Accelerating Value-Based Payment in Federally Qualified Health Centers: Options for Medicaid Health Plans

Webinar
August 29, 2019

Made possible by Blue Shield of California Foundation and the California Health Care Foundation
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Welcome and Introductions

Overview of Findings: Accelerating Value-Based Payment in California’s Federally Qualified Health Centers: Options for Medicaid Health Plans

Implementing a Health Plan/FQHC Partnership: The Rocky Mountain Model

Advancing VBP Arrangements with FQHCs in California: Inland Empire Health Plan

Moderated Question & Answer
Welcome and Introductions
Presenters

Greg Howe, Senior Program Officer, Center for Health Care Strategies

Patrick Gordon, CEO, Rocky Mountain Health Plans

Art Fernandez, COO, Mountain Family Health Center, Colorado

Tricia McGinnis, Executive Vice President and Chief Program Officer, Center for Health Care Strategies

Kurt Hubler, Chief Network Officer, Inland Empire Health Plan, California
Accelerating Value-Based Payment in FQHCs
Accelerating VBP in California’s FQHCs: Options for Medicaid Health Plans

- Report funded by California Health Care Foundation and Blue Shield of California Foundation
- Focuses on how MCOs and FQHCs can form innovative and mutually beneficial VBP arrangements
- Explores examples from across the country and in California
Many FQHCs are participating in health plan pay-for-performance programs

Ability to impact care across the health care spectrum by moving from incentive programs that focus on an FQHC’s own quality to new payment models that impact the quality and cost of care patients receive beyond the FQHC walls

Alignment with the commercial market

Opportunities for partnerships between health plans and FQHCs that do not require state or federal approval
Benefits of VBP for . . .

- **MCOs**
  - Opportunity for better quality and reduced costs
  - Greater provider stake in cost management
  - Creating greater alignment between provider-level and plan-level functions

- **FQHCs**
  - Greater flexibility on type of services provided
  - Ability to exercise greater control on care management
  - Opportunity to earn bonuses and incentive payments
The Four Most Common VBP Approaches

- Pay-for-Performance (P4P)
- Bundled Payments
- Shared Savings/Risk
- Capitation/Global Payments
FQHCs may need to build capacity to succeed in VBP models

FQHCs must be able to:

- Implement care models to manage complex patients
- Use data to support care delivery, improve quality, and reduce total cost of care
- Coordinate effectively with external providers and community-based organizations
- Build internal and external support

This involves:

- Tracking patients’ outcomes and costs
- Potentially significant start-up costs
- Changing business as usual
Prospective Payment System (PPS) rates are not flexible

» Per federal regulation, FQHCs cannot be paid below their PPS rates, so they cannot accept downside risk below that rate
FQHCs can contract with MCOs via upside-only VBP arrangements without concern for PPS restrictions

» Pay-for-Performance (Category 2B)
» Bundled Payments (Uprise Only, Category 3A)
» Shared Savings (Uprise Only, Category 3A)
» Risk-based Capitation (Uprise Only, Category 3A)
However, there are three ways that FQHCs can participate in VBP arrangements with downside risk

1. VBP programs involving services not covered under PPS rates
2. MCOs could pay FQHCs rates above PPS and put that portion at risk
3. FQHCs could join in VBP arrangements with organizations that are capable of taking on risk
State-based programs

» Capitated APMs (CO, OR, WA) pay rates above PPS and then put that portion at risk

» Quality rate adjustments (AZ’s proposed approach) allows an FQHC to earn a 0.5% increase of PPS rate for each of three clinical quality measures it meets (up to 1.5% total increase)

» FQHC-led Medicaid ACOs participate in shared savings programs in MA and MN

Local and regional examples

» Accountable Health Care Alliance of Rural Oahu

» Medical Home Network Accountable Care Organization

» Rocky Mountain Health Plans and Mountain Family Health Centers

Promising FQHC VBP Models
Implementing a Health Plan/FQHC Partnership: The Rocky Mountain Model
Western Colorado Health Communities

- 6 distinct “Health Communities”
- Population
  - 144,000 “PCCM” Members
  - 180,000 BH Benefit Members
  - 36,500 “Prime” MCO Members
  - 11,500 CHP+ Kids
- Community-based oversight & health alliances partnerships
- Aligned CMS programs – CPC+, SIM, AHCM, DSNP
We must drive all facets of integration

- Data & Operational
- Leadership
- Financial
- Clinical
First Principles

It’s not who you are – It’s what you do

Transparency

Inclusion

Performance
Basic to Comprehensive Care

1. Engaged leadership
2. Data-driven improvement
3. Empannelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and care coordination
10. Template of the future

It’s not who you are – it’s what you do.

Provider Commitments

- Mastery – BH, SDOH integration
  Open to all – Partner with RMHP
- Advanced competencies – Medicaid treated equally
- Competency development – Shared access policies
- Limited engagement – Medicaid differential access
Attribution by Tier

Practice and Membership Distribution by Tier

<table>
<thead>
<tr>
<th>Tier</th>
<th>Practice</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25%</td>
<td>39%</td>
</tr>
<tr>
<td>2</td>
<td>16%</td>
<td>21%</td>
</tr>
<tr>
<td>3</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>4</td>
<td>41%</td>
<td>24%</td>
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</table>
APM – Key Components

• **Attribution**: Tied to attribution – not auto/assignment. Higher payments for attributed members – straight Medicaid / Encounter Rate for non-attributed utilization.

• **Scope**: E&M services (and all FQ encounter carve in) is capitated, trended and risk adjusted.

• **Form**: Enhanced, risk adjusted capitation. Higher PMPMs for higher tier practices.

• **Incentive**: Shared savings % of delta between plan operating and quality-adjusted MLR floor. Higher incentive rates for higher tier practices.

• **Enhancements**:
  - “Community Integration Agreements” for Integrated BH (Tier 1 only)
  - PCCM Incentive Pass-Thru
  - Community Health Worker / “Health Engagement Team” Support
  - Care management tool access and detailed monthly stratification & drill-down reports.
CMHC Risk & Integration

- Partnership, not ownership

- Risk sharing and incentive targets:
  - 75% of IP risk
  - 25% of OP risk
  - 95% State BH Incentive Pass-Through (State 105% MCO Premium Model)

- BH Network on RMHP paper – not third party

- Claims paid by RMHP

- UM run on RMHP’s applications – deployed externally to CMHCs
- ADT alerts & crisis-response program integration
One Region – One care coordination network

RMHP Care Management Technology Adopters:

- North Colorado Health Alliance FQHC
- Northwest Colo Health FQHC
- Marillac Clinic FQHC
- Mountain Family Health Center FQHC
- Mesa County Public Health Local Public Health
- Centura Mercy Hospital Hospital / ED
- San Juan Basin Public Health Local Public Health
- Axis Health System FQHC-CMHC
- Whole Health, LLC CMHC Enterprise
- Tri-County Health Alliance Community Group
- Mindsprings CMHC
- SummitStone CMHC
- Heart-Centered Counseling Independent BH Group
- Center for Mental Health CMHC
"Four Quadrant" Stratification

- Using health plan risk scores, diagnostic codes and procedure codes
- Integrated criteria for physical and behavioral health strat.
- Population health interventions aligned with stratification
- Member level stratification, intervention data, and health outcome data
Our commitment – data production & transparency

• **Quarterly:** Plan financial performance w. state’s quality-adjusted MLR targets.

• **Quarterly:** Key performance Indicators, aggregate & provider-specific provider quality and utilization against risk-adjusted targets;

• **Monthly:** Total cost & utilization performance, attribution, risk-adjustment, “assigned but not attributed” (leakage);

• **Monthly:** Raw data – eligibility, spend by category of service, cpts, dxs, Rx & allowed amounts.
Prime Payment Model

RMHP PRIME Practice Summary Report
Report for: This Practice
As of: February 2019

Key Info:
PRIME = Medicaid Adults and Disabled members participating in the RMHP Prime program. RMHP pays claims.
Global payment in this report is for attributed members as payment for particular services, instead of fee for service.
Attributed = Per RMHP attribution logic looking at claims during the prior 15 month review period.
ABNA = Members assigned to this practice but not attributed to this practice.
Review period includes claims incurred and paid from 10/1/17-12/31/18.
Membership is per RMHP data as active on 12/16/18 and included on the HCPF PRIME Enrollment files for February.

PRIME Patient Summary for Practice:

<table>
<thead>
<tr>
<th></th>
<th>Attributed</th>
<th>All RMHP</th>
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</thead>
<tbody>
<tr>
<td>Count of PRIME patients</td>
<td>510</td>
<td>16,324</td>
</tr>
<tr>
<td>Average risk score (CDPS)</td>
<td>2.314</td>
<td>2.340</td>
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</table>

PRIME Payment Summary for Practice:

<table>
<thead>
<tr>
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<th>Fixed Portion</th>
<th>Risk Adjusted Portion</th>
<th>Total</th>
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<tr>
<td>Global Payment = ($20.89 ppm * 1.25) + $4 ppm</td>
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<td></td>
<td>$39.11</td>
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<tr>
<td>% of Global Payment</td>
<td></td>
<td></td>
<td>100.00%</td>
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<tr>
<td>Risk Relativity (this practice vs. all RMHP)</td>
<td>50.00%</td>
<td>111.75%</td>
<td>100.00%</td>
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<tr>
<td>Risk Adjusted Global Payment</td>
<td></td>
<td></td>
<td>$31.88</td>
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<tr>
<td>Total Payment (by provider is below)</td>
<td></td>
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<td>$19,757.00</td>
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PRIME Patients Cost of Care Summary for Practice:

Total cost of care for PRIME patients included in this report.

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<tr>
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<tr>
<td>Emergency Hospital</td>
<td>$267,380</td>
<td>$471,146</td>
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<tr>
<td>Inpatient Hospital</td>
<td>$770,680</td>
<td>$101,251</td>
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<tr>
<td>Outpatient Hospital</td>
<td>$642,250</td>
<td>$248,225</td>
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<tr>
<td>Pharmacy</td>
<td>$1,323,167</td>
<td>$181,156</td>
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<tr>
<td>Physician Services - Global Payments</td>
<td>$623,003</td>
<td>$32,716</td>
</tr>
<tr>
<td>Physician Services - Primary Care</td>
<td>$117,538</td>
<td>$13,090</td>
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<tr>
<td>Physician Services - Specialist Care</td>
<td>$478,649</td>
<td>$59,528</td>
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<tr>
<td>All Else</td>
<td>$585,505</td>
<td>$42,415</td>
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<td>Grand Total</td>
<td>$4,884,364</td>
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Prime Patient Drill Downs

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<tr>
<th>Patient Name</th>
<th>Attributed Provider (P = Patient Choice)</th>
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<tr>
<td>RMHP ID</td>
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<td>Provider Name</td>
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<td>Reicks, Gregory C.</td>
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Health Center 1
Health Center 2

**Average Risk Score**

- **You**
- **All**

**Average ER Visits Per 1000 Members**

- **You**
- **All**
- **YouNorm**

**Average IP Visits Per 1000 Members**

- **You**
- **All**
- **YouNorm**

**Average IP Readmits Visits Per 1000 Members**

- **You**
- **All**
- **YouNorm**

**Average Total Cost Per Member**

- **You**
- **All**
- **YouNorm**

**Average PMPM Cost**

- **You**
- **All**
- **YouNorm**
Advancing VBP Arrangements with FQHCs in California: Inland Empire Health Plan
Center for Health Care Strategies (CHCS): Accelerating Value-Based Payment in California’s Federally Qualified Health Centers (FQHCs)

August 29, 2019

Kurt Hubler
Chief Network Officer
Inland Empire Health Plan
Inland Empire Health Plan (IEHP) is a not-for-profit Medi-Cal and Medicare health plan headquartered in Rancho Cucamonga, California, within the Inland Empire (IE).

• Region’s first Medi-Cal managed care plan.
• Knox-Keene licensed plan and organized as a Joint Powers Agency.
• National Committee for Quality Assurance (NCQA) accredited.
• An annual revenue of approximately $4.5B.

**Governing Board**

- 2 Elected San Bernardino County Supervisors
- 2 Elected Riverside County Supervisors
- 3 Appointed Public Members
IEHP – Who We Are:
Managed Care Model

- Mixed Model HMO
  - IEHP Direct: 47% of total Membership
  - IPAs: 53% of total Membership
  - 16 IPAs

*Data as of August 7, 2019. IEHP Direct includes Medi-Medis.*
IEHP Membership by Region

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<th>Region</th>
<th>Medi-Cal</th>
<th>CMC</th>
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<tbody>
<tr>
<td>High Desert</td>
<td>13%</td>
<td>13%</td>
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<tr>
<td>San Bernardino Proper</td>
<td>28%</td>
<td>30%</td>
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<tr>
<td>Low Desert</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Temecula/Corona/Hemet</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>Riverside Proper</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>West San Bernardino</td>
<td>11%</td>
<td>9%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
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*Data as of August 7, 2019*
Medi-Cal Spending Trends are Unsustainable

California State Budget

Medi-Cal
$82,000,000,000 per year

Projected Annual Growth in CA Medicaid Spending (General Fund)
FY 2017-2022

9%

Medicaid spending growth in California is unsustainable relative to tax revenues and the growth of the economy.

If plans and providers can’t control costs, patients may face reduced access as pressure will increase to cut benefits or eligibility.

Source: Medicaid and CHIP Payment and Access Commission
Source: CA Legislative Analyst’s Office 2018-2019 Medi-Cal Fiscal Outlook
Value-Based Care is Necessary to Protect

By committing to a value-based approach to care, we can reduce cost increases while improving quality and protecting patients.

Value-based care is based on two broad ideas:

- Aligning incentives between providers and payers so that providers are rewarded for improving quality while controlling costs.
- Aligning the interests of patients and providers by increasing provider accountability for the full spectrum of care across office visits, hospital stays, and pharmacy use.

These ideas hold the promise of improving care while ensuring that our health care dollars are spent wisely to most benefit patients.
IEHP’s strategic priorities and initiatives support investments in value-driven care to improve member experience and foster a high-performing provider network.
Goal: Modernize the shared savings arrangements to create accountability for cost and quality of services beyond primary care and create a new financial opportunity for medical groups.

Traditional Capitation: Primary Care

Shared Savings Program: Hospital, pharmacy, professional &...
Shared Savings Framework

**Budget Target**
- Annual, PMPM-based
- Set prospectively
- Based on 12 months of historical claims for included services
- No provider responsibility for the top 1% outliers

**Actual Performance**
- Measured retrospectively for included services
- Risk-adjusted to account for any changes in patient panel composition

**Shared Savings**
(actual < target)
- Up to 60% of savings credited before potential quality adjustment
- Cap on potential gains at $4.50
- 1% “Minimum Savings” threshold

**Quality Measures**
- All Cause Readmissions
- Controlling High Blood Pressure
- NTSV C-Section Birth
- Exclusive Breast-Feeding Intent
- Post Discharge Visit within 7 Days of Discharge

*PMPM – per Member per month
*NTSV – nulliparous, term, singleton, vertex cesarean birth rate
Starting January 1, 2019, IEHP implemented 5 Shared Savings partnerships:

- **Social Action Community Health System (SACHS)**
  - FQHCs
  - Roughly 10,000 Shared Savings Members

- **Arrowhead Regional Medical Center (ARMC)**
  - San Bernardino county health system and family health centers (FHCs)
  - Roughly 43,000 Shared Savings Members

- **Riverside University Health System (RUHS)**
  - Riverside county health system and FQHCs
  - Roughly 55,000 Shared Savings Members

- **Riverside Family Physicians (RFP)**
  - Primary Care Physician (PCP) group
  - Roughly 5,000 Shared Savings Members

- **Providence St. Joseph’s Health-St. Mary’s**
  - Private health system
  - Roughly 9,000 Shared Savings Members
IEHP Commitment With Shared Savings

**IEHP is making the following investments to support Shared Savings:**

- Assess and help develop unique infrastructure for Shared Savings partners
- Develop and support plan operational infrastructure
- Reporting specific to organizations
- Data/analytics and progress in value-based care and systems

**Expectations from Shared Savings partners:**

- Significant commitment of time and energy
- Participation of clinical and administrative leadership
- IT systems development
- Coordination with IEHP
## Current Reporting

<table>
<thead>
<tr>
<th>Category</th>
<th>ACG Risk Scores</th>
<th>UM-Medi-Cal Acute Hospital</th>
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</thead>
<tbody>
<tr>
<td>IEHP Membership</td>
<td>Risk score by Risk stratification</td>
<td>Acute Hospital Bed Days</td>
</tr>
<tr>
<td>Health Plan Membership by COA</td>
<td>Risk score by ACG Stratification</td>
<td>Acute Hospital Admissions</td>
</tr>
<tr>
<td>Health Plan Membership by PCP</td>
<td>Quality Performance</td>
<td>Acute Hospital ALOS</td>
</tr>
<tr>
<td>Finance</td>
<td>UM-Inpatient – Bed Days by Line of Business (LOB)</td>
<td>UM-Member Level Detail</td>
</tr>
<tr>
<td>Claims Cost by Category of Service</td>
<td>Bed Days (Count)</td>
<td>Frequent ER Utilizers (Date of Birth, COA, Case Management Risk, Stratification, Special Programs)</td>
</tr>
<tr>
<td>Budget PMPM</td>
<td>Average Length of Stay (ALOS)</td>
<td>High Risk Members</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Admissions per 1000</td>
<td>High Cost Claims</td>
</tr>
<tr>
<td>Average Spend per Utilizing Member</td>
<td>Plan All Cause Readmissions</td>
<td>Special Programs</td>
</tr>
<tr>
<td>Brand vs Generic</td>
<td>ED Visits per 1000</td>
<td>Health Homes Program</td>
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<tr>
<td>Formulary vs Non-Formulary Spend Comparison</td>
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<td>P4P</td>
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<tr>
<td>Total Spend by Drug Class</td>
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</table>
IEHP has identified the following priority focus areas in support of Shared Savings Program:

- Data Connectivity and Integration
- Data and Reporting
- Empanelment
- Hospital Partnerships/Transitions of Care
- Population Health Strategies
- Pharmacy
- Pay-4-Performance (P4P) and Process Improvement
- Joint Value Based Care Leadership Meetings
### Value Based Payment Strategy Timeline:

<table>
<thead>
<tr>
<th>Month</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>November 2016</td>
<td>- hired consultant to help develop value-based payment strategies</td>
</tr>
<tr>
<td>November 2017</td>
<td>- created Shared Risk Program</td>
</tr>
<tr>
<td>April 2018</td>
<td>- started IPA capitation risk adjustment</td>
</tr>
<tr>
<td>June 2018</td>
<td>- shifted GQ P4P to PMPM payment</td>
</tr>
<tr>
<td>November 2018</td>
<td>- assessed potential Shared Savings partners</td>
</tr>
<tr>
<td>December 2018</td>
<td>- started implementation of Healthcare Group Transformation Strategy with each group</td>
</tr>
<tr>
<td>January 2019</td>
<td>- went live with 5 Shared Savings Program partners</td>
</tr>
<tr>
<td>June 2017</td>
<td>- transitioned from traditional, episodic Pay-for-Performance (P4P) Program to Global Quality (GQ) P4P Program</td>
</tr>
<tr>
<td>December 2017</td>
<td>- developed Hospital P4P Program</td>
</tr>
<tr>
<td>June 2018</td>
<td>- created OB/GYN P4P Program</td>
</tr>
<tr>
<td>November 2018</td>
<td>- started implementation of performance-based PCP Auto Assignment, aiming for January 2020 implementation</td>
</tr>
</tbody>
</table>
Questions?
Question & Answer