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Introduction

Policymakers at both the federal and state levels are focusing on how best to structure and align provider payments to promote quality, value and cost control. Because the highest risk consumers of health services are often Medicaid beneficiaries and health center patients, the safety net has been a natural place to test new payment models. It is important to note, as is evident in this report, that payment reform demonstrations are not occurring in a vacuum; they are just one piece of coordinated and multi-layered efforts to redesign how health care is both paid for and delivered.

The Affordable Care Act Promotes Payment Reform

With its incentives to promote quality, value and cost control, and to strengthen primary care as the foundation for a reformed health system, the ACA has already proven a catalyst for states to test payment reform models in Medicare, Medicaid and CHIP as well as through other multi-payer initiatives that move toward the Triple Aim¹. The ACA established the Center for Medicare and Medicaid Innovation “to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished” to Medicare, Medicaid or CHIP beneficiaries. In selecting such models, “the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals.”²

The State Innovation Models Initiative (SIM) has provided \$300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and CHIP. To date, 25 states have received grants under SIM for model design (16 states); model pre-testing (3); and model testing (6). Several of the initiatives discussed in this paper are being funded by SIM grants and are part of larger, state-wide efforts to test new payment and delivery system models. Several of the payment reform demonstrations discussed in this paper are part of wider initiatives authorized and funded by SIM grants and others are being undertaken separately.

Health Centers and Payment Reform

Payment reform demonstrations come in many different shapes and sizes and are at varying levels of progression. This report highlights initiatives and ideas in seven states that are already underway (CO, MA, MN, and OR) and others that are being proposed by health centers and primary care associations (CA, MD, VT). These initiatives and proposals focus on the Medicaid program, although not necessarily to the exclusion of other payers and all utilize one or more of the following three models:

¹ To improve patient experience (quality of care and satisfaction), improve population health, and reduce per capita costs

² Centers for Medicare and Medicaid Services. State Innovation Models Initiative <http://innovation.cms.gov/initiatives/State-Innovations/>

Pay for Performance/Incentive Payments

This model can include a variety of payments, including payments for attainment of quality benchmarks, payment based on actual utilization or costs or payments based on performance on episodes of care. This model is often realized in the context of Patient-Centered Medical Home initiatives.

Shared Savings Models/Accountable Care Organizations (ACO)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to patients they serve.³ Participating providers may also share in any savings associated with improvements in quality and efficiency. Although the concept of ACOs originated in the Medicare and commercial sectors, several states are actively developing ACO initiatives or similar shared savings arrangements in the Medicaid program. The structure of Medicaid ACO initiatives is influenced by individual states' history and experience with managed care, other existing care delivery arrangements within Medicaid, and the challenges inherent in serving low-income and chronically ill populations.⁴

Health Center-Specific Alternative Payment Methodologies (APM)

Health Centers are currently reimbursed based on a per-visit prospective payment system (PPS) which is essentially a bundled payment. The PPS baseline rate is intended to cover the cost of services provided in a single visit, although in many states, this is not the case⁵. The PPS methodology was established initially so that health centers' federal 330 grants would not be used to compensate for underpayments by Medicaid. Federal law allows states to negotiate alternative payment methodologies (APM) with health centers so long as the rates are not lower than what the health centers would receive under PPS. This flexibility allows states and health centers to work together on payment reforms while providing some degree of financial protection to the health center. To comply with federal law regarding payment for health centers, including APMs, new models must ensure that health centers are made whole.

³ www.cms.gov

⁴ Emerging Medicaid Accountable Care Organizations: The Role of Managed Care, Kaiser Commission on Medicaid and the Uninsured, May 2012.

⁵ The average reimbursement for Medicaid costs to health centers is 81% nationally

Examples of State Payment Reform Initiatives Involving Health Centers

<p>California</p>	<p>PPS-Equivalent Capitation Payment Model <i>Concept Proposal</i> <i>Status: In discussions with State</i></p> <p>With the goals of allowing health centers the flexibility to transform the way they deliver primary care, increasing primary care capacity to provide patient-centered, high-quality care, and reducing total health system cost by influencing decreases in inpatient utilization, California Primary Care Association (CPCA) and California Association of Public Hospitals (CAPH) have worked to design a payment reform pilot that can be tested while minimizing administrative burden for health plans. CPCA views piloting PPS-equivalent capitated payment as a first phase within payment reform efforts. This first phase focuses on transforming the method by which health centers receive revenue, creating more flexibility for health centers to provide care. CPCA continues to support supplemental PCMH/PCHH payment and alignment of incentives, including shared savings, as other phases of payment reform that can be layered in a comprehensive payment reform model to catalyze and sustain delivery system transformation.</p> <p><i>Rate Development/Payment</i> Within the managed care environment, health plans will pay pilot health centers a total amount equal to a per-member-per-month (PMPM) based on the equivalent of 1/12 of the PPS revenue per enrollee in a given aid category for a recent year.</p> <p>The capitation rates for each clinic site will be based on health center site specific utilization and site-specific PPS rates, stratified by Medi-Cal aid category (ex. SPD, TANF) by the following formula:</p> <ul style="list-style-type: none"> • PPS Equivalent PMPM= (Avg. annual site utilization per aid category) * (Site specific PPS rate) / 12 • Average annual site utilization will be based on recent 12 months utilization data cross-tabulated by aid category. Aid-category-specific rates will align with how the State pays health plans and will account for some risk adjustment given that utilization patterns of specific populations tend to be different. • The state will pay the managed care organizations (MCO) directly for any administrative costs incurred and would continue to pay PPS for non-managed care patients and certain carved out services for managed care patients. <p><i>Scope change, Rate Setting, Annual Increases, and Reconciliation</i></p> <p>This proposal includes the ability to do scope change, PPS rate setting and annual increases via the Medicare Economic Index (MEI) in line with current policy with the caveat that all pilot sites must have a final approved rate before entering into the pilot. In addition, reconciliation should only be done if CHC requests it on annual interval. This would decrease most of the costs associated with the current reconciliation process while still protecting health centers if they experience an unexpected upswing in utilization (ex. an unusually intense flu season).</p>
<p>Colorado</p>	<p>Accountable Care Collaborative</p> <p>The Colorado Department of Health Care Policy and Financing (HCPF) implemented the Accountable Care Collaborative (ACC) in the state’s Medicaid program in 2011. Under the program, a Regional Care Collaborative Organization (RCCO) is designated in each of the seven ACC regions of the state. Each RCCO is responsible for care coordination among providers, community organizations and government</p>

	<p>services. Within each RCCO, primary care providers offer a medical home for patients and work with the RCCO to coordinate care and manage patient needs across specialties and along the continuum of care. All community health centers in the state are signed on for the program and HCPF is estimating \$20 million in total savings for year one.</p> <p><i>Proposed Shared Savings Model (pending federal approval)</i></p> <ul style="list-style-type: none"> • Shared savings paid on top of the health centers' normal rate • 50% of total savings goes to the state • 50% of total savings distributed as follows: <ul style="list-style-type: none"> ○ 30% RCCO share including a base payment for participation (40%), a payment based on demonstrated savings (20%) and an enrolment-based payment (40%) ○ 70% Provider share including an attribution-based payment (90%) and payment based on quality metrics (10%)
Maryland	<p>Enhanced Patient Centered Safety Net Medical Home (PCSNMH) <i>Concept Proposal</i></p> <p>In December 2012, Maryland's health centers presented a concept paper to the state for a new voluntary Patient Centered Safety Net Medical Home pilot project that builds on the state-sponsored PCMH initiative but includes quality measures and a transition to a new enhanced capitated payment model. The proposal's primary goal is to advance a transformational model for health centers to move from an encounter –based reimbursement to a model of rewarding care outcomes, appropriate utilization of prevention and chronic disease management and cost reduction.</p> <p>The proposal outlines two stages of the pilot to provide all stakeholders (State Medicaid, MCO payers and health centers) with a gradual path for transformation and producing anticipated value-based results. The first stage maintains PPS as the baseline and adds value-based (VB) supplemental payments, practice support payments and targeted care management payments on top.</p> <ul style="list-style-type: none"> • PPS Base: PPS is retained for all face to face visits during the transitional phase. • VB Incentive Payments: Supplemental payments for assisting MCOs in meeting targets. Payment can be structured around a process. For example, a health center receives \$25 for every patient who is complaint with quality metric by end of CY and additional \$5 per compliant patient if the health center meets 60% of MCO identified opportunities; \$10 for 70%; and \$20 for 80%. • Practice Support Payments: These are monthly payments per assigned member in order to support growth of clinical care management staffing and systems. The level of PMPM would increase as PCMH recognition increased. • Targeted Care Management Payments: Rates are associated with high cost utilization history or high risk using evaluation models. These patients could include those with significant behavioral health needs. Consideration should be given for a specific rate for providing services to Limited English Proficiency patients to incorporate not only additional cost of interpretation and translation services, but slower productivity serving these patients. <p>For example, an health center has the following description in its final baseline year during Stage 1:</p> <ul style="list-style-type: none"> • 7,500 Assigned MCO patients average per month (based on total annual MCO assigned member months/12) • 500 Attributed Red Card patients average per month (based on total annual DHMH attributed member months/12) • 28,000 combined Medicaid visits paid at PPS. • PPS rate = \$150.00

	<ul style="list-style-type: none"> • Health center addresses 76% of the VB opportunities across all MCOs • Health center has 182 patients considered high risk assigned to them by the MCOs with the average targeted care management PMPM payment of \$75.00 <ol style="list-style-type: none"> 1) PPS Rate: 28,000 visits x \$150 = \$4.2 million 2) VB Payment: 2,850 VBP Hits (76% of 3,750 opportunities) X \$25 (\$71,250), plus \$10.00 per hit for being over 70% (\$28,500) = \$99,750 3) Practice Support: \$5 PMPM for practice support fee X 8,000 patients X 12 months = \$480,000 4) Targeted Support: 182 Targeted Care Management for high risk population X\$75 X 12 = \$163,800 5) Total Payment: \$4,943,550 <p>The second stage is to move health centers to a risk/reward model, compliant with the APM requirements in federal law to ensure no participating health center is paid less than PPS, but will be based on capitation and continuity of care as the primary vehicle for system financing. This staging process attempts to build a model that is based on evidence-based practice, adjusting for community and practice demographics, as impacted by the social determinants of health within the served community. It relies on having access to actionable data from payers and other providers of care via a Health Information Exchange. All costs associated with payments made in the first stage within categories 1, 2, 3 and 4 above will be calculated into a single per member per year payment level.</p> <p>Stage 2 PMPM for the 8,000 patients would be \$4,943,550/8,000 pts /12 months = \$51.50</p> <p>There would need to be reconciliation after each year of this Stage 2 Model to assure that the APM is no less than what would have been paid the center globally than what it would have received under the PPS system to remain compliant with federal guidelines.</p>
Massachusetts	<p>Primary Care Payment Reform Initiative (PCPRI)</p> <p>An RFP issued in March 2013 for a new payment reform initiative designed to transform the delivery of and payment for primary care services by supporting Primary Care Clinicians that transform into PCMH that integrate the provision of Behavioral Health Services. The PCPRI is seen as the second major step in Massachusetts' long-term strategic plan to reform payment and delivery in the Commonwealth.</p> <p>In July 2009, the Special Commission on the Health Care Payment System issued a report recommending that the state transition from Fee-for-Service to global payments as the dominant payment model for health care services in Massachusetts. To further its goals, the Massachusetts Executive Office of Health and Human Services (EOHHS) launched the Patient-Centered Medical Home Initiative (PCMHI) in 2010, in which 46 primary care medical practices across the Commonwealth were selected to participate in a three year demonstration designed to promote comprehensive, coordinated, patient-centered care delivered by providers and multidisciplinary teams of providers. The PCMHI requires participating practices to transform their practices into a PCMH model with Care Coordination and Clinical Care Management services. The payment mechanism for participants in the PCMHI includes a start-up infrastructure payment, per Panel Enrollee per month payments for PCMH activities and Clinical Care Management services, and potential payments for Shared Savings and quality.</p> <p>The PCPRI builds on the foundation the PCMHI, which began in April 2011. The PCPRI incorporates significant aspects of the PCMHI with regard to clinical delivery of services and quality of care, and provides a funding mechanism to further enhance EOHHS's goals which include the establishment of ACOs and a transition to alternatives to Fee-for-Service payments for ACOs and other provider</p>

	<p>organizations.⁶ The PCPRI consists of three main components: a clinical delivery model that aligns with the principles of PCMH, a quality measures and metrics model that, among other things, will determine eligibility for and calculate certain payments to participants, and a payment model, which is discussed in more detail below. To date, 16 health centers have applied for the demonstration, which is still undergoing refinement and is slated to begin later this year.</p> <p>The Payment Model includes the following three types of payments to Participants:</p> <ol style="list-style-type: none"> 1. The Comprehensive Primary Care Payment (CPCP), a risk-adjusted, per Panel Enrollee, per month payment for a defined set of Primary Care Services and options for a defined set of Behavioral Health Services; 2. A Quality Incentive Payment; and 3. A Shared Savings / Risk Payment, with an option of one of the following three Risk Tracks, with varying levels of financial risk and reward in each Risk Track: <ol style="list-style-type: none"> a. Risk Track 1 (Upside / Downside Risk); b. Risk Track 2 (Transitioning to Downside Risk); or c. Risk Track 3 (Upside Risk Only).
Minnesota	<p>Minnesota’s 2008 Health Care Reform Legislation</p> <p>In 2008, the Minnesota legislature passed a health care reform package that established a number of programs focused on improving quality and controlling costs by establishing a state-wide quality reporting and measurement system that underpins new delivery system and payment reforms, including:</p> <p><i>Quality Incentive Payment System (QUIPS):</i> As of July 1, 2010, the Commissioners of Minnesota Management and Budget and Human Services were directed to implement QUIPS for the State Employee Group Insurance Program (SEGIP) and all enrollees in state health care programs. The quality measures for clinics focus on diabetes care and vascular care and depression with optimal levels being risk adjusted by payer mix. Providers may be eligible for a quality-based incentive payment for either achieving a certain level of performance or for a certain amount of improvement, but not both.⁷</p> <p><i>Health Care Homes:</i></p> <p>Under the legislation, explicit payments for coordinating services in a certified health home, health plan companies, the state employee health plan, and state public programs must implement care coordination payments to health care homes by July 1, 2010 (or upon federal approval, for state public programs).</p> <p>FQHC Urban Health Network (FUHN)</p> <p>FUHN is part of a three year Medicaid payment reform demonstration (authorized by 2008 health care reform legislation) that formally launched in January 2013. The safety-net ACO model includes ten health centers in Minneapolis and St. Paul and currently has approximately 20,000 attributed individuals from the Medical Assistance and Minnesota Care programs. Attributions are based on claims history.⁸</p> <p>The current PPS rates still apply for the duration of the demonstration; however Total Cost of Care (TCOC) targets will be established which include inpatient, outpatient, professional, ancillary, and some mental health and substance abuse services. By meeting specified quality and performance standards</p>

⁶ Chapter 224 of the Acts of 2012. Enacted July 31, 2012.

⁷ <http://www.health.state.mn.us/healthreform/measurement/qipsreportupdate0513.pdf>

⁸ Minnesota Association of Community Health Centers

	<p>and achieving TCOC savings, the network participants will share those savings with the state:</p> <ul style="list-style-type: none"> • 2%: automatic state share • 98%: 50/50 split between state and FUHN participants⁹
Oregon	<p>Coordinated Care Organizations</p> <p>In 2012, Oregon received federal approval of an 1115 waiver that seeks to substantially change how care is delivered and paid for by creating community-based coordinated care organizations (CCO). A CCO is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions like diabetes and asthma. To date, 15 CCOs have been approved and all but one have begun serving patients. All health centers in the state are contracted with a CCO and shared savings will accrue to the CCO and will be allocated in a way that is yet to be determined.</p> <p>Health Center Alternative Payment Methodology</p> <p>Three health centers are participating in a pilot to test a new APM that seeks to de-link payment from the traditional face-to-face, patient-provider encounters and move toward value-based payment. The current FQHC PPS rate is converted into a bundled PMPM rate based on historic patient utilization data and the medical-only cost based rate for each specific health center. An MCO or CCO will pay a PMPM rate comparable to any primary care provider and the state will pay a PMPM wraparound payment based on the prior year's wraparound payments. Patient centered primary care home (PCPCH) payment, pay for performance or other bonus payments are separate. After receiving CMS approval of a State Plan Amendment in September 2012, the new APM went into effect in March 2013.</p> <p>New APM Formula</p> <ul style="list-style-type: none"> • If a health center's PPS rate = \$100/medical encounter; • The health center served 5,000 Medicaid patients at an average of 3.0 encounters/patient, for total Medicaid medical visit revenue of \$1,500,000 (excluding dental and mental health revenue). • APM rate is based on $\\$1,500,000 / 5,000 = \\300 per patient, per average number of months patient stayed with the health center. • The health center's PMPM: $\\$300/12 = \\25 PMPM.

⁹ Minnesota Association of Community Health Centers

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State Payment Reform Initiatives

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