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Emerging Issues #7
Health Centers and Payment Reform:
A Primer

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About the National Association of Community Health Centers (NACHC)

The National Association of Community Health Centers (NACHC) represents Community, Migrant, and Homeless Health Centers as well as Public Housing Health Centers and other Federally Qualified Health Centers. Founded in 1971, NACHC is a nonprofit organization providing advocacy, education, training, and technical assistance to health centers in support of their mission to provide quality health care to underserved populations. NACHC commissioned John Snow, Inc. (JSI) to develop a payment reform conceptual framework for health centers that draws on existing research and literature on payment reform; the expert understanding of Curt Degenfelder, President of Curt Degenfelder Consulting, Inc.; Craig Hostetler, Executive Director of the Oregon Primary Care Association; and JSI's own work with health centers and primary care associations on health reform.

Craig Hostetler has been the Executive Director of the Oregon Primary Care Association (OPCA) for over 10 years. OPCA and its partners support Oregon's community health centers in transforming their practices to patient-centered medical homes through robust learning communities. Recently, OPCA led an effort that aligned Medicaid payment for Oregon health centers with patient-centered, team-based care by delinking payment from face-to-face visits.

Curt Degenfelder is a consultant who has been working with community health centers for over 17 years. He assists community health centers in evaluating financial, operational, and strategic issues. He has participated in payment reform program design and financial issues for health centers in Oregon Medicaid and the Los Angeles County indigent care program.

JSI is a health research and consulting organization committed to improving the health of individuals and communities worldwide, with a focus on vulnerable populations. JSI has a deep commitment to improving the capacity of the healthcare safety net to deliver cost-effective, high quality care to underserved populations. JSI contributors to this paper include: Elena Thomas Faulkner, MA; Rachel Tobey, MPA; Jim Maxwell, PhD; Ann Keehn, CPA, MBA; Clancey Bateman, MPH, MS; Christine Barron, BA.

The considerations for payment reform and the required health center capacities identified in this paper were developed in part through JSI's work with the California Primary Care Association (CPCA) over the past two years. NACHC and JSI would like to thank Carmela Castellano, CEO of the CPCA, and the CPCA members for their contribution to the concepts presented in this paper.

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Executive Summary

Health centers are strongly positioned to achieve the Triple Aim – improved patient experience and population health, with reduced total health system costs per capita – within low-income and underserved populations nationwide. Payment reform efforts can align payments to support innovation and important resources for health centers to achieve their mission and address social determinants of health in their communities. Furthermore, payment reform that strengthens and supports the role of patient-centered primary care is critical to achieving the Triple Aim.

This paper describes a framework for health centers to understand the role of payment reform in achieving the Triple Aim. The framework is composed of three facets. The first facet provides for more flexibility of service delivery within current health center payment; the second provides the investments to support delivery system transformation (including health centers serving as Patient Centered Medical Homes and Integrators); and the third facet provides incentive payments for performance on Triple Aim outcomes.¹

The table below summarizes the financial objective of each of these layers, and their link to the delivery system transformation required to achieve the Triple Aim.

Figure: Three Facets for Health Center Primary Care Payment²

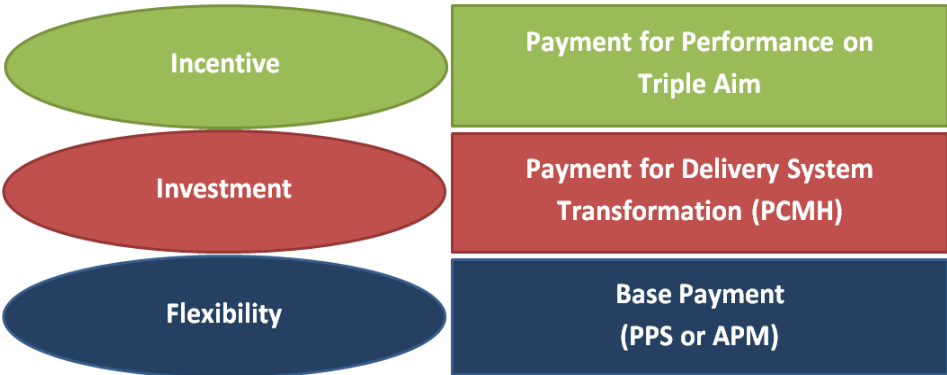


Table: Three Payment Facets Link between Financial Objectives and Delivery System Transformation

Payment Model Component	Financial Objective	Delivery System Transformation
Base (PPS)	Maintain comprehensive primary care during transition to new system	Flexibility to deliver care in more cost-effective and patient-centered ways
Transformation (PCMH)	One-time, substantive investment in transformation Ongoing (smaller) payment to sustain transformation	Increase the capacity and accountability of primary care as a PCMH “integrator” for the broader health system Support a robust team approach, and new use of team and team members
Performance on Triple Aim Outcomes	Reward for Achieving Lower Cost of care per capita and increased quality outcomes, access and patient experience Over long term, reward focus on preventing chronic conditions.	Maximize primary care role in integrated systems Provide the right care at the right time and place

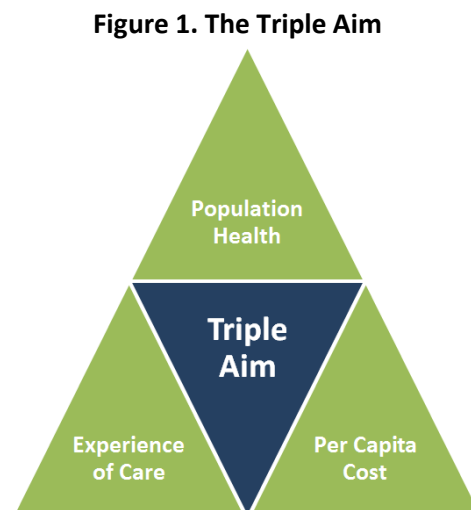
Depending on the local and state Medicaid environment and existing delivery system structure, the specific steps that each state Primary Care Association (PCA) and health center can take to examine payment reform efforts may vary considerably. However, PCAs and health centers could benefit from undertaking the following four key steps to move forward with a transformed payment and service delivery environment:

1. Develop and maintain a robust understanding of payment reform efforts in the state and local environment.
2. Ensure a clear, shared vision of their organization’s role in achieving the Triple Aim that can be used to assess emerging payment reform opportunities,
3. Critically assess current operations and capabilities, in particular Health center:
 - Existing work flow,
 - Ability to collect and report data, and to employ data to inform care at the team level,
 - Ability to transform to a more robust PCMH able to effectively address social determinants of health,
 - Ability to act as an integrator of care within the local health system, including the ability to take a leadership role in the local health system, and
 - Ability to administer and evaluate novel payment methodologies
4. Work collaboratively with other health centers, stakeholders and partners to accelerate transformation of the health care delivery system.

The conceptual framework for primary care payment reform identified in this paper describes how payment can be transformed to better support delivery system transformation, with primary care playing a pivotal role in the achievement of the Triple Aim.

Introduction

Health reform has elevated the importance of transforming the health delivery system. The Centers for Medicare and Medicaid Services (CMS) and many states have adopted the Institute for Healthcare Improvement's Triple Aim—to improve patient experience (quality of care and satisfaction), improve population health, and reduce per capita costs—as the guiding framework for this much-needed delivery system transformation. Across the nation, public and private sector entities are recognizing payment reform as a pivotal catalyst and support for a transformed health care system,ⁱ and payment reform initiatives are emerging at an accelerating rate.^{ii, 3} Because the existing system of payment for health services primarily rewards volume of services provided over health outcomes or cost, the Triple Aim framework has generally become the guiding framework in payment and reform initiatives to align of the best care for the whole population at the lowest cost.



Health centers, through their mission, structure, and programmatic focus, have a unique ability to provide high-quality, cost-effective care that engages patients, and thus to contribute substantially to the achievement of the Triple Aim. Both payment reform and delivery system transformation efforts are critical for health centers' financial performance, sustainability, and their mission of providing high-quality, patient-centered care to underserved populations in an increasingly competitive market. However, not all health centers are currently prepared to effectively engage in payment reform activities.

The objective of this paper is to provide leaders of Primary Care Associations (PCAs) and individual health centers with:

- 1) A description of the roles that health centers, as primary care providers, can play in a transformed delivery system with Triple Aim goals.

ⁱ While early innovation in payment methodology and delivery system design were led by the private sector, efforts in the public sector have increased over the past several years. In particular, CMS has undertaken substantive initiatives in both Medicare and Medicaid to support payment reform as a mechanism for transforming the delivery system. These include development of Patient-Centered Medical Homes (PCMHs), and dual eligible demonstration programs. It also includes clarification to states that they can use existing flexibility to better integrate and coordinate care, i.e., through 1115 waivers and Affordable Care Act Section 2703 funding to support new models of care and payment.

ⁱⁱ The growth of Accountable Care Organizations (ACOs) provides a good example. In 2009 the ACO was a new concept, with only a handful being developed in the private sector. Currently there are around 400 ACO initiatives, including ACOs focusing on Medicaid and/or CHP+ programs in 14 states.

- 2) A conceptual framework for payment reform that answers the question: How can primary care be supported in a transforming delivery system?
- 3) An overview of the skills and capacity that will help health centers engage successfully in payment reform efforts; and
- 4) Next steps for health center leaders to move ahead in the rapidly evolving environment.

This paper recognizes that some health centers are actively participating as lead organizations in risk-bearing entities such as ACOs, IPAs, and demonstration projects for dual eligibles.⁶ However, the emphasis in this paper is on health centers as primary care providers.

Key Terms Used in this Paper

Payment Reform: The implementation of any of a number of payment models based on value (including both cost and quality components).

Value: Increased quality, access and/or health outcomes at a lower cost.

Patient-centered Medical Home (PCMH): “An enhanced model of primary care in which care teams attend to the multifaceted needs of patients and provide whole-person, comprehensive, and coordinated patient-centered care.”⁴

Social Determinants of Health: The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.⁵

What roles can health centers, as primary care providers, play in the transformed delivery system with Triple Aim goals?

This section describes three key roles that health centers, as primary care providers, can play in a transformed on transforming delivery system that is focused on achieving the Triple Aim.

Health Center Role as a Patient-Centered Medical Home

The patient-centered medical home (PCMH) is being widely supported in public and private sector initiatives because of its advantages described in the literature, including reduced per capita costs, improved quality of care and patient satisfaction, and reduced health disparities.⁷ Medical home demonstrations and evaluations have shown promising results in terms of improving quality and reducing costs, including reducing emergency department visits and inpatient utilization.⁸ Medical homes, with their focus on care teams, also allow for a more flexible model of service delivery that depends less on billable services provided. Health centers' provision of enabling services adapted for vulnerable populations forms a strong foundation for health centers to serve as PCMHs for their patient populations moving forward. As a PCMH, health centers also have an opportunity to increasingly incorporate payment systems and practice transformations that address the complex interaction between social determinants of health and physical health for their patient populations.⁹ Finally, PCMHs are also evolving to include a broader role of coordinating care across the health system for patients. The sustainability of the PCMH model is dependent on payment methodologies that move away from face-to-face visit requirements and more directly support services aligned with the Triple Aim.

Health Center Role as Integrator in a Transformed Delivery System

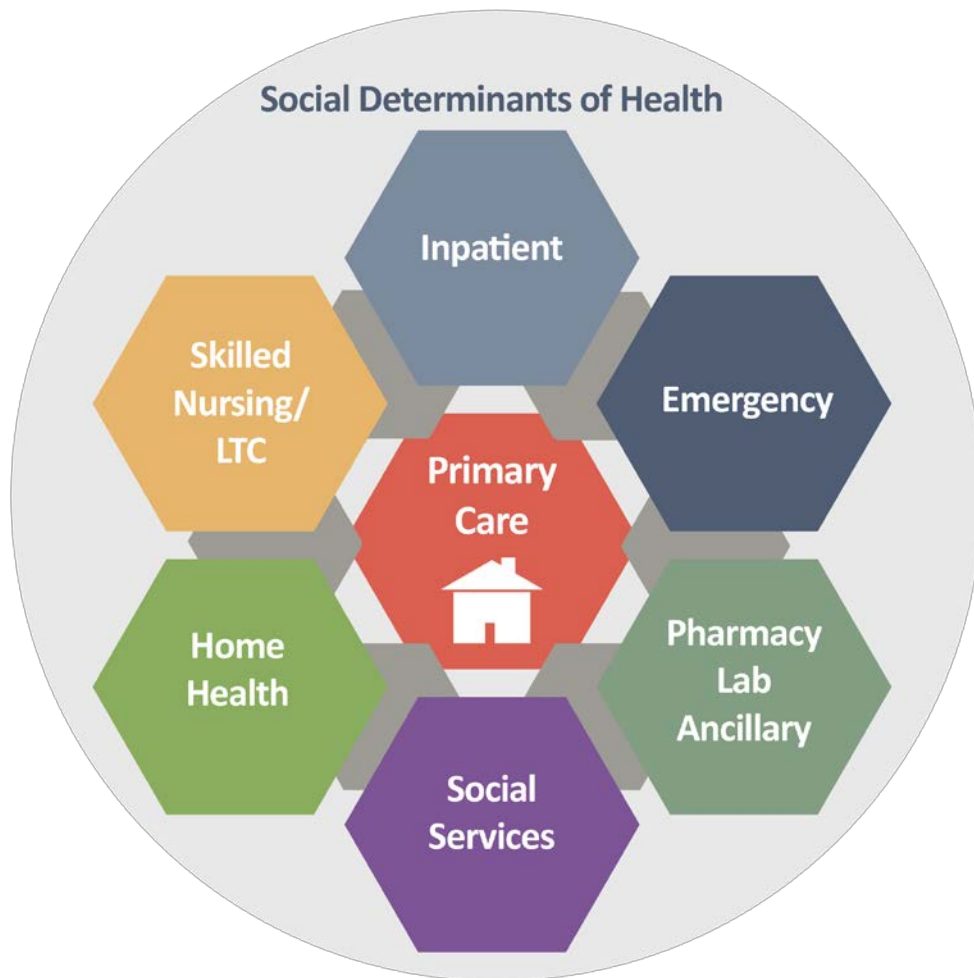
According to Donald Berwick and the Institute for Healthcare Improvement (IHI), the implementation of the Triple Aim requires the services of an “**integrator**” that will assume responsibility for all three components of the Triple Aim for a specified population. One of the key tasks of the integrators is to strengthen and redesign primary care services and structures. Primary care redesign, including development of robust patient-centered medical homes, involves establishing long-term relationships between patients and their primary care team, developing shared care plans, coordinating care across providers and settings, and using new forms of communication.¹⁰

Health centers can draw upon the strengths of their model and experience to act as an integrator within a transformed delivery system. Health centers improve patient health by integrating physical, behavioral, and oral health care, and by ensuring coordination and alignment with specialty medical providers and hospitals. In their integrator role, health centers work with other stakeholders to ensure payment reform efforts bolster and sustain the central role of primary care in attaining a health system with high-quality outcomes and reduced overall health system costs.

Health Center Role in Addressing Social Determinants of Health

Even as more individuals become insured under full implementation of the Affordable Care Act (ACA) in 2014, health centers will continue to be critical providers of care for the remaining uninsured, both in states that choose not to adopt Medicaid expansion under the ACA, and those who do. For many health centers, only a portion of their patient population (the insured) will fall under the umbrella of reformed payment systems. As safety-net providers, health centers will continue to depend on grant funding to maintain their ability to serve all patients effectively.

Figure 2. PCMH and Integrator in a Transformed Delivery System



How can payment models support primary care in a transforming delivery system?

In order to achieve the Triple Aim, payment reform should both support and reward care delivery models that promote value over volume and incentivize effective care modalities, staffing models, and service delivery models that are not reimbursable under the current system. In a flexible service delivery environment, physician time can be focused on the most medically complex patients or activities; other members of a care team can provide care and follow-up services for a patient to the full extent of their licensure, be involved in population management activities for health center patients, and engage in community efforts to address the social determinants of health.

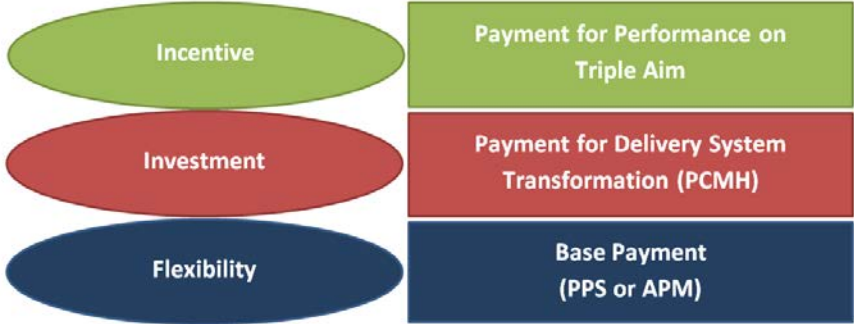
Health centers in many communities also will become “the provider of choice” for patients who become newly insured, and can use payment reform as a vehicle for transforming in patient-centered ways. Additionally, a transformed delivery system may allow primary care providers to better accommodate an influx of newly insured patients. For example, some health centers have noted a patient demand for phone and email visits, access to a case manager with whom they are familiar (but who is not billable), and use of self-management tools. Thus, payment reform creates an opportunity for services to be structured around the patient without the constraint of ensuring that a traditionally discrete billable service/event has occurred.

Health Center Payment Facets in Payment Reform Efforts

The payment reform framework described here for health centers consists of three payment facets that, together, support a stable but more flexible funding for core health center services, provide necessary financial investment to catalyze and sustain an evolving PCMH with integrator role, and reward health centers for achieving Triple Aim goals.¹² The aspect of paying primary care for its contributions to population and system-level outcomes is a new challenge and opportunity for health centers, whose payment today is mostly focused on billable encounters, and does not incentivize quality improvement that happen within the clinic walls. The three layers are illustrated Figure 3.

The following sections provide a description of the purpose and objectives of each layer.

Figure 3. Three Possible Facets for Health Center Primary Care Payment¹¹



The Base: Flexibility

The base payment provides payment equivalent to current health center per patient revenue as either PPS or Fee-For-Service. Payment establishes a degree of financial protection that facilitates the transition to new payment models without major disruption of services or reduction in current payment. The base payment allows for more **flexibility** in how care is provided by moving away from payment based on volume of traditionally billable services.

Health Center Payment Fundamentals

In 2001, the Budget Improvement and Protection Act (BIPA) established a prospective payment system (PPS) as a per-visit minimum payment for Medicaid patients seen in health centers based on the average of their 1999 and 2000 costs.¹³ The purpose of PPS was to prevent Medicaid programs from lowering reimbursements to a point that health centers had to “subsidize” low Medicaid rates with their federal grants to care for the uninsured.¹⁴ PPS rates increase annually by the Medicare Economic Index (MEI). The MEI, typically under three percent and since 2011 under one percent one percent), has not kept up with costs experienced by health centers.¹⁵ BIPA requires states to adjust rates based on changes in scope of services and to determine PPS rates for health centers established after 1999. There is considerable variability in how PPS is implemented across states. Rates for some health centers are impacted by the conditions in existence in the base years. Thus, the degree to which PPS rates in practice cover the cost of health center services is highly variable within and across states.¹⁶

PPS rates are based on an average cost for encounter, and paid based on the number of face-to-face encounters with providers. One way to provide for more flexibility would be to establish an Alternative Payment Methodology (APM) as allowed by regulation (see box on right) that supports increased flexibility in how payments are made and care is delivered, such as a primary care capitation-like APM for part or all of the base payment that is not reconciled to in-person encounters. In this way, the payment can support the use of modalities such as group visits, phone visits, electronic communication with patients, and novel care coordination services and allows health centers to

Under BIPA, states are able to implement an APM via State Plan Amendment. The total payments made to a health center under any APM must be at least equal to what the health center would receive under its BIPA PPS rate, and states are responsible for being able to prove this equivalence to CMS. Under current law, an FQHC must agree to the APM before it can be implemented. Thus, while an APM maintains a level of payment under PPS, it can also provide an opportunity for increased flexibility in how payments are made and thus how care is delivered.¹⁷

use the care team approach and each member of the care team more robustly, as well as to focus on population health and sick care. In Oregon, an APM is currently being piloted that allows for health centers to receive a lump-sum monthly payment (analogous to a capitation payment) for caring for enrolled Medicaid individuals.

Receiving an APM does not preclude health centers from receiving additional payments. In a number of states, health centers are receiving supplemental payments on top of a base PPS payment for either providing PCMH services or achieving performance on identified metrics.¹⁸ These payments are not included in the assessment of APM compliance with BIPA requirements. Layering of a base payment with additional payment facets creates stronger incentives to transform how care is provided.

The Investment Facet

Investment provides the infrastructure and ongoing payments needed for implementation of patient-centered medical homes, delivery system transformation, and the subsequent accountability for Triple Aim outcomes. As discussed above, this investment is critical to elevate the role of primary care in the overall delivery system, and to support PCMH and health centers' role as an "integrator." Delivery system transformation, with health centers serving as fully realized PCMHs and integrators, requires substantial human and financial investments in both the short and long term.

In the short term, investment in PCMH allows health centers to further extend the capacities developed through participation in the chronic disease collaboratives, including developing organizational capacity for engaging in rapid improvement cycles, integrated care, and new forms of patient engagement. PCMH practices allow health centers to transform how care is provided to patients, to create registries of patients and ensure care based on evidence-based guidelines, and to maximize patient experience. As health centers build this expertise, they can employ the PCMH as an effective model for addressing chronic conditions, providing preventive care, and addressing social determinants of health.

Payment in this facet facilitates health centers' efforts in examining existing work flows, redesigning them around patients, and moving away from structures designed to maximize revenue from the provision of billable services. While many Medicaid programs and some commercial payers provide small incremental payments (\$1-3 per member per month) for PCMHs that are helpful in beginning and sustaining PCMH efforts, movement to a fully realized transformation will likely require substantial one-time investments to transform work flows, train staff, and invest in health information and population management systems. Such investments could also be coordinated with local, state, and national foundations, third party payers, and insurers. For example Vermont's PCMH initiative (a multi-payer program which includes Medicaid), providers are required to meet NCQA recognition in order to receive two supplemental payments. The first is PMPM payment for care coordination and the second is a payment for infrastructure support.

This facet could support strategies to address social determinants of health by including payment enhancements based on characteristics of the population served (social determinants), for example by adjusting capitation based on patient disease risk and socio-economic status of the patient (i.e., homelessness or primary language other than English).¹⁹

Payment for System Level Performance

The third payment facet provides financial **incentives for the achievement of Triple Aim** outcomes. In contrast to traditional pay-for-performance programs that reward primary care mostly for quality process measures, these models will increasingly reward primary care for its contributions to the Triple Aim.

This facet can include a variety of payments, including payments for attainment of quality benchmarks, payment based on actual utilization or costs (shared savings), or payments based on performance on episodes of care (i.e., all the services surrounding a specific health need, such as a perinatal care). In states with managed care, this payment facet may begin in arrangements between managed care

organizations and states. One of Oregon’s largest Medicaid MCO, CareOregon, has established an reimbursement model to align metrics with Triple Aim goals. Provider payments, which include health centers, are grouped into three tiers. Tier 1 provides health centers with incentives to participate in its medical home initiative and primary care learning collaboratives, and to focus on population health management. In Tier 2, the plan rewards health centers for specific improvements related to preventive care, diabetes, hypertension, and continuity of care. Tier 3 rewards health centers who meet 90 percent of the metrics in Tier Two as well as those who reduce ED visits and ambulatory-sensitive conditions.

A payer may implement several performance payment mechanisms at once, and each payer will have their own set of initiatives. Currently, the majority of these payment methodologies are designed so that primary care providers have upside risk only (i.e., they do not lose revenue if targets are not attained, but can gain extra payments if they are).

One advantage of performance pay based on total system outcomes is the possibility for health centers to receive additional reward dollars based on their impact on overall system costs and performance. Numerous organizations and payers (private and public) are moving toward shared savings arrangements based on decreases in total cost of care relative to an agreed upon trend or control group. Since primary care providers cannot control the price of hospital utilization, which payers and hospitals negotiate, health centers could benefit from employing hospital utilization metrics as a proxy for how they can influence total cost of care.ⁱⁱⁱ

Typical measures used in pay for performance and shared savings models include:

- Avoidable hospital readmissions
- Hospital utilization
- Outpatient surgery utilization
- Emergency department visits
- Generic prescribing, and
- Medication compliance

However, it is important to note that along with the potential for increased dollars in this facet comes even more accountability. Providers must be able to document improved health outcomes of the population they serve, as well as total health system costs and utilization. This means, at the very least, that health centers would need the capacity to:

- 1) Access to complete utilization data for their patient populations (i.e., acute hospital utilization rates), and
- 2) Increased health information technology for real-time patient management at the care team level.

In considering participation in payment models, health centers should be keenly aware of how shared savings is calculated and distributed, as well as other analytical approaches for calculating payment (discussed in the Key Capabilities for Health Centers section below).

ⁱⁱⁱ Much has been written about early shared savings arrangements. For additional information, see: Bailit, M., Hughes, C., Burns, M., & Freedman D.H. (2012). Shared Savings Payment Arrangements in Health Care: Six Case Studies. The Commonwealth Fund.

The table below summarizes the financial objective of each of the three payment model layers described above, and its link to the delivery system transformation required to achieve the Triple Aim. Table 1: Three Payment Facets Link between Financial Objectives and Delivery System Transformation

Payment Model Layer	Financial Objective	Delivery System Transformation
Base (equivalent to PPS)	Maintain comprehensive primary care during transition to new system	Flexibility to deliver care in more cost-effective and patient-centered ways
Transformation (PCMH)	One-time, substantive investment in transformation Ongoing (smaller) payment to sustain transformation	Increase the capacity and accountability of primary care as a PCMH “integrator” for the broader health system Support a robust team approach, and new use of team and team members
Performance on Triple Aim Outcomes	Reward for Achieving Lower Cost of care per capita and increased quality outcomes, access and patient experience Over long term, reward focus on preventing chronic conditions.	Maximize primary care role in integrated systems Provide the right care at the right time and place

Specific capabilities needed for health centers to engage successfully in these components of payment reform are discussed in the section below.

Core Capacities for Payment Reform Participation

Payment reform efforts are taking place in a period of high innovation, with payers, insurers, and providers all working to refine the methodologies used. Health centers will need a core set of both analytic and operational capabilities to engage successfully in payment reform efforts, and Primary Care Associations can help make sure they are in place.

Keeping a Pulse on the Broader Health Care Reform Environment

In addition to ongoing participation in the development and implementation of primary care payment reform opportunities, health centers should stay abreast of state and national-level discussions around new payment reform and service delivery reform, including Section 2703 State Plan Amendments, CMS State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS state innovation models, Medicaid waiver efforts that involve delivery system transformation, and the development of Medicaid and Medicare ACOs.

Analytic Capabilities

The health center program is grounded in the understanding that provision of culturally competent, high quality primary care and enabling services result in savings to the system. In order to maximize participation in payment reform efforts, health centers must be able to demonstrate with data the overall systems savings, improved access, and quality that accrue to the system from their care. Health centers will need to develop a robust set of analytic capabilities to support the assessment of payment reform opportunities and demonstrate the value they can contribute. Successful health centers will be able to critically evaluate their own strengths and weaknesses, and generate reliable projections of the financial impact of participation in payment reform.

Document the Value of Enabling Services

The enabling services provided by health centers long distinguished the health center model from other primary care in the community. Because the delivery of and expertise in enabling services is a distinguishing characteristic of health centers compared to other providers, it is critical that health centers be able to describe the value of these services. However, because these enabling services have not historically been reimbursable, little work has been done to document the 1) scope, (i.e., range of services), 2) intensity (i.e., ranges of case management) and 3) impact of these services on health outcomes and system costs, or to differentiate them from patient navigator or care coordination roles that have emerged as part of PCMH models. Health centers involved in payment reform efforts will increasingly need to be able to capture and demonstrate the value of these services and their impact on system savings and health outcomes to ensure they are adequately supported under payment reform. This may include adopting emerging systems for coding these services in billing systems, and including them in electronic health record or practice management templates.

Assess Impact on Social Determinants

As noted above, one of health centers' core competitive advantages in the context of the Triple Aim is their ability to address social determinants of health. While health centers provide enabling services to help mitigate the impact of social determinants and capture some data regarding services provided, few health centers capture or utilize data on the social determinants of individual patients in the same way they do for chronic disease diagnosis or health risk factors (such as smoking). The Association of Asian Pacific Community Health Organizations (AAPCHO) has developed specific protocols and manuals for capturing the provision of enabling services, and for using the data collected to document the role and value of enabling services in addressing social determinants of health^{iv}.

Emerging models, such as ACOs, are beginning to explicitly include social service systems within their network and directly address the social determinants of health in their approach. Health centers must increase their ability to define and capture these determinants (including capturing patient socioeconomic characteristics and specific types of enabling services in their data systems) in order to better understand the social determinants faced by their patient base, ensure appropriate risk adjustment models are used when negotiating payment rates, and evaluate their success with specific groups of patients.

Use Data for Design, Monitoring, and Evaluation

Payment reform methodologies are heavily dependent on the availability of detailed and reliable data. Health centers will need access to inpatient, specialty care, long-term care, and ancillary data that has historically fallen outside their purview in order to understand the total cost of care and associated utilization drivers of their patient populations, and to assess their own successes and challenges in a transforming delivery system. For example, health centers will need to have data on all the health services their patients use (including specialty and hospital services) in order to identify opportunities to provide preventive care, and to assess impact of PCHM services on overall system utilization over time. Health centers can work to develop partnerships and strategies with health plans, provider groups, and the state in order to secure this data. For example, contracting agreements with health plans can include a provision that system-level claims data on patients seen by health centers be provided to health centers on a regular basis. In addition, state-level all-payer claims databases are another potential source for this data. While claims data is helpful in understanding longer-term care trends, real-time patient data is needed to inform practice transformation efforts and to manage patient care. Health centers can work to be included in regional and local health information exchanges, and to ensure that the way information is exchanged is appropriate for informing care provided by health centers.

Once data is secured, health centers will need the technical capability to work with the data in order to 1) evaluate its accuracy and any missing components relevant to primary care provided by health centers, 2) identify how the data reveals opportunities for improved care and care management, and

^{iv} For more information see <http://www.aapcho.org/projects/enabling-services-accountability-project> and http://www.nachc.com/client/Enabling_Services.pdf

3) ensure that the specific data elements being used to measure performance for payment incentives are sufficient and appropriate. In particular, health centers will need to use the data to:

- Evaluate whether risk tiers and benchmarks proposed by payers are appropriate,
- Evaluate the feasibility and desirability of taking on specific payment arrangements,
- Engage in ongoing data measurement and analysis to track and make adjustments to their own performance, and to provide information against which to compare data produced by payers and managed care organizations,
- Compare their own health record and information system data to that used by payers for payment in order to ensure data elements are being captured and analyzed correctly,
- Use their own utilization and cost data to understand the implications of any proposed changes in payment models and to validate the assumptions made by payers or health plans in their assessment of the model, and
- Identify the potential impact of taking on financial risk in the form of payment withholds or penalties, either individually or as part of a network of health center partners.

Health centers may need to invest in staffing or technology resources that allow them to make full use of the data, once secured. In particular, health centers will need to evaluate how two aspects of payment reform design, risk adjustment and patient attribution, will be addressed.

- **Risk Adjustment.** Risk adjustment is an analytical method used to allow for comparison of costs of populations that have underlying differences in illness burden. Risk adjustments help to provide more equitable payment for providers that see more complex patients. **However, no risk adjustment model exists for adjusting payment programs based on social determinants of health.**²⁰ Health centers may want to explore opportunities for patient risk adjustment based on a patient's social determinants, such as income, education, and language in addition to their medical conditions or health status.
- **Patient Attribution.** Because value-based payment models measure outcomes and/or costs for a specific patient population, they use an attribution method to determine the patients for whom a provider is responsible. Historically when patients have been attributed to providers, (for example, in most managed care plans), they have been "locked in" to a provider or provider group and unable to switch providers except under certain circumstances or enrollment periods. With increasing emphasis on patient-centeredness, there has been a move away from requiring patients to stay with their selected provider. Attribution models can include assignment of newly eligible populations based on the care patterns patients had prior to becoming insured, and incentivize providers for retention of patients in the system.

Operational Capacities

While analytics provide the basis upon which health centers can make decisions and transform their systems, there are core operational capabilities that health centers need to support involvement in payment reform and system transformation efforts. These include:

Leadership and Appetite for Innovation

Payment reform is rapidly evolving in response to changing market conditions as well as innovations in service delivery and health information technology. Often the payment model itself is being developed even while the broader initiative it supports is being implemented. Successful involvement requires an appetite and desire to transform the way care is provided within the health center, as well as in the community as a whole. The most competitive health centers in this environment are those that have developed an organizational framework for change and innovation, and have experience in change management.

Health Information Technology

Health information provides the basis for measuring outcomes within payment reform. Thus, **health centers that are using electronic health records and leveraging health information technology to inform care at the team level are more prepared to engage in payment reform.** In addition to having robust systems for data capture, health centers must be facile in using the data gathered to impact how care is provided, how care teams are designed, and how systems are organized. Data housed in an EHR or other repository is underutilized if it is not regularly employed at the team and organizational level to identify opportunities, trends, and challenges. Thus health centers need clinical and operational leaders who understand and support the value of health information technology, as well as the use of data to inform decision-making.

Partnership Capabilities

Emerging service delivery models require health centers to be engaged as partners with other providers in the community as models shift increasingly toward a population health focus. Emerging delivery models also require health centers to be engaged with organizations and sectors that can impact social determinants, such as social services and education. **Health systems, or other integrated delivery systems, are critical partners 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 system 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 and patient experience.

How to Get There from Here: Key Steps for PCAs and Health Centers

As the section above indicates, effective engagement in payment reform requires both specific technical capacities and the dedication of personnel to guide and shape health center involvement. For health centers and PCAs who have not been involved, or who are interested in increasing their ability to shape future payment reform efforts, it can be challenging to identify where to focus efforts in order to have the most impact.

The specific steps to be taken will vary considerably by state, depending on the local and state Medicaid environment and existing delivery system structure. However, all PCAs and health centers could benefit from undertaking the following four key steps to move forward with a transformed payment and service delivery environment. PCAs and health centers can:

1. Develop and maintain a robust understanding of payment reform efforts in the state and local environment.
2. Ensure a clear, shared vision of their organization's role in achieving the Triple Aim.
3. Critically assess current operations and capabilities. In particular, health centers should assess their:
 - Existing work flow,
 - Ability to collect and report data, and to employ data to inform care at the team level,
 - Ability to transform into a more robust PCMH that is able to effectively address social determinants of health,
 - Ability to act as an integrator of care within the local health system, including the ability to take a leadership role in the local health system, and
 - Ability to evaluate and administer novel payment methodologies.
4. Work collaboratively with other health centers, stakeholders, and partners to accelerate transformation.

Conclusion

Health centers are strongly positioned to achieve the Triple Aim – improved patient experience and population health, with reduced total health system costs per capita – within low-income and underserved populations nationwide. Payment reform efforts can align payment to support innovation and important resources for health centers to achieve their mission and address the social determinants of health in their communities. The implementation of health care reform involves testing innovations at the regional and state level through opportunities made available directly to providers or through the participation of state Medicaid agencies. **Yet these opportunities will not be realized without significant attention to the capabilities, education, and implementation steps needed in a system that places increasing emphasis on value over volume of services and on improving population health.**

There is increased recognition that a robust patient-centered primary care system is critical to achieving the goals of the Triple Aim, and that investment in primary care, such as those identified in the payment conceptual model above, is necessary for a transformed delivery system. While opportunities for involvement in payment reform will continue into the future, communities and states are currently in the process of developing the framework and structures for these reforms. This is a critical time for PCAs and health centers to ensure that health centers build the skills and capacity needed to prepare for and participate in payment reform efforts. The layered model for primary care payment reform identified in this paper provides a conceptual framework for understanding payment reform as it relates to delivery system transformation and the role of primary care in the achievement of the Triple Aim.

Information to include in sidebars in the design phase:

Is payment reform just 1990s Managed Care repackaged?

While payment reform in many states is being implemented within a managed care environment, it differs from prior iterations of managed care in significant ways. These include:

- A focus on value over cost containment
- A recognition that vertical and horizontal alignment of the system is needed to provide the right care in the right place at the right time
- Widespread use of health information technology to support population health management and patient care, as well as system integration.
- Expectation that patient care can be best managed at the practice level, and that primary care providers be active participants in achieving the Triple Aim
- Increasing efforts to address social determinants of health historically not addressed by the health care system

Health Centers and Delivery System Redesign

For more than a decade, health centers have invested substantial resources in delivery transformation through support for:

- Chronic disease collaboratives,
- Implementation of evidence-based practices such as group visits for pregnancy and chronic disease support,
- Transformation to a PCMH,
- Increased support of behavioral and dental health as core health center services,
- Electronic health record adoption,
- Increased capacity for rapid-cycle change and innovation.

Health centers that have built these capacities are poised for successful participation in a transformed delivery system.

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