



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

Executive Summary

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Executive Summary

Policy makers, payers and health centers agree that the delivery system requires fundamental change. 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 that emphasizes value over volume of care. 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. Thus, 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 necessary 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 and Methodology

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.

This report is based on an extensive review of the literature on payment reforms being implemented in both the public and private sectors. It is also based on telephone interviews with state officials or representatives of primary care associations (PCAs) in seven states, national experts on payment reform, and community health center leaders in California between April and November 2011.

The Conceptual Framework of Payment Reform

Through a conceptual framework for payment reform, we describe the major payment methodology alternatives to the fee-for-service (FFS) system, including incentive-based payment systems and capitation. We also posit that establishing a payment model requires stakeholders to answer a host of questions regarding the model elements:

- On what basis will payments be made to providers?
- Whom will be covered by the payment model?
- How and when will payments be made to providers?
- What domains will be measured and what metrics will be used to assess performance?
- How will payments be calculated?
- How can the data be analyzed such that providers are not penalized for treating sicker patients?
- Where will the funding for the payment model come from?

Key Findings on Areas of Payment Reform/Delivery System Transformation

Based on our research and interviews, we synthesized the overarching findings to respond to the question: what payment models should health centers consider? Key models included: pay for performance, patient-centered medical home, accountable care organizations, and primary care capitation.

Pay for Performance

Pay-for-performance 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 its focus on value and is being viewed as a stepping stone for increasing the accountability of health centers and other providers. P4P 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.

New P4P systems require agreement on common value metrics and the development of a data infrastructure among safety-net providers to collect and analyze the data. This data infrastructure and analysis can be used for internal management purposes, benchmarking and rate negotiations with health plans.

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 PCMH or health home is even more important for states as a way to bind patients to one provider as they move from uninsured to Medi-Cal or exchange insurance. Health reform also creates an opportunity for states to receive enhanced Federal funding for the creation of health homes for populations with chronic conditions through Section 2703 state plan amendments (SPAs). By establishing closer bonds with patients through PCMH or 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 most common payment methodology for PCMH is a supplemental per-member-per-month (PMPM) payment on top of FFS/PPS for providing medical home services. These PCMH payments—which range from \$2-6 PMPM for the general Medicaid population and from \$10-78.87 PMPM in proposed SPAs for enrollees with chronic conditions—represent a move away from volume-based pay toward value-based pay by investing in providers' engagement in improved coordination of care across the whole health system.

Accountable Care Organizations

Accountable care organizations are a relatively new idea still in the experimental stages nationally. Although the guidance from the CMS Medicare Shared Savings Program drives a strict definition of ACOs, there are also different varieties of ACO-like models being developed at the state and local levels. Most of these ACO-like organizations are united by three key aspects: 1) shared savings, 2) accountability for quality (metrics used to determine eligibility for shared savings), and 3) free choice of providers by patients. The common thread among ACOs and ACO-like structures regarding payment is in their use of sharing savings arrangements as an incentive for improved coordination and improved care delivery across the system. ACOs are exemplary for their pursuit of the Triple Aim and are being deeply influenced by local stakeholder negotiations. To this end, it is critical for health centers to “be at the table” in their local communities to ensure they are not left out of ACOs that may form.

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. 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. 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 fully capitated system for health centers under an alternative payment methodology to PPS. 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 non-reimbursed services while potentially reducing the costly reconciliation process within PPS. 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.

Key Principles for Health Centers Payment Reform/Delivery System Transformation

Establishing consensus among CCHCs and other stakeholders on underlying principles of payment reform will help CCHCs as they design 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 incentives 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.

2. Delivery system transformation requires both investment and payment reform. It will take additional investment in primary care and patient-centered medical homes in order to realize overall health system savings because PCMH services include additional services beyond the enabling services that health centers provide today. In particular, investments will need to center on developing the workforce for medical home, 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 in becoming “the provider of choice” under health reform.

3. Layering multiple payment models will be required to achieve all goals of delivery system change.

Payment reform will be a phased process accompanying delivery system change. One of the goals of delivery system change is to ensure that CCHCs, a critical provider for underserved populations, have the necessary resources to make the transition to a new delivery system and survive the change. The layers would include a base payment bounded by parameters of the current health center payment system (PPS or an APM); a partial capitated payment for novel medical or 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. It will be critical for CCHCs to be active participants in this phased process through participation in pilots and dissemination 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 provider as their medical home. Health plans can play a pivotal role in promoting and strengthening this bond through insurance design.

5. Data availability and transparency are critical. 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 the total cost of care. For CCHCs to understand the total cost of care and associated utilization drivers of their patient populations, CCHCs need to have access to realms of data that have historically fallen outside their purview. This will necessitate working more closely around data partnerships and strategies with both health plans and the State. Alignment with existing data collection efforts and building towards a system that can account for the social acuity of the Medi-Cal patient population will be important goals for CCHCs to promote within these partnerships.

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.

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. 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.

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. 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. Opportunities for consolidation of CCHCs could take the form of both organizational consolidation and strategic alliances.

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, and patient experience measures that CCHCs already collect.

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. 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 medical homes. CCHCs can promote the idea that PCMH emphasizes a new, increased level of care coordination across the health system. This added coordination will require additional resources for primary care patient-centered medical 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 PCMH 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 PCMHs 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 and General Principles outlined above, we have identified five next steps for CPCA and health centers to take regarding payment reform.

1. Pursue a Section 2703 State Plan Amendment for Chronic Care Medical Home

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 SPA, for the provision of health home services to individuals with chronic conditions. To leverage this federal opportunity to catalyze delivery system transformation, CPCA has committed to working with state officials on development and implementation of a Section 2703 SPA. The key positions that CPCA has put forward to the State regarding a 2703 SPA include a central role for primary care in the provision of health home services; an emphasis on the integration of primary care and behavioral health and improvement around care transitions; a tiered per-member-per-month (PMPM) payment for providers delivering health home services to enrollees with chronic conditions based on the Minnesota PCMH payment model (see below for description); short-term financing for the state portion of the match coming from providers (potentially supported by California foundation funding for CCHCs) and long-term financing derived from shared savings; and a recommendation that California pursue multiple SPAs, including a SPA targeting FQHCs and hospital outpatient clinics.

2. Advocate for a Supplemental PMPM Payment Model for patient-centered health home (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. The Minnesota payment methodology for PCMH 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 partial 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 use 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. 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.

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 PCHH. 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 PCMH 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. Other states are viewing the 2703 SPA as an opportunity to safely practice capitation for health home services without giving up cost-based reimbursement, as seen in Missouri. 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. 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 and the nation.

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.

In speaking with safety-net leaders, we heard multiple metaphors for the fact that some form of value-based payment methodology was inevitable. One state PCA leader expressed it this way: "The value-based 'bus' is coming. Are we [health centers] going to step off the curb blindly and get hit by the bus or are we going to figure out how to get on the bus?" Our hope is that this report will help CCHCs to determine how to "get on" and possibly even drive the "value-based bus."