Driving for Sustainability: Payment Reform Beyond the Affordable Care Act

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What We'll Cover

- National Backdrop and the Affordable Care Act (ACA)
- Payment Reform Framework for FQHCs
- FQHC Examples

NATIONAL BACKDROP AND THE AFFORDABLE CARE ACT

National Backdrop

Among other Organization for Economic Cooperation and Development (OECD) countries:

- US outspends on care and drugs
- Life expectancy at birth is 8th worst
- Projected at 34% of GDP by 2040

What is the main cause of our cost and quality problems?

A. Fragmentation
B. How we pay for care (FFS, lack of incentives)
C. Inadequate transparency
D. Inadequate competition
E. Inadequate patient “skin in the game”

Patient Protection and Affordable Care Act (ACA)

#	Title Name	Detail
1	Quality, Affordable Health Care for All Americans	Private Insurance Reform and coverage expansion
2	Role of Public Programs	Medicaid expansion/CHIP
3	Improving the Quality and Efficiency of Health Care	Medicare/delivery system reform
4	Prevention of Chronic Disease and Improving Public Health	Prevention/wellness/public health
5	Health Care Workforce	Workforce
6	Transparency and Program Integrity	Fraud, comp. effectiveness
7	Improving Access to Innovative Medical Therapies	Biosimilars
8	~~Community Living Assistance Services & Supports~~	CLASS (repealed)
9	Revenue Measures	New taxes and fees
10	Reauthorization of Indian Health Care Improvement Act plus Health Care Education & Reconciliation Act	Manager's Amendment plus HCERA

ACA Alphabet Soup

Cover*

- Medicaid Expansion: 26 states including DC
- 6 “Alternative Expansions”

Payment Reform

- DSRIP
- ACOs
- HRRP, HAC
- MACRA QPP
- CMMI
- SIM
- PCMH/2703 PCHH
- 1332 (2017)

*Source: State Reforum, Map: Where States Stand on Medicaid Expansion Decisions, Updated May 11, 2016.

ACA: Payment Reform

Increasing on Multiple Federal Fronts:

- New Managed Care Medicaid Regulations
- Medicare Access and CHIP Reauthorization Act (MACRA)
- Health Care Payment Learning and Action Network

JSI

Health Care Payment Learning and Action Network

CMS Alliance to Modernize Healthcare

Drive alignment in payment approaches across the public and private sectors of the U.S. health care system

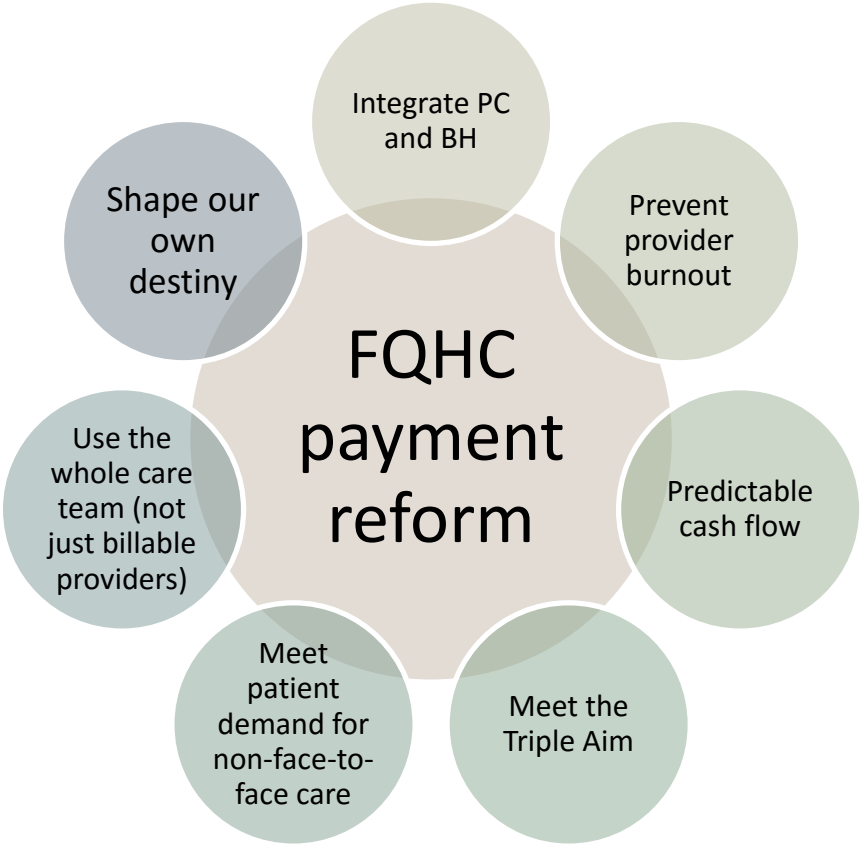
Figure 1. APM Framework (At-A-Glance)

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations B Pay for Reporting C Rewards for Performance D Rewards and Penalties for Performance	A APMs with Upside Gainsharing B APMs with Upside Gainsharing/Downside Risk	Partial Population Based Payments for Primary Care

When asked "would you rather work for change, or just complain?" 81% of the respondents replied, "Do i have to pick? This is hard."

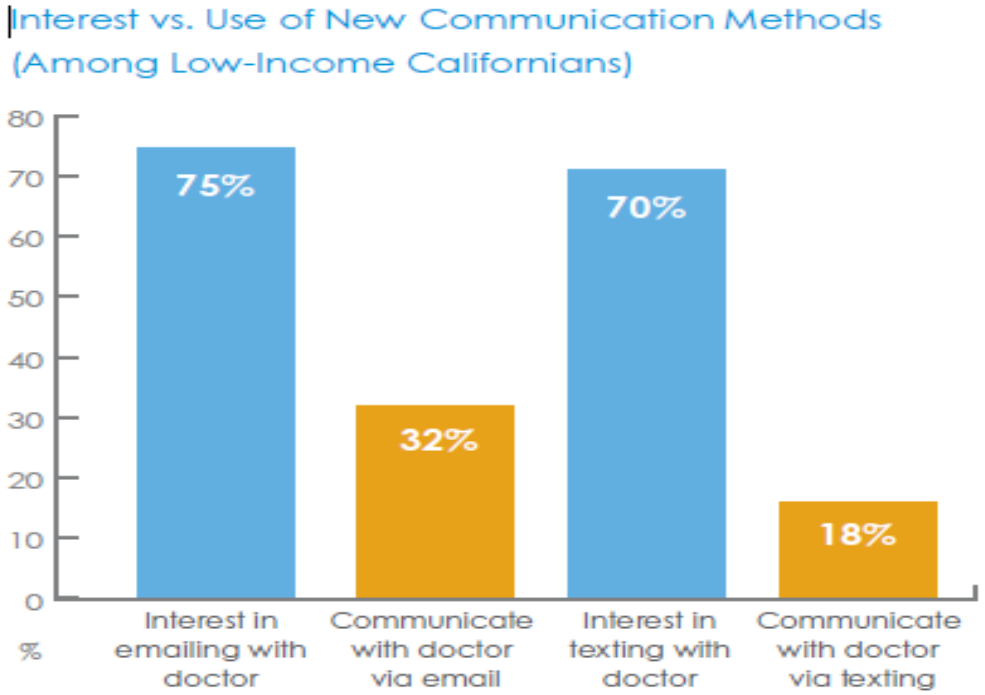
PAYMENT REFORM FOR FQHCS

Payment Reform for FQHCs: WHY?



Payment Reform for FQHCs: WHY?

- New Patient Data: Demand for Alternative Care
- Satisfied =retained?
- Strategy to increase market share?



Source: Blue Shield of California Foundation, 2015 Brief

Payment Reform for FQHCs: WHY?

- FQHCs are creating total health system value (MI)
- HRSA Value of CHCs study (12 states), including Mississippi

Social Determinants of Health Framework, Office of Disease Prevention and Health Promotion

Payment Reform: APM by CMS

- Alternative payment **models** include:
  - Accountable Care Organizations (ACOs), including Advance Payment Model ACOs.
  - Bundled payments,
  - Advanced primary care medical homes,
  - Others…
- *“Lowercase APM”*

Social Security Act 42 USC §1396a(bb)(6) and January 2001 State Medicaid Directors Letter (SMDL #01-014)
2010 State Health Official letter (SHO#10-004)

Payment Reform: APM for FQHCS

- Alternative Payment **Methodology**
- Congress allows use of an APM as long as:

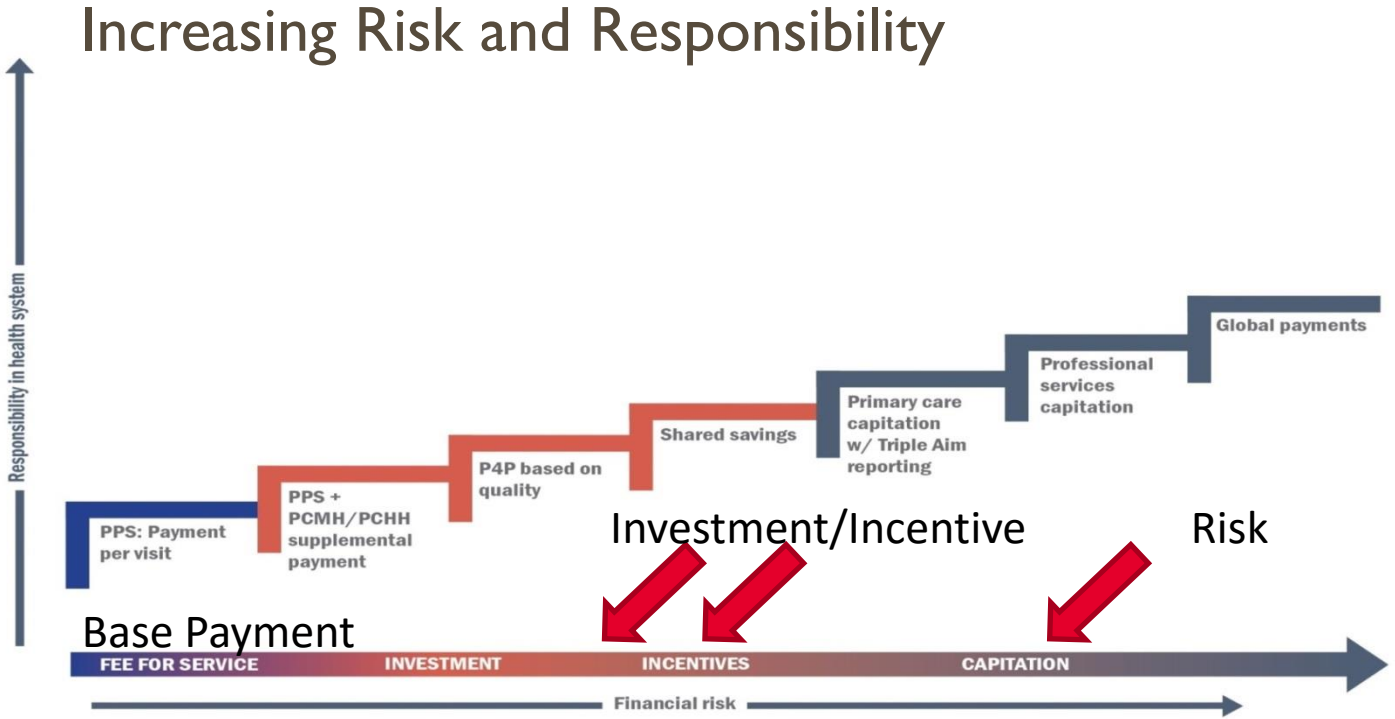
  1. It "results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic" under PPS

  2. It is agreed to by the state and the individual FQHC or RHC

- 2010: CMS Letter re: CHIP suggests written assertion is OK
  - *States "may accept an FQHC's written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC is entitled under the PPS."*

1) Social Security Act 42 USC §1396a(bb)(6) and January 2001 State Medicaid Directors Letter (SMDL #01-014)
2) 2010 State Health Official letter (SHO#10-004)

Payment Reform Framework for FQHCs



**“What if we don’t change at all ...
and something magical just happens.”**

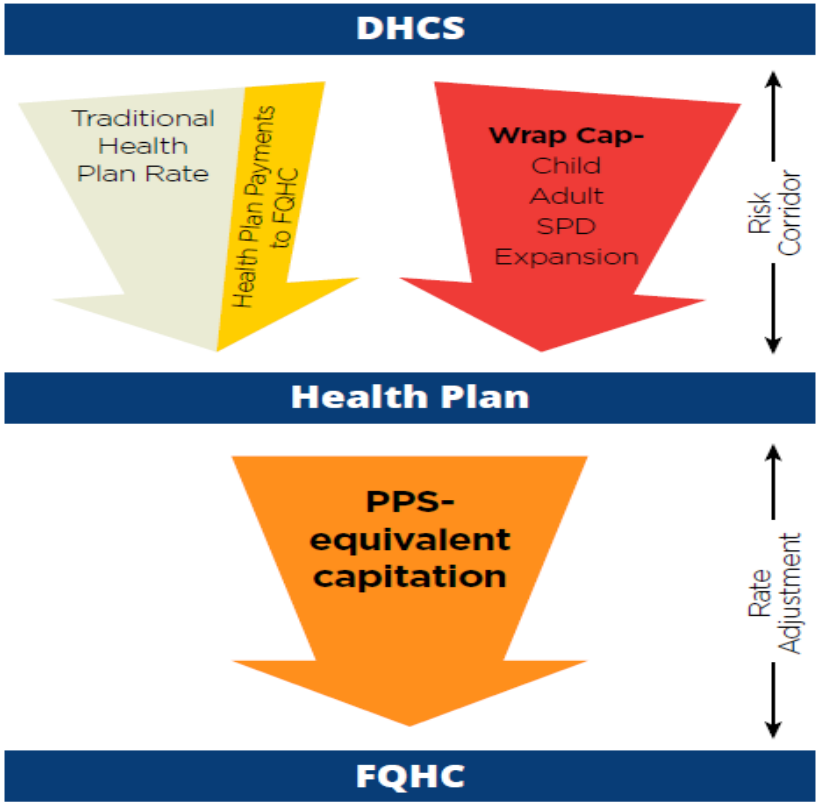
FQHC EXAMPLES

Examples of FQHC Payment Reforms

- California: APM (pilot)
- Oregon: APM
- Missouri: 2703 SPA
- Others

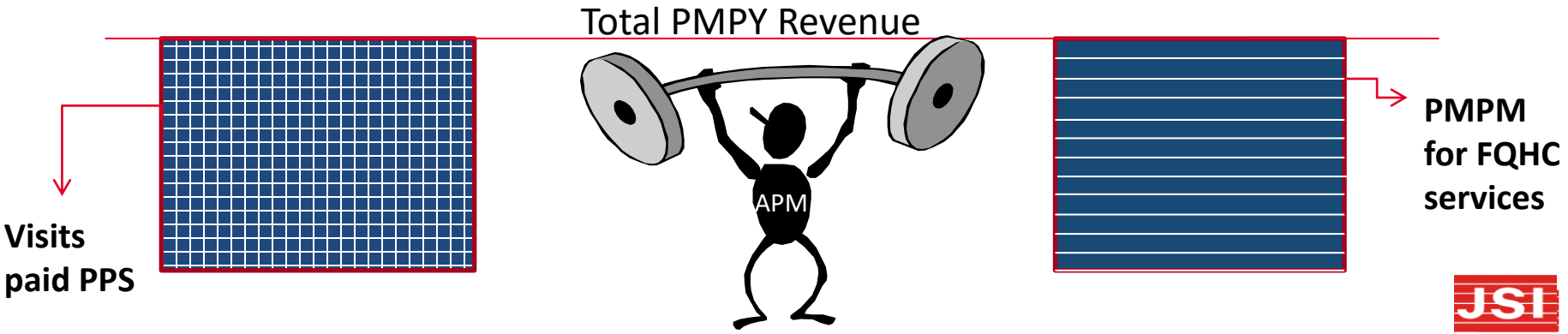
California

- California Department of Health Care Services (DHCS) sets rates for health plans
- Plan reports Medi-Cal members assigned to pilot sites
- State pays plans supplemental “Wrap Cap” for all APM - pilot assigned members
- Plan pays FQHC for all assigned members



California

Today: Volume-based PPS	PPS-Equivalent Capitation
• Volume-based payment • Face-to-face visits • Billable providers	• Monthly payment per member • Some visits converted to new modes of care (phone, email, group visits) • Care teams (including non-billable providers)



Oregon

- Medicaid pays PMPM
  - based on a fee-for-service baseline—with a promise to continue the movement toward value-based care.
- Working toward adjusting payments to a value-based system
  - accounts for behavioral health and social determinants of health
  - reimburses at a rate that allows the CHCs to succeed.

Missouri 2703 SPA

- (October 2011) Behavioral health patients served by community mental health centers
- (December 2011) Physical health conditions served by Federally Qualified Health Centers, Rural Health Centers and hospital-based primary care clinics.
- Bolstered by robust data system that can visualize data from any Electronic Health Record

Other efforts

- Actively pursuing APM
  - Minnesota
  - Colorado
- Actively engaged with system transformation
  - Alabama
  - New York

Lessons Learned from Examples …So Far!

Stakeholder relationships

Ongoing internal education and engagement

Robust health information technology

- Quality Improvement reporting
- Capturing “alternative touches” and social determinants
- Capacity for predictive analytics and reducing costs

Lessons Learned, Continued

Fiscal Awareness

- Understanding of costs/cost-effectiveness;
- Readiness to assume risk
- Influence on patients'/members' total cost of care

Practice Transformation

- Patient Centered Health Home
- Team Based Care
- Prepare for non-traditional care

Reflection

Photo from www.flowerinfo.org

Doing the best at this moment puts you in the best place for the next moment.

-- Oprah Winfrey

THANK YOU

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