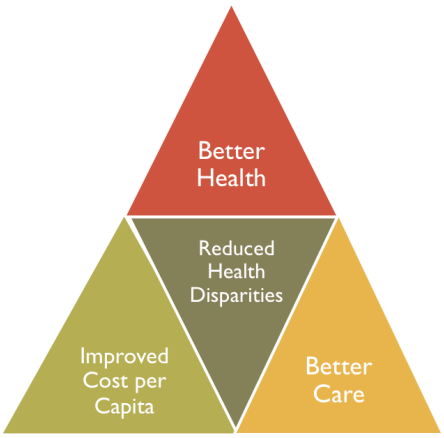
Payment Reform to Support Delivery System Transformation in California Clinics & Community Health Centers

Payment reform is a critical aspect of catalyzing and sustaining a transformed delivery system. Such a system has the potential to realize the Triple Aim[1] goals of better health, better care, and improved per capita costs across all populations.The field of payment reform and delivery system transformation in the safety-net is evolving rapidly as health centers, health system stakeholders, researchers, and policymakers design, pilot, and implement new payment systems and innovative care models.



The Triple Aim

Federally Qualified Health Centers (FQHCs) receive the bulk of their payments based on the volume of face-to-face encounters through the prospective payment system (PPS). FQHCs can also implement innovative payment models within an Alternative Payment Methodology[2] or as a supplement to PPS payments.

Changing the way payments are made to providers can come in the form of incentives and disincentives, and can provide flexibility for innovation in health care delivery and ensure stable revenue for safety-net providers during transformation.

In this dynamic environment of reform, JSI has collaborated with the California Primary Care Association (CPCA)—which represents more than 900 member clinics and community health centers (CCHCs) —to advance payment reform and delivery system transformation at the state and local levels. Over five interrelated projects, JSI has worked in collaboration with CPCA to research, identify, and advance alternative payment models to promote delivery system transformation to achieve Triple Aim goals. The following table highlights key activities and results of these efforts.

Key Reports	Key Activities
· *Building a Foundation for Payment Reform for Community Health Centers in California (January 2012)* · *Update on Payment Reform Trends: Implications for California Community Health Centers (January 2013)* · *Position Paper Regarding a State Option to Provide Chronic Care Health Home in California (December 2011)* · *Value of Community Health Centers Study: Partnership HealthPlan of California Case Study (January 2013)*	· Literature and policy review · Interviews with Medicaid and private sector leaders in 13 states regarding emerging trends and innovative efforts · Interviews with national thought leaders on payment reform/delivery system transformation · Interviews with California Clinics and Community Health Centers (CCHC) leaders · 30+ presentations on payment reform across the state · Workgroup facilitation to pilot payment reforms · Quantitative claims analysis of total cost of care and total health system utilization of FQHC patients vs. non-FQHC patients in a managed care Medi-Cal population

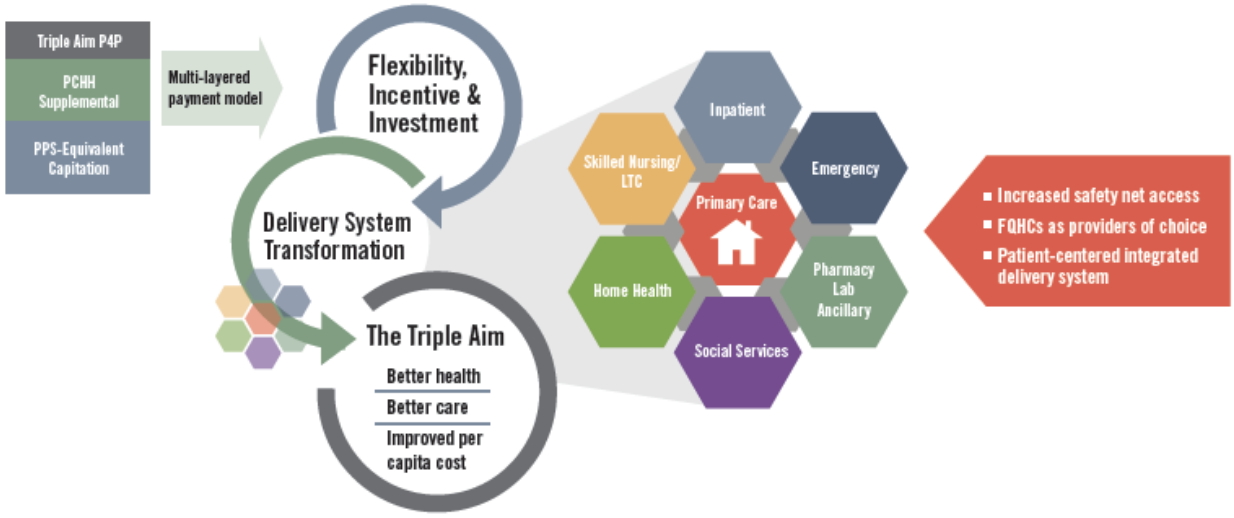
Key Strategies for Health Center Leaders

JSI has developed a set of key messages for health centers as they work toward a transformed health care system in which payment is increasingly tied to value, rather than volume, of services.

California CCHCs have begun to embrace a phased and multi-faceted comprehensive payment reform strategy to allow primary care to become part of a larger, more coordinated and integrated delivery system that will reduce spending and improve access, patient experience, and population health outcomes. The strategy, which is based on national research and tailored to California's environment, could be applied to a variety of Community Health Centers.

Rather than adopting a single alternative payment method, **JSI and CPCA's work has identified how combining discrete payment reform components can give health centers the necessary flexibility, investment, and aligned incentives to achieve Triple Aim goals.**

Figure 1. Payment Reform and Delivery System Transformation



A key notion emerging from JSI's research on payment reform is that a robust patient-centered health home[3] (PCHH) can serve as the fulcrum of a more **integrated and coordinated delivery system** and can drive **reduced inpatient utilization and system-wide savings.** Building on this notion, the key components of CPCA's payment reform strategy include:

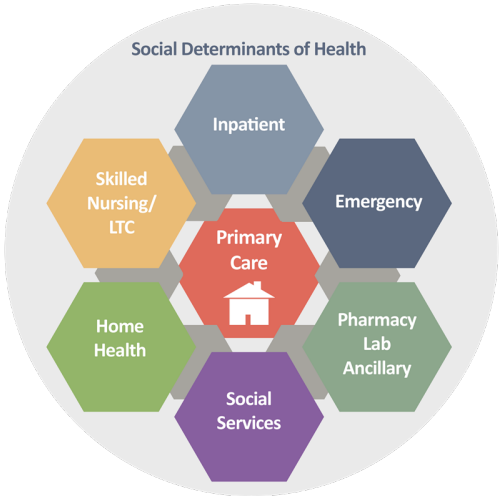
1. A **more flexible primary care base payment** that allows non-face-to-face care and care with non-billable providers can help CCHCs pursue cost-effective and high-quality care that is not incentivized in the current volume-based PPS payment system. Following Oregon's lead, CPCA has advanced a pilot for a PPS-equivalent capitated base payment for FQHCs that maintains revenue levels per capita and provides more flexibility in how dollars can be spent on patient-centered care. This **PPS-equivalent capitation will allow health centers to move away from purely volume-based care.**

2. Investing in PCHH, with **particular emphasis on high-cost and high-risk care and case management and coordination, offers the opportunity to drive down costs in the total health system and improve patient care**. PCHH supplemental payments are made on top of the base payment (PPS or PPS-equivalent capitation), and are usually paid on a per-member-per-month (PMPM) basis. Cost savings achieved through reduced inpatient utilization associated with PCHH services can sustain those services. Financing for PCHH supplemental payments can come from various sources:

    - More than 25 state Medicaid programs are investing in PCMH/PCHH in some way
    - 12 states to date have received Section 2703 federal funding to support care for Medicaid and dual-eligible individuals (Medicare/Medicaid) with chronic conditions and/or serious and persistent mental illness. A PCHH focused on a more coordinated and integrated delivery system for the highest-risk and highest-cost individuals is viewed as a key strategy for generating near-term cost savings in the health system and for transforming care delivery for complex populations such as dual eligibles.

3. **Pay-for-performance based on achieving better outcomes, better care, and reduced per capita cost aligns financial incentives with Triple Aim goals**. Triple Aim pay-for-performance expands quality-based pay-for-performance and broadly includes shared savings models being used in accountable care organizations and value-based payments to health centers by health plans. For many health centers, **gaining access to total health system utilization data in addition to quality and patient experience data is a first critical step in assuming accountability—and eventually increased payment—for meeting Triple Aim goals**.

4. In a growing national effort to account for **social determinants of health** in payment systems of the future, health centers recognize the importance of collecting data on transportation needs, housing, poverty, and literacy, as well as providing services to support these needs.



Opportunities for Health Centers

Health Centers are at a critical juncture with respect to payment reform. To optimize opportunities under payment reform, health centers can:

1) Become familiar with payment reform concepts in order to shape payment reform efforts and be protected from having terms of participation being dictated by other entities.

2) Build capacity to negotiate terms of contracts with payers.
3) Maintain focus on delivery system transformation as a primary goal of payment reform.
4) Use total health system data to prospectively manage the health of populations and retrospectively assess performance, with a focus on outcomes that primary care can influence.
5) Advance the case for accounting for social determinants of health by measuring common socio-economic issues that ultimately affect the health of CCHC patient populations.

California's Progress to Date

Based on JSI's research and ongoing consulting support, CPCA has helped workgroups to:

1) Develop a PPS-equivalent capitation model meeting APM requirements.
2) Promote a state initiative to pursue 2703 PCHH supplemental payments through stakeholder input for a State Innovations Model.
3) Pursue CMMI grant funding to pilot comprehensive FQHC payment reform and delivery system transformation in California.
4) Engage partner health plans and data analysis entities to look at Triple Aim measures in a standardized way.

JSI's work has allowed California's CCHCs to consider their role in payment reform and in transforming the larger delivery system in a rapidly changing environment. Building on the groundswell of interest in payment reform and delivery system transformation, CCHCs will need to collaborate with health plans, state governments, CMS, and other providers to find new ways to pay for health services in a manner that provides increased flexibility in delivering care to a growing Medicaid population; invests in increased care coordination and integration of services across the system; and rewards providers who achieve Triple Aim goals.

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[1] Institute for Healthcare Improvement. The Triple Aim. www.ihi.org

[2] The Prospective Payment System: 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: 1) 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; 2) 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.

[3] Patient-centered medical home (PCMH) is a term first developed over 50 years ago in the pediatrics community. CPCA has embraced the term patient-centered health home (PCHH) as the comprehensive set of whole-person-centered services and supports to promote, improve and maintain a person's health. CPCA supports emphasis on the importance of health –rather than medicine --as the ultimate goal of a transformed delivery system and a view of health services as a broader collection of services than traditional medical services. This definition is congruent with the definition of PCHH put forward in the Affordable Care Act's Section 2703 even though Section 2703 sets parameters for the target population as limited to Medicaid and dually eligible individuals having one chronic condition and at risk for a second; two or more chronic conditions; or a serious and persistent mental illness.

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