LPCA
LOUISIANA PRIMARY CARE ASSOCIATION
Louisiana's Community Health Centers

Leveraging the HCCN to Build CHC VBC Capabilities

LPCA Conference
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Working with Health Centers, PCAs and National Training & TA Partners to:

- **Develop value-based pay (VBP) game plans** that weave payment reform opportunities together into a cohesive strategy.
- **Influence VBP** to align with FQHC care transformation goals**.**
- **Prepare Health Centers** for VBP**.**
- **Align stakeholders** behind primary care **payment reform** strategies for vulnerable populations that supports practice transformation efforts..
- **Establish a primary care capitated payment methodology** for FQHC Medicaid patients that works with federal FQHC law, policy and guidance.
- **Facilitate strategic planning retreats,** board meetings and staff planning sessions.
- Define and improve the **Health Center value equation** in the context of VBP.
- Develop strategies to **increase FQHC Medicaid rates.**
- Connecting strategies for **FQHC Medicaid payment and VBP.**
- **Provide VBC education** to PCAs and CHC staff/board members**.**

What is Value-Based Pay (VBP) and Value-Based Care (VBC)?

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VALUE-BASED PAY

What does value-based pay mean to you?

What is VBP/VBC?

VALUE-BASED PAY (VBP): VALUE-BASED PAYMENT IS A GENERIC TERM USED TO DESCRIBE A PAYMENT MODEL WHERE THE AMOUNT OF PAYMENT FOR A SERVICE DEPENDS IN SOME WAY ON THE QUALITY OR COST OF THE SERVICE THAT IS DELIVERED.

VALUE-BASED CARE (VBC): VALUE-BASED CARE IS SIMPLY THE IDEA OF IMPROVING QUALITY AND OUTCOMES FOR OUR PATIENTS WHILE LOWERING COSTS.

SOMETIMES VBP AND VBC ARE USED INTERCHANGEABLY. HOWEVER, FOR THE PURPOSE OF OUR DISCUSSION, WE WILL REFER TO VBP WHEN WE DISCUSS PAYMENT MODELS AND VBC WHEN WE ARE FOCUSED ON THE CARE MODEL.

HERE IS A GLOSSARY OF TERMS YOU MAY FIND USEFUL. HTTPS://GLOSSARY.CHQPR.ORG/

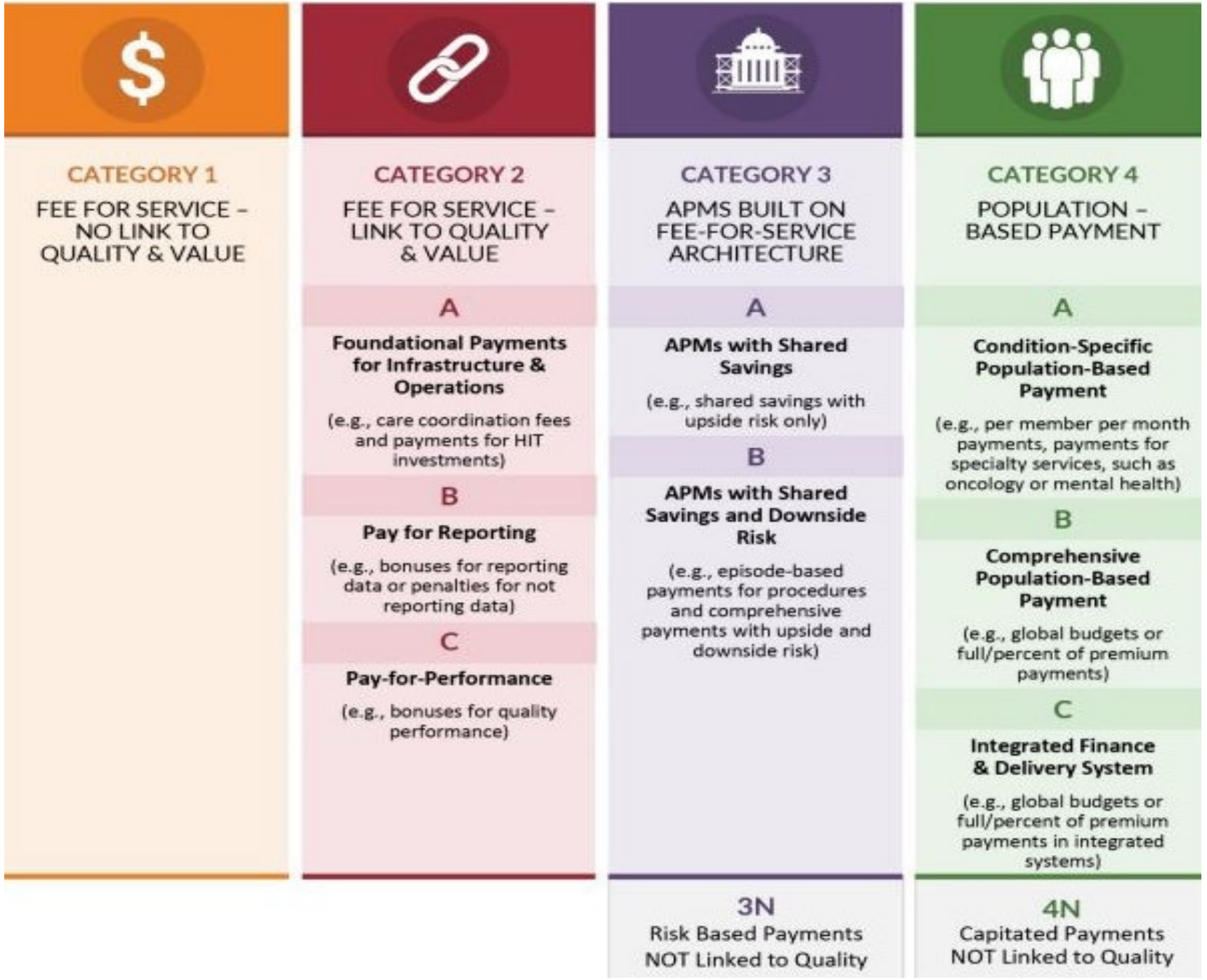
FEE-FOR-SERVICE FLAWS

- Rewards volume without accountability to quality or cost
- Focuses work on the billable provider instead of the work of the team
- Doesn’t reward continuity between the patient and provider team
- Doesn’t incentivize proactively managing patients
- Doesn’t incentivize provider organizations to work together
- Doesn’t incentivize efficiencies in the health care system
- Hasn’t sufficiently supported primary care and behavioral health integration
- However, FFS does track access to services and will have a role in VBP/VBC

IF DONE RIGHT, VBP CAN BE A BETTER WAY

- Value-based pay (VBP) can align payment to support and reward better care
- Otherwise, there is no point to changing payment
- Although there are many pitfalls to current VBP arrangements, there is energy behind continuing to move from volume to value
- Capitation can offer flexibility to advance the care model and build capacity for VBP…21 states are implementing or looking into capitated APMs for FQHCs
- There are some success stories in VBP of reducing costs and improving quality

HCP-LAN APM FRAMEWORK



CONSIDERATIONS

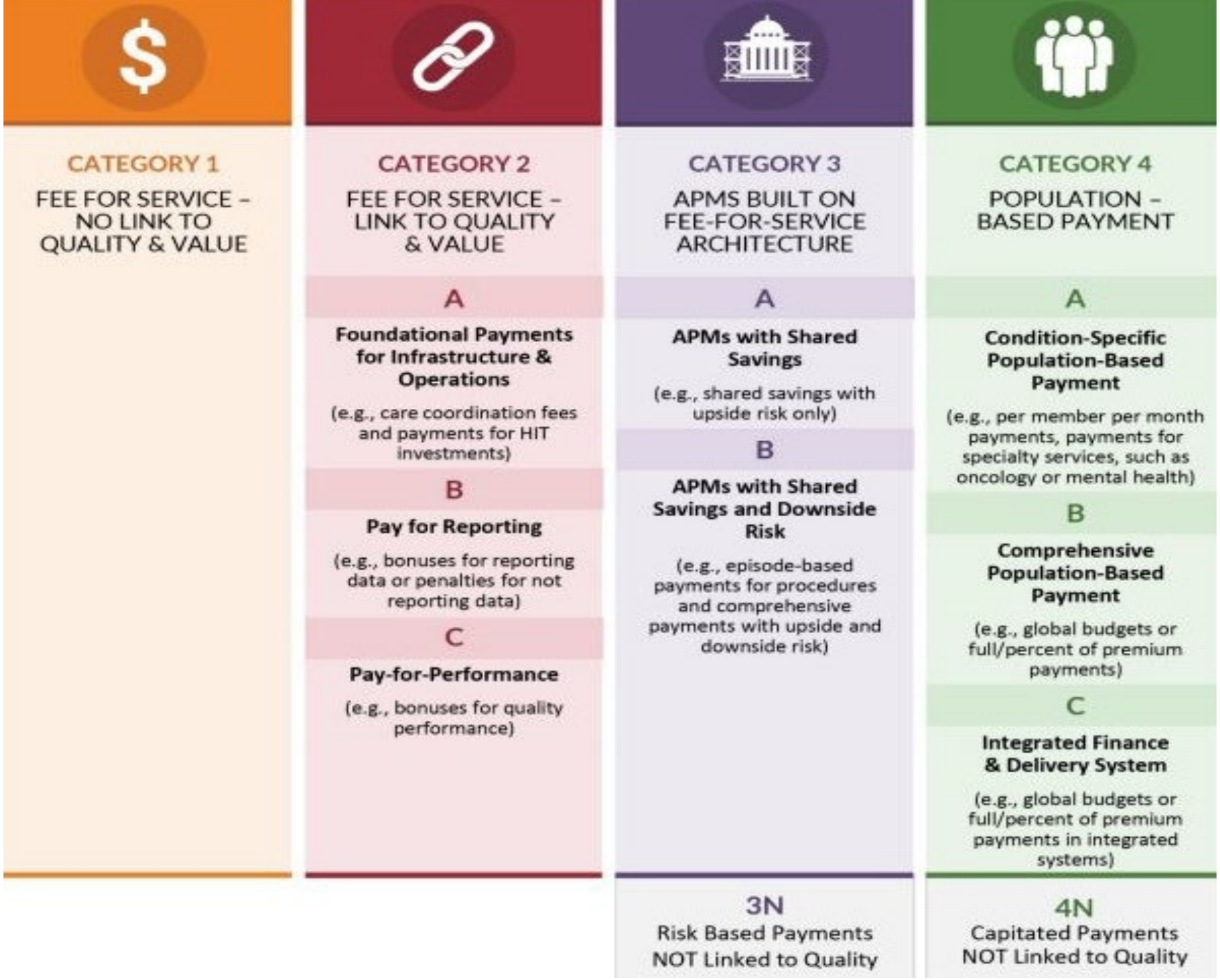
- Business opportunity to support advanced care models.
- Categories 2 and 3 are still based on FFS.
  - Shared savings is usually retroactive, limiting up front investments needed to achieve the savings.
- Primary care capitation = category 4A, if connected to quality.

CONSIDERATIONS

- Purpose is to find the right level of risk that supports the practice model you want to implement.
- Another goal is to increase resources to CHCs and gain a seat at the table to direct allocation of resources through VBP models.
- May need to partner to accept more risk (e.g., CIN, IPA, ACO).
- VBP can support the Quadruple Aim, including joy of work…or Quintuple Aim, including health equity.

Barriers to VBP & Why FFS Remains the Majority of Payment

- VBP should be different based on patient needs/provider services
- Attribution of patients
- Lack of resources to invest in transformation
- Data analytics capability at the clinic level
- Interoperability
- Lack of staff time
- Insufficient transparency between payers and providers
- Different numerators and denominators for performance measures among payers
- Whether performance measures can be impacted by primary care
- Unrealistic timeframes to move metrics
- **Lack of adequate risk adjustment, including behavioral health and SDoH barriers**


CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE
CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)
B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance
(e.g., bonuses for quality performance)
CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE
A
APMs with Shared Savings
(e.g., shared savings with upside risk only)
B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N
Risk Based Payments NOT Linked to Quality
CATEGORY 4
POPULATION – BASED PAYMENT
A
Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)
C
Integrated Finance & Delivery System
(e.g., global budgets or full/percent of premium payments in integrated systems)
4N
Capitated Payments NOT Linked to Quality

CALL TO ACTION

The disparate outcomes during COVID has increased health care's focus on decreasing health disparities.

APMs (CMS definition) present a significant opportunity to reduce inequities in care and outcomes.

LAN launched the Health Equity Advisory Team (HEAT).

LAN HEAT - DESIGNING PAYMENT INCENTIVES

- Acknowledgements
  - In some instances, APMs have increased health disparities.
  - The LAN recognizes that organizations delivering care to the underserved are often underfunded.
  - Adoption of these APMs will take time.
- Health equity performance is a significant % of quality score, at least 20%.
- Prospectively paid primary care/population health APMs, shared savings rates, and other performance-based payments adjusted based on health equity.
- An additional equity pool is available to historically underfunded providers serving vulnerable populations.
- Time-limited, upfront payment to support capacity building and practice transformation.
- Ensure payments adequately cover patient care costs.

LAN HEAT -OVERARCHING GUIDANCE FOR DESIGNING AND IMPLEMENTING APMs

- Align around a common definition and shared understanding of health equity.
- Partner with communities to understand the root causes of health equity.
- Support providers to understand and address health disparities.
- Payer and provider contracts reflect expectations for tracking and incentivizing health equity performance.
- Monitor and address unintended negative consequences.
- Develop transparency to assess impact on populations experiencing health disparities and under-resourced providers.

WHAT DOES THIS MEAN FOR HEALTH CENTERS?

Payment should support data, analytics, and care model changes that improve health equity.

Identifying and addressing SDoH will be a competitive edge.

Payment should support interdisciplinary teams, including CHWs.

Seeing patients that others won't see should not be a disadvantage in APMs.

Risk adjustment for behavioral and SDoH should be required.

Payment should support closed loop referrals to community-based organizations.

CMS/HRSA WANTS TO INCREASE SAFETY NET CLINIC PARTICIPATION IN VBP

- CMMI is actively seeking advice to increase safety net participation in VBP
  - Listening sessions
  - Duke-Margolis Health Policy Center convened an advisory group
- HRSA is interested in more FQHCs participating in VBP
  - BPHC staff are asking how they can support building VBC capabilities in FQHCs

Capabilities Needed for VBP

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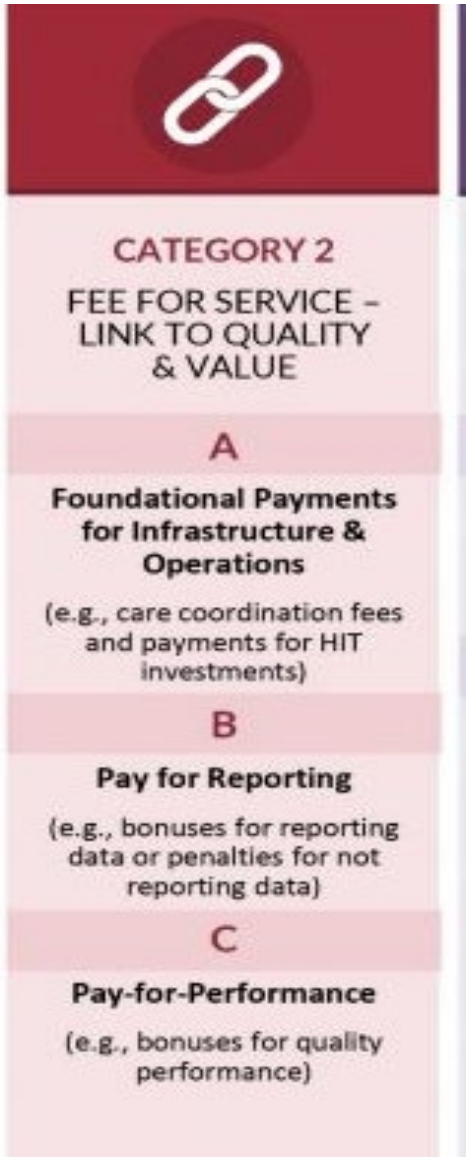
CAPABILITIES NEEDED FOR VBP

- Patient-centered, team-based care has become the baseline
- Population health approaches to care delivery, holistic care
- Building data/analytics and care model capabilities to improve health equity
- Integration of medical, behavioral health and oral health services
- Evidence-based & innovation (e.g., testing SDoH interventions)
- Care coordination/care management, particularly for high-risk pts
- Tracking and moving cost, quality and access metrics
- Open access
- Better data, including SDoH & data analytics
- Finance departments know costs, evaluate VBP opportunities and risk
- Culture of quality

FFS with Link to Quality and Capabilities Needed



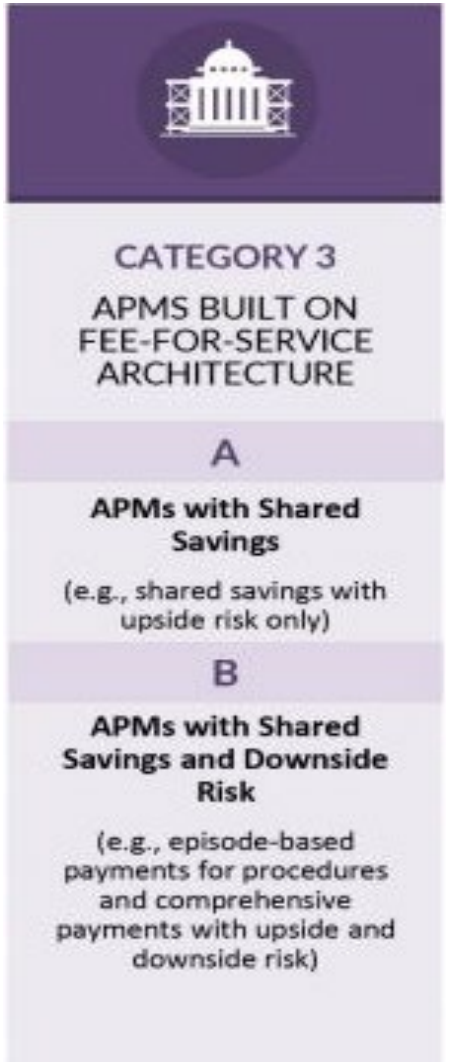
2A
- **Time to play**: build health home capabilities, like care coordination, data & HIT, leadership, health equity

2B
- Ability to capture and report data, usually quality metrics. SDoH/health equity is important for vulnerable populations, think about data for risk adjustment

2C
- Improving health equity
- QI & chronic disease management programs
- Registries and performance dashboards
- Patient experience performance reporting
- Data security infrastructure
- Financial and payment performance modelling
- Aligned incentive performance payment programs
- Cultural alignment with quality & adaptive reserve
- Change management expertise

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

APMs Built on FFS Architecture and Capabilities Needed

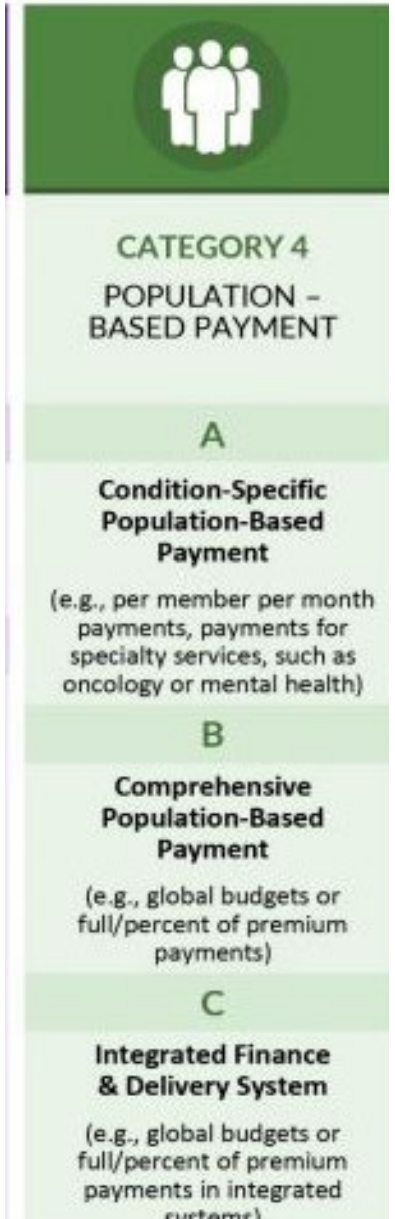


3A
- Master care coordination
- Set quality and utilization benchmarks and standards
- Establish clinical protocols and coordinated workflow processes
- Address health disparities
- Population health capabilities (e.g., risk stratification)
- Alternative visits

3B
- Care management capabilities, especially high risk
- Targeted disease management
- Medical oversight of coordinated care and disease management programs

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

Population-Based Payment and Capabilities Needed



In 4A, for primary care cap

- Need to know your costs
- Rates should reflect costs and stable utilization
- Analyze risks associated with quality requirements

In 4B & 4C, you need

- Utilization management and review
- Pharmacy benefits management
- Prevention and wellness programs
- Addressing health disparities
- Actuarial analytics & predictive modelling
- Payment processing and claims adjudication
- Underwriting, Reinsurance
- Reserves maintenance

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

LINKS TO LPCA HCCN WORKPLAN

Performance dashboard – compare performance to other CHCs, including utilization of a predictive analytics tool

HIT usability and adoption – aligning EHRs with clinical workflows, improving data capture and utilization

CHW focus on utilizing HIT innovations to collect data to improve patient care

Increase CHC quality of care and coordination of health services through the use of digital health tools

LINKS TO LPCA HCCN WORKPLAN

Patient engagement and utilization of digital health tools – patient portals, telehealth, RPM

Social risk intervention – collecting patient-level data to support patient care plans

Interoperable data exchange and integration – integrating CHC clinical information with clinical and non-clinical data across the health and health care continuum

Data utilization – predictive analytics, data visualization, inform VBC activities to impact quality and cost

HCCN Priorities in Other States

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Ingesting Data/Data Warehouse

- CHC EHR data – medical, BH, dental, SDoH
- Data from hospitals, specialists, LT care, home health, BH providers
  - ADT alerts
- Medications, labs
- Cost, utilization data from payers (sometimes hard to get)
- Public health, social services, CBOs
- Prisons, education, …

INTEGRATING DATA

Creating a holistic picture of the patient

- Medical, BH, dental, SDoH

Colorado HCCN Developing an interoperable Social Health Information Exchange

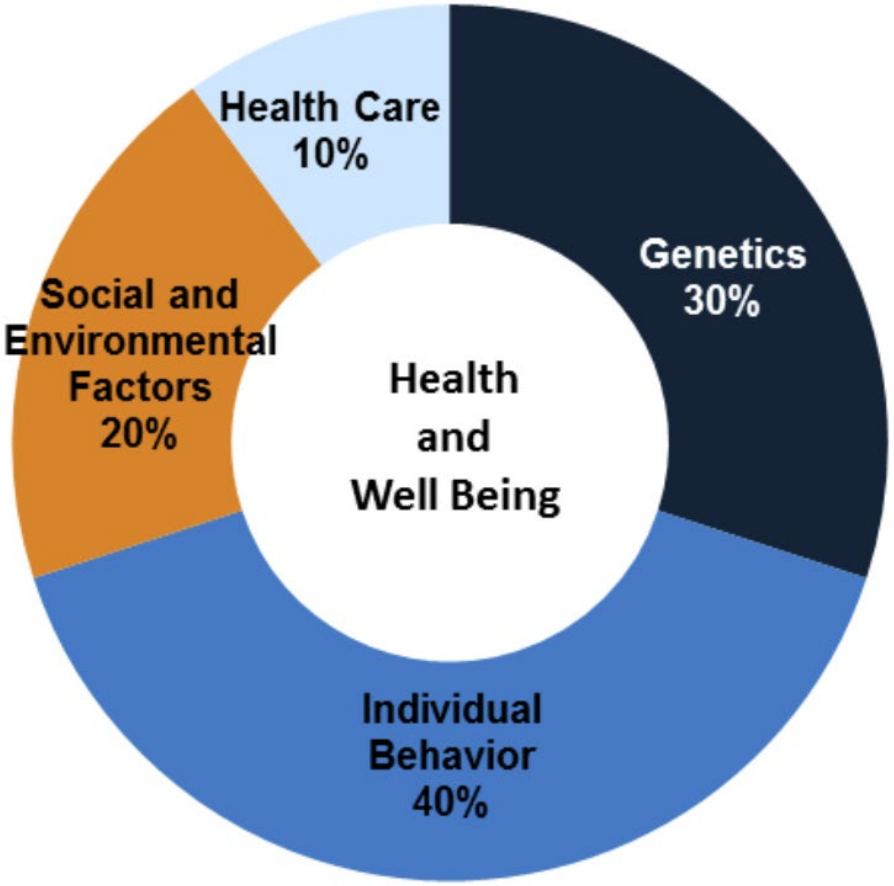
UNDERSTANDING SDOH/HEALTH DISPARITIES

HCCNs starting to focus more on identifying SDoH & health disparities in CHC populations

Data will be used to see how CHCs are doing re: addressing health disparities & SDoH needs

The end goal will be to address SDoH barriers & improve health equity by using data and HIT to support care teams

IMPACT ON RISK OF PREMATURE DEATH



Source: Schroeder, SA (2007), We Can Do Better, NEJM 357:1221-8 KFF slide

IMPORTANCE OF SDOH TO HEALTH OUTCOMES & TCOC

- Extensive literature has documented the correlation between socioeconomic status (SES): education/income and health.
- A substantial body of epidemiological evidence has linked social networks and social support to positive physical and mental health outcomes throughout the life course.
- The psychosocial work environment—particularly exposure to job stress—has been linked to the onset of several conditions, including cardiovascular disease, musculoskeletal disorders, and mental illness.

Genes, Behavior, and the Social Environment: Moving Beyond the Nature/Nurture Debate. National Academy of Sciences, 2006

IMPORTANCE OF SDOH TO HEALTH OUTCOMES & TCOC

- There are many studies that indicate poor SDoH are harmful to health both in the short and long-term.
- There is a growing body of evidence that demonstrates a positive impact of favorable social conditions to health outcomes.
- This article reviewed the literature that shows evidence-based efforts on addressing SDoH to achieve better health and lower costs.
- There was substantial evidence of improved health outcomes and/or reduced health care spending related to interventions that addressed housing, nutrition, income support, and care coordination and community outreach needs (e.g., mobile clinics).

IMPORTANCE OF SDOH TO HEALTH OUTCOMES & TCOC

- Examples of findings from studies
  - ✓ Housing and care management program: Cost savings of $6,307 per person. Among those who were chronically homeless, $9,809.
  - ✓ Enhancing ventilation in homes of children with asthma: Shifted 17% of children from severe to moderate asthma.
  - ✓ Green housing renovation: Self-reported general health improved from 59% to 67%.
  - ✓ Food assistance programs: Food insecure elders had higher BMI and higher depression.
  - ✓ Mobile van: high blood pressure reductions of 10.7mmHg and 6.2mmHg in systolic and diastolic blood pressure; associated with overall cost savings of $1.58 million in healthcare costs. The Family Van yielded a return on investment of 1.3.

USING DATA

CHC and site level integrated data

- Some HCCNs reporting integrated data at the provider team level

Improving CHC care

- Supporting team-based care (e.g., empanelment, care planning, patient outreach)
- Care management/care coordination
- Transitions of care

USING DATA

Population health analytics

- Gaps in care
- Health disparities
- Quality of care & cost of care

Risk modelling, stratification (low, rising, high risk)

- Understand health plan risk modelling
- Developing your own risk modelling

Predictive analytics

- Several HCCNs building this, including social factors

USING DATA

- Dashboards at the clinic and provider team level
- Data visualization, highlighting problem areas that need to be addressed
- Sharing data transparently among CHCs to identify and share best practices
  - Create healthy competition to improve metrics
- Developing visualization tools to strengthen communication across clinical and non-clinical settings

LEVERAGING HIT

- Innovation to stay relevant (e.g., modality of interaction with patient)
  - Telehealth
  - E-visits
  - Remote patient monitoring (RPM)

LPCA/CHC VBP/VBC Priorities

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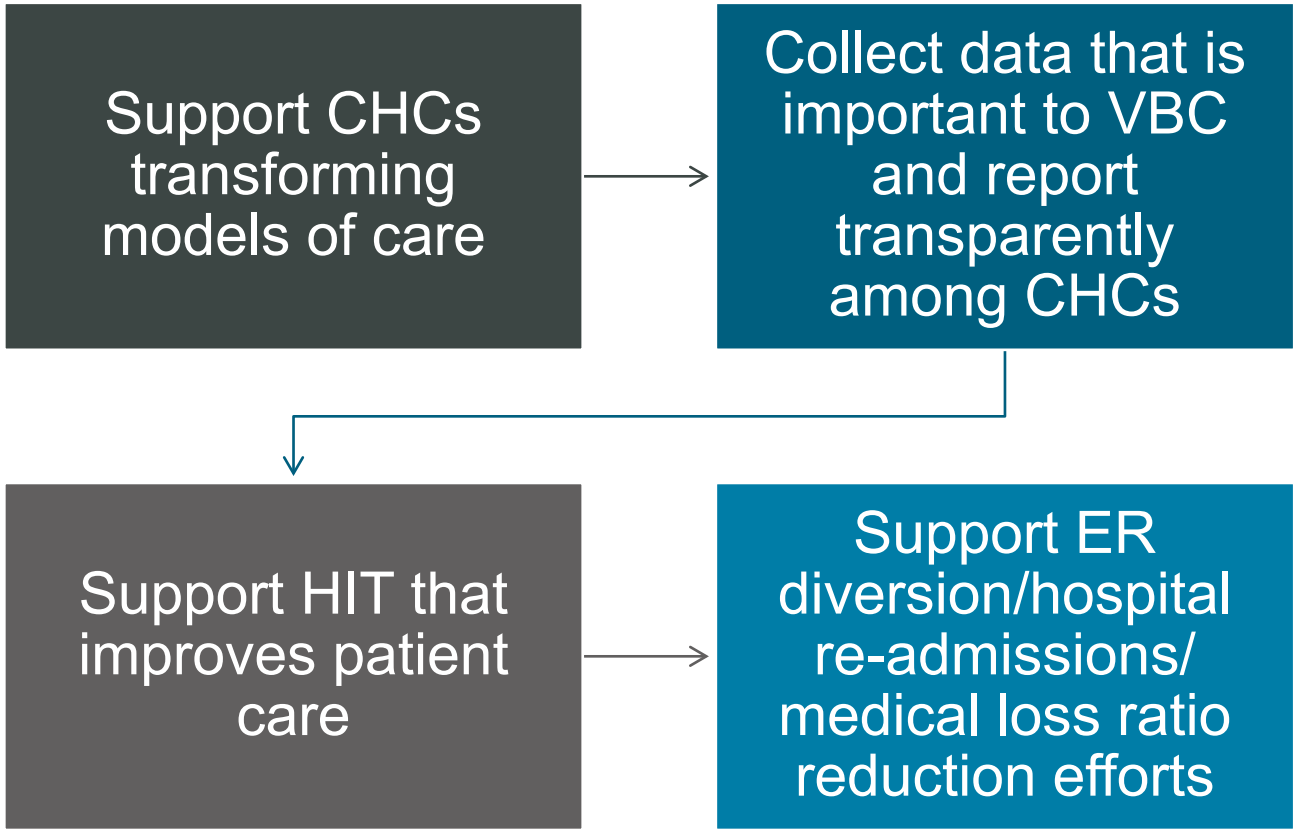
ADDRESSING MEDICAID PPS RATES

Strategies to bring FQHC Medicaid rates closer to costs to support comprehensive, patient-centered care

Addressing current rates and process for increasing rates in future years

Will require CHC cost reports and analysis of the gap between HC allowable costs and PPS rates

CARE MODEL


Support CHCs transforming models of care
Collect data that is important to VBC and report transparently among CHCs
Support HIT that improves patient care
Support ER diversion/hospital re-admissions/ medical loss ratio reduction efforts

WORKFORCE DEVELOPMENT

- Align with evolving model of care
- Optimize use of HIT tools in CHCs
- Integrate clinicians into VBP/VBC work
- Create workforce development training models to support all payment models

Support	Support data efforts to identify CHC status re: improving health equity
Influence	Influence VBP to include metrics important to care for populations CHCs serve
Address	Address SDoH barriers

HEALTH EQUITY

HEALTH CENTER ENGAGEMENT

Engage all 39 CHCs in VBP/VBC projects/priorities

Promote participation from multiple CHC-roles in setting/implementing VBP/VBC priorities

OTHER PAYMENTS

Consider	Consider implementing an FQHC capitated APM
Define	Define LPCA's role in VBP
Influence	Influence telehealth payment post-pandemic
Secure	Secure payments for non-providers who are addressing SDoH

MONITORING

Monitor national, state, and local VBP/VBC environments

Advance meetings with stakeholders to determine and influence VBP goals

COVID/POST-COVID

Align VBP with post-COVID evolvements

Support CHCs in the “new normal”

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