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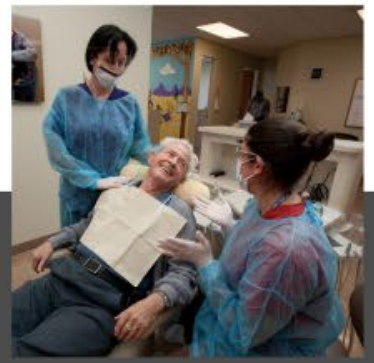



America's Voice for Community Health Care

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America's Voice for Community Health Care

The NACHC Mission

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

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Payment Reform Retreat

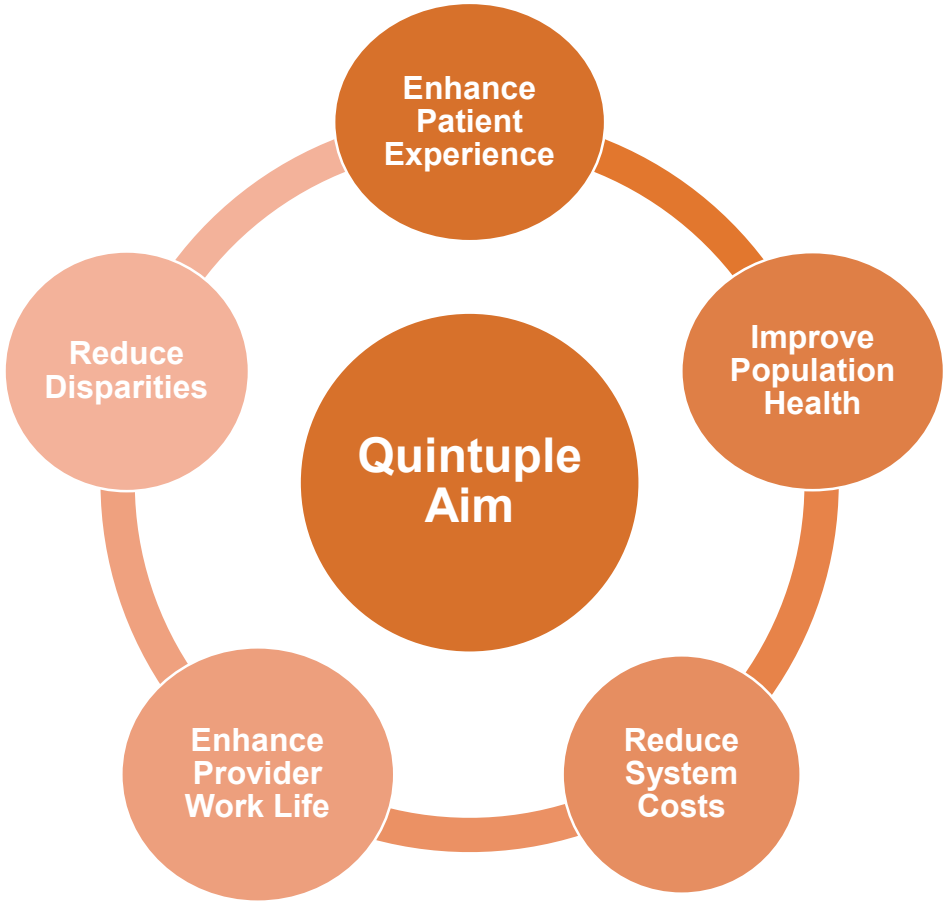
Maine Primary Care Association

April 29, 2019

Why Change Payment?

Common Health Center Responses:

- Mission
- Patient Care and Community Health
- Payment and Practice Alignment
- Workforce
- Financial Stability



Guided By Our North Star

Let's Chart Our Path!

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Key Steps for Successful Health Center Engagement

1. Develop and maintain a robust understanding of payment reform efforts in the state and local environment.

2. Ensure a clear, shared vision of the organization's role in achieving the Quintuple Aim that can be used to assess emerging payment reform opportunities.

3. Critically assess current payment model, operations, and capabilities.

4. Work collaboratively with fellow health centers, stakeholders and partners to accelerate transformation of the health care delivery system.

Systems Approach to Transformation

- Training & Technical Assistance
  - Quality Center
  - PRAPARE
  - Payment & Delivery Reform Summit
  - FQHC APM Academy
  - ACO Academy
  - Health Center Resource Clearing House
  - Various trainings and leadership development opportunities

- Policy, Advocacy, and Partnerships
  - Delta Center for a Thriving Safety Net
  - NACHC-NAMD Workgroup

Conversation Agenda

1. Common Language and Concepts
2. Health Centers and Payment Reform
3. Network Approaches
4. Market & Policy Developments
5. Key Steps for Success

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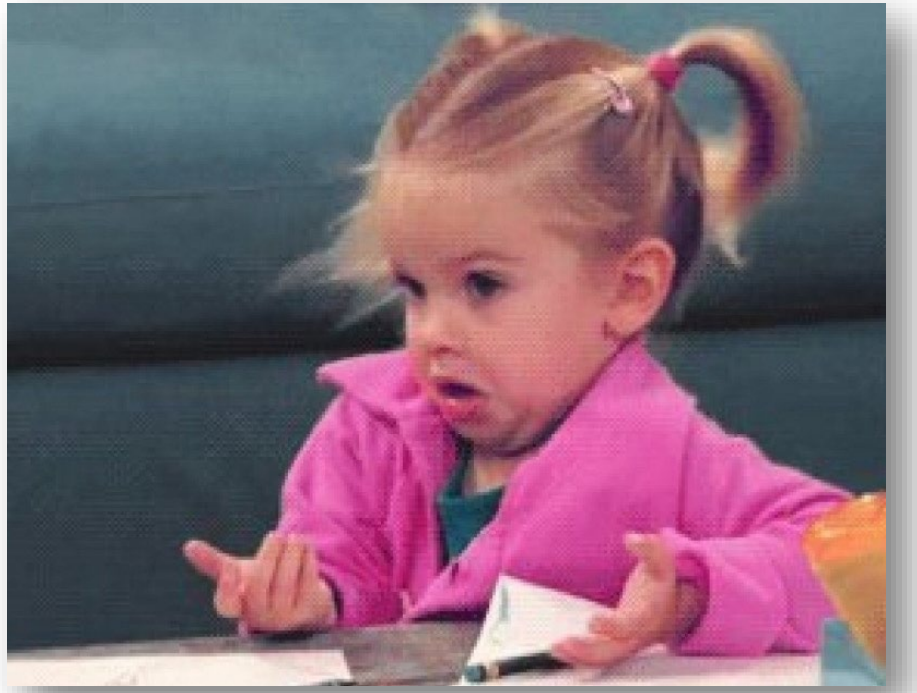
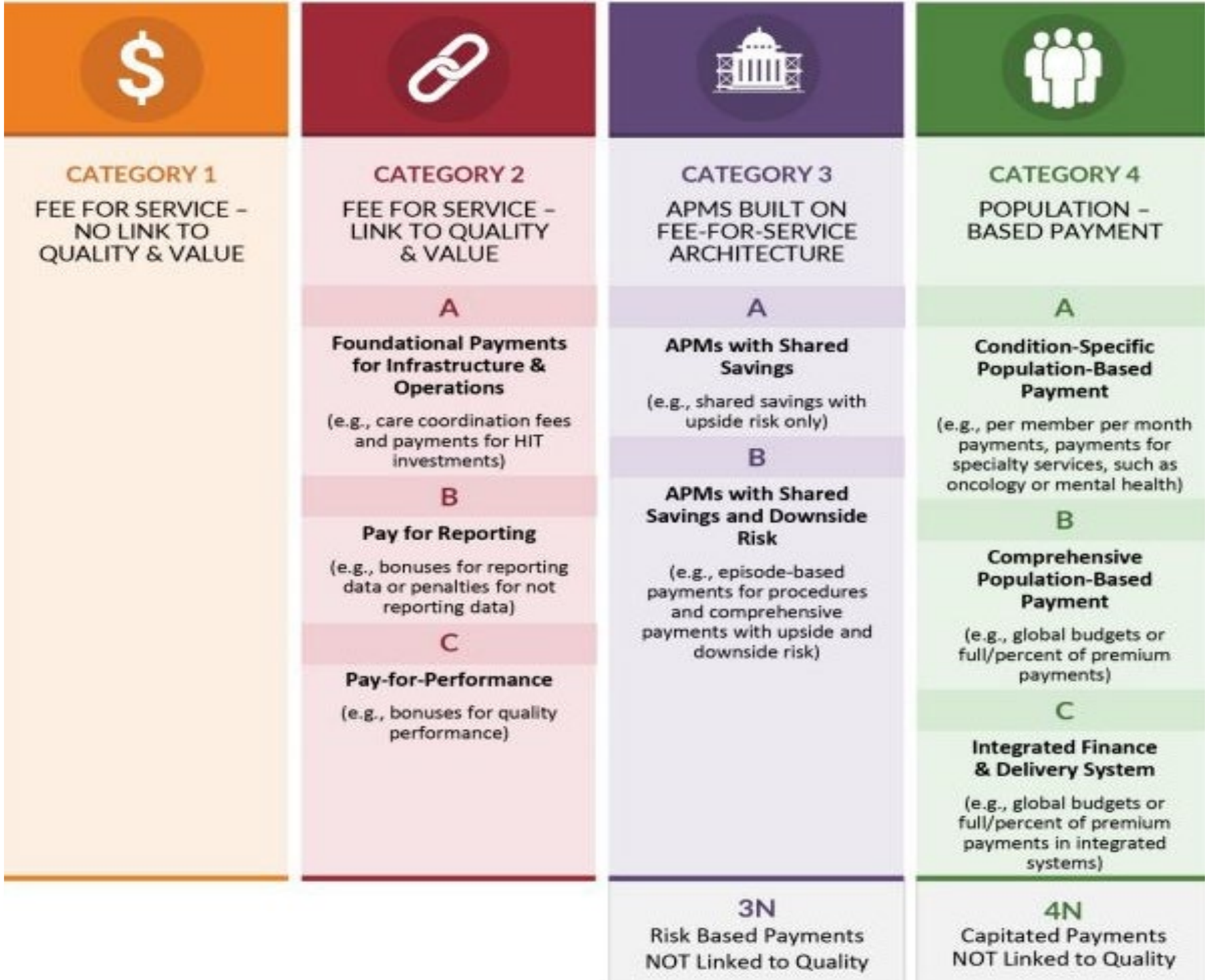
Common Language & Concepts



Health Care Payment Learning & Action Network

HCP-LAN

Alternative Payment Framework



Category 1: Fee-For-Service (No Link to Quality)

Payments made for units of service

Category 2: Fee-For-Service with Link to Quality & Value

- Utilize traditional FFS payments
- Subsequently adjusted based on infrastructure investments to improve care or clinical services

- **2A: Foundational Payments for Infrastructure and Operations** (*Example: Care coordination fees)*

- **2B: Pay for Reporting** *(Example: Data reporting bonus)*

- **2C: Pay for Performance** *(Example: Quality bonus)*

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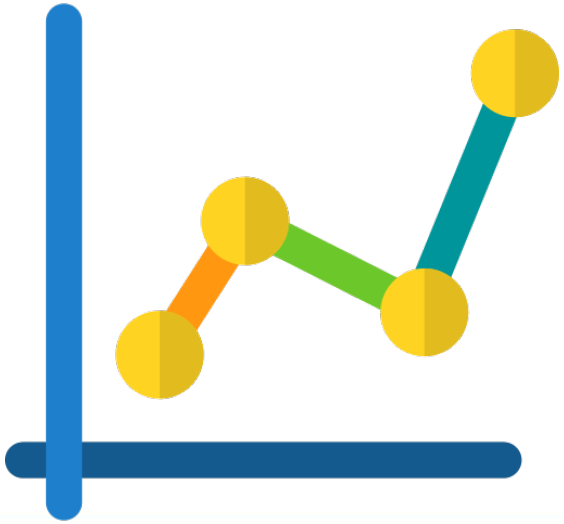
Category 3: APMs Built on Fee-for-Service Architecture

- FFS foundation with mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals
- Based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established
- Structured to encourage providers to deliver effective and efficient care

- **3A: APMs with Shared Savings (upside risk only)**
- **3B: APMs with Shared Savings and Downside Risk**
  (Examples: Maternity episode-based payment, Comprehensive payment with upside and downside risk)



Category 4: Population-Based Payment

- Prospective, population-based payments
- Structured in a manner that encourages providers to deliver coordinated, high-quality, person-centered care within either a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system

4A: Condition-Specific Population-Based Payment
(Example: Per Member Per Month for Primary Care)

4B: Comprehensive Population-Based Payment *(Example: Global Budget)*

4C: Integrated Finance & Delivery System *(Example: Kaiser Permanente)*

Avenues for Engagement

Payer Agreement

Network

Let's pause for questions!

Network Approaches

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Accountable for the Entire Health of a Population

- Working together with other HCs, hospitals, other providers
- Building trust so the care for the patient can truly be unified (aka integrated)
- Reduce costs and improve patient care:
  - Shifting ER care to the doctor's office
  - Managing cases better pre- and post- hospital stays
  - Automating processes and eliminating duplicate ones
  - Communication key to increase the quality of the patient experience
- Leads to true population health - higher risk and more rewards

Independent Practice Association (IPA)

An **Independent Practice Association** is an organization consisting of two or more independent physician practices that work jointly in some way.

Some IPAs accept payment contracts on behalf of their members, others provide mechanisms for multiple practices to share infrastructure costs or staff that would otherwise not be affordable for small practices.

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Clinically Integrated Network (CIN)

A **Clinically Integrated Network** is a collection of providers who **create processes and systems for managing and coordinating the care they deliver to individual patients**.

If a CIN meets specific standards established by the Federal Trade Commission (FTC), the providers in the network can **jointly negotiate with payers** in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk.

Things that a network **must do to show it is clinically integrated** under FTC rules:

- Developing and using detailed, evidence-based clinical practice guidelines;
- Limiting participation in the network to providers who are committed to following the clinical practice guidelines;
- Measuring the participating providers' compliance with the guidelines; and
- Enforcing use of the clinical guidelines.

Accountable Care Organization (ACO)

An **Accountable Care Organization** is a group of providers who have organized themselves in a way that enables them to take accountability for the overall quality of care and the total cost to payers of all or most of the healthcare services needed by a group of patients over a period of time.

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How Does an Accountable Care Organization Work?

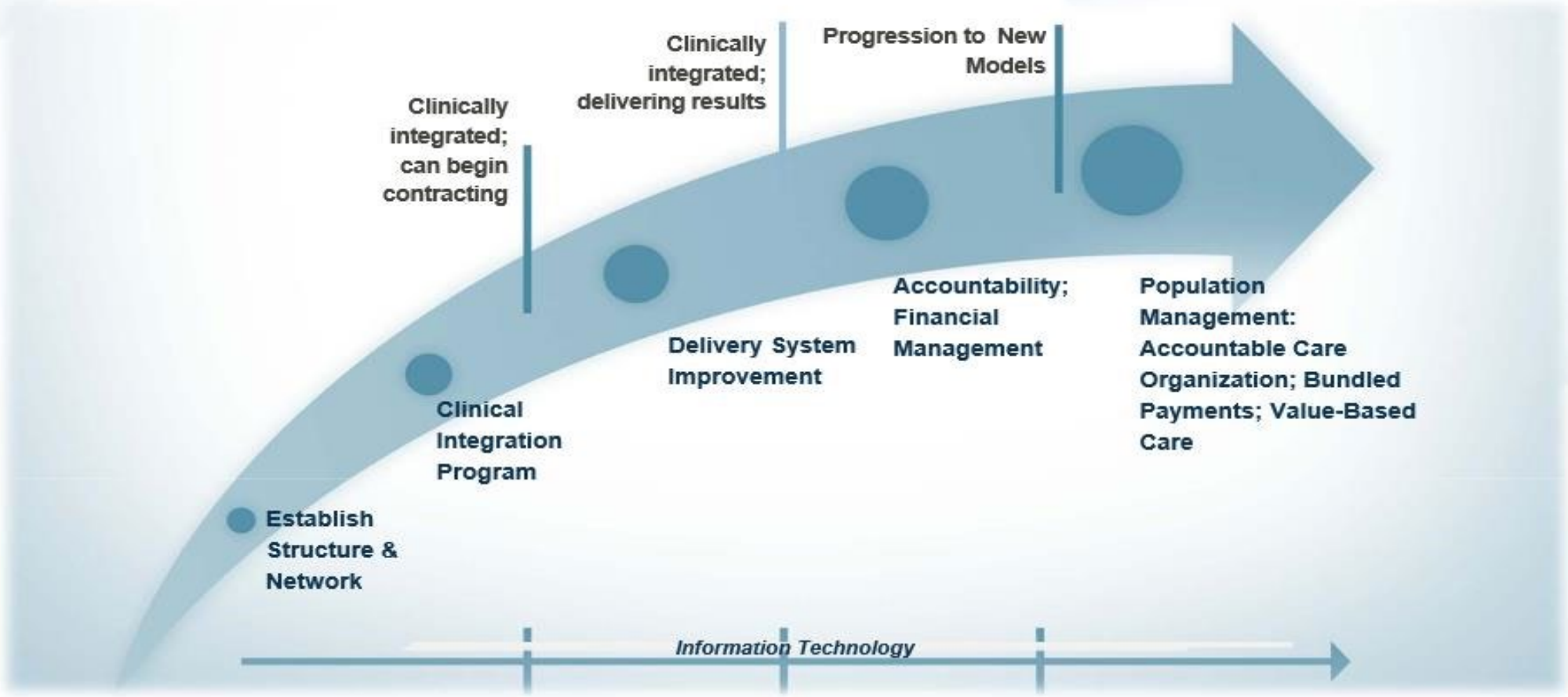
- An ACO is a provider-led organization whose mission is to be **accountable** for the overall cost and quality for a full spectrum of care for a defined population
- Prior research shows that most physicians already practice within referral networks around one or a few hospitals, paving the way for **care coordination**
- ACOs provide support to provider organizations through **shared savings** to coordinate and deliver care in new ways that improve outcomes while reducing costs
- Because the ACO framework offers a basic method of decoupling volume and intensity from revenue and profit, it is the first step to achieving a **sustainable health care delivery system**.

Who is the Health Center's Patient?

- *Defined by the Health Center*
- *Defined by the Payer / ACO*
- *Proactive vs. Reactive – do we understand the difference?*

Clinical Integration: Evolution to an ACO

Positioning for the future



Let's pause for questions!

Health Centers and Payment Reform

What Does Payment Reform Look Like for Health Centers?

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Quintuple Aim Performance Payment

PCMH and/or PCHH

PPS or APM

Incentivize quality and cost outcomes (upside incentives and/or downside risk/penalties)

Invest in new services/capabilities

Base payment: Funds most services with **flexibility** to deliver care differently

** Multiple payment reforms often work together*

** Ideally, payers are aligned*

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What Does Payment Reform Look Like for Health Centers?

Incentive

Payment for Performance

Investment

Payment for Delivery System Transformation (PCMH)

Flexibility

Base Payment (FQHC PPS/APM)

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Medicare FQHC PPS

- Medicare FQHC Prospective Payment System (PPS) created in ACA
- **Single, bundled national PPS** rate, adjusted for geography
- Health centers are paid based on the PPS rate or their G codes, whichever is less. (*Note:* ***CODING IS KEY***)
- PPS rate is paid for a **face to face** visit with one of the following provider types:
  - Physician
  - Physician's Assistant
  - Nurse Practitioner
  - Clinical Psychologist
  - Certified Nurse Midwife
  - Clinical Social Worker
  - *Sometimes* a Certified Diabetes Educator

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Medicaid FQHC PPS/APM

Medicaid FQHC PPS

- **Single, bundled rate** covers all of the services and supplies in a single visit
- Unique to FQHCs, other providers paid on the fee schedule
- Initial FQHC PPS rate was established by **averaging reasonable costs**
- Calculated at **each health center**
- Serves as a **baseline** payment

Medicaid FQHC Alternative Payment Methodology (FQHC APM)

- Currently used in over 20 states
- A state may implement a FQHC APM, as long as:
  1. total reimbursement is **at least equal to the PPS rate**
  2. each participating FQHC agrees

FQHC APMs in Medicaid

Five Categories of FQHC APMs

- Full FQHC PPS via Managed Care
- Reasonable Cost Per-Visit Bundled Payment
- Rebased Per-Visit Bundled Payment
- Per Member Per Month Bundled Payment
- Bundled Payment with Quality Indicators (PMPM & Per-Visit)

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State Example: Oregon FQHC APM

State Context:

- Health centers paid via FQHC PPS
- State developing Coordinated Care Organizations (CCOs)

Key Features:

- Launched 2013 pilot with 3 health centers
- Capitated PMPM payment based on historical PPS payments
  - Excludes dental and specialty mental health services

Rate Calculation for Oregon's FQHC APM

APM RATE =

$$\frac{\text{Applicable wraparound} + \text{Reconciliation revenue}}{\text{Health center member months}}$$

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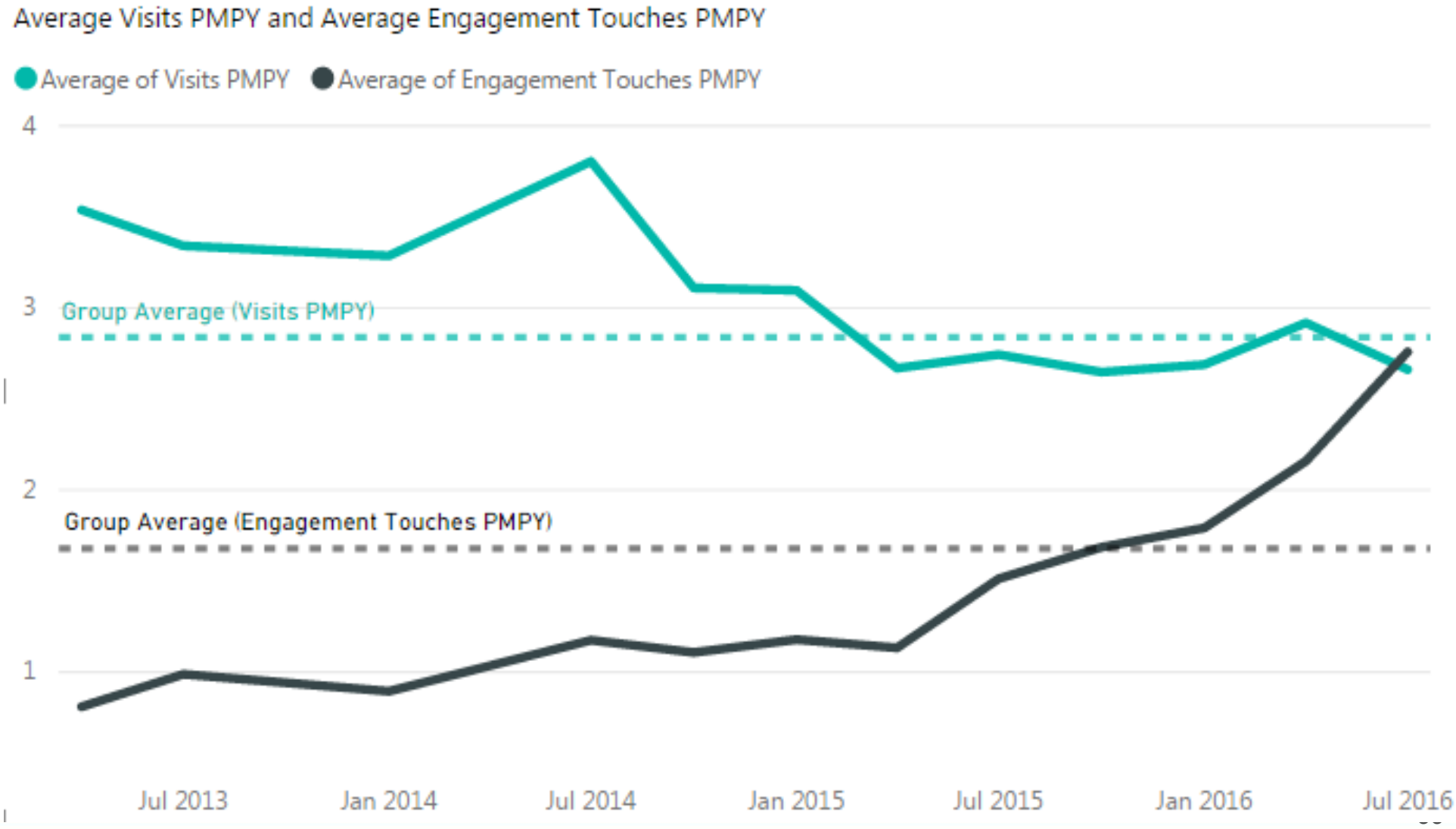
Oregon FQHC APM: Visits to Care STEPS (formerly “touches”)



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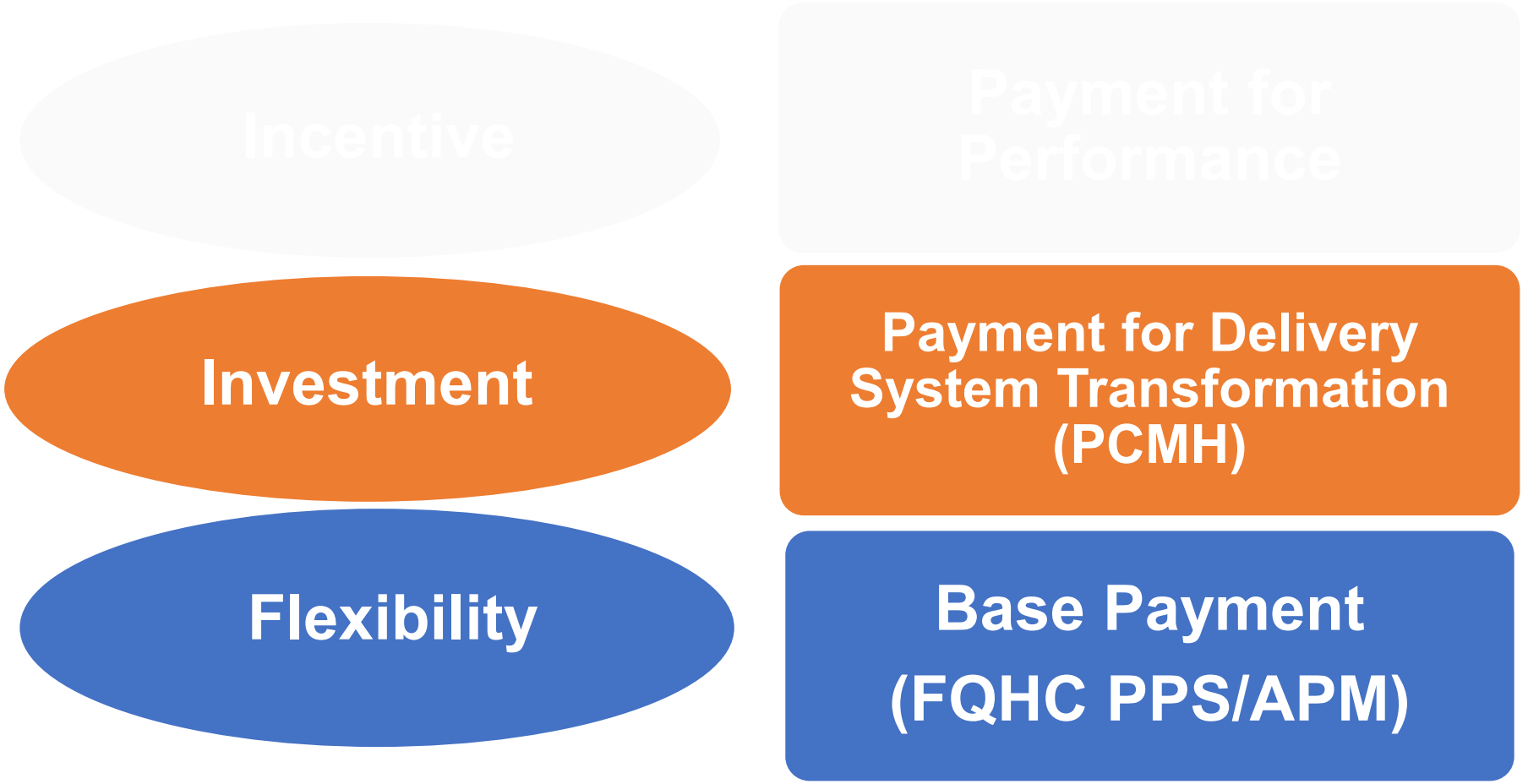
What Does Payment Reform Look Like for Health Centers?



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Medicare Payment for Care Management Services

- Since 2016, CMS has reimbursed FQHCs for Chronic Care Management.
- FQHCs are reimbursed for two HCPCS codes:
  - **General Care Management**: G5011 (which includes CPT codes 99490, 99487, 99484, and 99491) for at least 20 minutes of general care management.
  - **Psychiatric Collaborative Care Management:** G0512 (which includes CPT codes 99492 and 99493), for at least 70 minutes of collaborative care management.
- Starting in January 2019, CMS will reimburse FQHCs for:
  - **Communication technology-based service:** When an FQHC provider does a "virtual check in" with their patients – a non face-to-face visit, using communication technology, as long as it is not related to a face-to-face visit within the last 7 days or does not lead to a visit within 24 hours (or the soonest available appointment) with the patient.
  - **Remote evaluation:** FQHC providers can receive reimbursement for the evaluation of recorded video and/or images, as long as it is not related to a face-to-face visit within the last 7 days or does not lead to a visit within 24 hours (or the soonest available appointment) with the patient.

State Example: Ohio's Comprehensive Primary Care

- Multi-payer initiative that invests in primary care infrastructure intended to support improved population health outcomes
  - Includes Medicaid FFS and all managed care plans
- Patient-centered medical home program, which is a team-based care delivery model led by primary care practices that comprehensively manage patients' health needs.
- Started in 2017 with 20 participating Ohio FQHCs, making up the majority of the primary care providers in the program
- CPC practices eligible for two payment streams in addition to existing payment arrangements with the Ohio Department of Medicaid and MCOs:
  - Per-member-per-month (PMPM) payment, to support activities required by the CPC program
  - Shared savings payment, to reward practices for achieving total cost of care savings

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Missouri: Primary Care Health Homes

- Launched Primary Care Health Homes program in 2012
- Services offered statewide to Medicaid beneficiaries with 2 chronic conditions or 1 chronic condition and confirmed risk factors for developmental of additional chronic condition
- Emphasis on behavioral health
- Provider eligibility requirements for participation
- Home health providers receive a per member per month payment to cover health home functions that are not billable under the current Medicaid program
- Data plays a key role
- Initial estimated cost savings after 18 months = $7.4m ($30.79 PMPM)
- Significant improvements in health status among patients

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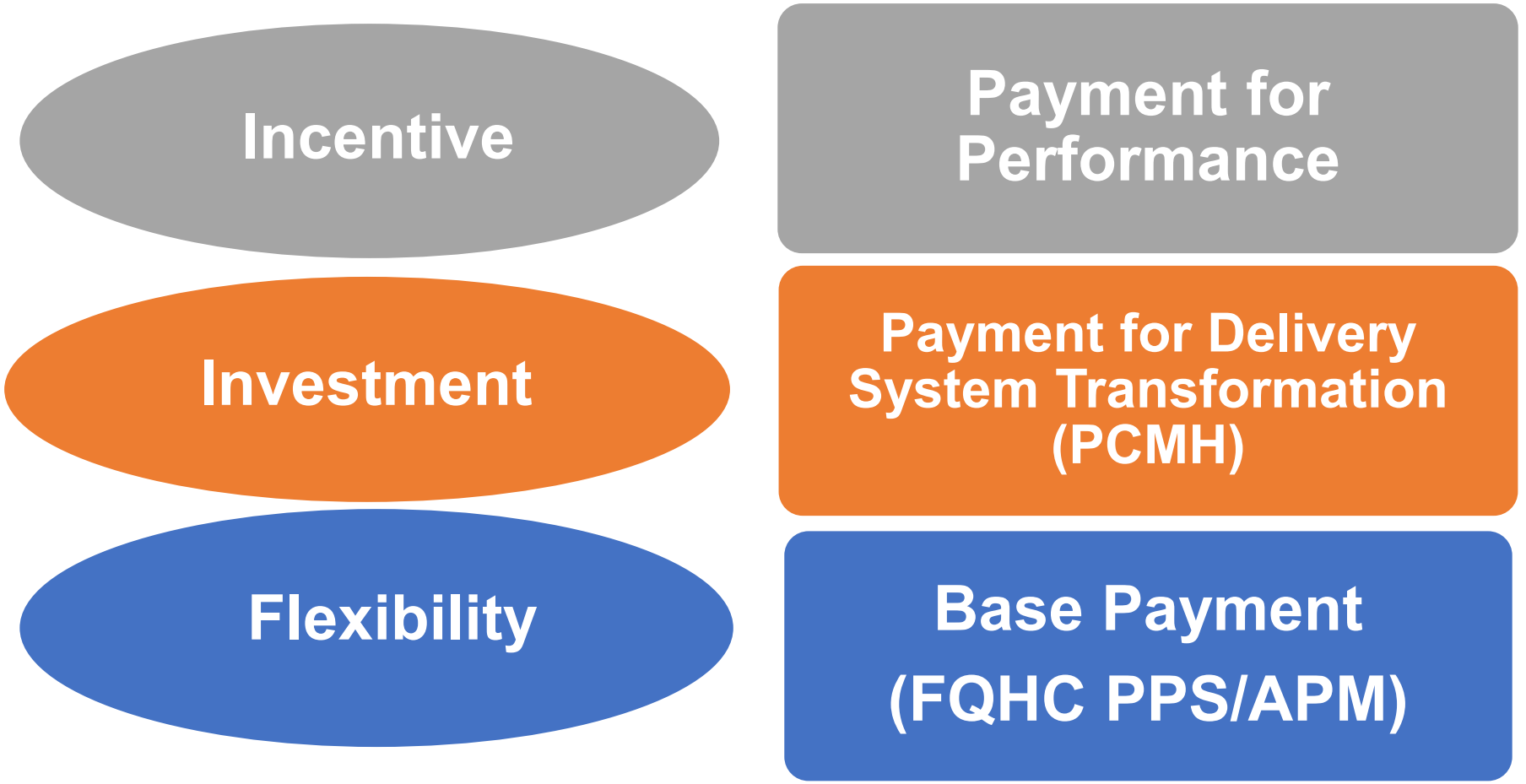
What Does Payment Reform Look Like for Health Centers?



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State Example: Minnesota's FQHC Urban Health Network (FUHN) ACO

- Part of state's Medicaid payment reform demonstration
- 10 urban health centers (40 delivery sites) located in the Twin Cities
- Responsible for total cost and care quality for assigned patient population
- First % of shared savings retained by state, 98% split 50/50 between state and ACO
- Results from 2013 through 2016 (*4 years*)
  - ER use ↓ 18%
  - Inpatient hospital use ↓ 8%
  - Slowed spending by 5%, Saved taxpayers ~$21.3m
- State's ACO program model evolving

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State Example: Vermont's Community Health Accountable Care (CHAC)

- CHAC is an ACO started by FQHCs in Vermont
- Included 10 FQHCs, 4 rural health clinics, 7 hospitals, 14 mental health and specialized services designated agencies, and 9 certified home health agencies.
- In 2014, entered into shared savings arrangements with Medicare, VT Medicaid, and Blue Cross and Blue Shield of VT.
- First year, CHAC saved $7.8 million in Medicaid costs and received $3.35 million through shared savings agreement.
- State is now transitioning to All-Payer ACO Model is that is merging the 3 ACOs in the state

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Payment Reform in Health Centers

Health Centers

- Quintuple Aim Performance Payment
- PCMH and/or PCHH
- FQHC PPS or APM

Through HCP-LAN Lens

- P4P (2C)
- Shared savings (3A)
- Downside risk (3B)
- Care coordination fees (2A)
- PMPM Payment for Primary Care under APM (4A)

Market & Policy Developments

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MACRA and the Quality Payment Program

- Needed a new *sustainable* update formula
- Combines several quality focused initiatives
  - PQRS, Physician Value Modifier, Medi*CARE* Meaningful Use
- Medicare providers must choose **one of two tracks:**
  - Advanced Alternative Payment Models
  - Merit-Based Incentive Program (MIPS)
- Went live **January 1**, **2017**, still much to learn
- **FQHC participation**
  - Limited to just those services billed to Part B**, NOT your Medicare FQHC PPS**
  - Option to **voluntarily report**

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Medicare "Pathways to Success" Program

- CMS rule in December 2018 finalized new name and direction for the Medicare Shared Savings Program (MSSP)
- Require Accountable Care Organizations (ACOs) participating in the MSSP to take greater financial risks
- Offers two tracks (July 1, 2019 start date w/ 5-year agreement)
  - **Basic:** Start with upside risk, gradual increases in downside
  - **Enhanced**: Highest level of downside risk
- Differentiates between high and low revenue ACOs, includes changes to benchmarking process and addition of patient incentives
- See NACHC's blog and final rule summary for more details on items of particular interest for health centers

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CMS' Primary Cares Initiatives

- In April 2019, CMS released **Primary Cares Initiative**, which consists of two new models to facilitate the improvement of patient care.

- **Pathway #1: Primary Care First** *(two models)*
  - Test financial risk and performance based monthly payments for PCPs
  - Includes varying levels of payment based on a practice's patient population
  - Launch January 2020, with 5 year performance period

See NACHC blog for updates

- **Pathway #2: Direct Contracting** (*three models*)
  - **Professional Population Based Payment (PBP)** – 50% savings/losses, provides risk-adjusted PMPM for enhanced primary care services
  - **Global PBP** – 100% savings/losses, provides two payment options - PC Capitation and Total Care Capitation (risk-adjusted PMPM for all services provided)
  - **Geographic PBP** – CMS currently seeking input via RFI
  - Launch January 2020, 5-year performance periods will begin 2021

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Medicaid Trends

- Continued state budget pressures
- State % targets for value-based payment
- Focus on the social determinants of health (states, MCOs, CMS)
- Role of data (in state and with CMS)
- Integration of behavioral health and substance use disorder services
  - CMMI accepting state applications for the Integrated Care for Kids demo
- Serving Dual-Eligibles (enrolled in both Medicare and Medicaid)
  - CMS sent letter to SMDs in April 2019 expressing support for state financing innovations to best serve populations
- Continued increase in Managed Care, new pressures
  - 81% of Medicaid beneficiaries in 2016

Let's pause for questions!

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Key Steps for Successful Health Center Engagement

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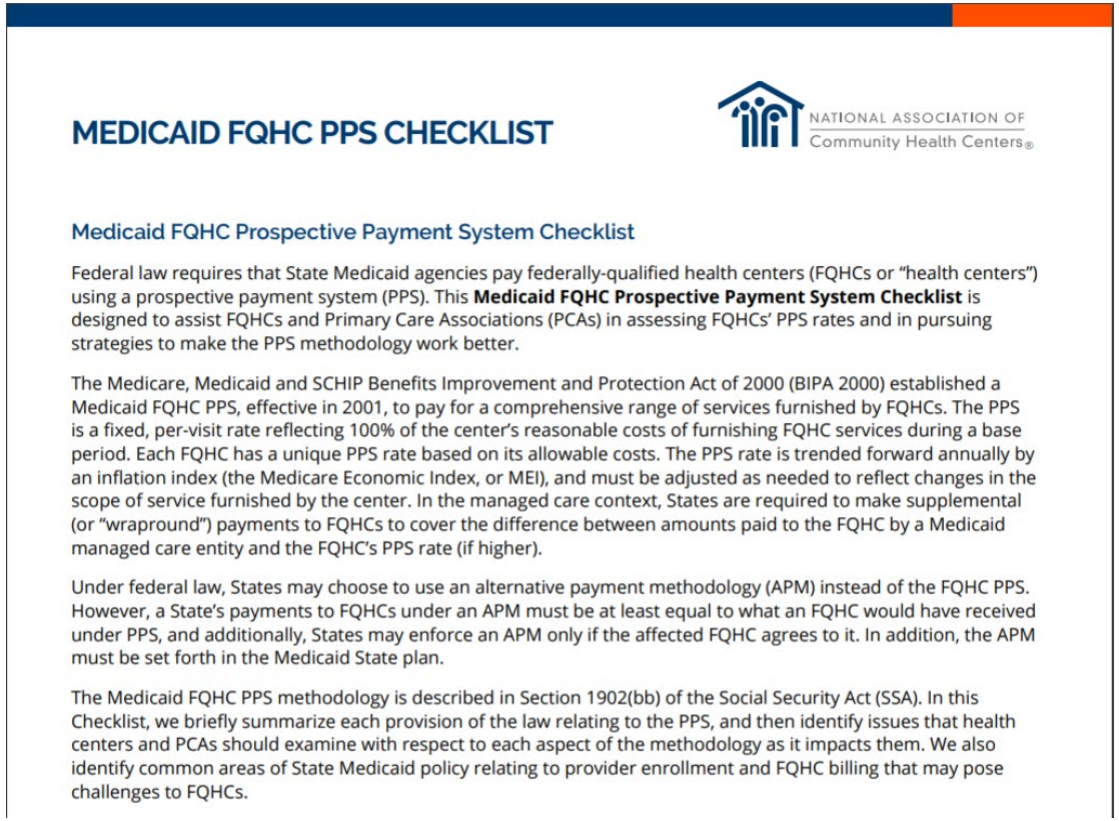
Prepare Your Current FQHC Payment for the Future



MEDICAID FQHC PPS CHECKLIST

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Medicaid FQHC Prospective Payment System Checklist

Federal law requires that State Medicaid agencies pay federally-qualified health centers (FQHCs or "health centers") using a prospective payment system (PPS). This **Medicaid FQHC Prospective Payment System Checklist** is designed to assist FQHCs and Primary Care Associations (PCAs) in assessing FQHCs' PPS rates and in pursuing strategies to make the PPS methodology work better.

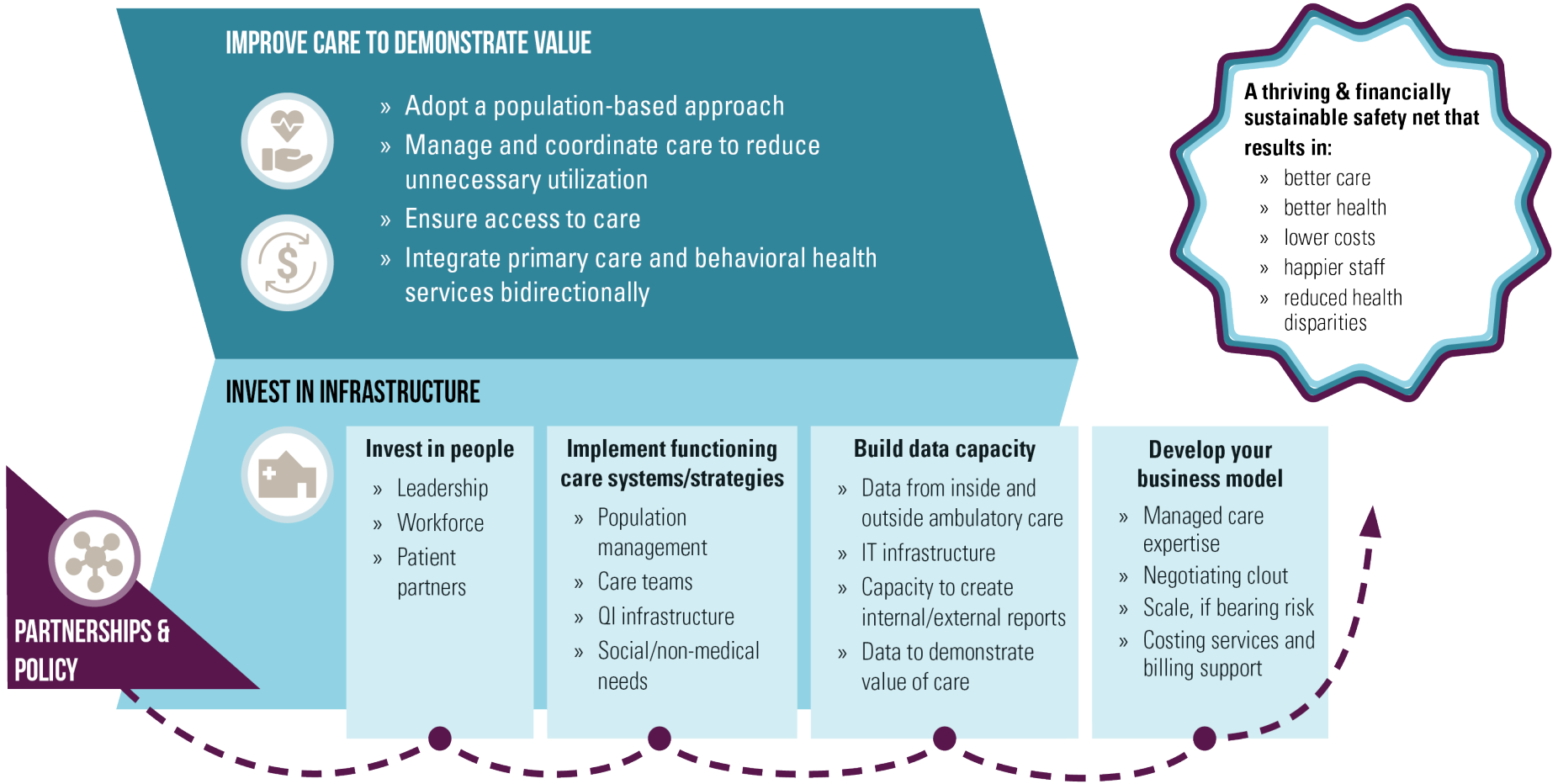
The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) established a Medicaid FQHC PPS, effective in 2001, to pay for a comprehensive range of services furnished by FQHCs. The PPS is a fixed, per-visit rate reflecting 100% of the center's reasonable costs of furnishing FQHC services during a base period. Each FQHC has a unique PPS rate based on its allowable costs. The PPS rate is trended forward annually by an inflation index (the Medicare Economic Index, or MEI), and must be adjusted as needed to reflect changes in the scope of service furnished by the center. In the managed care context, States are required to make supplemental (or "wraparound") payments to FQHCs to cover the difference between amounts paid to the FQHC by a Medicaid managed care entity and the FQHC's PPS rate (if higher).

Under federal law, States may choose to use an alternative payment methodology (APM) instead of the FQHC PPS. However, a State's payments to FQHCs under an APM must be at least equal to what an FQHC would have received under PPS, and additionally, States may enforce an APM only if the affected FQHC agrees to it. In addition, the APM must be set forth in the Medicaid State plan.

The Medicaid FQHC PPS methodology is described in Section 1902(bb) of the Social Security Act (SSA). In this Checklist, we briefly summarize each provision of the law relating to the PPS, and then identify issues that health centers and PCAs should examine with respect to each aspect of the methodology as it impacts them. We also identify common areas of State Medicaid policy relating to provider enrollment and FQHC billing that may pose challenges to FQHCs.

- What is the process for setting FQHC rates? Updating and adjusting rates?
- Which services are or are not included in FQHC rates?
- How is billing handled for dual-eligible beneficiaries at FQHCs?
- How is provider enrollment handled?
- Any limiting factors included?
- Which providers at FQHCs are considered "billable"?
- Where, when, and how can services be delivered?

MAHP 2.0: A Model for Advancing High Performance in Primary Care and Behavioral Health*



*Adapted 8/20/2018 from The MacColl Center for Health Care Innovation and JSI Research & Training Institute, Inc. (2018). *Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment,* California Health Care Foundation. Available at: https://www.chcf.org/publication/partnering-succeed-small-health-centers/

Questions?