costs elevate the critical role of HIT and system-wide data, including ensuring that patients are attributed appropriately and establishing cost projections, benchmarks and results for the cost of care and quality performance measurement.
- Accountable Care Organizations and similar accountability models must have the ability to access complete and timely information about the patients for whom they are managing care, the ability to exchange data with other providers, the ability to measure and report quality of care, and technology to facilitate population management and the coordination of care.
- The trend toward development of all-payer claims databases is increasingly seen as a key tool for quality and cost benchmarking and supporting high level analytics to understand and predict utilization patterns. Ten states have launched such databases, and six more are in the implementation phase.[16] North Carolina, Alabama and Colorado have established all-Medicaid claims databases.

Vanguard health centers are moving beyond using health data for retrospective analysis and pay for performance and toward more real-time prospective management and predictive modeling to intervene with patients before they might be readmitted to the hospital. For example, in Hawaii health centers are holding health plans accountable for making such actionable data available and easily accessible [See Case Study - AHARO].

The widespread use of the IHI's Triple Aim as a framework for optimizing health system performance, and the inclusion of total cost, population health, and patient experience (including quality of care) in the model underpins the need for robust data systems and capabilities. **In fact, the widespread availability of robust and actionable data on outcomes, utilization and costs at both system and provider level is held up as one of the major distinctions between current health system reform efforts and the managed care efforts of the 1990s.**[20]

The critical role of HIT in payment and system reform has been further reinforced in actions by major payers, accreditation bodies, and states. Important examples include:

- The establishment in the HITECH (Health Information Technology for Economic and Clinical Health) Act of 2009 of a national goal, and related incentives, to ensure "meaningful use" of interoperable electronic health records in the healthcare system. These goals are pursued toward the end of achieving improvements in care.
- Inclusion of health information capabilities in national recognition processes, such as the NCQA's Patient Centered Medical Home standards.

California is unlikely to establish an all-payer or all-Medi-Cal claims database, but could still benefit from developing a common dataset and metrics aligned with what FQHCs already report for UDS, OSHPD, and Meaningful Use requirements and pushing health plans to make data accessible to health centers. Regardless of state-level action, the ability for CCHCs to effectively utilize health information in planning, care coordination, and care delivery will increasingly be a core competency for all primary care providers, and a critical requirement for participation in emerging payment models.

National Trend 4: Medicaid ACOs and Increasing Accountability Across the Delivery System

- Medicare and commercial ACOs are emerging nationally and in California in both fee-for-service and managed care environments.
- Medicaid ACOs have been slower to develop in California than in many other states that have promoted them explicitly through legislation (e.g., Minnesota and New Jersey). Without state policy actively promoting them, Medicaid ACOs are emerging based upon the initiatives of safety-net providers in particular regions (e.g., AltaMed's Accoutable Care Network in Southern California).
- Medicaid ACOs are the most likely ACOs where health centers can participate and reap benefits of shared savings and system-wide care coordination, as they are not likely to be major players in Medicare and Commercial ACOs, dominated by large hospital systems and payers. Being part of an ACO can create internal capacity building for payment and delivery reform within health centers, including learning regarding data availability and quality, and negotiation and coordination with payers and hospitals.[21]
- **Even if California is not going to pursue Medicaid ACOs at a statewide level, the elements of ACOs—better coordination of services across the health system, a patient-centered health home, shared high-quality data, and shared savings incentives for providers based on both quality and cost outcomes—are still critical for CCHCs to be thinking about as they pursue Triple Aim goals.** Health center roles may include participating in ACOs and/or working with managed care organizations, health plans and hospitals to participate in broader networks, coordination of care across the delivery system and negotiating for shared savings based on influencing total health system utilization.
- The early experience of Medicaid ACOs, especially Hennepin Health in Minnesota, shows the potential value of a new ACO model that takes a social determinants of health approach to integrated care. This novel approach may be useful and applicable for California with its county-based Medicaid system, and especially in County Operated Health System counties.
- Payment reform efforts for FQHCs within ACOs are primarily focused on shared savings on top of receiving traditional volume-based PPS payments. However, global payment strategies will likely continue to put pressure on providers within an ACO to accept capitated base payments and shared savings.

The Affordable Care Act explicitly endorsed accountable care organizations (ACOs) for Medicare but not for Medicaid. The CMS Pioneer and Shared Savings programs have stimulated ACO formation throughout the country. Commercial ACOs have also begun to emerge in parallel, and in some cases in tandem, with the CMS shared savings program. The newest and one of the most active areas of ACO development involves Medicaid ACOs. Medicaid ACOs are especially important for health centers for which Medicaid is their primary payer.[22,23]

There is active ACO formation occurring in at least 12 state Medicaid programs with considerable variability across states.[24] Five states are explicitly promoting the development of ACOs on a statewide basis. North Carolina is developing an ACO model, building on its successful network model and state data infrastructure, which was estimated to have saved more than $1.5 billion in the past four years.[25] Colorado, Oregon, Minnesota, and Massachusetts are initiating new state programs for ACOs. Regional pilots are being established in other states such as Alabama. ACOs are emerging in states with mature Medicaid managed care programs as well as those with fee-for-service programs as a strategy for promoting critical delivery system transformation. Minnesota and New Jersey have adopted legislation that supports the development of ACOs, and in the case of Minnesota, the state's priorities for ACO formation are outlined in the legislation.[26]

Many Medicaid ACOs are adopting layered payment models that include shared savings, supplemental payments for health homes or network development, and pay for performance. Shared savings on top of traditional fee-for-service is the underlying payment model for most emerging ACOs, with most only assuming upside risk initially and plans for taking on downside risk.[27]

ACOs represent a next step beyond health homes in delivery system reform that coordinates care beyond primary care and includes a broader mix of services, as well as shifting many care coordination activities from managed care plans to health providers. An underlying assumption of most ACO models is that care coordination can be conducted most effectively in primary care or another health care setting rather than by health plans or MCOs. ACOs are introducing a variety of pioneering practices related to high cost case management and care coordination, which may require major organizational changes on part of entities sponsoring them. One prominent innovation in this area is Hennepin Health's development of a social ACO approach that explicitly applies a social determinants of health approach [See Case Study - Hennepin Health].

National Trend 5: Dual Demonstrations–A New Frontier in Payment Reform

- It has been long recognized that dual eligible Medicare and Medicaid patients are the most complex and most costly in the health system due to a constellation of socioeconomic issues and multiple chronic health conditions.
- Federal policy historically created financial disincentives for states to innovate around improving care for dually eligible populations with some notable exceptions such as Special Needs Plans (SNPs) and waiver programs in Massachusetts, New York, Minnesota, and Wisconsin.
- In April 2011, CMS launched duals demonstration projects in 15 states, including 8 counties in California,[iii] to test models to "increase access to quality, seamless integrated programs for Medicare-Medicaid enrollees."[28]
- Duals demonstrations in California are capitating health plans for cost, providing quality incentives, and introducing downside risk to health plans through withholds over time.[29] While FQHC payment in duals demonstrations has not been resolved yet,[30] health centers will need to anticipate that this downside risk may be passed down to providers in some form.
- Other states are leveraging Section 2703 dollars to finance PCHH for duals as a strategy to fund improved coordination of care for this high-cost, complex population.
- States are viewing existing and innovations in payment reform and delivery system infrastructure as the foundation for duals demonstrations. For example, demonstrations are utilizing Medicare Advantage SNPs, PACE programs, and prior capitated demonstrations.[iv] Furthermore, while challenging, states are still seeking to align their dual demonstrations with novel payment and delivery system reforms, including health homes, ACOs, and behavioral health integration.
- While dual eligibles have not been a primary target audience for health centers, some health centers are viewing the duals demonstrations coupled with the aging population as the best opportunity to coordinate care and participate in significant shared savings (with Medicare dollars, a sizable opportunity exists where it did not before).
- Capitated payments could provide much-needed flexibility to care for this complex population, and capitation rates might actually be high enough to truly affect change.
- Even if duals are excluded from the PPS-equivalent capitation pilot, CCHCs should aggressively pursue PCMH funding from health plans and negotiate for shared savings for duals. Not to do so would be a missed opportunity for care improvement and shared savings.

The state dual eligible demonstrations are another critical area of state payment and delivery system reform. Dual eligible individuals who have access to both Medicare and Medicaid are some of the most difficult and costly patients to manage in the healthcare system. Although states have implemented PACE programs and

[iii] Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino.
[iv] Senior Care Options program in Massachusetts; Partnership Program in Wisconsin; Minnesota Senior Health Options Program.

other integrated programs under waivers and Medicare Special Needs Plans, the current CMS dual eligible demonstration is accelerating the implementation of integrated strategies, which are supported by stronger financial incentives. Prior to this program, many state integrated programs for duals were limited by the fact that CMS did not have an easy and automatic mechanism for sharing savings from reduced inpatient utilization with states, their providers and health plans.

States are taking different approaches to integrating the delivery system for dual eligible beneficiaries, depending on both state priorities and existing infrastructure to support integration.[31,32,33,34,35] Some of the most common strategies include behavioral health integration, coordination with health homes efforts, use of non-traditional healthcare workers, and providing additional services not currently offered to duals in standard benefit packages [See Table 2 below].[36]

Table 2. Dual Demonstration Design Elements

Delivery System Transformation Element	States
Behavioral Health integration, co-location, or coordination with existing Medicaid BH carve-outs	AZ, CA, CO, IA, IL, MN*, NM, OH, OR, RI, SC, TX, WA
Health homes provision**	IA, MO, NM, NY, OH, VA
Use of community health workers or other non-traditional healthcare workers	MA, NM, OR, RI, SC
Supplemental benefits (beyond standard Medicaid and Medicare)	AZ, CA, CT, HI, ID, MA, MI, NM, NY, OH, OR, RI, SC, TN, TX, VA, VT, WA, WI

Source: Musumeci M. State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS. Kaiser Commission on Medicaid and the Uninsured. October 2012.
*MN demonstration is age 18-64 only.
**Of states with health homes provisions, only IA, MO, NY, and OH have 2703 SPAs.

The dual demonstrations can receive payments on a capitated or fee for service basis. The majority of states are relying on a capitated approach in which a global cap for services is provided to a health plan for services traditionally offered by Medicare and Medicaid, plus additional services considered useful and effective in managing care.[37,38] Some states, like California, in managed care environments are combining the global payments with pay for performance to incent the achievement of specified quality metrics. California's duals proposal includes a 1-3% withhold for quality performance from health plans' rates in years 1-3 of the demonstration. Health centers should be prepared that this "downside" risk will likely trickle down in some fashion.[39] States in non-managed care environment can still pay fee for service while participating in shared savings arrangements. Many states are also applying for 2703 Chronic Health Home SPAs as a mechanism for financing the necessary infrastructure investments among providers under the dual demonstrations. For example, Washington's plans for their duals demonstration are dependent on receiving the enhanced FMAP from 2703 to fund the demo. Washington hopes that the duals demo will be self-sustaining by the end of the 2-year enhanced FMAP period and will generate enough savings to fund the third year of the demo.[40]

Duals have not historically been as large a segment of the community health centers' population in California as elsewhere, but they represent a growing one and an opportunity for expansion. Some health centers in California have experience with PACE and SNPs, but for others this is an entirely new endeavor. For health centers, programs for duals require strengthening the health home for persons with multiple chronic conditions, offering a new service mix that includes the elements depicted in Table 2 above.

Accountable Healthcare Alliance of Rural Oahu (AHARO): CHC Leadership and Health Plan Accountability

Health Centers are increasingly exploring the way in which existing managed care relationships may interface with ACOs and other emerging delivery system models, including opportunities for influencing the development of "virtual ACOs," or collaborative relationships between providers and payers that embrace many tenets of an ACO but without a formal overarching governance structure. AHARO seized the opportunity to drive the formation of a "virtual ACO" through development and demonstration of core competencies and strong partnerships with health plans, including a health-center-owned plan.[41,42]

Key Takeaways for California CCHCs

- **Focus on the health center competitive advantage.** AHARO worked diligently to be the provider of choice in its communities. This includes provision of excellent, culturally specific care, and deep involvement and investment in the community, resulting in strong patient and community loyalty.
- **Leverage partnerships to build core capacity.** AHARO has engaged partners in helping to build infrastructure, such as access to specialty care and a strong data infrastructure. AHARO has been able to leverage its value to ensure that both health centers and health plans accept reciprocal responsibility for patient outcomes. AHARO has defined agreements whereby success in one set of indicators (initially, quality of care) has resulted in payment incentives to be used to further build infrastructure (for example, in data analytics).
- **Do not wait for leadership from the state or the Medicaid program.** AHARO regularly convenes a broad group of stakeholders, including community members and leaders, and health plans, to evolve its service delivery model and leadership role in the broader community. This has allowed AHARO to build trust and a shared vision with health plans in establishing a vision for the overall health of the community, and developing services targeted to achieving the vision.
- **Demonstrate the value of specific aspects of the health center model.** AHARO Health Centers have established a data and continuous quality improvement (CQI) infrastructure that allows them to track and demonstrate the value they bring to health plans. This is manifested in achievement of nationally recognized PCMH certification and locally developed Health Care Home Standards; achievement of quality targets; and documentation of enabling services and community services designed to meet community-identified needs. This information provides an important leverage point in negotiating payment rates with health plans.

- **Use market power to expand capacity of health centers.** This strategy may apply to rural California undergoing managed care expansion where CHCs are the only primary care providers. AHARO has insisted on contracting terms that hold health plans accountable for activities that contribute to a health center's effectiveness. This includes data transparency, a transparent risk pool that provides in real time dashboards on all performance metrics; and investment in health IT and health home.

Background

AHARO is a virtual ACO that functions as a contracting arm/umbrella for three FQHCs[v] serving approximately 40,000 patients annually on rural Hawaiian island of Oahu. AHARO was established through an interagency agreement and is responsible to the governing boards of the participating health centers. Having developed its market position intentionally over time, AHARO health centers are providers of choice in Hawaii, facilitating AHARO's ability to negotiate favorable payment methodologies with payers.

How It Works

AHARO has developed concrete ways to demonstrate value both conceptually and with quantitative metrics. AHARO began by developing a system to document (through coding) the level of enabling services and mental health services that health centers provide as well as the impact and value of those services. They have also pursued innovative transformation such as having 24-hour urgent care.

AHARO has also developed a process for community and stakeholder involvement in its service delivery design. At least annually AHARO brings together a group of around 100 stakeholders—thought leaders, health center leaders, health plans, civic leaders, and consumers (at least 50% consumer representation) to help design systems of care and/or community initiatives and secure buy-in from critical partners. For example, this stakeholder process led to the development of health center supplemental health care home standards and measures relevant to the wellbeing of target populations. The standards have components for health centers and health plans, promoting shared transparency and responsibility, and serve as an underpinning for payment arrangements. For example, the percent of shared savings a health center can access depends on what degree health centers and health plans meet defined goals within each area of accountability listed in the table below:

Table 3. AHARO Accountability Measures

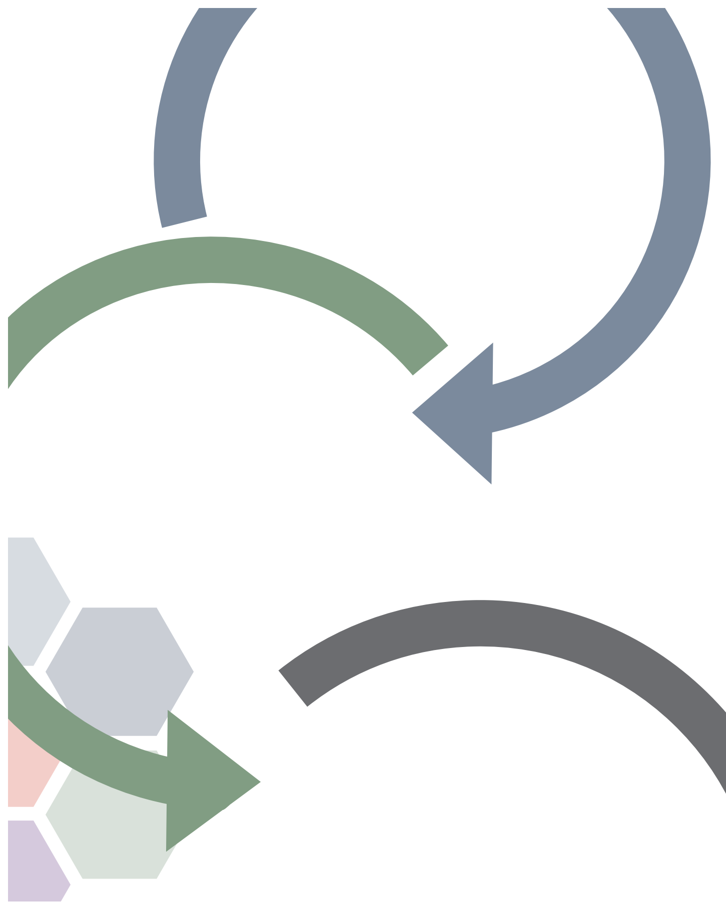
Health Center Accountability	Health Plan Accountability
• PCMH recognition • Care enabling services • Cultural proficiency • Patient/Community involvement • Workforce/Employment referral service	• Primary care network adequacy • Claims processing • Access to specialists • Data dashboard • Support for health IT interface (primary care- specialists) • Integration of primary care and behavioral health services

[v]Koolauloa Community Health and Wellness Center, Waimanalo Health Center, and Waianae Coast Comprehensive Health Center.

Key Result: A Multi-Layered Payment Model

AHARO has a multi-layered payment model in its health plan contracts. While AHARO developed the model in collaboration with a health-center-owned plan, it has extended this model to two commercial payers. The payment layers include:

- PMPM ($2-3) for medical home proficiency and related CQI work plans.
- A $5 PMPM match from the health plan for investment in HIT and care coordination. The infrastructure facilitates reporting on high-value metrics (e.g., hospital admissions, readmissions, ED visits, generic drug use) and dashboards designed to reveal health disparities.
- Shared savings are based on seven high-value metrics. AHARO receives 50%-75% of the savings, depending on the relative health center and health plan performance on financial metrics and accountability measures as noted in Table 3 above.



Blue Cross Blue Shield Alternative Quality Contract (AQC): Lessons from Risk Contracting

- The private sector is increasingly moving to risk-based contracting, and others are following; the AQC is an example of the new world that CHCs will need to learn to navigate.
- Shared savings will likely be greatest for systems that are less integrated and least where providers are already in risk-bearing and/or managed care now.
- Savings are based on total cost of care, which is a function of utilization and price of services. Health centers can potentially influence inpatient utilization but not the price of inpatient services that health plans negotiate. FQHCs may benefit from using utilization metrics as a proxy for total cost.
- The state of Massachusetts is already moving to regulate prices—especially inpatient and procedure prices—as a result of learning from the AQC experience.

Background

In 2006, Massachusetts Health Reform expanded coverage to 97% of state population, but costs soared. In 2009, in an attempt to control costs in its managed care contracts while also increasing quality, Blue Cross Blue Shield (BCBS) of Massachusetts instituted prospective global budgeting with performance incentives for quality.[43,44]

How it Works

- A global budget is calculated prospectively based on prior utilization for a defined group of patients. The budget is risk adjusted by health status and is increased at the regional network rate of inflation for the five-year contract period.
- Providers or provider/hospital collaborations agree to assume responsibility for all quality and costs associated with the assigned patient population (assigned to a PCP within managed care), including inpatient, outpatient primary and specialty care, pharmacy, behavioral health, and ancillary services. BCBS assumes risk for very high-cost cases.
- Provider groups are paid by the health plan FFS for the services they render.[45] Total claims costs are reconciled at the end of the year to determine whether there were savings compared to the global budget or a deficit. The percentage of savings that the provider receives (or percent of the overspend the provider is responsible for) is determined by how many of a defined set of quality targets the provider's assigned patient population achieved: the higher the quality performance, the greater the provider's share of savings.
- BCBS provides participating providers with a broad array of data and reports to assist in managing cost and quality outcomes. BCBS also convenes forums for sharing best practices.
- Providers can also receive up to 10% of the global budget in quality incentive payments.

Results

Participation in contract and reported in *Health Affairs* led to:

- Overall savings of an average of 2.8% annually compared to controls
- The only significant decreases in cost and utilization were among the non-HMO providers who had been paid fee for service prior to the contract (8.2% average annual savings achieved). BCBS reports drivers of total cost of care declines were associated with decreases in inpatient admissions, use of high-tech radiology services, and increased use of lower cost care settings.
- The main driver of cost decrease (<2% annual average) among the providers who had been in risk contracts prior to the ACQ was substitution from higher to lower priced services concentrated in imaging, procedures, and tests.
- Quality improvements were demonstrated in some areas (e.g., chronic care management and depression), and the ACQ group showed overall better quality scores than controls.
- Despite upside and downside risk (providers would have to pay BCBS back for portion of overspend), because of the coupling with quality incentives, this has resulted in providers making no net payments back to BCBS by providers to date.
- Even as results are emerging, other private payers are following BCBS of Massachusetts' lead.
- The public sector also following. Massachusetts Medicaid is planning move to risk-based contracting with the passage of the most recent cost containment bill.

Table 4. Results of Alternative Quality Contract First 2 Years and Reported in Health Affairs - 2009 Cohort

# of Subjects (% of cohort)	Prior Risk arrangement	Year 1 Savings	Year 2 Savings	Total average savings	Predominant driver for savings
428,892	All	1.9%	3.3%	2.8%	75% outpatient facility concentrated in imaging, procedures, and tests
88%	Prior risk	1.1%	1.8%		Substitution from higher to lower cost services; no significant changes in utilization
12%	Fee-for-service	6.3%	9.9%	8.2%	Drivers of total cost of care declines associated with decreases in inpatient admissions, use of high-tech radiology services, and increased use of lower cost care settings.

Source: Song Z, Safran DG, Landon BE, et al. The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending and Improve Quality. Health Affairs. 2012. 31(8): e1-e10.

How FQHCs are Involved

- There are FQHCs involved in the contract as part of bigger organizations, but this was mostly focused on BCBS's commercial business. They did not lead or influence the process.
- However, this model is being widely emulated by public and private sectors alike and became a building block for Massachusetts' State Health Reform which heavily included the public sector.

Delegation of PPS Payment to Health Plans: The Kansas and Mississippi Experience

States are interested in delegating FQHC payment to health plans in order to streamline payment methodologies and reduce their own administrative role in making direct payments. PPS payment by health plans could potentially increase the cash flow and efficiency of payments for health centers, particularly if health plans include the entire payment at the time a claim is paid, or provide more timely or frequent wrap payments and/or reconciliation than the state. However, there are potential disadvantages of delegation of PPS payment to health plans including:

- Potential disinclination on the part of health plans to contract with FQHCs
- Lack of transparency of data needed to ensure health centers are being paid the equivalent of their PPS rate.

Key Strategies for Protecting PPS Payment in California

The experience of the PCAs and health centers in Kansas and Mississippi indicate that FQHCs should take the following key actions to ensure appropriate payment to FQHCs under an arrangement where health plans are administering PPS payments:

- **Contracting Language.** Health Centers should identify contracting requirements they need (such as timely payment, regular reports of data upon which payment is made, etc.) and detailed descriptions of method by which encounters are determined. The language should state that health centers maintain their ability to engage in IPAs, and to contract through IPAs to ensure favorable contracting terms, including pay for performance and shared savings arrangements.
- **Access to Data.** Contracting requirements should detail the way in which health centers will be provided data to validate that they are receiving at least a PPS equivalent, including reports of data upon which payment is made (or denied), detailed descriptions of method by which encounters are determined, and a process for addressing inaccuracies. A regular reconciliation process should be included unless health centers are convinced that the data they are receiving, and the payments made, are accurate.
- **Align incentives/disincentives to prevent steering patients away from FQHCs.** Health plans could "steer patients away" from FQHCs by either not contracting with health centers or by contracting with but not assigning patients to health centers. In cases where health plans make the entire PPS payment to FQHCs at time of service, and in which the health plans' capitation is calculated to include FQHC payment, state contracts should provide disincentives that discourage health plans from steering patients away from FQHCs. FQHCs should also ensure that MCO contracting mechanisms (including RFP requirements and evaluation criteria) create incentives for health plans to contract with health centers, such as setting administrative fees health plans can charge in a way that it is slightly favorable to continue to contract with and assign patients to FQHCs. Stronger than an

incentive would be requirements for health plans to include essential community providers in their networks when bidding for Medicaid contracts. Language that simply "encourages" health plans to contract with FQHCs is less effective.

- **Maintain a process for change of scope.** Health centers should ensure that a process exists to make scope (and payment adjustments), without having the State renegotiate health plan rates. Change in scope and MEI adjustments should be routinized, and should happen at least as well under MCO-delegated PPS as they did with the state. A change of scope process should be included in any new PPS procedures, as should a mechanism for new PPS rates to be communicated to health plans.

Background

In Kansas, Medicaid health plans currently pay FQHCs on a fee-for-service basis, and the state makes a wrap payment for the difference between FFS payments and the PPS rate to the health centers at the end of the month. The state also conducts a reconciliation process at the end of each year. With the expansion of managed care in Kansas beginning January 2013, the state is moving to a model whereby health plans will pay health centers their PPS rate at the time of service, with no wraparound or reconciliation process. The state issued an RFP for health plans that strongly encourages, but does not require, that health plans contract with safety-net clinics. At the current stage of development there is little detail regarding the requirements the state will make of the health plans regarding PPS rate administration, and reporting of data to support payments made to FQHCs.

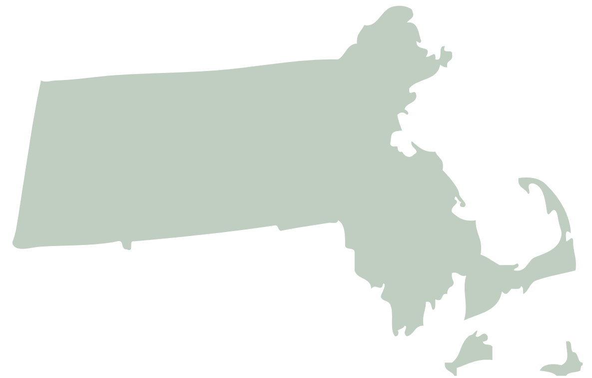
PPS and APM

Federal law (BIPA) requires that health centers be paid either their Medicaid PPS rate, or a rate established through an Alternative Payment Methodology (APM). Federal guidance states that state Medicaid departments must make wraparound payments to health centers to make up for any difference in rates paid by Medicaid managed care organizations and a health center's PPS rate. CMS has allowed states to establish APMs in which health plans directly pay the wraparound payments. There are several statutory requirements related to an APM to note in developing a methodology where health plans administer the full PPS payment (either up front, or through a wrap) to health centers.

- An APM must be agreed to by the state and the individual center or clinic. The state must continue to pay PPS for clinics that do not choose to participate in the APM.
- An APM must result in payment to each health center that is at least equal to what the health center would have received if paid its Medicaid PPS rate. The state must develop a process that annually demonstrates the APM is at least equal to what payment would be under PPS.

Mississippi has recently delegated PPS payment to Medicaid health plans. Health plans pay FQHCs their PPS rate on an encounter basis. There is no wraparound process, and the state notifies health plans of increases in the PPS rates of health centers due to annual MEI adjustments or scope changes. The state MCO contract does not require health plans contract with FQHCs, but this has not been an issue as FQHCs are the primary providers for Medicaid patients in most communities. Health centers have been pleased with the payment at time of service, but are finding that there have been inconsistencies in how the health plans have defined and identified encounters for payment. FQHCs are able to request detailed reports of payments made, but are not provided with this information as a matter of course.

Massachusetts Primary Care Payment Reform Initiative and Global Budgeting



- Massachusetts Medicaid is moving to primary care capitation with shared savings across all of its programs. Primary care capitation is a step towards developing Medicaid ACOs in the state.
- The new payment system is designed to promote flexibility in the delivery of primary care and to support the integrated health home that includes behavioral health.
- Health home and primary care capitation are planned steps in a broader strategy for delivery system transformation and payment reform that also includes ACO development and integrated programs for dual eligibles.
- Under the state's recent cost containment legislation (Chapter 224), the state is innovating by establishing global budgeting that will put pressure on reducing prices as well as the utilization of services.
- Hospital payment reform will support ACO development and may include enhanced efforts to reduce readmissions and improve care transitions.
- Within a few years, health providers will need to develop global budgets and report progress in achieving them to the newly established Health Reform Commission.

Background

The Primary Care Payment Reform Initiative is part of Massachusetts' overall strategy for cost containment and payment reform within the Medicaid program (MassHealth), resulting from legislation passed in August 2012 (Chapter 224). Chapter 224 emphasizes innovative payment methodologies as a means to reducing costs while enhancing the quality and efficiency of care, both for MassHealth and other payers.[46,47] As part of this movement, the PCPR initiative aims to drive quality improvement through global payments that allow primary care providers more flexibility in how they deliver care to Medicaid patients.[48,49,50] These payments may support expanding the care team, offering phone and email consultations, allowing group appointments, and targeting appointment length to patient complexity. An RFP for health providers will be released in January 2013, with implementation set to begin in July 2013.

How it Works

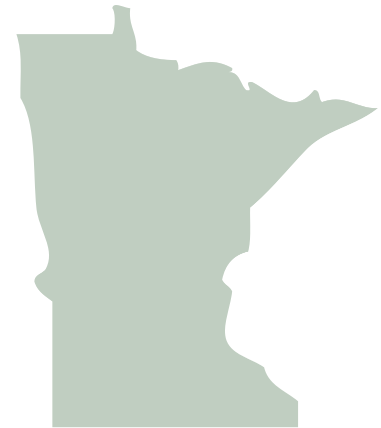
- The initiative is based on a patient-centered medical home model with a heavy emphasis on integration of behavioral health services. A patient's medical home can be either a primary care or behavioral health site.
- Practices of a range of types and sizes can participate, including FQHCs.
- The payment methodology combines a risk-adjusted PMPM payment with performance-based incentives for quality and shared savings. Providers must manage a global budget for all patients.
- The initiative is using a shared savings model whereby providers must meet quality standards in order to participate. Participation in shared savings requires review of the provider's finances to ensure ability to take on financial risk. They can participate in one of three risk arrangement tracks: 1) upside/downside risk; 2) transitioning to downside risk; and 3) upside risk only.
- Rates for FQHCs are expected to be comparable to or greater than their current PPS rate.

How FQHCs are involved

Community health centers are one of the designated groups that can participate in this new initiative, as they see a large portion of MassHealth patients. Health centers were also part of an extensive stakeholder engagement process across the state.

Overall, health centers responded favorably to the RFI that was released in August. However, they have also expressed some concerns about participating in the program, including: the underlying payment rate structure; the financial infrastructure required to receive payments differently; data availability and infrastructure; and requirements for quality reporting.[51] A key concern for health centers regarding the rate structure stems from the RFI, which states, "There may be different processes for pricing the CPCP based on the Participant. For example, a CPCP for a participating community health center (CHC) might be based on the existing visit rate."

Hennepin Health Social ACO Model



- Even within a managed care environment, new models are still needed to influence social determinants of health. This is an example of a promising new model with positive early results for an ACO that is trying to address social determinants of health and further integrate social services and health services, resulting in efficiencies for the larger public system and improved care for patients.
- This model of a "Social ACO" could be most readily applied in COHS counties in California where County systems are in charge of both health and social services.
- The Social ACO represents a powerful idea that strong leadership in safety-net organizations could emulate through collaborations between FQHCs and other County-level social services.

Background

Minnesota has recently encouraged healthcare providers to develop alternative and innovative healthcare delivery systems, including ACOs, for enrollees in the state's Medicaid program. In 2010, the Minnesota legislature created the Health Care Delivery Systems Demonstration (HCDS) to pilot these innovative delivery systems by providing enhanced payments for providers under a state plan amendment.[52,53] While not one of the demonstration sites, Hennepin Health's goals were aligned with this legislation and with broader payment reform strategy in the state; Hennepin is a regulated Medicaid managed care plan innovating under special agreement with the state. Hennepin Health represents a unique social ACO model that integrates primary care with behavioral health, social services, and other services provided in Hennepin County such as housing and transportation.[54]

How it Works

The Hennepin County Integrated Health System Pilot is a capitated ACO serving a Medicaid expansion population, composed of a county HMO (Metropolitan Health Plan), public hospital (Hennepin County Medical Center), a Federally Qualified Health Center (NorthPoint Health & Wellness Center), and the county Human Services and Public Health Department. The pilot focuses on the state's early expansion population of childless adults with incomes at or below 75% FPL, with over 6,000 patients enrolled and plans to enroll 10,000 by the end of 2012. Hennepin uses a prospective capitated financing model for all health services under Medicaid (social services are still carved out), with Hennepin County at full risk for the ACO population. The care model integrates medical, behavioral health, and human services in patient-centered model of care.

The goals of the pilot are to:

- Reduce redundancy in case management
- Coordinate and intensify the workforce, including community health workers, social workers, care coordinators, social services navigators, and a chemical dependency coordinator
- Create flexibility to address drivers of inappropriate care
- Reduce acute care costs by 10% and increase preventive care visits by 5% in year 1
- Expand the model to the dual eligible population over time

Early Results

Hennepin is actively tracking outcomes in four key areas: 1) clinical quality and patient safety, 2) patient experience and engagement, 3) costs of care (and related utilization changes), and 4) provider experience and engagement. They have identified early successes and a number of areas for improvement, including data quality. Early findings include:

- Improved case management. For one patient, 6 case managers were reduced to a single whole-person-centered case manager coordinating health and social services.
- Patient satisfaction. 86% of patients were likely to recommend Hennepin for health services
- Increase in primary care visits and non-billable phone and email visits.
- Reduced medication costs.
- Increased connection of patients to social services, including food assistance, transportation, and financial assistance.
- Increased connection of patients to substance abuse and mental health services, thereby reducing ED visits.

Endnotes

[1] IHI Triple Aim Initiative. Institute for Healthcare Improvement. Available at: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx. 2013.

[2] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012. Available at: http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pateint-centered_medical_home_0.pdf.

[3] Markovich P. A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led to Savings in First Two Years. Health Affairs. 2012. 31(9):1969-1976.

[4] Mari Cantwell. December 12, 2012 Meeting between CPCA and DHCS, Sacramento, CA.

[5] Mechanic RE and Zinner DE. Many Large Medical Groups Will Need to Acquire New Skills and Tools To Be Ready For Payment Reform. Health Affairs. 2012. 31(9): 1984-1992.

[6] Weissman JS, Bailit M, D'Andrea G, and Rosenthal MB. The Design And Application Of Shared Savings Programs: Lessons From Early Adopters. Health Affairs. 2012. 31(9):1959-1968.

[7] Bailit M, Hughes C, Burns M, and Freedman DH. Shared Savings Payment Arrangements in Health Care – Six Case Studies. The Commonwealth Fund. August 2012.

[8] Song Z, Safran DG, Landon BE, et al. The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending and Improve Quality. Health Affairs. 2012. 31(8): e1-e10. Available at: http://www.bluecrossma.com/visitor/pdf/news-articles/HealthAffairsAQCarticle_2012.pdf

[9] Takach M. About Half Of The States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations. Health Affairs. 2012; 11:2432-2440.

[10] Medical Home & Patient Centered Care. National Academy for State Health Policy. Available at: http://www.nashp.org/med-home-map. 2012. Accessed December 18, 2012.

[11] Mary Takach, personal communication. October 23, 2012.

[12] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012. Available at: http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pateint-centered_medical_home_0.pdf.

[13] Centers for Medicare and Medicaid Services. Letter to State Medicaid Directors re: Health Homes for Enrollees with Chronic Conditions. Available at: http://www.cms.gov/smdl/downloads/SMD10024.pdf. Published November 16, 2010.

[14] State integration activities: health homes. Integrated Care Resource Center. Available at: http://www.integratedcareresourcecenter.com/hhstateresources.aspx. 2012. Accessed December 18, 2012.

[15] Townley C and Takach M. Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues. National Academy for State Health Policy. Available at: http://www.nashp.org/sites/default/files/health.home_.state_.option.strategies.section.2703.pdf. Published July 2012.

[16] Health care home: overview. Missouri Department of Mental Health. Available at: http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm. 2012. Accessed December 18, 2012.

[17] Medicaid Health Homes. New York State Department of Health. Available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm. 2013. Accessed December 18, 2012.

[18] Mary Takach, personal communication. October 23, 2012.

[19] Interactive State Report Map. All-Payer Claims Database Council. Available at: http://www.apcdcouncil.org/state/map. 2012. Accessed December 7, 2012.

[20] Emmanuel EJ. Why Accountable Care Organizations are Not 1990s Managed Care Redux. Journal of the American Medical Association. 2012; 21(307): 2263-2264.

[21] Goroll AH and Schoenbaum SC. Payment Reform for Primary Care Within the Accountable Care Organization: A Critical Issue for Health System Reform. Journal of the American Medical Association. 2012. 308(6): 577-578.

[22] Lewis VA, Larson BK, McClurb AB, Boswell RG, and Fisher ES. The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles. Health Affairs. 2012; 31(8):1777–85.

[23] Berwick D. ACOS – Promise, Not Panacea. Journal of the American Medical Association. 2012. 308(10): 1038-1039.

[24] McGinnis T. Advancing Accountable Care Organizations in Medicaid. The Commonwealth Fund Blog/ Available at: http://www.commonwealthfund.org/Blog/2012/Aug/Advancing-Accountable-Care-Organizations-in-Medicaid.aspx. Published August 15, 2012.

[25] Our Results: Making Headway on Cost and Quality. Community Care of North Carolina. Available at: https://www.communitycarenc.org/our-results/. 2012. Accessed January 4, 2013.

[26] Health Care Delivery System Transformations. Minnesota Department of Human Services. Available at:http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441. 2013. Accessed December 18, 2012.

[27] Frakt AB and Mayes R. Beyond Capitation: New Payment Experiments Seek to Find the ‘Sweet Spot’ in Amount of Risk Providers and Payers Bear. 2012. 31(9): 1951-1958.

[28] Bella M. Coordinating Care for Medicare-Medicaid Enrollees. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 16, 2012.

[29] CalDuals: Keeping you informed about Medicare/Medi-Cal integration. CalDuals. 2012. Available at: http://www.calduals.org/

[30] B. Wunsch, personal communication. October 2012.

[31] Larson M. Vermont’s Vision for People who are Dually Eligible. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 16, 2012.

[32] Parker P. Contracting with Special Needs Plans for Long Term Care. NASHP Annual State Health

Policy Conference 2012. [presentation] Presented October 16, 2012.

[33] Lindeblad M. HealthPath Washington: Medicare & Medicaid Integration Project. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 16, 2012.

[34] Saucier P. State Managed Care Approaches for Dual Eligibles. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 15, 2012.

[35] Tatar M. California's Coordinated Care Initiative. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 16, 2012.

[36] Musumeci M. State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS. Kaiser Commission on Medicaid and the Uninsured. October 2012.

[37] Ibid.

[38] Saucier P. State Managed Care Approaches for Dula Eligibles. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 15, 2012.

[39] CalDuals: Keeping you informed about Medicare/Medi-Cal integration. CalDuals. 2012. Available at: http://www.calduals.org/

[40] Stein MM. Washington To Finance Duals' Demo With Elevated Health-Home Match Rates. Inside Health Policy [blog]. Available at: http://insidehealthpolicy.com/Inside-Health-General/Public-Content/washington-to-finance-duals-demo-with-elevated-health-home-match-rates/menu-id-869.html. Published October 31, 2012.

[41] Bettini, R. Engaging Consumers in Healthcare Transformation: A Medicaid Shared Savings Model. [presentation] Accountable Healthcare Alliance of Rural Oahu. Available at: http://www.hawaiipca.net/media/assets/AccountableCareinRuralCommunities.pdf. Published August 23, 2012.

[42] Accountable Healthcare Alliance of Rural Oahu. AHARO Payment Reform Model. Available at: http://www.aharo.net/download/AHARO%20Payment%20Reform%20Model_updated%209-17-12.pdf. Published September 17, 2012.

[43] Blue Cross Blue Shield of Massachusetts. Massachusetts Payment Reform Model: Results and Lessons. BCBS. Available at: http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf. Published October 2012.

[44] Song Z, Safran DG, Landon BE, et al. The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending and Improve Quality. Health Affairs. 2012. 31(8): e1-e10. Available at: http://www.bluecrossma.com/visitor/pdf/news-articles/HealthAffairsAQCarticle_2012.pdf

[45] Dana Safran (Blue Cross Blue Shield Foundation of MA), personal communication [email]. December 11, 2012.

[46] Massachusetts General Laws Chapter 224. An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation. 2012 Massachusetts Acts. 6 August 2012.

[47] Seifert R and Gershon R. Chapter 224 of The Acts of 2012: Implications for MassHealth. Massachusetts Medicaid Policy Institute. Available at: http://bluecrossmafoundation.org/publication/chapter-224-acts-2012-implications-masshealth. Published September 2012.

[48] MassHealth. Introduction to Primary Care Payment Reform Initiative. Available at: http://bluecrossmafoundation.org/sites/default/files/download/related/MassHealth%20Slides%2012.5.12.pdf. [Presentation] Published November 27, 2012. Accessed January 11, 2013.

[49] Primary Care Payment Reform Initiative. Massachusetts Executive Office of Health and Human Services. Available at: http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/primary-care-payment-reform-initiative.html. 2012. Accessed December 20, 2012.

[50] Comprehensive Primary Care Payment Initiative: Request for Information. Massachusetts Executive Office of Health and Human Services. Available at: http://www.mcaap.org/CPCPRFI8912FINAL%20%282%29%281%29.pdf. Released August 9, 2012. Accessed December 20, 2012.

[51] Aurelia Chaudhury, personal communication. January 15, 2012.

[52] Health Care Delivery System Transformations. Minnesota Department of Human Services. Available at:http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441. 2013. Accessed December 18, 2012.

[53] Leitz S. Medicaid Payment and Delivery System Reforms: Minnesota's Experience. NASHP Annual State Health Policy Conference 2012. [presentation] Presented October 17, 2012.

[54] Hennepin Health: The County's Health Care. Hennepin County, Minnesota. Available at: http://www.hennepin.us/healthcare. 2012. Accessed December 18, 2012.

Appendix: Interviews Conducted October–December 2012

National Experts

- Mary Takach, RN, MPH – Program Director, National Academy for State Health Policy
- Charles Townley – Policy Analyst, National Academy for State Health Policy
- Anne Gauthier, MS – Senior Program Director, National Academy for State Health Policy
- Allison Hamblin, MSPH – Vice President for Strategic Planning, Center for Health Care Strategies
- Dawn McKinney – Director of State Affairs, National Association of Community Health Centers
- Deborah Kilstein, MPA – Vice President for Quality Management and Operational Support, Association for Community Affiliated Plans
- Michael Bailit, MBA – President, Bailit Health Purchasing, LLC
- Amy Boutwell, MD, MPP – President, Collaborative Healthcare Strategies

State Contacts

- Amanda Cassel Kraft, MPP – Policy Manager, Massachusetts Executive Office of Health & Human Services
- Judy Zersan, MD, MPH - Chief Medical Officer/Clinical Services Office Director, Colorado Department of Healthcare Financing and Policy
- Cayla Lewis – Chief Resource Officer, Kansas Association for the Medically Underserved
- Wendy Jameson, MPH, MPP – Executive Director, California Health Care Safety Net Institute
- Nermeen Iskander, MS – Program Associate, California Health Care Safety Net Institute
- Robert Pugh, MPH – Executive Director, Mississippi Primary Care Association
- Rich Bettini, MPH, MA – Chief Executive Officer, Waianae Coast Comprehensive Health Center (Hawaii)
- Robert Moon, MD – Chief Medical Officer and Deputy Commissioner Health Systems, Alabama Medicaid Agency
- Ross Owen – Product Manager, Hennepin Health (Hennepin County, Minnesota)
- Scott Leitz, MPA – Assistant Commissioner of Health Care, Minnesota Department of Human Services
- Aurelia Chaudhury – Program Manager, Massachusetts Executive Office of Health & Human Services

Informal Interviews

- Joseph Thompson, MD, MPH – Arkansas Surgeon General, Arkansas Department of Health
- Pamela Parker – Manager of Special Needs Purchasing, Minnesota Department of Human Services
- MaryAnne Lindeblad – Assistant Secretary for the Aging and Disability Services Administration, Washington State Department of Social & Health Services
- Jeanene Smith, MD, MPH – Administrator, Office for Oregon Health Policy and Research (OHPR)
- Douglas Thompson, MPP – Chief Administrative Officer of Accountable Care Organization (ACO) Development, Cambridge Health Alliance
- Evan Benjamin, MD – Senior Vice President for Healthcare Quality, Baystate Health