Building the Foundation for Payment Reform for Community Health Centers in California

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Introduction

Health centers, payers and policy makers agree that the delivery system requires fundamental change. Policymakers and payers, including Medi-Cal, have decried the unsustainable escalation of healthcare costs and the payment for volume of services rather than the value of services. Health centers have long advocated for and worked towards improving the health of populations, understanding that the patient experience with the health services they receive is critical to achieving improved health. The Affordable Care Act elevated the Institute for Healthcare Improvement's Triple Aim--to improve patient experience and population health while reducing costs to the overall health system--as the guiding principles for a much-needed delivery system transformation. There is also a growing recognition at the national and state levels that fundamental changes are required in payment systems in order to achieve the Triple Aim. Payment reform is both a prerequisite for and a core element of a transformed delivery system. In effect, if California wants systems to deliver the most cost-effective, high-quality care that engages patients and better integrates and coordinates their care, the payment system must support new ways of delivering care and must reward providers for achieving improved patient care, improved population health, and reduced overall costs.

Inasmuch as health centers receive the bulk of their payments based on the volume of face-to-face encounters through the prospective payment system (PPS), it is critical for health centers to consider how alternative payment models will best support the delivery system transformation that will be required to achieve the Triple Aim goals. These multiple pressures for payment and delivery system reform pose a challenge for the California Primary Care Association (CPCA) and its member clinics and community health centers (CCHCs).

Report Purpose

CPCA contracted with John Snow, Inc. (JSI) to investigate alternative payment models for health centers within the PPS framework or as a viable alternative to PPS. The purpose of this report is to provide California health center leaders with:

- A conceptual framework and vocabulary for payment reform discussions;
- Key findings regarding four payment reform/delivery system transformation models that represent the areas of most activity nationally and in California: pay for performance (P4P), patient-centered medical home (PCMH), accountable care organizations (ACOs), and primary care capitation;
- General principles for CPCA and its members to consider as they evaluate new payment models;
- General recommendations regardless of the payment model pursued; and
- Specific recommendations for next steps CPCA can take to help health centers play an active role in shaping the future of payment reform.

In addition to identifying national trends and best practices related to alternative payment methodologies, we also propose an optimal approach for health centers to achieve the transformation of primary care within a new delivery system and to survive the transition successfully.

Methods

This report is based upon an extensive review of the literature on payment reforms being implemented in both the public and private sectors. Our review includes studies of pay for performance, payment for patient-centered health homes, shared savings arrangements, accountable care organizations, episode-based payments, and capitation. These payment models are examined in both managed care and fee-for-service (FFS) environments. To obtain an understanding of the dynamics of these payment models and emerging trends, we conducted telephone interviews with state officials or representatives of primary care associations in nine states including: Washington, Oregon, Minnesota, Vermont, Massachusetts, Pennsylvania, New York, North Carolina, and Missouri. Interviews with state officials were supplemented by interviews with national experts on payment reform. In addition, we interviewed more than ten representatives of community health centers in California in order to obtain information on existing incentive reimbursement methods being employed in managed care contracts and CCHC leaders' perspectives on alternative payment methodologies that could be implemented along with PPS or in place of the current PPS system.

Background information on PPS/APM

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 created a Medicaid Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs). The Budget Improvement and Protection Act of 2001 established PPS as a per-visit minimum payment for FQHCs based on the average of their 1999 and 2000 costs, inflated by the Medicare Economic Index (MEI). The MEI, typically under 2 percent, has not kept up with health care costs experienced by FQHCs. BIPA also has a provision to adjust FQHC PPS rates based on changes in scope of services and to determine PPS rates for FQHCs established after 1999.

The Bureau of Primary Health Care (BPHC) provides FQHCs with federal grant dollars under Section 330 of the Public Health Service (PHS) Act to subsidize the care that FQHCs provide to patients who cannot pay. PPS is designed to ensure that these Federal Section 330 grant dollars, intended to offset the costs of treating uninsured patients, are not used to subsidize Medicaid reimbursements.

Alternative Payment Methodology

In addition to establishing BIPA PPS as a payment floor, BIPA also permits states to establish an Alternative Payment Methodology (APM) for FQHC services. A state may adopt an APM as long as it does not exceed any applicable upper payment limit provisions, and it meets two key criteria:

1. The APM does not pay less than what the FQHCs would receive under BIPA PPS
2. The FQHCs agree to the APM (if an FQHC does not agree to the APM, the State is obligated to pay the FQHC's PPS rate).

Under an APM, the state must develop a process to provide proof that the payment rate is not below the BIPA PPS for that fiscal year. The state plan needs to provide this assurance, but does not need to describe the actual rate calculation. In most cases, the process is described in state regulations. In 2003, the State of California received federal approval for an alternative payment methodology that bases FQHC payments based on rates for the year 2000 (instead of an average of the 1999 and 2000 rates).(1)

In California and other states, APMs are being viewed as vehicles for payment reform. In the near term and as long as Federal PPS law remains unchanged, any payment reform for health centers in California will need to meet the APM requirements specified by BIPA. In other words, even if health centers are to adopt an APM, the total payments must be at

least equal to what they would receive under PPS. That said, an APM offers the possibility of experimenting with new payment models while still ensuring current revenue levels. Perhaps more importantly, receiving an APM does not necessarily preclude CCHCs from receiving additional payments on top of the APM (or their PPS rate). Examples from other states and in California reveal that CCHCs are receiving supplemental payments for either providing PCMH services or achieving performance on identified metrics without having these payments included in the PPS reconciliation process. Some of these examples will be explored in detail in the *Key Findings on Payment Reform and Delivery System Transformation* section of this report.

Payment Reform Goals and the Role of Health Centers

The goals of payment reform extend beyond short-term reductions in health expenditures by large payers. As shown in Figure 1, the Triple Aim seeks to obtain simultaneous improvements in population health and the patient experience (quality and access to care) along with reductions in costs. The goals of the Triple Aim are not independent and should be conceived as part of a comprehensive strategy for health systems transformation. According to Berwick and the Institute for Healthcare Improvement (IHI), the implementation of the Triple Aim requires the services of an "integrator" that will assume responsibility for all three components of the Triple Aim for a specified population. One of the key tasks of the

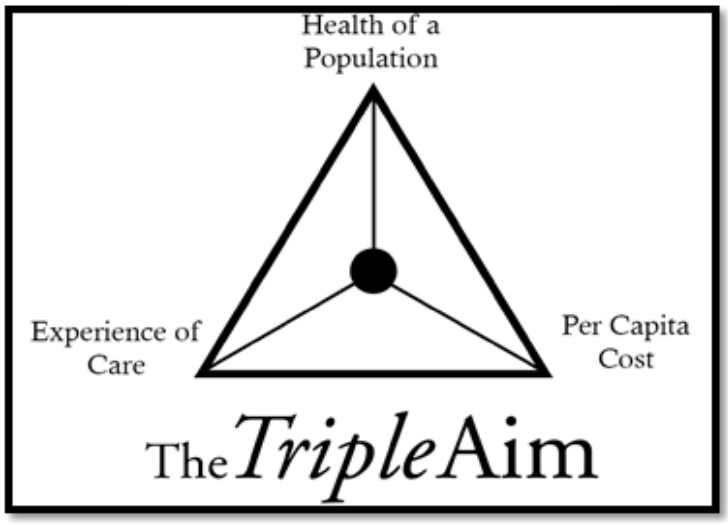


Figure 1. The Triple Aim

integrators is to strengthen and redesign primary care services and structures. Primary care redesign involves establishing long-term relationships between patients and their primary care team, developing shared care plans, coordinating care across providers and settings, and using new forms of communication. (2) In many respects, CCHCs are well-suited to serve in the role of integrators. As part of this role, CCHCs will need to articulate to other health system entities and policymakers how payment reforms can both bolster and sustain a primary care fulcrum of a health system with high-quality outcomes and reduced overall health system costs.

A Conceptual Framework of Payment Reform

The major payment alternatives to the fee-for-service (FFS) system are incentive-based payment systems and capitation. These payment models can either be combined with or layered on top of fee-for-service payment models or can replace FFS models altogether.

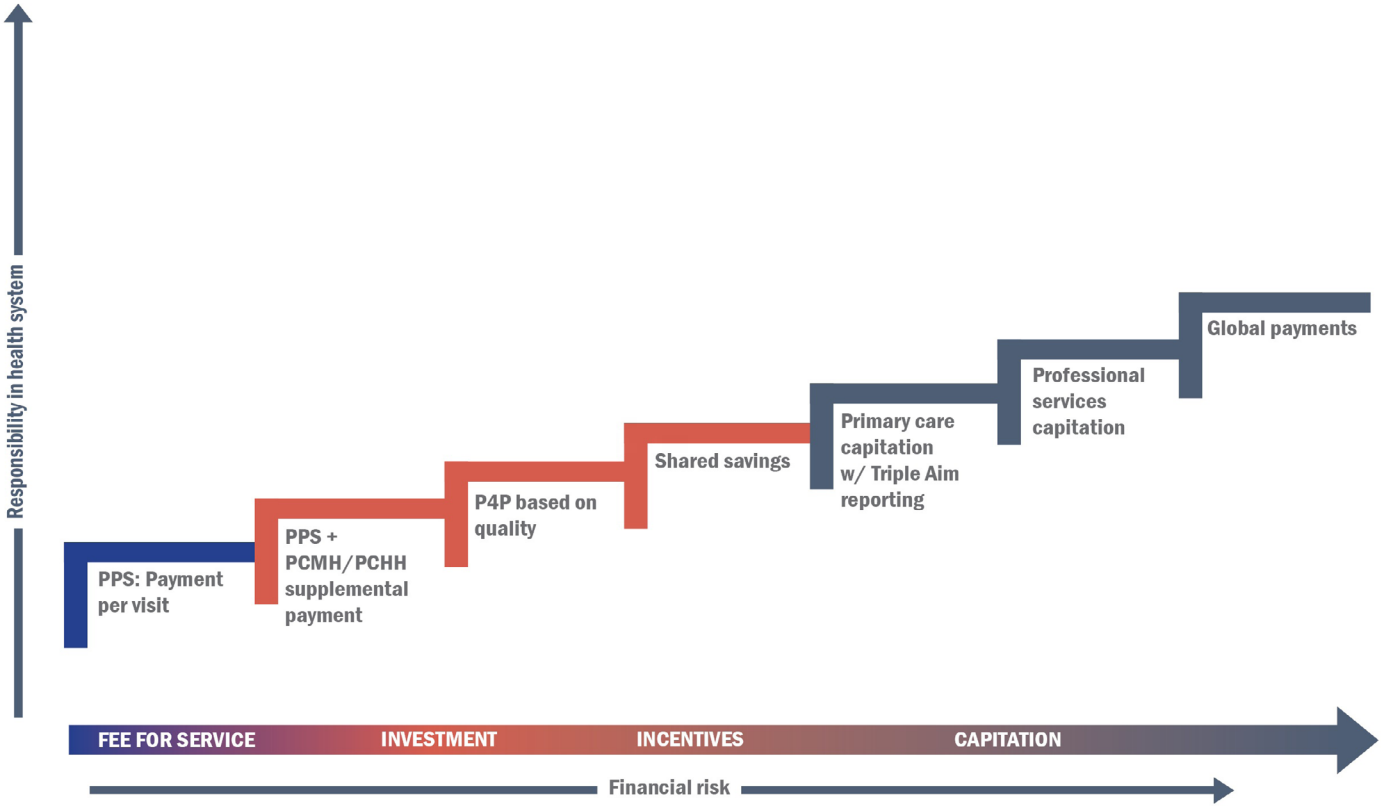


Figure 2. A Continuum of Payment Reform

In Figure 2, models of payment reform are depicted as a continuum ranging from fee-for-service, where individual services are reimbursed on a per-unit volume basis, to global payment, where one single payment is made to a health system on behalf of a beneficiary. Each step in the continuum involves increasing emphasis on payment for value compared to payment for volume. Additionally, as one moves up each stair step of the continuum, providers move from bearing no risk in fee-for-service, to upside risk only with incentive models, to assuming increasing amounts of upside and downside risk in the capitation models.

Fee for Service/PPS

Fee for service (FFS) is depicted as the lowest step in the continuum of payment methodologies. Providers are paid established rates for rendering, for the most part, face-to-face health consultations and procedures for patients. This payment methodology has formed the basis of how Medicare, Medicaid, and commercial health plans have historically paid most primary care and specialty care providers. The financial incentive under this system is for providers to see more patient volume and to do more highly reimbursed procedures. There is no incentive to use high-value approaches or deliver on desired outcomes. While PPS is actually a bundled payment for a host of clinical and enabling services, because health centers are paid on per-face-to-face visit with a provider, we place PPS in this step of the continuum.

"Fee for Service Plus" or "PPS Plus" with PCMH/PCHH Supplemental Payment

"Fee for service plus" or "PPS plus" encapsulates the first generation of incentive programs that are layered on top of the traditional FFS or the PPS payment methodologies. Under PPS Plus, payers pay CCHCs an additional per-member-per-month (PMPM) for case management and care coordination associated with being a patient-centered medical home (PCMH) or patient-centered health home (PCHH). As of 2012, over half of states (30) had implemented PCMH initiatives for the general Medicaid population. FQHCs were largely receiving supplemental PMPM payments for PCMH recognition or components of PCMH (e.g., case management, care coordination) on top of PPS rates. 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. PPS Plus can also take the form of payment for discrete processes that a payer wants to incentivize (e.g., $10 extra for a well-child visit). Detail regarding how incentive models are structured and examples of how various models are currently being used can be found in subsequent sections of this paper.

Pay for Performance based on Quality

Pay for performance represents a step up in the continuum because these methodologies make payments contingent on achieving outcomes. Pay for performance based on quality measures is evolving to include performance payments tied to metrics aligned with the Triple Aim goals of improving health outcomes, patient experience, and total cost per capita. Managed care plans tend to administrate these programs, which can vary widely

across plans. Some plans create composite scores based on performance on multiple metrics within a number of measurement domains. Health plans also vary in the level of transparency of how many at-risk dollars are in a performance-based pool and whether or not the pool is increased if all providers reach performance targets.

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 reduction in total cost of care. Most often, any upfront investments, such as PCMH supplemental payments, are netted out before calculation of savings. Shared savings is an 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.

Primary Care Capitation with Triple Aim Reporting

Primary care capitation is where a provider agrees to a set payment PMPM to provide a defined set of primary care services to an assigned membership population. It is the first step in the continuum where a provider can assume both upside and downside risk. The downside risk is limited by the fact that a provider would only be responsible for the cost of extra primary care services that a beneficiary seeks. In exchange for this risk, a provider also gains flexibility on how to spend the dollars received. The financial incentive is to provide the most cost-effective modes of care. The fear with capitated payment methodologies is that providers will limit access or compromise on quality. However, adding Triple Aim reporting (that includes health outcomes, patient experience, and total cost per capita) to capitation payments can counterbalance the disincentive to maintain high-quality and access. A critical aspect of capitation arrangements is ensuring a patient is "bound," or attributed, to a provider assuming responsibility and payment for that patient's care. Providers can be paid their entire fee under a capitated arrangement or a portion of the fee, which we refer to as partial capitation.

Professional Services Capitation

Professional services capitation is when an organization or group of providers assumes financial risk for all professional costs associated with primary care, ancillary services, and specialty care. In addition to the incentives and benefits of primary care capitation, professional services capitation adds an incentive to establish pre-negotiated rates for ancillary services and specialty networks. It also adds the downside risk of being financially responsible for all professional services an assigned member receives. The use of high-value specialty networks has been identified as a key component of medical homes that have demonstrated high levels of cost savings. (3)

Global Payment

Global payment occurs when an organization or group of providers accepts a single payment per capita for the total health care of a population. Under global capitation, an organization bears significantly more risk than under other capitation arrangements because the organization must assume payment responsibility for inpatient facility costs, which form a much larger proportion of total cost of care than professional costs. Under global payments, an organization assumes both clinical risk for the management of conditions and a certain degree of insurance risk for the occurrence of conditions within a population. To mitigate the substantial downside risk under a global payment arrangement, providers must negotiate some protection from total insurance risk through mechanisms such as risk adjustment of payments, reinsurance, or limits or caps on high-cost cases. A key consideration for health centers is that once an umbrella organization, such as an accountable care organization (ACO) or a managed care organization (MCO), accepts a global payment, there still must be a method to distribute dollars to all providers, including primary care providers, providing services to assigned beneficiaries.

Episode-based or Bundled Payment

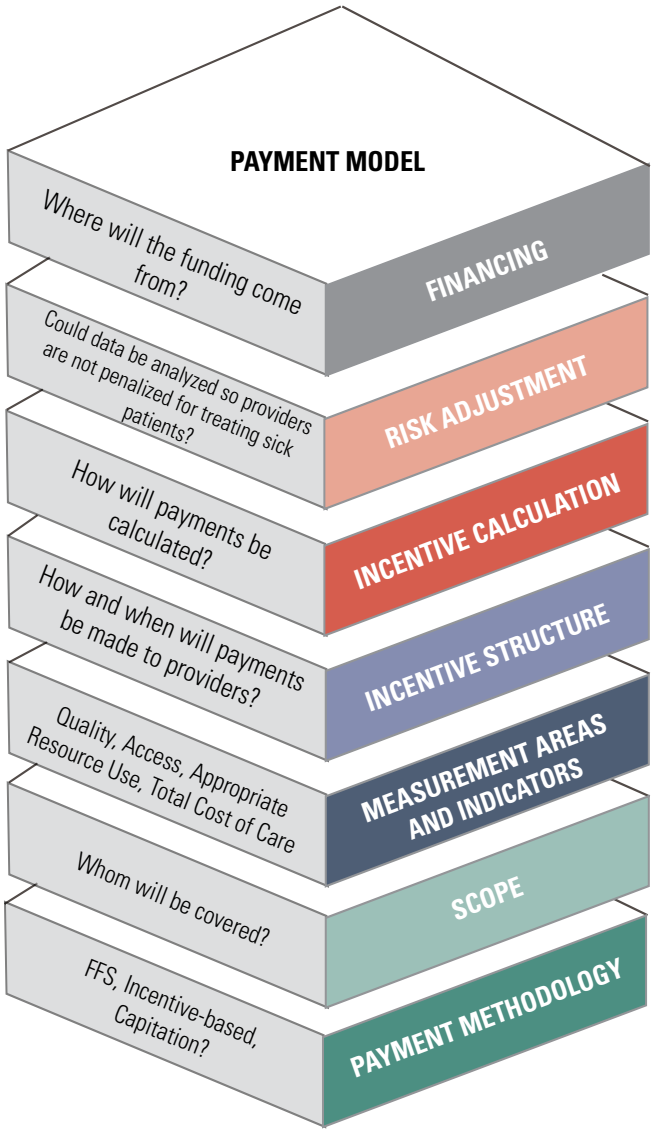
It should be noted that episode-based and bundled payments are also payment models that are being implemented as an alternative to the FFS payment methodology. Episode-based payments and bundled payments have theoretical appeal because they create an incentive to reduce waste and increase efficiency within a discrete episode of care. However, paying for episodes still incentivizes volume of episodes. Episode-based payments are being tested mostly for acute conditions in the hospital setting (e.g., total hip or knee replacement or colonoscopy) where the episode-based payment encourages providers to provide the service in the lowest cost setting and to prevent complications. Central challenges with episode-based payments include attribution of the episode to a dominant provider and how each

individual provider will be paid for his/her portion of the episode of care. Most health center primary care visits address overlapping "episodes" since few patients have only a single, isolated health condition. For the most part, primary care-based systems and health centers are not considering episode-based payment methodologies because of the acknowledged complexity of administrating them in primary care.

Payment Model Elements

Developing a novel payment model requires making a series of decisions regarding the model elements. Model elements refer to the building blocks of any payment model. With each building block, there are different choices that one can make, thus allowing for many different payment model permutations. Figure 3 shows the core building blocks of any payment model and the major associated questions stakeholders must answer in building a payment model.

Figure 3. Building a Payment Model



Payment Methodology

The first question to answer in adopting an alternate payment method is which methodology to use. The previous section describes candidate payment methodologies ranging from FFS to incentive-based payment to various forms of capitation. It should be noted that one or more payment methodologies can be employed simultaneously. A common example of this is layering an incentive payment on top of FFS payments or capitated payments.

Scope

Scope refers to which populations are covered by a given payment model. While many health plan payment methodologies have a broad scope (e.g., the entire beneficiary population), there are

numerous examples of payment programs being targeted at specific sub-populations. For example, Section 2703 of the Affordable Care Act allows states the option of receiving an enhanced federal match for health home services provided to Medicaid and dual-eligible enrollees with chronic conditions.

One consideration regarding limiting the scope of a payment method is that calculating evaluation metrics for sub-populations can be an administrative burden. Health centers already track and report on a large number of quality, service, and access measures, but these metrics are reported for their entire patient populations. Even if the same metrics are used, developing reports for sub-populations can become onerous. For example, the state option to provide chronic care health home services requires tracking quality metrics for patients with two or more chronic conditions or one chronic condition and a risk for a second, but most systems do not track only this targeted population separately.

Incentive Structure

Incentive structure refers to how payments are made to a provider. Three distinct options are as follows, with the latter two incentive structures employed most frequently in California and other states:

- An upfront lump sum or withhold
- An ongoing per-member-per-month payment (PMPM)
- Retrospective payment based on performance

A lump-sum incentive paid upfront has the benefit of providing necessary funds to finance delivery system transformation. The advantage of these payments is they are negotiated once, and there is no ongoing need for data analysis. In private sector risk-bearing arrangements, some providers have agreed to have a portion of a capitated payment withheld in order to have the opportunity to earn back the withhold plus an additional upside for meeting defined targets.(4)

The main advantage of an incentive PMPM payment is that it can be negotiated in advance and can even out cash flow for a provider. These payments are often supplemental to a provider's current payment system, whether that is a capitation rate, FFS payments, or PPS payments. Even though it is theoretically possible for a PMPM payment to vary based on performance, we did not see this mechanism utilized by states or health plans.

Retrospective payment based on performance is most commonly used in incentive-based

models. Retrospective payment can be simple or can depend on more sophisticated data analysis. Examples of simple retrospective payments include flat supplemental payments to providers for completing discrete activities such as screenings, advance care planning forms, or well-child visits. More complex retrospective payments involve computing composite scores made up of performance on multiple indicators and rewarding providers incrementally for overall performance in domains such as appropriate use of resources, use of health information technology, access, and member satisfaction.

Measurement Areas and Indicators

Measurement areas refer to the general domains of the healthcare delivery system to which payment will be tied. Indicators help to refine which specific measures within each domain will be reported and rewarded if defined outcomes or targets are met. Engaging provider and payer stakeholders in the selection of measurement areas and indicators is critical in order to achieve provider buy-in on what is most important to measure and to balance the desire for information with the cost of reporting.

Quality + Efficiency = Value

While quality measurement dominated the healthcare discourse for years, the area of cost efficiency, or value, has attracted increased attention in recent years as payers have demanded more accountability from providers on appropriate use of resources while maintaining quality. Value measurement has focused on metrics such as emergency room utilization, hospital admissions and readmissions, and generic drug use. Increasingly, total cost of care is being used as an efficiency measure (see IHA Case Study). While payers have traditionally been most interested in the realm of efficiency, as healthcare costs continue to skyrocket, and the notion of shared savings has developed, more stakeholders are becoming acutely aware of the need to understand the total health system costs per person. Some health centers are already engaging with health plans or independent practice associations (IPAs) to receive a reward if goals around total cost of care are met.(5)

Patient Experience and Access

Patient Experience and Access constitute two other realms of measurement that are often grouped together. Patient experience is increasingly being recognized as an important metric by providers and health plans as they look ahead to health reform bringing 2-3 million new beneficiaries into Medi-Cal and health insurance exchanges, allowing additional previously uninsured individuals to be covered. Health centers are already beginning to recognize the importance of being “the provider of choice” within a more competitive market and are

investing in improving patient experience as one way to achieve that end. Access can be measured in terms of availability of appointments or after-hours care, patient satisfaction with his/her appointment time, or having a provider who speaks the same first language as the patient.

Medical Home

Even though medical home is a delivery system model that encapsulates a simultaneous focus on clinical quality, patient experience, access to care and cost containment, recognition for medical home emerged as a measurement area that health plans are beginning to pay for and/or providers are beginning to seek. As part of pilot projects or well-established programs, the National Association of State Health Policy (NASHP) reported in December 2011 that 41 states are experimenting with medical home to some degree. (6)

Incentive Calculation

Incentive calculation refers to how a provider's performance is judged, including to which standards the performance is compared, how targets are set, and how large the payment is. Performance can be judged relative to:

- A provider's own previous performance
- A control group
- Regional or national benchmarks

Based on our review of current practices, it emerged that a hybrid method that rewards both improvement and performance relative to a national or regional benchmark is optimal. While creating incentive for an absolute high-level of performance is the ultimate goal, paying for improvement is important for helping to bolster lower performers showing promise, to mitigate the disincentive for providers to treat the sickest patient populations, and to prevent further exacerbating disparities in health resources.

Setting targets is a second important aspect of payment incentive calculation. There are three predominant mechanisms that incentive programs use for setting goals or targets:

- Payment for reaching a single target
- Incremental payments for tiered targets
- Payment based on a Composite Score of multiple measures

Health center leaders in California report liking the clarity associated with payment for meeting a single target, and health plans use this technique for motivating providers to help

meet a health plan objective. (7) Incremental payment for tiered targets is more complex to explain and administer, but can maintain the power of the incentive for providers across the performance spectrum. Health plans are offering stratified incentive plans to CCHCs, whose leaders can then decide what specific target within the stratified incentives they can realistically meet in a given year. (8) A composite score made up of multiple measures, often with tiered performance on each measure, places importance on the many different measurement areas that are important to overall delivery system performance. This method of target-setting is also the most complex to administer and explain, yet was the approach of the most sophisticated and high-paying performance programs in which CCHCs were participating with their health plans. (9)

Financing

Financing pertains to where the funds for a given payment program will come from. There are three general ways a payment method can be financed:

1) Infusion of new dollars was the most common financing method we encountered in pay-for-performance incentive programs and medical home programs in other states and in California. The most prominent challenge regarding the use of new dollars as financing for payment reform is convincing payers to increase spending in an era of extremely tight budgets, even when it is widely acknowledged that the delivery system transformation is a worthwhile investment.

2) Reallocation of existing dollars is another mechanism for financing a payment model. For example, Oregon is proposing an APM where PPS dollars would be paid as a capitation payment rather than a per-visit payment (See Oregon Case Study).

3) Shared savings is increasingly being hailed as a way to finance new payment models. The essential idea behind shared savings is that through increases in the efficiency of the delivery system, the actual costs of care will be less than a projected amount. The difference between the actual spending and the projected spending is considered savings to the system that can be split between providers and payers. While the idea of shared savings is appealing to policymakers and many providers alike, there are numerous decisions, and associated negotiations, regarding how savings are calculated and distributed. One decision is whether total cost of care, costs associated with selected measures, or most costs with some exclusions (e.g., extremely high-cost cases) will be used for the comparison of actual costs to projected costs. A second decision is whether the projected cost will be based on

past utilization and cost trended forward at some agreed upon rate of increase or whether the projected amount is based on the costs of a control population of patients. A final challenge is who will compute and administer the savings, which is especially problematic when a CCHC does not have trust in a health plan or the State's ability to reliably calculate accurate metrics with current data and data systems.

Risk Adjustment

Risk adjustment is an analytical manipulation of data to allow a fair comparison of costs of populations that have underlying differences in acuity. Risk adjustment is also being used by at least 19 states to estimate health care expenses based on the disease conditions of a patient population and to distribute capitation payments across plans based on the health risk of the members. (10) The reason for doing risk adjustment within a payment model is to maintain an incentive for providers to treat sick people rather than fearing that taking on complicated patients will compromise their ability to earn incentive payments. There are a number of methodologies available that rely on diagnosis data, pharmacy data or both as a proxy for illness burden, including MedicaidRx, the Chronic Illness Disability Payment System (CDPS), and Adjusted Cost Groups (ACGs). (11) (12) Risk adjustment is a complex, data-intensive process that depends on the underlying quality and completeness of the data. It has also been noted that no risk-adjustment methodology is perfect (13) and finding one that seems fair and comprehensible to all stakeholders can be a formidable challenge.

Key Findings on Payment Reform and Delivery System Transformation

As described in earlier discussion of the Triple Aim, delivery system transformation and payment reform are inextricably linked and must be mutually reinforcing. In this section, four payment reform models are presented that health centers might consider individually or combine to promote delivery system transformation. The models selected are based on the areas of major activity across the nation, their applicability to California's health centers, and each includes examples from states that have successfully employed them. Based on our research and interviews, we synthesized the overarching findings around each of these models: pay for performance, patient-centered medical home, accountable care organizations, and primary care capitation.

The use of these payment and delivery models has been largely driven by Medicaid and other state officials. As such, FQHCs may not always play a strong role. Where applicable, we give examples of FQHC involvement and leadership.

> *"To drive major improvements, performance-based payments must exceed 10% of total provider income. Incentives of this magnitude can only be mobilized if they originate in payer savings."*
>
> -Arnold Milstein, MD, MPH,
> Director of Stanford Clinical Excellence Research Program

Pay for Performance (P4P)

The most widely used incentive reimbursement method among state Medicaid programs is pay for performance layered on top of a FFS payment arrangement. (14) In pay-for-performance (P4P) systems, individual providers or provider groups are paid for meeting targets on defined metrics over a specified time period. The most common approach to P4P is to pay providers a bonus payment for meeting quality metrics or thresholds. Another P4P approach employs withholding payment to discourage adverse events or practices, such as non-payment for preventable adverse events (sometimes known as "never events"). (15) Although early P4P programs have largely used quality metrics, they have begun to incorporate measures of cost efficiency, such as generic drug use and emergency

department utilization. Several limitations of existing of P4P programs have been widely discussed including, among others, inaccurate quality metrics, incentive payments that are too low to change provider behavior, and insufficient return on investment for payers. (16)

History and Current P4P Activities

P4P has been widely implemented by state Medicaid programs, as well as by private payers. A recent survey of state Medicaid agencies by the Kaiser Foundation and Health Management Associates reported that at least 19 states with MCOs were using P4P to improve quality or value. (17) States reported using both bonuses and withholds to reward performance among MCOs.

Although there is strong support for rewarding providers based upon their performance, the evaluation results from these programs have been mixed. There are, however, several examples of successful P4P programs among both public and private payers. Prominent examples from state Medicaid programs and one preeminent example from the commercial sector (See IHA Case Study) are detailed below.

Oklahoma SoonerCare Choice Enhanced Primary Care Case Management

In transforming its Medicaid SoonerCare Choice primary care case management program to a medical home program, Oklahoma incorporated performance-based bonus payments for some preventive services, HEDIS quality measures, and performance on the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). (18) The state makes incentive payments through the SoonerExcel program based on the following measures: the 4th DTaP (diphtheria, tetanus, and pertussis) vaccine, breast cancer screening, cervical cancer screening, emergency department utilization, EPSDT (pediatric preventive) services, generic drug prescription rate, and making visits to inpatients. (19) Providers can receive a lump-sum payment of approximately $2800 per year for meeting performance benchmarks based on quality. Since the program's start in 1997, EPSDT rates have increased over 20%.

CareOregon: Aligning Payment with the Triple Aim

CareOregon, the largest Medicaid MCO in the state of Oregon, has recently established an incentive reimbursement system to align metrics with the Triple Aim goals. Additional payments are made to health centers and other Medicaid providers based on three separate tiers. Payments are grouped into three tiers: 1) payment for capacity, 2) payment for improvement, and 3) payment for outcomes. Tier 1 provides practices with incentives to participate in its medical home initiative and primary care practice learning collaboratives,

and to focus on population health management. In Tier 2, the plan rewards practices for specific improvements related to preventive care, diabetes, hypertension, and continuity of care. Tier 3 rewards providers who meet 90 percent of the metrics in Tier Two as well as those who reduce ED visits and ambulatory-sensitive conditions. Early results of the CareOregon program indicate savings of $400 per member per month as well as improvements in patients' experience of care and quality of life. Other safety-net health plans are adopting similar P4P systems to implement Triple Aim goals. (20)

Emerging Trends in P4P

To address the limitations of existing P4P programs, states and private payers are redesigning their programs in order to enhance their effectiveness. This is done by increasing the level of bonus payments (where possible) to have a stronger effects on provider behavior, and by targeting programs to clinical areas and services where there exists potential to generate a high return of investment (ROI).

The most important new trend in P4P is setting performance targets based upon value. Consistent with the Triple Aim, this means setting targets to reduce the use of costly services that are of marginal clinical value, to prevent the need for high-cost inpatient care through a more robust primary care system, and to better coordinate transitions between care settings. Private and many public payers are coalescing around improving performance around a limited set of common measures, including:

- avoidable hospital readmissions
- hospital utilization
- outpatient surgery utilization
- emergency department visits
- generic prescribing, and
- medication compliance

P4P programs successfully implemented around these measures hold the promise of generating substantial cost savings while improving quality. Payers can provide incentives to providers through shared savings approaches where providers receive a significant share of the avoided costs. For example, in some regions of the Pennsylvania Chronic Care Initiative, providers can receive up to 40-50% of shared savings as a value reimbursement payment if cost savings are realized. (21) Rewarding these limited high-value targets can help CCHCs to prioritize improvement efforts and can give primary care providers a financial impetus to focus on improving care transitions, as most of these measures are based upon hospital utilization.

Case Study: California and The Integrated Healthcare Association (IHA)

The Integrated Healthcare Association (IHA) has been a pioneer in the use of P4P for quality and is leading the national effort to move toward value-based purchasing. Its member organizations represent 90% of the commercial HMO population in California, with eight participating health plans that cover 10 million beneficiaries. For over ten years, IHA has brought together a multi-stakeholder group composed of representatives of large medical groups, hospital systems, and health plans committed to improving value in the health care system.

Originally, IHA focused on quality measures, including preventive screening, childhood immunizations, and patient experience indicators. However, health providers expressed concern that bonuses for achievements were too small to have the desired effect on quality of care. (63) Insurers were not willing to put up additional incentive funds without clear indication of a return on their investment. As a result, the IHA worked to develop more efficiency/value measures that would both generate funding for larger provider bonuses and reduce costs.

The IHA serves several key functions in value-based purchasing. It brings together a broad stakeholder group to agree on a common set of value measures and then works to develop operational definitions for each of these measures. It acts as data repository that collects information on these quality and value measures. This data repository function is particularly valuable to primary care health provider groups, as they usually lack information on hospital utilization and total cost of care. Health plans pay IHA a fee for producing performance reports and benchmarks, and health plans make their own decisions regarding how payments to providers are made. As part of its recent value-based purchasing initiative, the IHA has identified six appropriate resource use measures: 1) inpatient readmissions within 30 days, 2) inpatient utilization—acute care discharges, 3) inpatient utilization—bed days, 4) outpatient surgeries utilization—% done in an ambulatory surgery center, 5) emergency department visits, and 6) generic prescribing. The priorities of this unified measure set are aligned with the national movement towards payment reform, and will aid stakeholders in creation of ACOs. This data could also potentially be of great use in health providers' rate negotiations with health plans.

Over the next five years, the IHA plans to transition to a Value-Based P4P program that encompasses both cost and quality. As part of its transition to Value-Based P4P and in order to address concerns related to affordability, the IHA is placing increasing emphasis on reducing the total cost of care (TCC) in addition to improving quality. (61) Using cost data, providers will be rewarded based on two cost metrics: the risk-adjusted TCC per member per year by contracted health plan, and a risk-adjusted TCC per member per year across all contracted plans. These TCC metrics will be used to determine a base incentive payment for participants, which will then be adjusted according to participants' performance on quality metrics.

The IHA's movement towards value-based P4P is part of the national movement towards value-based purchasing in both the public and private sectors. Speaking on IHA's value-based program funded by the Robert Wood Johnson Foundation to look at total health care costs, IHA's director commented, "This effort will merge both quality and cost measures to create a more comprehensive view of performance" that will "benefit consumers and reward high-performing providers." (62)

An emerging trend in P4P is to create incentives for health providers to reduce their patients' total costs of care, including costs of inpatient, primary care, specialty, and ancillary services. The Integrated Healthcare Association has been a pioneer in pursuing such value-based P4P on a large scale (see IHA Case Study). Rather than focusing on specific high-value targets, providers are rewarded for contributing to reductions in the total cost of care. Some health centers are beginning to work with their health plans to acquire and understand total cost of care data, bringing to the forefront the need for collaborative working relationships around data accuracy and data sharing that health centers must have with both health plans and the state. (9)

P4P Activity in California Health Centers

CCHCs in California have a long history of participating in P4P programs. A prominent example was the Local Initiative Rewarding Results (LIRR) Collaborative demonstrations to develop an incentive program to be implemented within the Medi-Cal and the state's Healthy Families program. (22) Although the results of the demonstration were mixed, these safety-net health plans were the first to implement widespread incentive payment structures exclusively for the Medi-Cal program.

All of the California FQHC leaders we interviewed were already engaged in P4P initiatives with their health plans. Across the state, health centers participate in a wide range of P4P programs ranging from receiving incentive payments for simple actions (e.g., conducting a cervical cancer screening), to performing on a complex composite set of measures. Some health centers in two-plan counties or geographic managed care counties are participating in multiple P4P programs. For example, the Council of Community Clinics in San Diego manages reporting to at least five different health plans or IPAs on behalf of health centers. Of a list of 22 metrics tracked for these P4P programs, only two measures were exactly the same. (23)

P4P programs vary significantly across California health centers, with some programs starting with a payment for processes while others are being rewarded for performance on efficiency and quality outcomes. For instance, San Francisco Community Clinic Consortium has worked with the San Francisco Health Plan (the local initiative) on a Practice Improvement Program where clinics earn points for satisfying defined goals in the areas of systems improvement, data quality, clinical quality and patient experience. Some of the targets include frequency of encounter submissions, attending patient experience training and quality improvement (QI) training programs, and submission of QI and patient experience project plans. (24)

In some instances, health centers stand to receive a substantial reward for participating in P4P programs if they reach benchmarks. For example, one FQHC reported being able to receive a sizable proportion of their cap rate through the P4P program offered by their health plan by achieving a certain composite score derived from performance on quality, access, appropriate resource use and use of health IT indicators. This same FQHC network, in close collaboration with their health plan, was also interested in exploring total cost of care. Incentive payments under managed care contracts have significant financial advantages for FQHCs since the FQHCs receive incentive payments on top of their PPS rates.

Key Findings on Pay-for-Performance

Pay for performance (P4P) systems have long been employed to achieve quality improvements, and are now being used to affect health care costs, particularly the total cost of care. As a result, P4P is gaining new life because of the focus on value and is being viewed as a stepping stone for increasing health centers' and other providers' accountability. The following are our general findings related to P4P:

- Pay-for-performance is being reinvented around improving the value and cost-efficiency of care. Medicaid agencies and other major payers are placing increasing emphasis on measuring total cost of care and other high-cost measures, such as hospital readmissions.
- P4P is being combined with shared savings approaches to give health centers and other providers incentives to enhance performance on high-value metrics. By participating in this new generation of P4P programs focused on value, health centers can demonstrate their commitment to quality, efficiency and cost performance.
- Health centers could benefit from common value metrics and access to a data repository, which could reduce the administrative burden due to lack of standardization of metrics across plans, and could enhance the information available for negotiating with health plans.
- P4P based on value is an essential building block to layer on top of other payment models because it establishes a clear link between payment and value of services, including both quality and cost reduction.

Patient-Centered Medical Home

"The patient-centered medical home (PCMH) is an enhanced model of primary care in which care teams, led by a primary care provider, attend to the multifaceted needs of patients and provide whole-person, comprehensive, coordinated, and patient-centered care." (21) Utilizing the medical home model is endorsed as a way to achieve the goals of the Triple Aim. Because of the growing emphasis in health policy on health system improvements, states are using financial incentives to encourage the development and spread of medical homes. Many states are seeking to make medical homes available to all or large segments of their Medicaid populations. The patient-centered medical home is being widely supported because of its advantages described in the literature, including reduced per capita costs, improved quality of care and patient satisfaction, and reduced health disparities. (26) Medical home demonstrations and evaluations have shown promising results in terms of improving quality and reducing costs, including reducing emergency department visits and inpatient utilization. (21) Because of PCMH's focus on care teams, another impetus for the creation of medical home includes the nationwide shortage in primary care supply, which will continue without changes in the organization of primary care practice.

> *"The more enlightened value-based payment systems require enrollment in a medical home."*
>
> -Arnold Milstein, MD, MPH,
> Director of Stanford Clinical Excellence Research Program

The National Committee for Quality Improvement (NCQA) has been instrumental in setting standards for medical home by creating a tiered recognition process for providers. The NCQA represents an objective, third party that can evaluate a provider's performance on process and outcomes measures linked to aspects of providing a high-quality medical home for patients. The NCQA standards are based upon the Chronic Care Model, which has been heavily evaluated and found to improve quality and cost effectiveness of care. (27) Most states with medical home initiatives are using either NCQA or a modified version of NCQA standards to ensure medical homes meet certain specifications. (21)

For the purposes of this paper, we use the term "medical home" when referring to the existing PCMH programs in other states and their connection to NCQA's PCMH recognition process. In contrast, the idea of a "health home" is based on a longstanding history of medical home, but with a broader focus on linking patients to community and social

supports, including behavioral health care. (28) Health home services may also be provided outside of the primary care setting. Despite these distinctions, health home and medical home are consistent in their goals and are aligned in improving patients' quality of care and care coordination across the health system. That said, we will use the term "health home," as explicitly defined by Section 2703, as it applies to state plan amendments and the future of medical home programs, which will likely be shaped by the broader concept of health home.

History and Current Activity around Medical Home and Health Home Payments

In order to support the delivery transformation required to implement medical home, payment structures must support the start-up and ongoing costs of medical home implementation. Start-up costs may include those associated with recruiting, hiring and training new staff members, participation in learning collaboratives, implementation of health information technology systems, and developing reporting systems. Ongoing costs include data collection and increased provider time for providing care management and care coordination services.

States have almost universally budgeted for PCMH under the assumption that the investment will be cost neutral and may save money over the long term. The major mechanism for cost savings is through moving costs from the inpatient setting to the more cost-effective primary care setting. Community Care of North Carolina has the longest history nationally and the most data on PCMH implementation; the most recent data estimated savings to the state of $1.5 billion over a two-year period (2007-2009). (29)

Enhanced payments may occur in a number of different forms, including: PMPM payments for providing ongoing PCMH services or care coordination across the system, upfront lump-sum payments for transformation to PCMH, and incentives for achieving NCQA recognition. (21) The most common payment methodology is that practices receive a supplemental PMPM payment for PCMH on top of the current payment system. Seventeen state Medicaid programs have medical home initiatives where the supplemental medical home payments range from $1.20 to $79.05 PMPM. (21) In proposed Section 2703 state plan amendments for enrollees with chronic conditions, payments range from $10-78.87 PMPM for health home services. (30) (31) In 2009, NASHP found that twelve states have established multi-payer medical home initiatives in which commercial plans, Medicaid and Medicare all participate in paying providers additional dollars for provision of medical home services. (32) A handful of states, including Pennsylvania and Oklahoma, pay practices a lump sum for

achieving a defined level of medical home recognition. Medical home payments can also be combined with additional incentive payments based on performance measures.

Medical Home Activity in Other States

Medical home activity is widespread across the nation, with more than 41 states engaging in medical home efforts over the last five years. (32) Below, we describe three examples of states with established programs and the payment methodologies they are using to support the provision of patient-centered medical homes.

Vermont Medical Home Initiative

Vermont's medical home initiative is one of the earliest state PCMH initiatives. It is a critical component of the state's Blueprint for Health program, established in 2006 as part of comprehensive health reform legislation. (33) The medical home initiative is a multi-payer program with Medicaid as one of the payers. The program covers 10 percent of the state's population located across ten pilot communities. (34) Providers are required to meet NCQA recognition in order to receive two separate supplemental payments, one PMPM payment for care coordination and a second enhanced payment for infrastructure support. The care coordination payment ranges from $1.20-2.39 PMPM, depending on the number of points scored on the NCQA PCMH assessment tool rather than on achieving a given NCQA tier. Providers must achieve a threshold of 25 points to receive any payment. (19) Legislation provided funding for technical support, data infrastructure, and other transformation costs for providers. An innovative dimension of the initiative is that care management and other services are delivered through community-based care teams comprised of a public health prevention specialist, community health workers, a chronic care coordinator, and care integration specialist. These community-based care teams are jointly paid for by all payers. (35) The use of this community-based team is a critical component of Vermont's medical home initiative, providing a demonstration of a concept that is being encouraged by ACA.

Results from 2010 demonstrate that the first medical home pilot community saw a 31 percent decrease in ED visits and a 36 percent decrease in PMPM costs over a two-year period. (21) In 2008-2009, the longest-running pilot community demonstrated cost savings of 12 percent for privately insured patients. The State plans to expand the program across the entire state by 2013. (6) Health centers played an integral role in the initiative with a mandated seat on the executive planning committee for Blueprint for Health. FQHC representatives also participated in the local stakeholder groups at each of the first three pilot sites for medical homes. (35) Additionally, the state's Primary Care Association provided state-funded technical assistance on medical home to its members.

Pennsylvania Chronic Care Initiative

Similar to Vermont, Pennsylvania is another state that has pursued medical home with health centers playing a significant role. An executive order in May 2007 established the Pennsylvania Governor's Chronic Care Management, Reimbursement and Cost Reduction Commission. The Commission worked with stakeholders to implement policies and programs that result in a measurable and sustained improvement in health status of under-served populations. The resulting Chronic Care Initiative is a multi-payer program using Ed Wagner's Chronic Care Model as a guiding framework for the state's patient-centered medical home program. Implementation of the initiative was rolled out on a regional basis, starting in 2008 in the Southeast region of the state. (19) The program also requires that providers participate in medical home learning collaboratives.

Providers participating in the initiative must obtain a modified NCQA medical home recognition in their first 18 months of participation in order to receive incentive payments. The types of incentive payments vary across the different regions. For example, in the northeast region, providers receive both a fixed monthly payment for care management and value-based reimbursement, as well as the opportunity to share in savings "only if the savings exceed the annual value of the other ongoing medical home payments." (35) In the Southeast region, where the initiative began, providers can receive a lump-sum payment for start-up costs, such as going through the NCQA recognition process. Care coordination payments range from $3.00-8.50 PMPM across regions, and initial financing for the program came from health plans. The state plans to use shared savings to finance the ongoing medical home payments over the long-term. (36)

Minnesota Health Care Homes

As part of health reform legislation in 2008, Minnesota established a multi-payer Health Care Homes Program (HCH) within the state Medicaid program for both fee-for-service and managed care enrollees with chronic conditions. (37) (38) The state's HCH program has a broad focus on improved health care coordination, community involvement and health promotion. The state worked with providers to define what constitutes a health home, and only state-certified HCHs are eligible to receive supplemental care coordination payments. As of December 2011, the state has 134 certified health care homes. (39) The Minnesota HCH Program's approach to payment represents an innovative and compelling payment model because of its incorporation of tiered payments for chronic conditions and additional payment for social acuity factors (See Case Study Minnesota Health Care Homes).

Case Study: Minnesota Health Care Homes: Innovation in PCMH Payment

Minnesota's Health Care Homes payment methodology is an innovative model that other states are using as an example in determining how to pay medical home providers. The State makes tiered PMPM payments to providers ranging from $10 to $61 PMPM based upon the patient's number of chronic conditions as assessed by a provider. The tiered payments were created based on studies of the actual amount of time spent on care coordination for patients with chronic conditions, where time increases with the number of conditions. (38) Minnesota's PMPM payments are substantially higher than those in other states' medical home programs.

Providers also receive additional payment for patients with certain social acuity factors, such as a behavioral health diagnosis or non-English language. (59) For each factor a patient has, the PMPM payment is increased by 15%. These additional payments for social acuity represent a key innovation in Minnesota's payment system for health homes based on the recognition that the presence of comorbid mental health and substance abuse disorders, and numerous other social factors influence the health needs of patients and the resources required to treat them. Accounting for these factors will be especially important for health centers that specialize in treating these specific populations. As it targeted its health homes to persons with chronic conditions, the Minnesota medical home program is an important precedent for the chronic care health homes being developed under Section 2703 of the Affordable Care Act.

Minnesota's payment approach is compelling for three main reasons. First, Minnesota's model has been in place since 2008 for the state's chronic care health home initiative. The payment model was implemented under a budget-neutral imperative, with an average of $50 PMPM estimated as the point where investment in HCH would equal cost savings generated as a result of the investment. Second, it represents an easy-to-administer method of risk-adjusting payment to the severity of patients' chronic conditions. Because providers determine the number of chronic conditions a patient has, there is no need for a resource-intensive, retrospective claims analysis to determine payment rates. Third, including adjustment for social acuity is an innovation in payment reform that benefits health centers because they have long recognized that presence of comorbid behavioral health and substance abuse disorders, homelessness, domestic violence and numerous other psychosocial factors influence the health needs of patients, and such factors are not adequately accounted for in existing risk-adjustment methodologies nor are they reimbursed under in existing payment systems. Other health center leaders are recognizing that measuring and accounting for psychosocial factors will be critical for health centers to prove and be rewarded for their value (See Oregon Case Study).

Health Homes in California

Even in the absence of a statewide initiative, California CCHCs are taking first steps towards becoming patient-centered health homes (PCHH) with help from foundations, the California Primary Care Association (CPCA), and the federal government. For example, in its 2011-12 Strategic Plan, CPCA has stated, "every CCHC will have assistance in becoming a Patient-Centered Health Home." In September 2011, the Community Clinics Initiative, funded by the Tides Foundation and the California Endowment, awarded ten Health Home Innovation grants to safety-net coalitions across the state. As part of each project, the coalition partners were asked to incorporate an element of payment reform into their health home models. The Blue Shield Foundation has also provided funding to select health centers to explore payment reform as part of health home transformation grants. (40) Finally, 70 FQHCs in California are participating in the FQHC Advanced Primary Care Practice Demonstration, which will evaluate the effectiveness of medical homes for Medicare beneficiaries. (41) While these projects are disparate initiatives and funding streams, all of this activity demonstrates that there is both interest and commitment among CCHCs to pursuing the transformation into PCHHs as a model delivery system. However, California also has a significant opportunity to promote statewide PCHH transformation and to achieve health system savings as a long-term result.

Health Homes and Payment Reform in Section 2703 of the ACA

Health reform creates a number of new payment opportunities to reward states for patient-centered health homes. (42) One such opportunity is the Section 2703 State Plan Amendment (SPA) option for states to create health homes for Medicaid and dual eligible enrollees with chronic conditions, including physical and behavioral health conditions. Section 2703 aims to improve care for complex Medicaid patients with an emphasis on care coordination, comprehensive care management, and care transitions, and requires states to collect and report on specific quality and efficiency measures. Under the SPA agreement with CMS, states will receive an enhanced Federal medical assistance percentage (FMAP) of 90% for the first eight calendar quarters that designated health home providers deliver health home services. After the two-year period, the FMAP will be reduced to the regular match for Medicaid services.

The State of Missouri is the first state in the nation to have received federal approval for two SPAs, one of which targets adults with serious mental illness and children with serious emotional disorders, and a second SPA aimed at adults with chronic conditions (excluding serious mental illness and substance use disorders), including developmental disabilities

Case Study: The Missouri 2703 SPA Experience: The First SPA Targeted to Safety-Net Providers in the Country

Section 2703 of the Affordable Care Act describes the opportunity for states to submit a state plan amendment (SPA) for provision of health home services for Medicaid and dual eligible enrollees who have two chronic conditions, one chronic condition and are at risk of having a second chronic condition, or one serious and persistent mental health condition. Once the Center for Medicare and Medicaid Services (CMS) approves a state plan amendment (SPA), the Federal medical assistance percentage (FMAP) is 90% for the first eight calendar quarters that designated health home providers deliver health home services. While three SPAs have been approved as of December 2011 for small sub-populations in Rhode Island and the severely mentally ill population in Missouri, the State of Missouri will soon be the first state to have a SPA approved for a general population with chronic conditions. More importantly for health centers, the health home providers under the SPA are limited to FQHCs, several RHCs and two safety net hospitals with outpatient primary care clinics. In addition, the payment rates for health home services are substantial and in line with the high level of resources and effort that safety-net providers report it takes to coordinate and manage care for Medicaid and dual eligible enrollees with chronic conditions. The Missouri SPA's capitated payments for health home services that are to be tracked as separate lines of business from the care delivery resources included on the health centers' cost reports are as follows:

- $58.47 PMPM for chronic care health home services (net to health centers is $55; $3.47 will go back to State to support administrative services)
- $78.87 PMPM for health home services for the severely mentally ill

While not in the original SPA, health centers were successfully able to negotiate to have the concept of earning additional shared savings over and above the PMPM payments, and the State plans to submit an amendment to the original SPA.

A number of key lessons from the Missouri 2703 experience emerge that can be valuable to health centers and the California Primary Care Association as they consider influencing the State in supporting health home transformation.

1) Be involved from the early stages of the SPA process as a close partner with Medicaid

In Missouri, the FQHCs through the Primary Care Association (PCA) were the first ones speaking with the Medicaid Director about how the state could capitalize on this federal funding opportunity. The PCA reported that it was helpful that they have a strong and positive relationship with the State Medicaid Director and the State Budget Director. Through these relationships, it became clear that it was politically important to ensure the other safety-net stakeholders were invited to participate as long as they could come up with their own financing sources as well. Finally, influencing the state approach to a Section 2703 SPA was both time and effort intensive: "We attended a lot of early morning meetings and conference calls," Susan Wilson, COO of the Missouri PCA, commented.

As a result of being closely involved from the outset, health centers were able to help the State set criteria for the application for providers to participate in the SPA. These criteria included having used an EMR for a threshold amount of time and willingness to seek NCQA medical home recognition, both of which health centers met. Thus, while the invitation to apply went out to all providers on Missouri's Medicaid email list, the only providers who wanted to participate and met the criteria were the FQHCs, two outpatient hospital departments and several rural health clinics.

2) Set clear, simple goals

The PCA started in the process with three simple goals: inclusion of start-up costs; a PMPM rate paid over and above the current cost-based reimbursement system and sufficient to cover the health home services described in Section 2703; and the possibility of participating in shared savings. They succeeded in achieving the latter two of the three goals in the SPA. CMS did not allow the inclusion of start-up costs such as the cost of recruiting, hiring, and training

new staff; or refurbishing space because under a SPA, CMS requires that payments are for services provided. The substantial PMPM payments for health home services were achieved by clearly explaining the additional workforce and roles in order to provide the necessary care coordination and management services described under Section 2703. Another key part of the PMPM success was that the PCA was able to have their cost reimbursement system (akin to PPS) amended so that Meaningful Use incentives and health home incentives are not considered part of cost report process. Finally, while the details are still to be worked out, the proposed concept in the SPA is if there are shared savings, a provider must demonstrate that they contributed to the savings to receive a distribution based on performance on quality indicators.

A challenge in setting and driving toward clear goals is to simultaneously clearly define who is leading the process. In Missouri, they were simultaneously implementing a multi-payer medical home initiative, and the PCA reported that it was often confusing "who was driving the bus." As an example, the multi-payer task force on metrics heavily influenced Medicaid with respect to the list of metrics for the SPA. In California, establishing clear leadership to coordinate the many stakeholders will be critical.

3) Find the financing – even in tight economic times

For many states facing ever mounting budget gaps, financing the 10% state portion of the 90-10 federal match can seem like an impossible challenge. In Missouri, it took creative thinking and galvanizing financing in distinct ways for the three main stakeholder participants:

- The PCA is dedicating $1M per year from its annual state appropriation to finance the state match for FQHCs and one RHC
- Public hospitals are using intergovernmental transfers (IGTs) for their portion of the state match
- RHCs are using Federal Reimbursement Allowance (FRA) funds, a state hospital tax, to finance their portion of the state match

In addition, the Missouri Foundation agreed to fund a consultant to write the SPAs and is funding learning collaboratives as part of a larger multi-payer medical home transformation initiative. The PCA used to receive $9 million annually under a state budget allocation, most of which was passed through to health centers for innovation and expansion. In recent years, this amount was cut in half. Thus, the decision to commit almost a quarter of the remaining funds to this initiative was significant. They reported having "lively discussion" with health center members, one of whom commented, "So, you're going to take away my grant money and give it back to me and tell me what to do with it." Nevertheless, the PCA held strong to the notion that this delivery system transformation and associated payment reform is both important and a valuable investment in the long run. While no specific plans are made yet, the PCA expressed confidence that if this program proves effective in producing cost savings, the Missouri State legislature will continue to fund it after the two-year initial period.

4) View 2703 as a "safe" opportunity to leverage federal money and take a step towards capitation

Under the Missouri 2703 SPA, the provision of chronic care health home services are considered outside of the cost-based reimbursement system and must be tracked separately. While an administrative challenge to do separate cost tracking, health centers see 2703 as a clear way to leverage more federal money. Susan Wilson, the COO of the Missouri PCA, captured the opportunity and the challenge that Section 2703 presents: "We have encouraged health centers to endure and use this as a learning opportunity while they still have cost-based reimbursement to learn how to deal with a PMPM capitated payment effectively. Because FFS is not likely going to be around for much longer, this is a chance to practice and become proficient at managing under a more defined budget for delivery of services."

Sources: This case study is based on conversations with Susan Wilson and Angela Herman from the Missouri Primary Care Association, analysis of the Missouri SPAs, and conversations with Michael Bailit of Bailit Health Purchasing, LLC.

payers (see Case Study Missouri). The second SPA is particularly relevant to California health centers because it is targeted to FQHCs, RHCs attached to rural hospitals, and safety-net hospitals with outpatient primary care clinics. The Missouri Primary Care Association was intimately involved in developing the SPA by partnering with the state Medicaid office. According to Susan Wilson from the Missouri PCA, the PCA leadership saw the SPA as important way of experimenting with payment reform early and in a proactive way before it was dictated by outside forces. (43)

Key Findings on Patient-Centered Medical Home

There exists a long history of patient-centered medical home programs across the nation, with several notable examples resulting in improvements on quality of care and cost savings. As health reform is implemented, the concept of a health home is even more important for states as a way to bind patients to one provider as patients move from being uninsured to having Medi-Cal or exchange insurance. By establishing closer bonds with patients through medical and health home models now, health centers will be well situated to be patients' providers of choice when the pool of publicly insured and publicly subsidized patients burgeons in 2014. The following are our general findings related to patient-centered medical home:

- Investment in patient-centered medical home is the most active area of payment reform for state Medicaid agencies as a strategy to reduce overall health system costs and improve patient care and population health.
- Incentives for PCMH are designed to bolster and improve the primary care system and the care system overall rather than to target specific outcomes. Promoting the development of medical and health homes will allow California to achieve broad system transformation.
- Becoming medical homes allows health centers to become the provider of choice for patients, especially for those with chronic health conditions. One challenge for health centers implementing PCMH is to more closely connect patients to their medical home for operational purposes, which would also facilitate correctly attributing patients to their medical home for payment purposes.
- The most common payment methodology for PCMH is a supplemental PMPM payment on top of FFS/PPS for providing medical home services. In state Medicaid programs, most payments range from $2-6 PMPM for the general Medicaid population. In proposed SPAs for enrollees with chronic conditions, payments range from $10-78.87 PMPM for health home services.
- Current PCMH payments represent a move away from volume-based pay toward value-based pay by rewarding providers for engaging in improved coordination of care across the whole health system.

Accountable Care Organizations

Accountable care organizations (ACOs) can be defined as integrated networks that combine primary care clinics, specialists, hospitals, and sometimes health plans, in communities or regions under a single governance structure. The concept of an ACO derives from The Affordable Care Act's authorization of the Centers for Medicare and Medicaid Services (CMS) to establish a Medicare Shared Savings Program under Section 3022, and an ACO is a new category of health care provider that would administer this program. As described by Fisher and colleagues, ACOs are designed to have the responsibility and accountability for driving efficiency and quality in a community's health care system. (44)

The CMS October 2011 release of a final rule on the Medicare Shared Savings Program (MSSP) drives a strict definition of ACOs in defining regulations, including how an ACO should function and how payments to providers should be administered. Under the CMS guidance,

> *"The principle underlying the per-member-per-month payment is that the ACO should be reimbursed prospectively for the costs of its care management programs, rather than be obliged to wait until shared savings are calculated and funded at some time in the future."*
>
> - James Robinson, Professor of Health Economics, UC Berkeley

provider groups continue to be paid under their current model (mostly FFS), but have the potential to achieve an upside gain through shared savings if threshold quality benchmarks are met. (45) According to UC Berkeley Health Economics Professor James Robinson, the regulations of the MSSP constrain and are slowing down the development of ACOs to serve the Medicare population. One issue is that the regulations prohibit payment for care coordination, which reduces the incentive for the delivery of these essential services. A second limitation of the CMS regulations for ACOs is that they are required to attribute patients retrospectively, rather than prospectively, to providers. (46) Retrospective attribution makes it more difficult to manage population health if the ACO is not responsible for the patients over the course of their treatment during a particular year.

The private sector is less constrained in how ACOs and ACO-like models are developing. The majority of these ACO-like models are united by three key aspects: 1) a governance structure that assumes accountability for population health management, 2) free choice of providers by patients, and 3) shared savings. (47) These emerging ACOs allow patients a free

choice of healthcare providers but they are expected to join and maintain a connection to a medical home. Although ACOs are usually considered to be synonymous with shared savings, the financing for these ACOs and ACO-like organizations often rely on hybrid systems that incorporate fee-for-service, care coordination fees, and shared savings. (48)

ACOs forming within state Medicaid programs have the opportunity to build off the existing framework and resources provided by primary care case management programs, disease management, managed care organizations, and other safety-net initiatives. (49) Several states have already developed ACO-like models exclusively for Medicaid and dually eligible enrollees created through state plan amendments or waivers. The ACA provides a number of paths for Medicaid ACOs to take shape, including through the Pediatric ACO Demonstration, Global Payment Demonstration, and through the encouragement of new payment models. Health centers could play a number of different roles in ACOs, including ones that are multi-payer, and could likely expect a larger role in Medicaid-specific ACOs.

Past History and Current Activity around ACOs

ACOs and health homes share many of the same motivations of trying to address the problems of care coordination and care transitions across provider settings that currently plague the health care system. Some have argued that ACOs have much less opportunity in areas dominated by managed care or integrated delivery systems, where MCOs are fulfilling some of the care coordination roles envisioned for ACOs. Nevertheless, there has been a flurry of activity around the ACO concept since the passage of ACA, with some private sector ACOs in the vanguard claiming impressive results. (50)

Within state Medicaid programs, there are several examples of ACO-like organizations that either pre-date or do not follow the ACO guidance released by CMS. Both North Carolina and Colorado (see Colorado Case Study) have examples of ACO-like structures that predate the CMS guidance, and other states, such as Oregon, are currently working to develop similar organizations that have flexibly interpreted the federal criteria. Below we highlight ACO activity in three states where health centers are participating in a substantial way. Oregon's activity around their version of ACOs is relevant because it highlights how health centers must push to be involved.

Community Care of North Carolina (CCNC)

One of the best-known precursors to ACOs is the Community Care of North Carolina (CCNC), operating within the state's Medicaid program since 1998. The CCNC began as a pilot of eight networks, one of which was an FQHC, and has since expanded to cover the entire

state through 14 networks serving more than 1 million Medicaid beneficiaries. (35) Under this program, providers are required to form nonprofit networks that include primary care, safety net, and specialty care providers in collaboration with the local health departments, departments of social services, and hospitals.

North Carolina makes two separate PMPM payments for each enrolled patient—one to the patient's primary care provider and one to the provider's network. (32) The networks in CCNC receive a $3.72 PMPM payment to implement population management strategies such as disease and care management, population stratification, preventive services and care coordination across delivery settings. Upon enrollment in the networks, providers receive an additional incentive payment of $2.50-5 PMPM (depending on the complexity of the Medicaid patient) if they provide enhanced access through extended hours and meet thresholds for using data. Each network is assigned a care manager that works with practices and their patients to implement mechanisms for improved patient and care management. Data is collected and administration is housed outside of the state Medicaid program in a nonprofit umbrella organization, North Carolina Community Care Networks (NCCCN). Evidence suggests that CCNC has been successful in reducing healthcare costs for Medicaid enrollees and also in improving quality and utilization measures. The most recent data estimates that the CCNC program has resulted in savings of $1.5 billion between 2007 and 2009. (6) The program has also seen a 40% reduction in hospitalizations for asthma and 16% reduction in ER visits. (26) In addition to reducing costs to the system, a 2011 report ranked CCNC in the top 10 percent in performance on national quality measures for diabetes, asthma, and heart disease. (6)
Although several FQHCs were initially invited to form networks under CCNC, only one large FQHC practice, Gaston Family Health Services, opted to serve in a leadership role. By leveraging pre-existing relationships with the local public health department and a community hospital, Gaston formed an affiliated nonprofit network called Community Health Partners. Community Health Partners now serves 47 Medicaid practices and 33,000 Medicaid enrollees. (35)

As the result of legislation in July 2010, the state plans to transform the CCNC into a program that more closely resembles an ACO and anticipates releasing detailed plans by October 2012. The program will: use quality of care, access, and utilization measures; pay performance incentives; and employ a shared-savings model. (49)

Case Study: Colorado Accountable Care Collaborative (ACC)

In 2009, budget action by Colorado's Department of Health Care Financing and Policy created the Accountable Care Collaborative (ACC), an ACO serving only Medicaid beneficiaries. The ACC is implemented through the Regional Care Collaborative Organizations (RCCOs) designated for each of seven regions across the state. (60) The goal of the ACC is to improve care coordination for Medicaid patients within RCCOs, where the patient's primary care medical provider (PCMP) serves as their medical home. This delivery system aims to move away from traditional FFS to a more patient-centered system that is both regionally based and focused on health and cost outcomes. The ACC is currently in its pilot phase, and it is not clear if health centers will be able to demonstrate real savings in the relatively short time period of 12 to 18 months.

The ACC program enrolls Colorado's fee-for-service Medicaid clients (those not currently enrolled in managed care programs). Its objectives are to: expand access to comprehensive primary care; provide a focal point of care/medical home for all members including coordinated and integrated access to specialty, inpatient and other services; and ensure a positive member and provider experience and promote member and provider engagement.

The ACC also includes the development of statewide data and analytics functionality to support data sharing and the measurement of health care costs and outcome indicators. RCCOs are expected to use data to support providers and members, bring down costs, and improve health outcomes. RCCOs must have plans to monitor their own performance and that of their provider networks, and quickly integrate this information into their system of care, adjusting as needed. The Department has committed to support them in these efforts.

Colorado's FQHCs and RHCs played a pivotal role in organization of the RCCOs in five out of the seven regions designated by the state. Nearly all of Colorado's health centers are participating in the ACC pilot phase (only three of fifteen are not). HCs played a number of different roles in bids for each of the seven RCCO regions: as organizers, co-founders of an RCCO entity, and as providers. (60) Polly Anderson of the Colorado PCA communicated that the health centers were chosen to participate in the pilot because:

- 1. FQHCs see a relatively high concentration of Medicaid patients and one third of the state's Medicaid enrollees;
- 2. FQHCs had networks of relationships with providers in their communities that formed an existing infrastructure on which to build an RCCO; and
- 3. FQHCs were viewed as long-standing models of medical homes. (64)

The FQHCs and RHCs can serve as Primary Care Medical Providers (PCMPs) within an RCCO. In order to qualify as a PCMP within an RCCO, providers must be enrolled as a Colorado Medicaid provider; serve as the client's dedicated source of primary, preventive, and sick medical care; and be committed to specific principles of the Medical Home model identified by the ACC.

The funding rationale for the ACC Program is based on the system savings that can be used to support the care coordination and practice models of the ACC. In the initial phase of the program, per-member-per-month (PMPM) payments are available to the RCCOs and PCMPs. These payments are in addition to the FFS payments currently in place. PCMPs receive a $4 PMPM during the initial phase of the pilot. During the expansion phase (July 2012), the PMPM is reduced to $3, with $1 going into an incentive pool. Providers have the opportunity to earn $1 PMPM dependent on meeting specific utilization targets at the RCCO level. During expansion, the ACC plans to add incentives and bonus payments, financed by shared savings, whereby RCCOs may develop their own incentive measures for compensating PCMPs.

The initial measurement areas for incentive payments are broken into two target levels and based on improvement over the regional FFS baseline per 1,000 enrollees for three utilization measures: 1) emergency room visits, 2) hospital re-admission, and 3) outpatient service utilization of MRIs, CT Scans and x-rays. Additionally, there is an opportunity for RCCOs and PCMPs to share in any savings the Department achieves beyond budget neutrality, although the methodology for a shared savings component is still under development. (60)

Oregon Care Coordination Organizations (CCOs)

Similar to Colorado, the state of Oregon is currently working to create an ACO model within its Medicaid program through Care Coordination Organizations (CCOs). (51) The CCO model will incorporate: accountability to metrics, a global budget, integration of mental health services, and a shared savings approach in the long term. The PCA is advocating that eventually providers should receive additional payments based on psychosocial factors, such as homelessness or other demographic info, and health centers are exploring how to collect such data. In December 2011, the State released a draft of the CCO criteria, specifying that almost all Medicaid enrollees will be enrolled in CCOs, and CCOs will be paid through a global budget to "[allow] CCOs maximum flexibility to dedicate resources toward the most efficient forms of care." (52) Quality incentives will later be incorporated into the global budget methodology to reward CCOs for improvements on specific measures. CCOs also have the flexibility to use alternative payment methodologies, and are encouraged to use tested and successful methods that promote quality of care over volume. Analysts conservatively estimate that CCOs will reduce the state's total Medicaid spending by "over $1 billion over the next 3 years and $3.1 billion over the next five years." The state expects to begin enrolling Medicaid patients in CCOs by June 2012.

The PCA (and FQHCs) currently have a "seat at the table" for stakeholder conversations determining what CCOs will look like, but FQHCs have struggled to be involved in decision-making. "When the big CCO in Portland was forming, the big idea was that it would involve the whole health systems, but when payers started looking into a CCO for a CMS grant, the FQHCs were left out of the original discussions and had to elbow their way back in," observed Craig Hostetler at the Oregon PCA. (51) FQHCs have been able to argue for their inclusion based on the fact that they now serve 30% of Oregon's Medicaid population.

CCOs are also forming around managed care organizations in the state. In the first discussions with the Oregon Healthcare Authority, ideas centered on a provider-run ACO, but over time, "it went from primary care provider-run ACO to a hospital-run ACO to, in Oregon, an insurance company." (51) It remains to be seen how the new CCOs will differ from the dominant MCO players within them.

Current ACO Activity in California

With its preponderance of large physician organizations, California is an environment primed for ACO formation. (53) In the private sector, existing physician organizations (both integrated medical groups and IPAs) of varying sizes already fulfill many of the roles of ACOs specified

in Federal guidelines. The ACO activity on the commercial side is likely due to the private sector's realizations that, 1) employers and insurers want to use ACOs to lower costs as an alternative to HMOs, and 2) integrated delivery systems already exist that can take on role of an integrator responsible for population health. As such, the private sector is creating new insurance products under an ACO governance structure with PPOs at their core.

A prominent example of this private sector interest is an ACO recently formed in Northern California, with already powerful players leading the charge. In 2010, an ACO pilot was formed through the California Public Employees Retirement System (CalPERS) and private physician groups. CalPERS is the largest purchaser in the state, and has an interest in driving delivery system change directly through providers rather than health plans. The ACO does not conform to the CMS guidance, but was instead modified to fit the needs of stakeholders in the region. Having all of the stakeholders in the same room together, including a hospital, health plan, and provider leaders, was especially important in the formation of the ACO. (40) Data from the first year of the pilot demonstrated significant success on a number of measures, including a 17% reduction in hospital readmissions and 14% reduction in inpatient hospital stays, which are estimated to save $15.5 million over the course of the pilot phase. (50) With CalPERS as the driver of this initiative, they are likely to shape how ACOs will form in the rest of the state. Uniting the key players in Northern California to have conversations around identifying shared goals and deal-breakers was essential for this pilot formation and its early successes.

Despite the flurry of activity on the commercial side, the safety net has been slower to engage in ACO formation. A key question for health centers is whether or not they can participate in commercial ACOs or if they need to be involved specifically in efforts targeted at the safety net. Similar to the private sector, there are networks and IPAs of safety-net providers in the state that could form the clinical foundation for an ACO. Health centers in California are just now beginning to experiment with extending ACOs to the safety-net population.

The formation of a safety-net ACO in South Los Angeles indicates that California's health centers are taking their first steps into ACO formation. In South Los Angeles, FQHCs, a local hospital, and a low-income health insurance plan are currently working together to create the Healthcare First South L.A. ACO for safety-net populations. (40) (54) The formation of the ACO is supported by a three-year demonstration grant from CMS as well as strong leadership from both the L.A. Care health plan, which serves low-income populations in the diverse area

of Los Angeles County, and St. John's Health Center. Currently, the ACO is limited to a small subset of the Medi-Cal population, with only L.A. Care members eligible; they eventually plan to expand the populations served. One of the payment models that will be used is a capitation rate separated into smaller capitation pieces, with $13 PMPM devoted to care coordination. The model has a strong emphasis on the importance of primary care through the provision of the patient-centered medical home, and stakeholders are working around prohibitive reimbursement structures to find payment models that will support a PCMH model.

Both of the examples presented above point to the importance of collaboration between stakeholders in the creation of ACOs. Cynthia Carmona, of the Community Clinic Association of Los Angeles County, indicated that having equal numbers of FQHC, hospital, and health plan partners was a key success factor in launching Healthcare First South L.A. At the same time, Healthcare First also encountered a number of challenges in uniting different stakeholders initially, and the stakeholders are still working to define their ACO. Previous research commissioned by The California Endowment on the potential for delivery system integration in South Los Angeles indicated a disparate activity around ACOs occurring concurrently, with little collaboration between groups. (55) They also revealed differing concepts of ACOs and the need for improvement in areas of data infrastructure and quality measurement. Based on these examples from both Northern California and Los Angeles County, it is clear that ACO formation will be locally driven and depends heavily upon the stakeholders involved.

Key Findings Related to ACOs

Accountable care organizations are still in the experimental stages nationally, with numerous ACO demonstration projects being federally funded. Although several ACO-like systems have been and continue to be formed at the state and local level, they may not conform to specifications set forth by CMS's guidance. The following are our general findings related to ACOs:

- ACOs are still being defined at the federal, state, and local levels. Many examples of ACO-like integrated delivery systems are currently forming or have existed for a long period of time (e.g., Community Care of North Carolina), but do not necessarily conform to the CMS standards for ACOs.
- Whether or not ACOs are developing and how ACOs are evolving depends heavily on the local context and the stakeholders involved.
- ACOs or ACO-like systems are more integrated into and closer to the care system than traditional managed care plans.
- ACOs and ACO-like structures are using numerous payment arrangements to provide incentives for improved care delivery across the system. The Medicare Shared Savings Program regulations propose combining fee-for-service or capitation with shared savings. In the private sector, payers are combining use of fee-for-service, care coordination fees, and shared savings.
- A key question for health centers is whether or not they can participate in commercial ACOs or if they need to be involved specifically in efforts targeted at the safety net. However, the experience of health centers in other states and in Los Angeles County suggests that CCHCs can play an important role in the formation of these systems.
- ACOs may have more clinical and cost benefits in non-managed care environments, which is consistent with the emergence of ACO PPO products in the California market.

Primary Care Capitation

State Medicaid agencies and other payers are considering moving to primary care capitation as an alternative to FFS despite the managed care backlash of the 1990s. Primary care capitation has been used in various forms for decades in managed care settings. It has been used in both partial and fully capitated systems. Partial capitation refers to paying a flat PMPM payment for a limited set of services. Partial capitation systems have been used extensively in Medicaid Primary Care Case Management (PCCM) programs. In these programs, providers receive a PMPM fee for care coordination and preventive services in addition to their FFS payments for traditionally reimbursed services. With the expansion of Medicaid managed care, the interest in capitated payment systems is growing rapidly, yet wide variation exists in the experience and comfort level CCHCs have with various forms of primary care capitation.

> *"It is important to distinguish the structure of physician payment (e.g., capitation versus fee-for-service) from the level of physician payment (e.g., high versus low payment rates)."*
>
> - James Robinson, Professor of Health Economics, UC Berkeley

Challenges associated with capitation include a strong bond between a patient and a capitated provider, determining the appropriate level of payment, and the need to mitigate the risk for underutilization. A critical component of any capitated payment methodology is being able to reliably attribute a patient to the provider receiving the capitation. This requires an increased level of patient engagement with a medical home in addition to a provider assuming responsibility for a designated patient population. Strengthening this bond between provider and patient presents a particular challenge in the safety-net given the relative transience of the Medi-Cal population. Many CCHC leaders express skepticism about primary care capitation because the notion of capitation is strongly associated with the low capitation rates paid by California MCOs. Finally, to counter the incentive for restricting access under capitation, most capitation arrangements being used or explored include either quality and access threshold requirements and/or incentive payments for performance on value, quality and patient experience indicators.

Nevertheless, capitation for primary care and other services is gaining momentum, as it is the only payment reform model that truly makes a complete break from a volume-

based system. There are two alternatives for exploring primary care capitation: 1) move to partial capitation systems (e.g., PMPM for a subset of health center services), or 2) move to full capitation for all health center services. In exchange for assuming some risk, using a capitation payment model increases health centers' flexibility to improve and deliver primary care by providing more upfront dollars to cover uncovered services while potentially reducing the costly reconciliation process within PPS.

History and Current Activities around Primary Care Capitation

There are three major areas of activity around primary care capitation systems. First, there continues to be development around the use of enhanced partial capitation systems in PCCM programs. Evaluations of these programs have shown PCCM programs to be equivalent in costs to capitated arrangements with MCOs, while providing state Medicaid agencies with an alternative to contracting with MCOs. Although California does not have a PCCM program, other states' experience with PCCM has relevance for the state, especially for regions still operating on a FFS basis.

A second major area of activity is to use partial capitation systems as a replacement to FFS or as a transition to primary care or global capitation. Partial capitation systems have been proposed for reforming Medicare and other public and private payment systems. For example, under such a system, physicians could receive a percentage of pay on a fee-for-service basis and the rest as a monthly capitation. The percentage of the capitated payment could vary depending on the experience of provider groups in accepting capitated payments. A Congressional Budget Office report estimated that the savings for a partial capitation system would be $1.2 billion by 2014 and $5.2 billion by 2019. (56) Partial capitation fits well with the movement to health home, which is being promoted through PMPM payments for the work that is uncompensated in existing payment systems.

A third and emerging area of activity is on developing capitated systems for FQHCs under an APM. Such capitated systems are being proposed in Oregon and are being discussed widely in other regions. The 2012 California State Budget proposal pushes the capitation concept beyond an APM and proposes a capitated rate equivalent to 90% of what health centers would have received under PPS. *[Note: The Governor later removed this proposal from the final budget after CPCA advocated for payment reform to proceed outside of a budget proposal.]*

Oklahoma SoonerCare Choice Enhanced Primary Care Case Management

In 1996, Oklahoma reformulated its Medicaid program to include a PCCM program with the intention of reducing costs to Medicaid. (18) Oklahoma became the first state to utilize a partial capitation payment methodology when the SoonerCare Choice program was implemented in rural areas. Providers received an upfront capitated payment equal to approximately 10% of patients' predicted costs (about $12 PMPM) and then received the remainder of their reimbursement on a FFS basis. The cap covered office visits, EPSDT (pediatric preventive) services, immunizations, and basic lab and X-ray services. Since the program's start in 1997, EPSDT rates have increased over 20%. Evaluations by the Oklahoma Health Care Authority in 2003 indicated that the program also increased patient satisfaction. The state has now incorporated these partial capitation payments into a payment model that combines medical home payments for care coordination and case management with additional performance-based incentive payments. The medical home payments range from $4-9 PMPM, substantially less than the partial capitation rates had been previously.

Oregon

Oregon is a preeminent example of health centers spearheading the movement to primary care capitation under an APM (see Oregon Case Study). The State has already approved a state plan amendment that includes a capitation rate calculated by multiplying the monthly average number of visits by the clinic's PPS encounter rate to result in a PMPM dollar amount for medical services, with the assumption of budget neutrality. The objective of a capitated system under an APM is to give health centers greater flexibility in practicing primary care in a health home model and achieving the goals of the Triple Aim. Oregon is also beginning to explore the foundations to risk-adjust payments for psychosocial factors in addition to adjusting for health care inflation as part of a strategy to achieve a sufficient level of payment for caring for the safety-net population.

Activity in California Around Capitation

In the private sector, integrated medical groups and IPAs have long been familiar with capitated payments, most of which have been used to cover physician services, while some may receive a prospective capitation rate for hospital services. The public sector has been slower to adopt risk-based capitation rates.

While the notion of capitation is ubiquitous in California given that the penetration of managed care is approaching 60%, the safety net has yet to fully participate in capitated

Case Study: Oregon Paves the Way for Primary Care Capitation for Health Centers

While many health centers nationally are participating in value-based incentive payment arrangements with health plans and multiple states are paying supplemental health home payments on top of the current Prospective Payment System, Oregon is in the vanguard in pursuing an Alternative Payment Methodology (APM) that would allow health centers to receive a capitated payment rather than their current PPS per-visit rates.

The case of Oregon is useful for health centers and the California Primary Care Association to consider because of the vision of the future that it brings, the stepwise approach to change, the challenges that the PCA has encountered, and an associated agenda for health centers to catalyze progress in both delivery system transformation and payment reform.

The Vision of the Future

As the Oregon Primary Care Association planned for health reform, they saw a landscape where the inflexibility that PPS created around types of reimbursed visits could create a liability for health centers trying to be the provider of choice in a market where cost-effectiveness and patient-centered care were paramount. The PCA also saw an inevitable movement toward more value-based reimbursement and the need for health centers to learn to work within that new paradigm rather than resist the change. In this view, the benefits of moving away from a per-visit payment and toward capitation are twofold: 1) To have flexibility in improving and delivering primary care in an increasingly competitive environment, and 2) To receive more upfront dollars to make investments in delivery system transformation. In exchange for this flexibility, health centers would be assuming primary care related professional risk and would give up the capability to "be made whole" on a per-visit basis through a wraparound payment from the State. Rather, in line with federal guidance around APMs, clinics will "be made whole" on a per person basis, thus abiding by the federal law that an APM must pay at least as much as a clinic would receive under PPS.

A Stepwise Process

Despite this notion of inevitable change to value-based payment and delivery system transformation, Craig Hostettler, CEO of the Oregon PCA, also clearly expressed, "We cannot run to value-based pay and put FQHCs that take care of 30% of the Medicaid population out of business by moving too quickly." Oregon has made two incremental steps over recent years that are allowing health centers to change the way they practice health care and to change the way are paid—all within the parameters of current federal law.

The first innovative step that Oregon took in recognizing that patient-centered health home was a cornerstone of a transformed delivery system was that several health centers sought a change of scope. In 2008, a number of health centers filed for change of scope in PPS to account for the time intensity of patients, the ongoing cost of medical records, and prospective payment for the medical home, "opening the door to as much as possible." About half of FQHCs in the state went through a similar change of scope to include many enabling services that they had not been allowed to bill for previously.

The major innovation that Oregon is spearheading currently is the creation an APM that is a monthly capitation payment. The APM is calculated as the average of annual visits per capita multiplied by a clinic's PPS rate (and divided by 12). In addition to the APM rate, clinics can also receive value-based pay from MCOs and eventually a PCHH payment through the state's 2703 SPA. Both of these are parallel payment systems will initially be separate and additive to the APM with the expectation that they will be merged in the future. The PCA had originally proposed including dental and mental health under the capitated rate in an attempt to move toward less siloed care, but they did not include these in the APM in the end due to attribution issues with MHOs and DCOs (mental health and dental MCOs) even though there was agreement that mental health and dental would be rolled in over time. Nevertheless, a capitation rate represents a major change for Oregon's clinics that currently receive fee-for-service payments from MCOs that receive a capitated rate from the State. The roll-out plan is for three large clinics to begin accepting the APM as soon as it is approved and to have 3-6 more clinics adopt it within

a year. As of January 2012, the State granted approval for the APM to go forward and the PCA hopes to have CMS approval by April 2012.

Two Key Challenges: Reconciliation and Patient Attribution

Oregon has been involved the movement toward capitation for over a year and the PCA reports that they are "still moving forward, but it has been excruciating." Early on, one question that emerged was how to avoid an onerous reconciliation calculation to ensure that the APM was at least equal to what the clinic would have received under PPS. A year into the discussions, the PCA reports that the stakeholder discussions have determined that reconciliation is needed based on the federal requirement but that the clinics and the state are working to make sure that it is not solely dependent on reconciliation to the visit. Clinics must also agree to the APM, since the APM is ultimately voluntary. The state is currently awaiting the CMS response their State Plan Amendment for the APM. A final challenge that MCOs and clinics worked through was MCOs' resistance to paying health centers differently than other providers. The solution they agreed upon was that clinics would receive a "wrap cap" from the state based on a historical wrap payment per patient per year, and MCOs could continue to pay clinics similarly to other providers.

Accurately attributing patients—especially those who do not currently have a usual source of care or those that see more than one clinic—has been the most difficult issue on which MCOs, the clinics and the State must reach agreement. This discussion has highlighted the importance of "hanging on" to a patient. The health centers have been able to negotiate that an encounter with any licensed member of the health home team, not just the medical provider, should be included in the attribution methodology. However, for patients with multiple sources of care, payers and clinics are still coming to a resolve on how to attribute these patients.

Next Steps for Health Centers and PCAs

In speaking with the Oregon PCA about their experience in pursuing payment reform in the safety-net community, three messages emerged:

1. Support Delivery System Transformation: As PCAs and CHCs proceed down a path of payment reform, it is critical to begin thinking about how to reorganize clinics to accommodate PMPM payments instead of FFS. To this end, the Oregon PCA has hired an expert in transformation to patient-centered care to begin providing transformation assistance to CHCs.

2. Create consensus that better health will be achieved through health home, and health home requires investment. In conversations with policy makers, the PCA must further promote growing agreement that health homes can help achieve improved health and lower costs. However, a gap exists around what it costs to be a well-run health home. The Oregon PCA believes there is value in showing the State what it costs the private sector for effective health homes, with the underlying assumption that the State currently undervalues health home services.

3. Build foundation for payment adjustment for psychosocial factors to prevent increasing inequality and health disparities. As a first step in this process, health centers need to collect data regarding behavioral health and social acuity factors, such as homelessness, so health centers can start advocating for payment for the increased intensity of delivering services to complex and socially disadvantaged patient populations.

payment with health plans due to PPS. CCHCs within the managed care counties are familiar with primary care capitation through their contracts, and CCHCs receive a significant percent of their expected payments in advance, thus providing the same benefit as a cap in terms of smoothing out cash flow. However, the vast majority of CCHCs are not assuming the financial risk associated with capitation since individual CCHCs receive wraparound payments from the State that make up the difference between their capitation revenue and their PPS rate multiplied by the number of face-to-face encounters the CCHC had with Medi-Cal patients. Because CCHCs' financial models and California's payment systems still hinge on PPS as a bundled fee per visit, a move to capitation would represent significant change for CCHCs.

There are a handful of California health center networks already accepting full professional capitation rates as part of risk-bearing arrangements with their health plans. Community Health Center Network in Alameda and both AltaMed Health Services Corporation and Health Care LA IPA in Los Angeles have professional risk contracts that cover both primary and specialty care. As of a 2008 report commissioned by the Tides Community Clinics Initiative and the California Endowment (4), these clinic networks cited benefits, including better access to data for quality improvement, improved negotiating position with their local initiative health plan, improved relationships with community specialists, and financial benefits. (4) However, it should also be noted that individual health centers within these risk-bearing networks still bill the state for wraparound payments based on their PPS rates.

There is also increasing pressure to move to more capitated systems within the safety net for three cited reasons: to allow provision of a broader mix of services than PPS allows as seniors and persons with disabilities move into managed care; to hold down state costs in a tight budgetary environment; and to move away from volume-based payment for health services. (57)

These pressures to move toward capitation culminated in a January 2012 budget proposal from the California Governor that would change payments to FQHCs and RHCs under Medi-Cal managed care contracts "from a cost and volume-based payment to a fixed payment to provide a broad range of services to its enrollees." (58) The proposal also includes allowing FQHCs and RHCs to use group visits, telephone visits and telemedicine and creating flexibility for clinics to "ensure that medical care is provided by the most appropriate and affordable medical professional and allow clinics to perform multiple services on the same day." The California DHCS has indicated that the "fixed payment" described is a capitated rate that would translate a CCHC's PPS revenue to a capitated rate that would then be reduced by 10

percent to account for "efficiencies." The proposal mentions the "possibility for performance-incentive payments in the future" with no additional details. Because of the flexibilities and the 10% reduction in payments compared to PPS, the State recognizes that a waiver from CMS would be required to implement this proposal.

Key questions for California health centers in the face of this proposal are: 1) Would it be possible to ultimately achieve efficiencies worth more than the 10% cut dollars? 2) Since SPD populations have limited experience in health centers, how would capitation rates be increased sufficiently to account for the higher level of utilization of SPD populations compared to historical health center populations? 3) Given the transient Medi-Cal population, how would health centers be compensated for seeing non-attributed patients? 4) Given that all other states are investing in primary care and in PCMH as a strategy to reduce overall health system costs, how will a 10% cut to primary care safety-net providers compromise California's capacity to deliver on the Triple Aim goals?

Key Findings on Primary Care Capitation

State Medicaid agencies and other payers are considering moving to primary care capitation as an alternative to FFS despite the managed care backlash of the 1990s. Although there is substantial experience with partial primary care capitation systems in Medicaid, thus far, Oregon is the only state that has moved to develop a capitated system for health centers under a PPS APM. Some states, such as Vermont, see primary care capitation as a stepping-stone for global capitation payment models. The following are our general findings related to primary care capitation:

- There are two alternatives for exploring primary care capitation: 1) move to partial capitation systems, or 2) move to full capitation under PPS.
- In a partial capitation system, providers are still receiving FFS or PPS and receive additional PMPM payments for care coordination services on top. Partial primary care capitation has been successfully used in Medicaid primary care case management (PCCM) programs for more than a decade.
- Using a capitation payment model increases health centers' flexibility to provide previously uncovered services and allows health centers to improve primary care delivery by providing more upfront dollars, while potentially reducing the costly reconciliation process within PPS.
- The managed care environment in California makes a transition to capitation easier, as already established infrastructure is in place to make these payments.

- A capitated rate model creates possible risks of underutilization and associated poor quality and patient care, and health centers need to take measures to prevent this potential consequence.
- Capitation models depend on a stronger bond than exists today between a patient and a health home.
- Capitation for primary care and other services is gaining momentum, as it is the only payment reform model that truly makes the break from volume-based system.

Key Principles for Health Center Payment Reform/Delivery System Transformation

Several key themes or principles emerged from our analysis of payment reforms being implemented in other states and the private sector. Establishing consensus on these or related general principles will help CCHC leadership to build agreement for proceeding with payment reform and can be used as selection criteria for designing an alternate payment strategy. Based on our analysis, the general principles of payment reform and associated delivery system transformation for CCHCs can be summarized as follows:

1. Payment reform should create incentive to achieve Triple Aim goals. The Triple Aim goals are to improve patient experience and population health while reducing costs to the overall health system. By adopting the Triple Aim as the overall goal of payment reform, CPCA will align its strategy for payment reform with CMS and other major payers. This will likely mean building new incentives to achieve cost reduction and improvement in population health and patient experience and eventually severing the tie between a face-to-face visit and payment.

2. Delivery system transformation requires investment and payment reform. It will take additional investment in primary care and health homes in order to realize overall health system savings because health home services include additional services beyond the enabling services that health centers already provide today. One of the key investments that payment reform will need to support will be in new hiring and training of the workforce to deliver health care and care coordination in novel ways. In particular, investments will need to center on improving coordination of care transitions and better integrating behavioral health and primary care. In order to encourage delivery system transformation, payment reform must also give CCHCs the flexibility to invest their payments to be "the provider of choice" under health reform.

3. Stacking multiple payment models will be required to achieve all goals of delivery system change. One of the goals of delivery system change is to ensure that CCHCs, a critical provider for underserved populations, must survive the transition to a new delivery system. The layers would include a base payment represented by the current payment system; a partial capitated payment for novel health home coordination services; and value-based incentives to reward performance on high-value measures such as reducing readmissions. Likewise, payment reform will be a phased process. It will be necessary to pilot, reevaluate and make modifications until desired outcomes are achieved. Over time, the relative size of the three

layers may change. The base payment model may eventually be substituted. Two layers may fuse. It will be critical for CCHCs to be active participants in this phased process through participation in pilots and communication of results.

4. To engage patients and families, value-based insurance design must align with provider incentives for medical home and ACOs. Providers and patients must be acting in concert with one another to realize the promise of medical homes or ACOs. In fact, for both medical home and payment reform to optimally succeed in meeting the Triple Aim, patients must be tightly bound to a medical home. Health plans can play a pivotal role in promoting and strengthening this bond through insurance design. For example, co-pay structures should be lower for a patient to see a primary care health home team than to visit an emergency room.

5. Data availability and transparency are critical. CCHCs depend on data to manage patient populations, to assess performance, to identify areas for improvement, and to earn traditional reimbursement and incentive-payment. Yet today multiple data challenges exist for CCHCs. First, many CCHCs do not trust the measures that health plans or the State are calculating based on CCHC patient data. Given that electronic health records are still relatively new or have yet to be implemented in many CCHCs, engaging in iterative reporting efforts will be necessary to ensure that the data CCHCs are passing to health plans is of the highest quality.

Moving toward a more value-based payment system will elevate the importance of high-quality, accessible data and reporting. Engagement between health plans and CCHCs around developing trusted reports underlies any significant move to value-based payment. While quality and patient experience measures will continue to be important, the emphasis for incentive payment is increasingly focusing on value and even total cost of care. For CCHCs to understand the total cost of care and associated utilization drivers of their patient populations, they need to have access to the realms of inpatient, specialty care, long-term care, and ancillary data that has historically fallen outside their purview. This will necessitate working more closely around data partnerships and strategies with health plans and the State. Advocating for alignment with existing data collection efforts will also benefit CCHCs that currently have a multiplicity of disparate reporting requirements. Finally, if payments are to be fair for CCHCs going forward, due to the high prevalence of psychosocial factors in the Medi-Cal population, CCHC payments also need to account for social acuity of the patient population they serve.

General Recommendations: Building the Foundations for the Role of Community Health Centers under Payment Reform

Regardless of any new payment models that might be pursued based on meeting the General Principles described, there are a number of actions that CPCA can take in order to build the foundation for payment reform for CCHCs. By pursuing the recommendations below, CPCA will help CCHCs with improving P4P, receiving fair payment for PCHH, optimizing CCHC success in ACOs, and/or setting the stage for capitation-based payment models.

Help CCHCs build relationships with hospitals today

Hospitals are a critical partner to engage because much of the delivery system transformation rests on moving care out of the inpatient setting and into more cost-effective outpatient settings. Building relationships with hospital leaders is fundamental to payment and delivery system reform because improving care transitions from the inpatient to the community setting represents a significant opportunity to generate cost savings and improve quality of care. No single entity in the health system has consistently viewed care transition as its primary responsibility. Care transitions are an explicit responsibility of the PCMH and ACOs, and the results of those transitions (e.g., reduced readmissions) are a metric for many P4P programs.

Additionally, because many shared savings arrangements hinge on effectively shifting resources from hospitals to other entities, it will be critical to work with hospital leaders to identify shared goals, to come to an agreement of general principles for delivery system transformation and payment reform, and to identify and work through obstacles. Building strong relationships up front will set the stage for the more detailed negotiations around issues such as apportioning shared savings.

For some CCHCs, this means building on an established relationship with local hospital leaders. For others, it will mean starting the conversations with local hospitals around how CCHCs and hospitals can work together to improve care coordination across the delivery system. In either case, having “a seat at the table” to shape the conversation represents a critical first step for CCHCs. In other states, FQHCs have had to fight for a seat at the table, and when they noticed other activity occurring between health plans and hospitals, they have had to “elbow their way” back in to the conversations.

Identify consolidation opportunities for CCHCs

There is a clear trend in the healthcare industry as physician practices, hospitals and health plans consolidate through mergers and acquisitions. (36) CCHCs would benefit from coming together as well. Payment reform will require many negotiation conversations, and CCHCs as a consolidated group would have much more negotiating power vis-a-vis a hospital system or a health plan than as individual health centers. As evidenced by activity in other states, creating a notion of the CCHCs as a unified group caring for a significant portion of the Medi-Cal population makes it much more difficult to exclude CCHCs from policy or rate negotiations.

Opportunity for consolidation of CCHCs could take the form of both organizational consolidation and strategic alliances. Organizational consolidation might be vertical integration with a health plan or having a skilled negotiating team on behalf of CCHCs to determine shared savings contracts with a consolidated hospital system. Strategic alliances might include having health centers push their safety-net health plans to participate in a third-party data collection and analysis with standardized measures. Through such alliances, CCHCs might also leverage the experience that some CCHCs have in negotiating beneficial agreements with their health plans.

Build a safety-net data infrastructure that employs standardized data and measures

Promoting movement toward more standardized data and measures across CCHCs will help alleviate the large and growing reporting burden that CCHCs have and will strengthen CCHCs' position in negotiating incentive programs with health plans through better understanding of the utilization patterns of their patient population across the health system. Standardizing data and measures can also build provider trust in data, a necessary prerequisite for affecting change at the clinic level, and can help CCHCs hone improvement efforts towards a limited set of goals.

A standard measure set will need to include total cost of care and appropriate use measures in addition to aligning the quality, access, patient experience measures that CCHCs already collect. Like with building hospital relationships, building relationships with large safety-net health plans will be critical in this process.

CCHCs would also benefit from having an independent data repository and analytic entity to facilitate the discussions around data and measurement; to collect, analyze and communicate health plan data back to CCHCs; and to establish regional and statewide

benchmarks on measures to help CCHCs assess their performance relative to their peers. Benchmarking may also allow for outlier analysis on risk-adjusted total cost of care measures. With robust benchmarking reports, CCHCs will be able to better act on performance-improvement opportunities and will be able to engage in well informed negotiations with health plans and/or the State regarding performance-based payment. The Integrated Healthcare Association (IHA), which manages the largest data aggregation and standardized results program in the country on behalf of eight California health plans representing 10 million commercially insured individuals, has a new Value Based P4P Program which could serve as a strong example of what the safety net should pursue.

Build support for managing patients in novel ways within a medical home

CPCA at the state level and CCHCs at the local and regional levels can play a key role in educating policymakers about Triple Aim goals and what it will take to achieve these goals, including becoming fully actualized patient-centered health homes. CCHCs can promote the idea that PCHH emphasizes a new, increased level of care coordination across the health system. This added coordination will require additional resources for primary care patient-centered health homes upfront in order to ultimately reduce overall health system costs through decreased hospital utilization. CCHCs will also need to clearly communicate the message that achieving reductions in costs and improved population health and patient experience requires delivering care differently, and in order to deliver care in novel ways, CCHCs need to be paid differently. Finally, CCHCs can communicate that the optimal methods for engaging a patient in a PCHH may also be more cost-effective than traditional modes of care, yet many cost-effective modes of care are not reimbursed today. A new payment model will: encourage CCHCs to use the most evidence-based, cost-effective modes of care; include resources for PCHHs to provide novel, value-added coordination services; and reward performance for achieving Triple Aim goals.

Recommendations for Next Steps Forward

Based on our research of alternate payment models and interviews with California CCHCs and national experts, this section outlines five next tangible steps for CPCA and health centers to take regarding payment reform.

1. Pursue a Section 2703 State Plan Amendment for Chronic Care Health Homes

Section 2703 of the Affordable Care Act offers an opportunity for California to address the growing burden of chronic illness by receiving a 90/10 Federal match for eight calendar quarters, under a state plan amendment (SPA), for the provision of health home services to individuals with chronic conditions. In October 2011, JSI made the above recommendation to CPCA, and CPCA immediately contracted JSI to research other state SPA activity and to compose a position paper advocating that the State of California take advantage of the significant opportunity offered under Section 2703 to catalyze a delivery system transformation that will ultimately benefit all Californians. Through this position paper and conversations with the State, CPCA has committed to working with state officials on development and implementation of a Section 2703 SPA. The key positions that CPCA put forward to the State regarding a 2703 SPA included:

- Primary care should play a central role in the provision of health home services, while developing strong partnerships with other health system players.
- The California SPA should emphasize integration of primary care and behavioral health integration, and improvement around care transitions.
- California should adopt a tiered per-member-per-month (PMPM) payment for providers delivering health home services to enrollees with chronic conditions based on the Minnesota PCHH payment model (see below for description).
- CPCA proposes that the financing for the state portion of the match should initially come from providers (potentially supported by California foundation funding for CCHCs); in the longer term, the state portion of a PCHH payment should be derived from shared savings that result from the implementation of the chronic care health home.
- CPCA proposes that California pursue multiple SPAs, including a SPA targeting FQHCs and hospital outpatient clinics. These providers care for a large number of Medi-Cal beneficiaries currently and share a mission of serving the State's most vulnerable

populations. Many public hospital outpatient departments and CCHCs also are likely to be more ready to provide health home services than other community providers because many CCHCs and public hospital outpatient clinics have existing infrastructure and health teams that provide some health home and enabling services today.

2. Advocate for a Supplemental PMPM Payment Model for PCHH based on the Minnesota Model

Minnesota's innovative payment model could be applied to a chronic care health home model under a 2703 SPA and to PCHH for the more general population. As detailed in this report, the Minnesota payment methodology for PCHH includes a supplemental PMPM payment ranging from $10 to $61 that is adjusted upward by 15 percent for patients with social acuity factors, including a behavioral health diagnosis and requiring services in a language other than English. This methodology is compelling for its three-year longevity under a budget neutral imperative, its easy-to-administer method of risk-adjusting payment to the severity of patients' chronic conditions based on provider assessment rather than claims analysis, and its innovation in adjusting payment for social acuity factors.

This payment model also meets a number of criteria put forward in our General Principles of Payment Reform. As a partial capitation rate, it does not tie payment to face-to-face visits with a provider and would allow CCHCs flexibility in using these funds. The substantial PMPM amount acknowledges the investment necessary to provide additional care management and coordination services to fully realize the promise of a PCHH. As a supplemental payment on top of the current PPS payment system, it is an incremental step that allows CCHCs to "try on" managing a distinct set of health home services under a capitation rate without exposing CCHCs to the downside risk of a fully capitated rate.

3. Pursue P4P based on value and efficiency measures

While pursuing a long-term goal to build a safety-net data infrastructure that employs standardized data and measures, CCHCs would benefit from working with their health plans to pilot and devise an incentive program around the IHA appropriate resource measures of hospital readmissions, hospital discharges, inpatient bed days, ER utilization, generic drug prescribing and total cost of care. By adopting these high-value metrics that are already defined and have been well tested on a large commercial data set, CCHCs could demonstrate an immediate and solid commitment to the goal of reducing health system costs along with pursuing quality improvement through measures that CCHCs collect for

other reasons (e.g., UDS). Gaining familiarity with these measures will also help CCHCs to communicate their value in payment reform discussions with health plans and the State.

Another related priority is that the CPCA could help to develop metrics for social acuity that could be used across payment models, including P4P. Existing risk adjustment models do not take psychosocial factors, such as homelessness or comorbid mental health disorders, into account when adjusting payments. The CPCA should work with Oregon and other PCAs to develop social acuity factors that ensure that health centers are paid appropriately for the populations that they serve. By having better data on the factors that make the Medi-Cal and dual eligible populations challenging and resource-intensive to care for, CCHCs will be better able to make the case for enhanced payment for health home services or improved risk-adjustment for total cost of care measures.

4. Build the foundations for ACOs

Much debate still exists as to whether and how ACOs will truly take hold in the safety net in California. The private sector is actively reorganizing into ACOs, spurred by pressure from large employers and insurers. It is not clear how quickly safety-net plans will follow the lead of the private sector, learning and borrowing from both the private sector experience and health centers' own regional networks and IPAs. However, whether or not safety-net ACOs develop in a given region will depend heavily on the local context and relationships between the hospital, health plan and provider organizations in that area. Thus, building the foundations for ACOs can mean building the relationships with local health plan(s), hospital and IPA leaders, or beginning to talk about the type of data reporting, service delivery and IT infrastructure that will be required for achieving these goals. What is clear is that if ACOs are developing in a CCHC's region, it is important for CCHC leaders to "be at the table" where conversations are occurring.

As a key part of building these foundations, CCHCs should be prepared to discuss payment within the context of ACO discussions. Even though the overarching governance structure of an ACO is one of its distinctive features, ACO Triple Aim goals and the actions necessary to achieve those goals are aligned with the goals of patient-centered health homes. Because the ultimate goals are aligned, we would recommend that CCHCs advocate for their payment under an ACO governance structure to consist of three layered payment models including: a base payment (either PPS or primary care capitation under an APM), a PMPM payment for providing PCHH services, and P4P based on value and financed through shared savings.

5. Pilot primary care capitation as preparation for a move to primary care capitation in the medium- to long-term

Over the long-term, many experts believe that capitation payment models will predominate in the public sector as they have in California's private HMO market. There are many ways in which CPCA can help CCHCs to prepare for this eventual move. The first is to encourage development of and participation in primary care capitation demonstration projects. It is interesting that other states are viewing the 2703 SPA as an opportunity to safely practice capitation for health home services without giving up cost-based reimbursement (See Missouri Case Study). It will also be important to watch Oregon closely as they become the first state to adopt an APM that essentially converts their PPS rate to a capitation rate (see Oregon Case Study). As early findings emerge from both the Oregon APM and California demonstration projects, CPCA can help CCHCs by disseminating findings from pilots to health centers across the state.

As California discusses the Governor's proposal to move health centers to a capitated rate equivalent to 90 percent of their PPS revenue, CPCA can play an instrumental role in ensuring that capitation must be accompanied by incentives to reduce overall health system cost and improving population health and patient care through investing in robust patient-centered health homes as the cornerstone of a new delivery system.

Conclusion

Payment reform is an essential component of delivery system transformation designed to support the Triple Aim. The Centers for Medicare and Medicaid Services and state Medicaid agencies as well other public payers are driving various forms of payment reform. As a result of these efforts, there will be increasing pressure to modify the PPS system that has been the staple of health center financing for over a decade. Payment reform will thus need to invest in a transition to a new delivery system where primary care serves as the cornerstone of that new system and is rewarded for helping to reduce overall health system costs while concurrently improving patient experience and population health. Health centers have the option of responding to new payment models in an ad hoc manner or proactively trying to shape California's emerging strategy for payment reform. The Missouri, Colorado, and Oregon PCAs represent important examples of health center leadership in pioneering new payment models. As the largest PCA in the country with over 800 member CCHCs, the California PCA is in a unique position to innovate and lead safety-net efforts around payment reform in California and nationally.

Appendix: A Post PPS-World

As state budgets get tighter and as health reform promotes a movement away from payment for volume to payment for value in the health system as a whole, thought leaders across the nation and in California acknowledge that there is a real possibility that PPS will not be around forever. Yet no state has taken as aggressive an action as the California Governor's budget proposal that clearly demonstrated that the State is aggressively promoting a capitation methodology as a mechanism for value-based payment and as a replacement for PPS. This Appendix describes how the models we have presented and the recommendations we have made in this report might differ in a world where PPS were no longer in place. It should be noted that if the protections of PPS were completely removed, having policymakers and other stakeholders agree on General Principles of payment reform and the specific roles that community health centers would play in a new system are equally if not more central than the details of the payment models.

Our near-term recommendations to Pursue a 2703 SPA for Chronic Care Health Home, to Advocate for a Supplemental PMPM Payment Model for PCHH, and to Pursue P4P based on value would not change in any fundamental ways. If anything, in a post-PPS world, a supplemental payment for PCHH and incentive for achieving on high-value measures become even more critical aspects of a payment model for health centers. Health homes will form the cornerstone of a transformed delivery system that can achieve better care, better health, and reduced costs. Finding a way to invest in new health home services—especially those that focus on care transitions and integration of behavioral health and primary care—will be necessary to effect this transformation. California should not miss the opportunity to use federal dollars to catalyze this move to a new delivery system. Incentive payments for value will be critical to reward health centers for helping the larger health system reduce overall per capita costs.

The biggest difference in a payment model in a post-PPS scenario centers on how a capitation payment for health centers would be calculated. First, based on our research, we believe that some form of capitation will eventually supplant PPS. In the meantime, under an APM, a capitated rate would have to be calculated to be equal to what a health center would have received under PPS. However, in a post-PPS world, a capitation payment would either be calculated by actuaries or would need to be negotiated. The hazard of either of these scenarios is that the resulting payment may underestimate the dollar amount that

health centers require to deliver services to the Medi-Cal population. The second hazard in a post-PPS world is that Medicaid programs historically have proven to be unreliable partners for health centers in that they cut payments during poor economic times, regardless of the consequences on the delivery system and access to care.

Level of Payment

Thus, while the structure of incentives is important, the level of payment is equally important. In a transformed delivery system that meets the Triple Aim, primary care is expected to do more rather than less and needs to be rewarded for these important roles and functions. In the absence of PPS protection, the overall level of payment for health centers still must somehow be guaranteed so that state policymakers cannot make arbitrary cuts when it is necessary to balance budgets. In addition to ensuring some protection for the overall level of payment, negotiation regarding the relative amount of payment for each layer in the payment model described below would be a critical piece of work for health centers.

A Proposed Payment Model in a Post-PPS World

In order to help health centers achieve the Triple Aim in a transformed delivery system, we would suggest that CPCA work with MCOs and the State in adopting the following three-layered payment model.

Base Layer: Primary Care Capitated Payment

We would recommend that health centers advocate for a primary care capitation payment that takes enabling services into account, that is higher for more acute populations, that increases with a realistic inflation factor, and is adjusted upwards based on social acuity factors. We recommend that a co-morbid behavioral health diagnosis would be one factor used for capitation adjustment. However, we recommend that health centers begin the process of identifying a handful of other social acuity factors, piloting studies to confirm their influence and then developing systems to expand data collection. By following these steps, health centers will be able to argue compellingly for data-driven adjustment of capitation payments based on the psychosocial complexities of the populations they serve.

Second Layer: Supplemental Payment for Patient-Centered Health Home

Because primary care capitation in itself does not provide specific incentives for health home transformation, we also recommend that health centers push for an additional and substantial PMPM payment for providing patient-centered health home services. We would

recommend that the PMPM payment be tiered based on the number of chronic conditions that a patient has (see the Minnesota Payment Model). As more seniors and persons with disabilities are moved into managed care and are assigned to health centers, more health center patients will require broad-based health home services. The health home services paid for by this supplemental cap would include a host of care coordination services, particularly surrounding care transitions and integration of behavioral health, which health centers are not yet doing because the current reimbursement system does not pay for health centers to fulfill these roles. Health home services would also involve employing new health home team members such as community health workers. In order to be eligible for this supplemental payment, health centers (or other providers) would need to demonstrate NCQA Tier 3 medical home recognition. Together, the primary capitated payment and the PCHH payment should exceed what most health centers receive today under PPS based on the fact that they will be significantly expanding the services they provide for their assigned patient population. Such investments in primary care have been associated with significant returns on the investment in terms of reduced overall health system costs. Community Care of North Carolina is the longest running program with estimated total savings to the state of $1.5 billion over two recent years. Even if this supplemental payment might change over time, it is critical to stimulating the transformation to a new delivery system.

Top Layer: Incentive Payment for Value

The final building block of a post-PPS payment model would be an incentive payment for value. This incentive should promote systems thinking that extends beyond what occurs in the clinic. The incentive payment would need to be based on a standardized set of value-based P4P measures, including total cost of care in addition to a limited, standard set of appropriate resource use, quality, access, and patient experience measures. The Integrated Healthcare Association sets an example in that within a managed care context, paying for quality alone was not sufficient to keep health plans engaged in incentive payments. Pushed by payers, IHA has evolved to adopt total cost of care as a central metric in value-based performance measurement.

We recommend that the incentive payment be financed through shared savings, understanding that negotiating the terms of shared savings would be a challenge. If no savings are achieved, no payments would be made. The rationale for this incentive payment is to reward health centers that are truly helping to achieve total cost reduction across the health system as a whole.

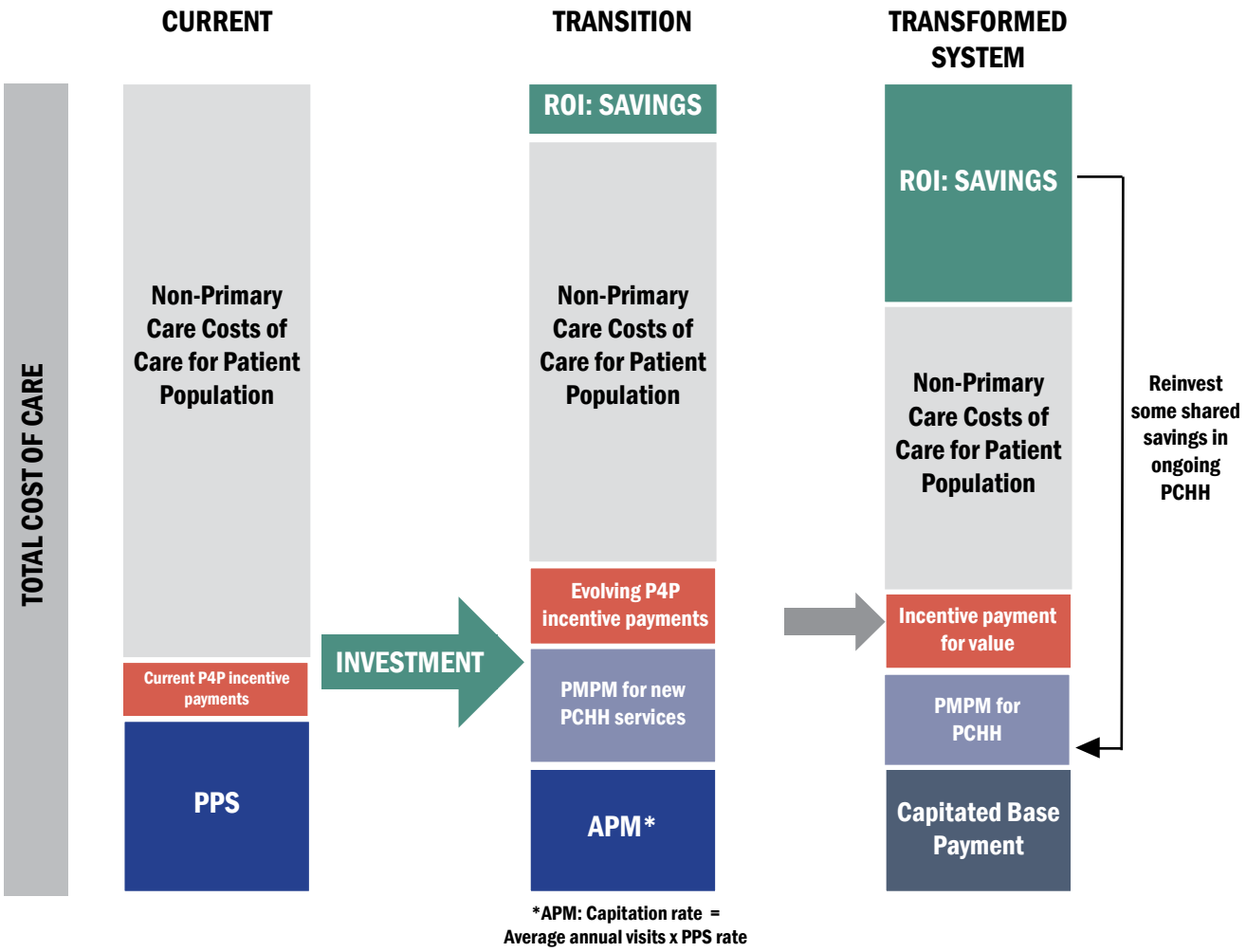
Transition Strategy

Because delivery system transformation will take time to occur, we also recommend that health centers advocate for a transition strategy to allow providers, health plans, hospitals, and patients to adapt to a new way of delivering and paying for health care, to confront challenges such as how to make fair and accurate calculations for capitation rates and shared savings, and to improve data and payment transaction systems.

There are a number of possible transition strategies; we outline two strategies that could help health centers to successfully make the necessary changes required in a new delivery system while maintaining access to care for underserved populations throughout the transformation process.

Transition Strategy 1: The Oregon Model – Capitation Equivalent to PPS Revenue

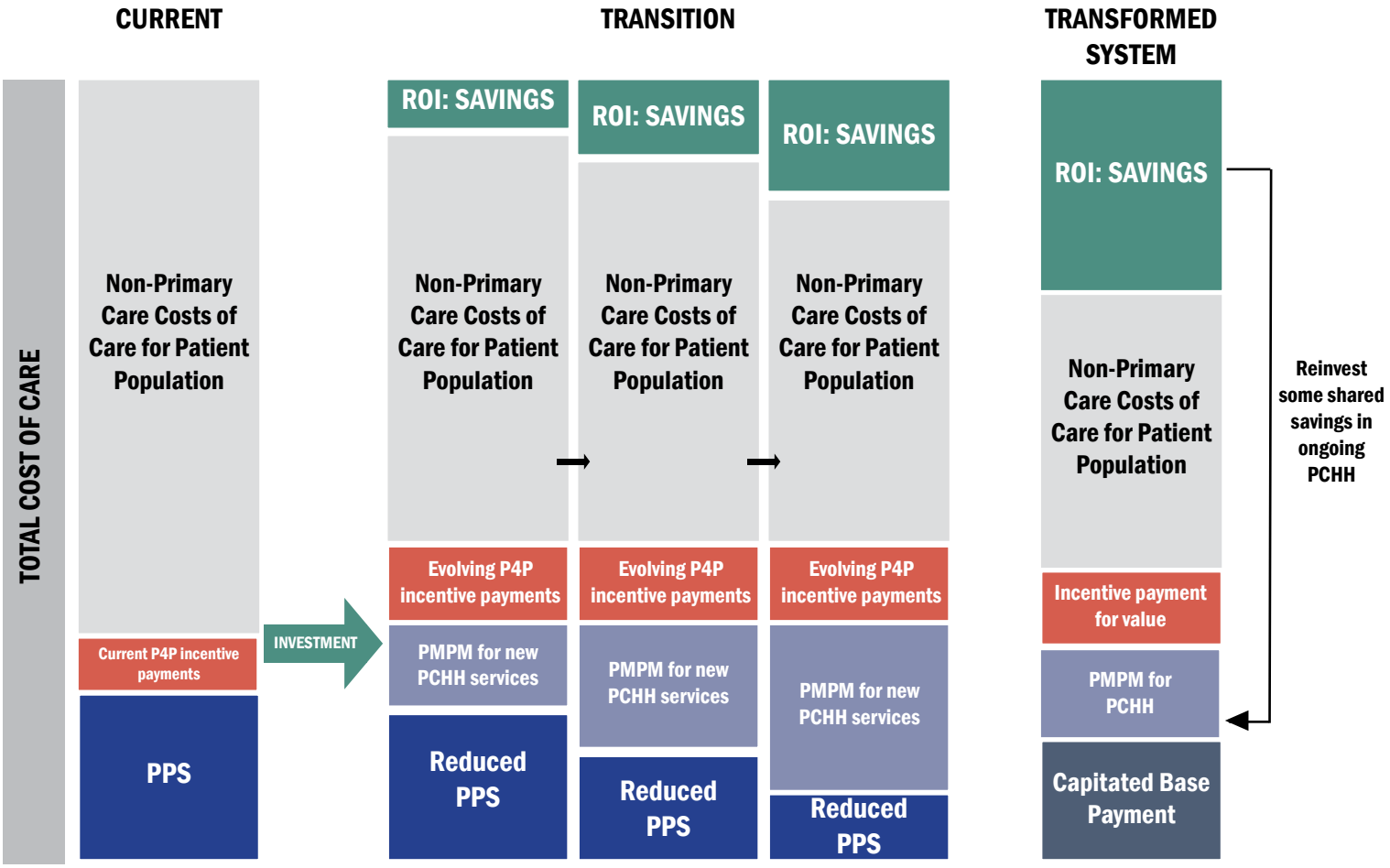
As a base-layer payment moves from PPS to a capitated rate, this transition strategy would be to move to a capitated rate that is equivalent to what a clinic would have received under PPS (See Oregon Case Study). While more flexibility on types of visits may allow health centers to realize some efficiencies immediately (e.g., converting some face-to-face visits to group visits or phone visits), any cost efficiencies gained would need to be invested in other resource-intensive transformations in the way health centers deliver care. These resource-intensive changes include investing in hiring and training new workers, implementing new systems (e.g., telehealth), and developing new processes (e.g., care coordination around hospital discharge) that will result in long-term efficiencies.



Transition Strategy 2: Reduce PPS Rates Incrementally While Increasing a Capitated Health Home Payment

Another potential transition strategy would be to reduce PPS rates incrementally while increasing a PCHH PMPM (a partial capitation rate) incrementally over time. Some would describe this as a PPS withhold that is paid in the form of a PCHH PMPM payment instead. Maintaining a portion of total health center payment in the form of volume-based payment would allow health centers to be compensated for non-attributed patients whom they would inevitably provide services for as the insurance systems devise better ways to bind patients to a health home. The PCHH PMPM payment would eventually become large enough to essentially become a full primary care capitation rate.

Under either transition path, pursuing supplemental payment for health home and incentive payment for value financed through shared savings are both important for achieving the Triple Aim. These payment models would be the same payment models that we would recommend whether the health center is negotiating for this payment under an ACO governance structure, a managed care structure, or a county (as health centers in FFS counties are today).



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Interviews

Health Center Leaders

- Steve O'Kane, CEO, Council of Community Clinics
- Janet Vadakkumcherry, Director of Contracting, Council of Community Clinics
- Dean Germano, CEO, Shasta Community Health Center
- Kevin Mattson, Senior Vice President, San Ysidro Health Center
- Mary Maddux Gonzalez, Interim CEO and CMO, and Eric Holzberg, CFO, Redwood Community Health Coalition
- Louise McCarthy, President & CEO, and Cynthia Carmona, Director of Governmental & External Affairs, Community Clinic Association of Los Angeles County
- Marty Lynch, Executive Director & CEO, Lifelong Medical Care
- Harry Foster, CEO, Family Healthcare Network
- Bruce Carp, CFO, La Clinica de La Raza
- Tim Reilly, CFO, L.A. Care

National Thought Leaders

- Mary Takach, Program Director, and Jason Buxbaum, Policy Analyst, National Academy for State Health Policy
- Dawn McKinney, Director of State Affairs, National Association of Community Health Centers
- Michael Bailit, President, Bailit Health Purchasing LLC
- Arnold Milstein, MD, MPH, Director of Stanford Clinical Excellence Research Program
- Emma Dolan, Policy Analyst, and Gail Rusin, Program Manager, Integrated Healthcare Association

Primary Care Associations

- Craig Hostetler, Executive Director, Oregon PCA
- Susan Wilson, COO, and Angela Herman, Clinical Programs Manager, Missouri PCA
- Polly Anderson, Policy Director, Colorado Community Health Network

State Medicaid Leaders from the Following States

- Washington
- Colorado
- Minnesota
- Vermont
- North Carolina
- Pennsylvania