FQHC Readiness for Value-Based Payments: Priorities for Success

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November 17, 2015

HealthManagement.com
The Single Aim is Value

- Improve individual experience
- Improve population health
- Control inflation of per capita costs

Primary Care Mission and Strategies

Improving the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.

- Increase access to primary health care services
- Modernize primary care infrastructure and delivery system
- Improve health outcomes and health equity
- Promote performance-driven, innovative organizations

Increase Value of Health Center Program
Samples from Physician Practice Reports…

Source: Q-Corp in Oregon
Medicaid Accountable Care Organizations by State

Effective 8/15

States with active Medicaid ACO programs
States pursuing Medicaid ACO programs
Practice Transformation Financial Model

Fee-for-service
PPS

PCCM/PCMH
P4P
Shared savings
Partial Capitation
Medical Home Network
The Building Blocks for Delivery System Transformation & Population Management

Organizational Structure
- Shared vision & culture of accountability
- Established governance
- Competent leadership

Connectivity
- MHNConnect Portal
  - Real-time alerts
  - Information exchange between 17 hospitals and 150 primary care sites
  - Bridge to social service agencies
- Foundations for population health management

Actionable Reporting & Analytics
- Timely & actionable reporting based on integrated historical & real-time data
- Advanced analytics to support high-risk population management
- Transparent provider-performance reporting that drives improvement
- Integration of BH and LTSS into model
- Complex Care Coordination Capability

Practice Transformation
- Team-based model of care implemented
- Pertinent patient information available at point of care
- Integration of BH and LTSS into model

Workforce Development
- Develop education & training around the new model of care
- Create pipeline of allied health professionals prepared to work in underserved communities

Value-Based Payment
- Active pay-for-performance program that rewards reductions in utilization, improvements in quality, as well as program implementation

Patient Engagement
- Fostering the accountable patient
- Remote home monitoring for CHF & hypertension patients
- E-consults & virtual visits

Redesign Delivery to Achieve Triple Aim
Better Health | Better Healthcare | Lower Cost

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**Goal:** All health centers are PCMH recognized

**Next steps on your journey:**
- Optimize/enhance your PCMH
  - Team based care
  - Integration of care
  - Patient engagement
- Engage with the Medical Neighborhood
  - Care coordination
- Build Community Partnerships to address social determinants of health
  - Housing
  - Nutrition
  - Education
  - Social Services
  - Aging & Disability Supports
  - Transportation
Go It Alone? Part of a FQHC IPA?

- LTSS
- Specialty
- Hospital
- Behavioral Health
- Substance Abuse
- Social Services
- Patient Centered Medical Home
- Public health
- Health-related community resources (e.g. parks)
Part of a Clinically and Financially Integrated Delivery System?
Factors to Consider

• FQHC market share and geographic coverage
• Availability of value-oriented providers willing to partner in an egalitarian fashion
• Overlap of current patient populations
• IT connectivity with potential partners
• Financial stability with reserves
• Historical success with VBP opportunities
• Payer attitude toward provider integration
MSSP ACO Results for 2014

- 333 participating ACOs
- 92 (28%) delivered large enough reductions to be able to share in the savings
- Number with a ROI ????
- Percent generating shared savings by start date
  - 2012 37%
  - 2013 27%
  - 2014 19%
MHN ACO  Improvements in Outcomes & Engagement

ANALYSIS MHNConnect™

Improvements in Outcomes & Care*

40% BETTER OUTCOME

Inpatient Days/1000

30% BETTER OUTCOME

Readmission Rates

20% BETTER OUTCOME

ED Visits/1000

Improvements in Patient Engagement via Complete HRAs**

HRA COMPLETION RATE

MHN ACO  71% COMPLETE
External Network  31% COMPLETE
129% DIFFERENCE

*Source: Based on July CountyCare reported utilization stats 7/1/14-5/19/15
**Source: CountyCare State Filings

As of June 30, 2015
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Bridging Connections Across the Continuum of Care

Medical Home Network In Action

Three Steps to Better Care Coordination:

1. Receive Alert
   Care Coordinators in the clinic receive a real-time email alert when a patient presents in the hospital/ED

2. Interact via MHNConnect & Analytics
   Care Coordinators assess patient utilization and health history by using the data integrated in MHNConnect and Consilink analytics

3. Patient-centered Care Management
   Care Coordinators proactively reach out to patients resulting in data-informed population health management & increased access to care
Medical Home Network

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Targets for Improved Value

1. Primary care
2. Specialty care
3. Outpatient diagnostics and therapeutics
4. Behavioral health
5. Pharmacy
6. Emergency department
7. Inpatient care
8. Long term services and supports
Successful Implementation

• Improving transitions of care
• Care Management of high-risk ACO members
• Reducing low-value medical practices
• Performance on Quality Parameters
Challenges to Care Coordination Services

- Patients expected to coordinate on their own
- Telephonic care management ineffective in engaging patients
- Lack of systematic approach to care management with tools and electronic platform
- Outpatient providers unaware of patient admits and discharges
- Lack of timely bidirectional information exchange
Evolving FQHC Focus—Target Resources Based on Person Centered Needs

- Healthy
- Chronically ill but under control
- Chronically ill at risk of being high use
- High need/complex

% of Beneficiaries

A
Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

B
Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care

C
Promote and maintain health (e.g. via patient-centered medical homes)
Medial Home Network
Care Management Connect *Tracking Quality Assessments & Indicators*
Practice Redesign or Payment Reform
Medical Home Network
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# 2014 UDS Quality Improvement Awards

<table>
<thead>
<tr>
<th>Type of Awards</th>
<th>National</th>
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<tbody>
<tr>
<td><strong>QUALITY AWARDS</strong></td>
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<tr>
<td>National Quality Leader Award</td>
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<tr>
<td>Health Center Quality Leader Award</td>
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<tr>
<td>E H R Reporter Award</td>
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<tr>
<td>Clinical Quality Improver Award</td>
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<tr>
<td><strong>ACCESS ENHANCERS</strong></td>
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<tr>
<td><strong>HIGH VALUE HEALTH CENTERS</strong></td>
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Continuum of Risk-Based Contracting
P4P/Shared Savings/Capitation with Uniform Incentive Criteria with Aggregated Basis for Payment

Reimbursement Structure:
- All MCOs/Payers offer P4P with uniform parameters measured in a standardized fashion
- All MCOs/ACEs offer shared savings/capitation based on standard set of services
- Contracts cover most if not all of a provider’s panel

Integrated Delivery System/ACO

IDS/ACO
- Aggregates data from multiple MCOs for total actual performance & provides to MCOs
- Establishes a performance/incentive method to pass rewards to the practice level to providers that are creating value
- Provides performance reports, transparency & consultation to individual practices/providers
- Manages contracting process

Managed Care Organizations & Direct Payers
Transitioning from Strict Face-to-Face PCP Visits to Virtual Member-Centric Visits

• Team-based care
• Nurse triage
• Patient portal
• Pre-visit screening
• Teaching member self-management
• Member notification of diagnostic results and next steps without a face-to-face visit
• IT support to detect gaps in care with member notification
National Association of Community Health Centers APM Core Principles

• Incentivize Triple Aim outcomes and support the unique role of FQHCs in their communities
• Abide by federal law
• Promote transformation of primary care
• Align financial incentives--and possibly financial risk--with total health system outcomes
• Account for scope, diversity, and risk of FQHC populations
• Account for relationships between FQHCs and MCOs, FQHCs and their State, and FQHCs in different states
Negotiating Shared Savings/Risk/Cap

• Which populations to target
• Which services to include
• What percentage of premium to target
• What cut of the savings
• What metrics and thresholds to gain access to savings
• What stop loss and risk corridors to establish
Organizational Leadership

Commitment to:

• Venturing from the safety of the known
• New collaborations/integration with payers and providers
• Demanding delivery system and payment reform
Coming in January 2015…

• HMA and CohnReznick will release web-based value-based payment readiness assessments for:
  – FQHCs and other primary care providers*
  – Behavioral health providers

• Tools will enable individual organizations or groups of organizations to assess value-based payment readiness across multiple domains
  – Will indicate specific strengths and gaps and highlights capabilities that are core/essential for VBP as well as gaps that should be an implementation priority
  – Will be complement to the NACHC VBP assessment tool and will enable organizations to pinpoint improvements and/or systems that will be critical to their success under value-based payment

* Developed in partnership with the DC Primary Care Association