



Navigating and Advancing Health Center Payment Reform: Development and Implementation Lessons from Primary Care Associations



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About 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 non-profit organization providing advocacy, education, training, and technical assistance to health centers in support of their mission to provide quality health care to underserved populations.

About JSI

John Snow, Inc., (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 health care safety net to deliver cost-effective, high-quality care to underserved populations. JSI contributors to this paper include: Stacey Moody, MSW; Elena Thomas Faulkner, MA; Caitlin Hungate, MDP; Morgan Anderson, MPA; Jeremy Make, MA; and Mary McCrimmon, AA.

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In this document, unless otherwise noted, the term “health center” is used to refer to organizations that receive grants under the Health Center Program as authorized under Section 330 of the Public Health Service Act, as amended, (referred to as “grantees”) and FQHC Look-Alike organizations, which meet all the Health Center Program requirements but do not receive Health Center Program grants. It does not refer to health centers that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grant.

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Executive Summary

Across the nation, health care delivery systems and payment models are transforming to respond to the tenets of the Triple Aim: improving patient experience and population health while reducing system costs. The Affordable Care Act (ACA) has stimulated the testing and spread of new delivery models, a shift toward value-based payments and the development of resources for system-wide improvement.

As Primary Care Associations (PCAs) and health centers navigate the myriad of system and payment reform efforts, ranging from quality and value-based incentives to population-based payment models, there is a desire to learn from other states about their experiences developing and implementing various payment models. This report synthesizes highlights from conversations with seven PCAs and their key partners about their experiences with payment reform. The report discusses key findings and considerations to guide PCAs as they, with health centers in their state/region, prepare for and engage in payment reform models including:

- Important “ingredients” for successful PCA and health center engagement in payment reform efforts
- Considerations regarding the payment reform model to be pursued
- Key payment reform design considerations for health center-focused alternative payment methodologies (APMs) and broader reform models

This report seeks to build upon shared experiences and bolster capacity within the health center community to successfully advance and engage in payment reform efforts by identifying common experiences and describing various approaches taken by PCAs.

Ingredients for Successful PCA Engagement

PCAs in each state interviewed laid the groundwork for and supported their payment reform efforts by

Understanding State Goals – PCAs established a strong understanding of their state’s goals for payment reform.

Enlisting Vital Partners – PCAs engaged and built trust among partners to strengthen support for and development of the payment reform effort.

Establishing a Strategy to Support and Sustain PCA and Health Center Involvement in Payment Reform Efforts – PCAs invested substantial resources in order to be substantively involved and/or to lead the reform process.

Involving Health Centers Systematically – PCAs established a process for health center input into and securing ongoing involvement in payment reform efforts.

Demonstrating Health Centers' Value through Data – Health center data proved critical in demonstrating the value health centers bring to the communities they serve and informing the design of payment models.

Leveraging Health Center Commitment to and Experience with Practice

Transformation – Practice transformation efforts harnessed a deeper appreciation of how payment can support or hinder transformation and served to inform the development of payment reform models.

Considerations for Payment Reform Model Development

Key informants identified specific decision points that a PCA and health centers within its state/region face when identifying and pursuing a payment reform model.

Shared Understanding among Health Centers about the Scope and Purpose of Payment Reform Being Pursued

Differentiate between Health Center-Specific and System Transformation – Health center efforts, whether focused on Prospective Payment System (PPS) or broader payment reforms, were framed within the broader environment. PCAs found it helpful to be clear about the goals of specific payment reform efforts and their relationship to broader delivery system transformation.

Be Clear about the Role of Specific Payment Reform Efforts vis-a-vis the End Goal – PCAs distinguished between changes in payment designed to facilitate incremental service delivery system or practice transformation and more comprehensive payment reform that would sustain transformed practice over time.

Be Responsive to a Fluid Environment – PCAs and health centers established a vision and goal for payment reform, and adapted their efforts based on challenges and opportunities that emerged over time.

Be Rigorous about Readiness – PCAs ensured that health centers were truly ready to engage in and succeed with payment reform models, often starting payment reform efforts with a small group of health centers.

Working with Partners

Set Expectations around Health Center Prospective Payment System – PCAs and health centers ensured the state Medicaid department and other partners, including managed care organizations (MCOs), understood federal requirements around the PPS, and health centers critical role in the delivery system. They also sought explicit agreement with the state about how PPS requirements would be addressed within the payment reform effort.

Engage with Partners and Other Key Stakeholders – PCAs built new partnerships and/or maintained open dialogue with key stakeholders to encourage vital support for health center priorities.

Address Practical Considerations in Working with the State – PCAs established a relationship with the state Medicaid agency, and engaged in ongoing discussions around the payment model and technical details.

Key Payment Reform Design Considerations

Interviewees identified specific design choices that PCAs will face as they develop or address payment reform models in their states.

Transforming PPS through an APM – PCAs and health centers that find PPS' focus on face-to-face provider visits limits their ability to implement new care models have pursued alternative payment methodologies (APMs) that reimburse for a population instead of a visit. Design considerations for APM-focused models include:

Legislative or Administrative Approach – PCAs and health centers considered whether to establish payment reform models through state legislation, the state regulatory process, or through state and local transformation efforts.

Pursuing Reform in a Managed Care Environment – PCAs considered the relationship of PPS wrap-around to payments that flow through MCOs.

Monitoring for Unintended Consequences – Interviewees shared that moving from fee-for-service (FFS) or volume-based payment to capitated or outcome-based payment is a process, and if poorly defined, it can lead to unintended consequences.

Defining the Population Covered by Reform – PCAs clearly defined the population for which health centers are responsible under a payment reform model.

Pursuing Reform in a Managed Care Environment – Interviewees noted the importance of understanding and accounting for existing delivery system structures and payment flow in payment design.

Demonstrating Outcomes from Payment Reform – All stakeholders recognized the critical need to evaluate the success of the payment model.



Introduction

Payment Reform Environment

At federal and state levels, the Triple Aim—with its focus on improving patient experience and population health while reducing system costs¹ (and thus optimizing performance)—has become the guiding framework for system delivery and payment reform efforts. There are myriad models being tested and employed, as illustrated in the HCP LAN Alternative Payment Models Framework in Appendix A. These models range from those that are built on a fee for service infrastructure and include a link to quality and value payments or penalties, to population-based payments that are de-linked from traditional service-based payment structures. Depending on the state and local environment, PCAs and health centers may have the opportunity to participate in one or more of these models.

The Affordable Care Act (ACA) contains provisions for “testing new delivery models and spreading successful ones, encouraging the shift toward payment based on the value of care provided and developing resources for system-wide

Value-based payment shifts the health care system toward paying providers based on the value (cost and quality) of care provided to populations.

improvement.”² In addition to the flexibility that currently exists to pursue alternative payment methodologies (APMs) for health centers, states can pursue payment reform through any of the following opportunities: Medicaid health homes under Section 2703; new payment and service delivery models promoted by the Centers for Medicare & Medicaid Innovation³ (The Innovation Center), including reforms tested through State Innovation Models; and the Delivery System Reform Incentive Payment (DSRIP) program designed to support hospitals and other providers in transforming care delivery. Federal and state payers are progressively setting targets for moving toward value-based payment, as are private payers. Primary Care Associations (PCAs) and health centers within their state/region are increasingly paying attention to and engaging in service delivery and payment reform efforts.

Health centers have a unique role to play in providing high-quality, patient-centered care to underserved and vulnerable populations. As they transform care to better meet Triple Aim

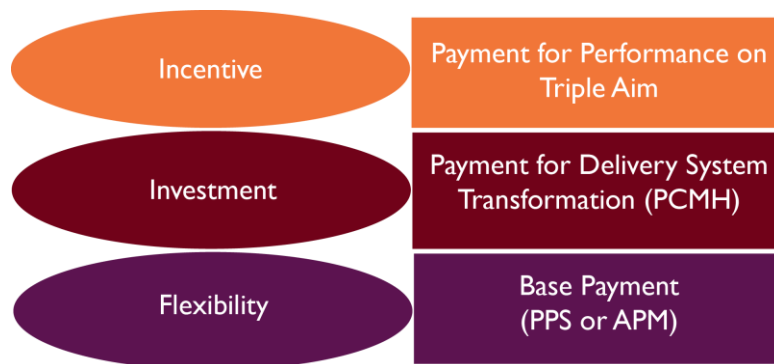
¹ Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value. (2015, January 26). Retrieved from <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>

² Abrams, M. K., Nuzum, R., Zezza, M. E., Ryan, J., Kiszla, J., & Guterman, S. (2015, May 7). The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>

³ Centers for Medicare & Medicaid Services. (n.d.). Innovation Models. Retrieved from <https://innovation.cms.gov/initiatives/#views=models>

goals, they need a payment model that provides flexible and stable funding for core health center services, necessary financial investment to catalyze and sustain practice transformation, and rewards for achieving Triple Aim goals.⁴ A 2013 NACHC Issue Brief, [Health Centers and Payment Reform: A Primer](#), describes a payment framework for health centers consisting of three facets: Base payment reform allows for **flexibility** in how care is provided by moving away from payment based on traditionally-billable services; **investment** in service delivery transformation can support and sustain transformed systems; and financial **incentives** can reward performance in achieving Triple Aim outcomes, such as reaching quality benchmarks and/or reducing total cost of care.⁵

Figure I. Three Possible Facets for Health Center Primary Care Payment⁶



Increasingly, service delivery transformation models include a value-based payment component, and state Medicaid agencies are exploring ways to pay for value within or outside of a managed care organization, and through a variety of service delivery structures. Most payers and thought leaders, such as the Health Care Payers Learning Action Network (HCP LAN), describe a broad spectrum of payment reform models ranging from the linking of quality and value to FFS payment to the implementation of population-based payment that are not built on a FFS architecture [see Appendix A for HCP LAN’s Alternative Payment Model Framework]. The PCAs interviewed for this document were increasingly interested in moving beyond payment reform that is layered on or runs parallel to FFS structures to those that are population-focused, and often talked about FFS-linked payment reform as a step toward population-based payment. Oregon health centers, and now those in California, are at the leading edge of transforming health center PPS payments to allow for greater flexibility in service delivery.

⁴ Tobey, R., Maxwell, J., & Bateman, C. (2012). *Building the Foundation for Payment Reform for Community Health Centers in California*. John Snow, Inc.

⁵ *Ibid.*

⁶ John Snow, Inc. (2013). Update on Payment Reform Trends: Implications for California Health Centers. Prepared for the California Family Health Council and the Regional Associations of California.

As PCAs and health centers navigate the myriad of system and payment reform efforts in their states and regions, and hear about efforts underway in neighboring states, there is a desire to learn from each other's experiences with developing and implementing various models. This report synthesizes highlights from conversations with seven

Prospective Payment System (PPS) and Alternative Payment Methodology (APM)

In 2001, the Budget Improvement and Protection Act (BIPA) created a PPS as a “per-visit minimum payment for Medicaid patients seen in health centers based on the average of their 1999 and 2000 costs” that was designed 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.” The ways PPS rates are implemented vary across states but in all cases are based on face-to-face encounters with specific provider types. BIPA also allows states to develop an APM via a State Plan Amendment. APMs allow states more flexibility in “how payments are made and care is delivered” as long as APM payments are at least equal to what the center would otherwise receive under the PPS rate and the health centers agree to it.

PCAs and some of their key partners about their experiences with payment reform. The report discusses key findings and considerations that could help other PCAs and health centers in their state/region as they prepare for and engage in payment reform models including:

- Key ingredients and steps for PCA leadership
- Considerations in payment reform model development
- Key payment reform design considerations

The findings presented in this report should not be seen as a “road map” to establishing payment reform, as the environment and drivers of payment reform differ from one state to another. Rather, the report seeks to synthesize shared experiences and build capacity within the health center community to proactively engage in payment reform efforts.



Research Approach

NACHC's research objective was to learn from the experience of health centers that have engaged substantively in payment reform efforts, with a particular focus on reform involving an APM. To this end, JSI conducted two sets of interviews.

- I. Interviews were held with PCA representatives and up to four representatives from key partners in states where health center payment reform models have been established, or are in the very final stages of development (Oregon, California, and Missouri) [see Appendix B for state example health center payment models]. Two of these, Oregon and California, have pursued APM reforms.



2. Interviews with PCA representatives in four states in the relatively early stages of payment reform efforts (Alabama, Colorado, Minnesota, and New York). Of these, Colorado and Minnesota area actively exploring APM-related reforms.

States were selected based on initial background research conducted by JSI and NACHC, and input from NACHC's Payment Reform Workgroup.

JSI developed an interview guide to support the research objectives of the project, focusing on the process, not the technical aspects, of payment reform. The interview guide was structured to identify key facilitators and barriers to the reform effort, key action steps and decisions, and the influence of the state environment on payment reform development. Interviewees were the lead staff with the PCA, state Medicaid agency (where possible), and partner organizations who were identified by NACHC or through other interviewees in the state. Key informant interviews lasted approximately one hour, and were conducted between December 1, 2015, and January 29, 2016.

JSI analyzed the interview data with two objectives: (1) identify common themes across the states, and (2) identify state-specific experiences that could provide insight to other states. The findings presented below represent the best effort to identify commonalities, while respecting the nuances, across the states represented in the interviewees.



Key findings

Ingredients for Successful PCA Engagement

Interviewees identified specific elements, or ingredients, essential to developing and implementing payment reform efforts in their state. Interviewees noted that they either had these elements in place prior to engaging in payment reform, or found it necessary to develop them simultaneously with the pursuit of payment reform. The six ingredients to support the payment reform development process were:

Understanding State Goals - PCAs established a strong understanding of their state's goals for payment reform. This included the broad goals, such as achieving transformed care and better patient outcomes, to specific goals, such as reducing Medicaid spending. This understanding was one reason the payment reform proposals were able to gain traction, as the health centers' goals were aligned with their state's goals even if they may have had different motivations for pursuing reform. The following table provides a high-level description of payment reform goals for the reform component examined in the interviews.

Table I. Focus of Payment Reform in States where Interviews Conducted

State	Focus of Interview*	State Goal	PCA Goal
<i>Interviews Focused on Health Center APM Transformation Efforts</i>			
CA	Health Center APM transformation	Increase access to patient-centered care and align financing with managed care Medicaid	Define health center value in overall system; identify and shape financing model for the future
CO	Health Center APM transformation	Regional care coordination; integration	Align care delivery with patient needs; convert to PMPM payment away from visit-based
MN	Health Center APM transformation	Moving toward payment for quality and outcomes	Address limitations of current APM; prepare for payment reform and practice transformation
OR	Health Center APM transformation	Improve care, delivery system, and integration	Provide better care to patient and population; move toward value-based care
<i>Interviews Focused on Broader Payment Reform Efforts</i>			
AL	RCO and Managed Care Implementation	Transition to Medicaid managed care; improve quality and slow cost growth; focus on financing	Ensure health center viability in managed care; practice transformation
MO	2703 Health Care Home	Practice transformation; lay foundation for payment reform	Initially: Mitigate funding loss; prepare CHCs for team-based care and value-based payment
NY	State Payment Reform and DSRIP efforts	Transform delivery system through system transformation and value-based payment	Ensure meaningful health center participation in regional efforts; readiness for value-based payment

*PCAs may be involved in additional and/or broader payment reform efforts—not the focus of the interviews and thus not represented in this chart.

Enlisting Vital Partners - All PCAs engaged and built trust among partners to strengthen support for and development of the payment reform effort. The types of partners varied depending on key stakeholders in each state. PCAs identified the following as particularly important in partner engagement:

- Identify the strengths of each partner, including knowledge, expertise, and/or political power.
- Develop a positive working relationship with the state Medicaid agency to support productive negotiations on the model details and help maintain forward momentum.

- Invest time and resources to develop and maintain strategic partnerships.
- Ensure that leadership within each partner organization supports the functions and direction of the partnership.

Approaches:

The Oregon Primary Care Association (OPCA) approached the state Medicaid agency about changing how health centers were paid to allow for greater flexibility in how care was provided by de-linking encounters from payment. OPCA's strong partnership with the Medicaid agency proved paramount not only to the development of a payment reform model, but to ensuring successful implementation and continued growth of the model during state budget decisions.

The California Primary Care Association (CPCA) partnered with the California Association of Public Hospitals and Health Systems (CAPH), which represents public hospital and health systems-based health centers, to develop their payment reform model and maneuver through the legislative process. The relationship between CPCA and CAPH was built during the process and proved a significant driver in the successful passage of health center payment reform legislation. A solid foundation of trust sustained the success of the partnership.

Community Health Care Association of New York State (CHCANYS) partnered with a coalition of community-based organizations to jointly communicate a need for health care resources to shift from tertiary to primary care and community health in order to support transformation. In addition to health centers, other coalition members included home health care representatives, behavioral health providers, family planning providers, and Medicaid consumer advocates. Together they increased their leverage for a shift in resources to support the critical role of primary care.

Establish a Strategy to Support and Sustain PCA and Health Center Involvement in Payment Reform Efforts - All the PCAs JSI spoke with, whether proactively developing payment reform models or working to ensure state-driven reforms work for health centers and their patients, had invested substantial resources in order to be substantively involved and/or to lead the process. Common aspects of the involvement included:

- Making sure PCAs and health centers have a “voice at the table” for payment reform decision making, even if there is no specific funding to support involvement when reform efforts begin. This is especially important in situations where a state agency, not the PCA, is driving reform efforts.
- Ongoing education and engagement of health centers, as well as health center and local partner mobilization when needed to support negotiations or legislative efforts.
- Building internal staff expertise on payment reform over time. This is important both to sustain the effort internally, and for health centers within the state/region to feel

confident that the model details are being developed in the best interest of health centers and their patients.

- Engaging outside expertise needed to inform model development and/or build a case for health center value.
- Identifying and clearly communicating the PCA's roles and responsibilities during development and implementation, including recognizing any limitations to PCA capacity or expertise.

Approaches:

- All PCAs re-prioritized staff time to focus on reform efforts, some within current resources and others with additional funding.
- In Missouri and California, state-level foundation dollars helped to move the process forward. In Missouri, foundation dollars supported the development of the 2703 SPA and later supported practice transformation efforts. In California, foundation dollars were secured to support staff time and efforts at the PCA, the California Association of Public Hospitals and Health Systems, and at the state. Foundations also recognized the limited bandwidth of the state Medicaid agency and provided funding for consultants to work directly with the state agency to move model development forward.
- In New York State, the PCA established the expectation with the state that each Value Based Payment Workgroup subcommittee would include the PCA and two health centers, ensuring health centers were involved in developing the details of payment reform implementation and dialogue regarding the impact on health centers.
- A core group of health centers in each state contributed staff time to be present at the table with the state, and to vet proposals and models.
- PCAs identified a specific need for technical expertise to advance payment reform efforts, including convening and/or process facilitation; claims analysis demonstrating cost-effectiveness of health centers; claims and financial analysis to model the impact of proposed models on health centers; risk analysis (to inform care coordination and payment models); managed care contracting and readiness for managed care contracting; Accountable Care Organization formation; incorporating social determinants of health into payment models; and practice transformation and patient centered medical home implementation. It was common for the PCA to hire an outside consultant to work closely with the PCA to support specific analyses or provide technical expertise.

Involve Health Centers Systematically - All of the PCAs interviewed had established a process for health center input and involvement in payment reform efforts. The specific mechanisms used varied according to the PCA's historic approach to health center engagement in strategy development, whether the PCA and health centers were leading the development of a model or responding to state-led reforms, and the stage and nature of the payment reform efforts themselves. PCAs that JSI spoke with found it helpful to:

- Engage opinion leaders within the health center community. They can help the PCA formulate its policy reform agenda and help ensure broader engagement of health centers over time.
- Engage all health centers within the state/region on a regular, substantive, and ongoing basis. This could be through established member meetings, or at special meetings convened to discuss service delivery transformation and payment reform specifically. Broad-based engagement ensures health centers within the state/region are aware of what is going on and can provide meaningful input.
- When designing payment reform approaches start with health centers that are ready to move forward and are actively engaged in thinking about payment reform—they have the interest to be engaged at a meaningful level and to ask tough questions. Identify a small group of health center staff with leadership skills and specific areas of expertise, including clinical, financial, and health information technology, to help develop the payment reform model and inform the PCA's efforts.

Approaches:

In-depth, targeted engagement and education

The California PCA (CPCA) undertook an extensive process in which PCA staff and consultants traveled across the state in a “road show” to engage health centers in conversations about payment reform. These conversations, hosted by regional PCAs and extending over several years, helped CPCA refine a payment model to put forward, and helped health centers understand why specific options were being considered.

Leverage existing mechanisms

The Missouri PCA (MPCA) used established quarterly board meetings as a way to keep health centers within the state up to date on progress, while a small group of health center representatives participated in weekly meetings led by the state Medicaid agency to develop specific components of the 2703 model.

Targeted updates

In addition to providing updates at PCA board meetings, several PCAs developed mechanisms for targeted updates. The Alabama Primary Care Association (ALPCA) conducts monthly in-services about how the model is developing, and uses its existing bi-annual “manager forums” to conduct strategy sessions with health center managers. The Minnesota Association of



Community Health Centers (MNACHC) holds frequent webinars to share payment reform developments with health centers within the state.

Demonstrating Health Centers' Value through Data - Health center data proved a critical tool to demonstrate the value health centers bring to the communities served. Health center data was used to demonstrate who health centers served and how they were cared for. This led to a better understanding of health centers' impact on the total cost of care and the population they cared for. Robust data on utilization and costs was also critical for defining the parameters used in new payment models.

- PCAs assisted health centers on data validation and quality data reporting/collection, which required PCAs to invest additional staff time and funding.
- Data analysis, such as identification of high-risk populations, helped PCAs and health centers develop the payment reform model. Central data warehouses or other data repositories were used by PCAs and health centers to develop the model and to test various components of the proposed model. Claims data was a beneficial resource in understanding the services and revenue at health centers. Access to comprehensive data allowed PCAs and health centers to assess how the model would impact health center services and revenue.

Approaches:

The California PCA commissioned a value study of health centers in the state. The study was designed to help understand health center patients' total system utilization and associated costs. The study focused on managed care Medi-Cal patients with a health center as their usual source of care compared to non-health center patients on high-cost value metrics, such as hospital readmissions, emergency room visits, and hospital bed stays, and total cost of care (TCC). The study findings show that health center patients incurred fewer high-value medical costs and have lower TCC. The study proved a critical first step in analyzing system-wide Triple Aim goals and assessing health center patients' utilization in the larger health care system, thus illuminating how health centers influence total health system costs.

Missouri health centers' previous experience working with the state on health homes established a better understanding of health centers' value in the health care system. The recognition that Missouri health centers serve a high percentage of the Medicaid population, along with their data capabilities (described below), supported their importance in the state's 2703 health home efforts and helped secure their involvement in design of the 2703 State Plan Amendment.

Both the Oregon and Missouri PCAs utilized rich health center data sets, developed over time by the PCA and involving significant prior investment, to develop and test the proposed payment reform model. Missouri's PCA invested resources to develop a data reporting and

visualization tool that can incorporate data from any EHR. Oregon's PCA continues to use health center data sets to develop changes to their current payment reform model. They are currently developing methods to adjust for severity or social determinants of health (SDOH) by collecting and stratifying data to test services that respond to a potential link between SDOH and specific diseases (i.e., testing food insecurity with diabetes). Similarly, New York's PCA houses a data warehouse, in which 75% of health centers participate, with extensive reporting capabilities and a wraparound program of technical assistance to support clinical quality improvement, health center planning, participation in delivery system and payment reform initiatives.

Leveraging Health Center Commitment to and Experience with Practice Transformation

- Practice transformation and payment reform displayed a mutually reinforcing relationship. As health centers engaged in practice transformation, they gained a deeper appreciation of how payment can support or hinder transformation. Practice transformation provided a catalyst for payment reform efforts both prior to and throughout reform, as health centers desired payment reform that supports a different model of care.

PCAs and health centers made significant investments in infrastructure and staff to support practice transformation, and were able to demonstrate capacity to implement practice transformation. Common aspects of practice transformation investments included:

- States interested in payment reform also supported health centers to increase their capacity for practice transformation.
- Practice transformation efforts built relationships that facilitated the development of payment reform.
- Health centers engaged in practice transformation were well positioned to participate in payment reform due to a higher level of readiness, capacity, and use of data systems.
- Efforts naturally oscillated between practice transformation and payment reform. Efforts on one slowed when attention shifted to the other.

Approaches:

Prior to the pursuit of Missouri's 2703 SPA, Missouri's health centers had experience with practice transformation. As early as 2007, health centers had demonstrated the value of embedding behavioral health providers into their practices. The Missouri PCA's Board of Directors quickly recognized the importance of the National Committee for Quality Assurance (NCQA) PCMH recognition and built capacity to achieve recognition.

California's and Oregon's PCAs engaged health centers that had undergone practice transformations to pilot new payment reform models. Supporting transformation at the practice level continues to be an integral component to reform in each of these states. In

California specifically, the PCA secured foundation funding to provide training and practice transformation coaching support in the areas of population health management, financial modeling efforts, and data collection and analysis.

As Colorado begins its pursuit of health center payment reform, the PCA recognizes practice transformation as a specific facilitator for reform. Transformation to team-based care is being tested at one health center through a care transformation practice reform grant from their Regional Care Coordination Organization (RCCO), the ACO-like entities in Colorado's Medicaid program. The grant allows the health center to experiment with care teams and assess how various approaches impact revenue. Other health centers have designed and redesigned teams without this added support.

Considerations for Payment Reform Model Development

There are a number of specific decision points that a PCA and health centers within the state will face when pursuing a payment reform model. The path health centers take will depend on a number of factors, the most important of which is the ultimate goal of the model being pursued. Each of the interviewees stressed that payment reform is not the ultimate goal of their efforts, but rather a step toward a broader goal of transformed care and better patient outcomes. Even in situations where the impetus for state Medicaid agency or PCA involvement in payment reform is in response to financial considerations, it is within the framework of a broader value-based or Triple-Aim-focused effort.

The following key findings illustrate decision points and/or steps that were common across the states interviewed, and that PCAs and health centers pursuing payment reform will need to grapple with as they move forward.

Develop a Shared Understanding of Payment Reform Scope and Purpose

Differentiate between Health Center-Specific and System Transformation

The states interviewed fell into two broad groups: states where PCAs and health centers are focusing on health center-specific reform through Medicaid APM to provide more flexibility in how care is provided (OR, CA, MN, and CO), and states in which PCAs and health centers are approaching payment reform primarily in the context of state-driven payment and service delivery reform (MO, AL, and NY). However, given the numerous and simultaneous delivery system transformation and payment reform efforts occurring in most states, it is important to frame reforms within the broader environment, and be clear about the goals of specific payment reform efforts and their relationship to delivery system transformation. For some PCAs, this has meant being involved in multiple efforts simultaneously, demonstrating their value to the system and making a case for payment transformation.

- In California, it was important for the state to see that the PCA is committed to broader system transformation, focused on providing patient-centered care, and that the interest in APM reform for health centers is driven by this broader goal.
- In Oregon, the state Medicaid agency was receptive to an APM because of health centers' important role in the Medicaid delivery system, and their involvement in Oregon's Coordinated Care Organization structure.
- In New York, the PCA has worked hard to secure a seat at the table for health centers in the state DSRIP, while simultaneously preparing for and participating in payment reform discussions.

Be Clear about the Role of Specific Payment Reform Efforts vis-a-vis the End Goal

For each of the states JSI studied, interviewees were careful to distinguish between changes in payment designed to facilitate incremental service delivery system or practice transformation and more comprehensive payment reform that would sustain transformed practice over time. Most interviewees noted that their current payment reform efforts lay the foundation for more fundamental payment reform and system transformation in the future:

- In Oregon, the APM is considered a bridge to payment reform, allowing the flexibility to provide better care to patients and populations. Similarly, the proposed change in APM methodology in Minnesota is seen as a step to preparing health centers for payment reform and transformation; and Colorado is working toward an APM that will facilitate movement along a continuum from FFS to capitated payment.
- In New York, the state DSRIP program is investing resources into transforming the broader delivery system of care with a goal of moving 80%-90% of Medicaid into value-based payment arrangements, some with downside risks or capitated payments.
- The Missouri 2703 SPA allows for investment in practice transformation. While the state included shared savings in the proposed SPA, that component was not in the approved SPA. The state is studying cost and savings from 2703 implementation as a step in exploring a shared savings payment model for the future.

Be Responsive to a Fluid Environment

None of the PCAs JSI spoke with had charted out a neat path to their ideal payment reform model and followed it precisely. While they stressed the importance of having a vision and goal for payment reform, each adapted their efforts based on challenges and opportunities that emerged over time. For some PCAs, their involvement in payment reform was the result of state payment reform efforts that required a response, while others were promoting a health center-specific reform, typically focused on APM. In both scenarios, PCAs were able to engage in state-level initiatives, and also develop and promote their own payment reform priorities.

- Early on, the California PCA focused on promoting development of a 2703 health home initiative within California. When it was clear that initiative was not gaining traction, the

decision was made to begin simultaneous pursuit of an APM as another strategy for supporting transformed practice. With continued encouragement around both 2703 and APM, the state ultimately decided to pursue both reforms.

- In Missouri, state support for uninsured funding had eroded, and the state wanted to use health center dollars from the uninsured program to support a 2703 initiative. The PCA took the opportunity to be one of the key groups participating in 2703 and worked closely with the state to shape the design of that effort.

Be Rigorous about Readiness

Interviewees stressed the importance of ensuring that health centers are truly ready to engage in and succeed in payment reform. PCAs recognize that payment reform can be a daunting prospect, and that not all health centers will benefit from participating in early iterations of payment reform. In states where PCAs are involved in designing payment reform efforts, such as Oregon and California, interviewees stressed the value of starting with those health centers that are most ready and interested, learning from their experience, and adding other health centers as they are ready. In states where health centers are participating in broader reforms, interviewees stressed the importance of advocating for layered payment reform models so that health centers can engage according to their readiness.

Interviewees identified specific strategies for understanding and addressing health centers' level of involvement.

- In Missouri, health centers dug into their own data sets to examine the degree to which the data was (or wasn't) consistent with health centers' vision of themselves, their services, and their patients. The process helped to identify the need for a common accurate data set and core analytics.
- In Alabama, health centers underwent a rigorous assessment of their readiness to engage in managed care systems and identified areas where they needed to build capacity.
- In Oregon, health centers are joining the APM in small cohorts of around three health centers a year, as they become ready to do so. Health centers must be up to date on their Medicaid reconciliation and financially strong in order to participate.
- In New York and Alabama, the payment reform models are layered, so health centers can engage at a level of risk that is appropriate for their level of readiness. This allows the opportunity for health centers to move along the payment reform and risk continuum over time as they develop the capacity to do so.

Working with Partners

Set Expectations around Health Center Prospective Payment System

In each of the states interviewed, PCAs have worked to ensure the state Medicaid agency and other partners, including MCOs, have a clear understanding of federal requirements around PPS, the reasons behind these requirements, and the critical role of health centers in the delivery system. They also sought explicit agreement with the state about how PPS requirements would be addressed within the payment reform effort.

- In California in 2012, as the PCA was developing its payment reform strategy, the governor included a cut in PPS in the state budget. In addition to the ensuing effort to stop this, the PCA openly expressed interest in engaging the state in dialogue about how to best address PPS, with an agreement that PPS would be addressed through a programmatic approach, not budget cuts.
- In New York, CHCANYS was able to add language to the statewide Roadmap for Value Based Payment, ultimately submitted to Centers for Medicare & Medicaid Services (CMS), stating that the state would continue to reimburse health centers using PPS and that the state payment reform initiatives were not intended to dismantle the PPS system in any way.

Engage with Partners and Other Key Stakeholders

PCAs interviewed also noted that they had built new partners in the course of working on payment reform, or kept open dialogue with other key stakeholders who aren't always partners but who have a role to play. This ability to keep dialogue open, and to find mutual interest and commitment with new partners, can provide vital support to health center priorities.

Interviewees stressed the importance of spending time understanding the perspectives and business models of other key stakeholders.

- In Alabama and New York, the PCAs have maintained ongoing communication with hospitals because of the dominant role that hospitals are playing in transforming the delivery system.
- In New York, a coalition of community-based health providers including home health, family planning, and behavioral health providers has been advocating for shifting resources toward primary and preventative care.
- In California, MCOs were not substantively engaged in the original planning around an APM. As a result, they had questions about what the APM would mean for their business model and processes. Once MCOs were more actively engaged, they provided critical expertise and insight into technical aspects of the model.

Address Practical Considerations in Working with the State

Key informants stressed the importance of establishing a relationship with the state Medicaid agency, and engaging in ongoing discussions around the proposed payment model and the related technical details. In some cases the state itself convened the discussions, while in others PCAs served as the initial convening entity. PCAs noted it is important to understand the realities of state systems and resources, and how those might impact the development and roll-out of a payment model. Where MCOs are involved in the payment model, their constraints and capabilities are equally important to understand. Implementation plans should take into consideration the timeframe needed for system changes. The following examples illustrate areas to be aware of:

- **Internal Communication.** Interviewees noted that having a dedicated contact at the state agency that is invested in working on payment reform with health centers and has decision making power is very helpful. They also noted the importance of ensuring that others in the state agency, especially those from whom approval will be needed, and those responsible for making the model work within state systems, be involved in the process at appropriate junctures.
- **Cash Flow Requirements of Model.** In Oregon, the roll-out of new pilots has been delayed at times because the addition of new APM participants requires a cash outlay from the state. The initial pilot sites serve a high percentage of the Medicaid population, creating a state budget issue since the state needed to pay reconciliation payment plus per-member-per-month (PMPM) up front. Thus, states should be aware of and consider fiscal implications of the payment flow that is part of the design model.
- **System Change Queues.** State management and information systems take time to change. Most states already have a queue of pending requests; so, it is important to understand where those related to payment reform fall in terms of priorities and resource requirements.
- **Data Systems.** There was wide variability across the states interviewed regarding the source of data used in the payment reform model. In some cases, health centers supplied data to the state, extracting it from a health center-supported data warehouse. In other cases, the payment model relies on claims data flowing through the state or MCOs. Interviewees stressed that it takes time to map and validate data flows, and to ensure that there is consistency across the various systems being used.

Note

Where APM methodology is defined in state statute, legislation may be needed to pursue a change in the model. All APMs must be approved by CMS, and individual health center participation in APM must be voluntary.

Payment Reform Design Considerations

The previous sections describe design considerations that PCAs should be aware of as they move forward with their own efforts. This section of the report describes specific design choices that PCAs will face as they develop or address payment reform models in their states.

Transforming PPS through an APM

PCAs and health centers that find PPS' focus on face-to-face provider visits limits their ability to implement new care models have pursued APMs that reimburse on a population basis (instead of a visit). While PCAs and health centers involved in payment reform recognize that the system's focus on face-to-face provider visits can limit their ability to implement new care models, moving to an APM can be a daunting and sometimes frightening prospect. Interviewees had the following observations about moving to an APM:

- Hearing from providers about how the current payment structure impacts health centers' ability to provide patient-centered care can be very powerful, and helps to ensure the focus of payment reform is a facilitator of transformation and improves the way care is provided.
- Committing to an iterative process, in which an APM structure is proposed, vetted using available data and health center expertise and then refined, helps to address concerns and secure participation. Similarly, pilots can be used to test out the model.
- APMs must, by federal definition, be voluntary: each health center must agree to participate. This requirement, and the knowledge that a health center can stop participating in an APM if needed, provides a level of flexibility for health centers. This requirement also allows a leverage point for health centers in shaping an APM.

Health center-specific reforms focused on developing an APM, share a number of design considerations with other reform approaches, and are addressed below. However, interviewees identified several that are specific to APM design:

Legislative or Administrative Approach

PCAs interviewed were very deliberate about choosing whether to establish payment reform models through state legislation, through the state regulatory process, or through state and local transformation efforts. Key factors in the decision included the level of collaboration and dialogue existing between the state and the PCA when payment reform discussions began, and the state Medicaid agency's interest in and dedication of resources to developing the payment reform model. The legislative environment regarding health reform is also important—some states may choose to avoid a legislative route because of a general legislative antipathy toward the ACA and health care reform, while in others legislation is important to provide safeguards and/or ensure higher priority for reform efforts.

- In Oregon, both the PCA and the Medicaid director had identified the existing payment model as a barrier to team-based care. Their established relationship, their shared focus on providing better care, and the broader emphasis on system reform at the state level allowed them to move forward without a legislative mandate.
- In California, the legislation defines key terms, and links components of the APM to existing state and federal statutes. Legislation requires the Department of Health Care Services to authorize, with federal approval, a 3-year APM pilot that includes an APM supplemental capitation amount to be paid to Medicaid managed care plans for all Medicaid members assigned to pilot APM sites. The MCOs are, in turn, required to ensure that all pilot sites receive a site-specific PPS-equivalent PMPM payment for all assigned members in defined APM aid categories.

Establishing Thresholds

Any APM must be at least equivalent to what the health center would have received under PPS. Thus, one of the challenges of an APM is meeting this requirement and demonstrating that access to care is not reduced, while moving away from the face-to-face visit model upon which PPS is based.

- In Oregon, the APM model includes thresholds for changes in access (face-to-face visits and touches) that would trigger reconciliation with PPS.
- The California pilot calls for a review if health center utilization is more than 30% lower than anticipated. If decreased utilization is determined to be the result of delivery system transformation, including the use of “alternative encounters,” the health center would retain all capitation payments received; in instances of greater than 30% decline in traditional utilization without evidence of transformation, a health center could be required to repay some funds to the MCO.

Monitoring for Unintended Consequences

As discussed above, payment reform reinforces practice transformation efforts and moves payment that is tied to volume to payment that is based on value. Yet moving from volume-based payment to capitated or outcome-based payment is a process, and if poorly defined, it can lead to negative unintended consequences (such as limited access to needed care). Each state model addresses this challenge in a unique way, influenced by the state environment and delivery system. States exploring new payment reform models will want to consider the range of possible options.

- In Oregon, a small group of health centers worked with a consultant and practice transformation practitioners to develop a capitation methodology and process. Under the APM, health centers receive a monthly capitation rate, and report both face-to-face visits and alternative touches, such as case management and telephone/telemedicine encounters, to the state, as well as quality measures. The PCA used UDS to analyze use

rates and how the mix of services drove utilization. The analysis also helped define services for which use varied greatly across health centers (dental, obstetrics, and behavioral health) and didn't make sense to include in the capitated rate. The PCA and state worked closely to define touches and agree on those that provide added value, and to develop the visit/touches thresholds used by the state to monitor access.

- In Missouri, the 2703 health home provides a PMPM payment to health centers to sustain a specific staffing mix and provide specific health home services for high-risk Medicaid patients with chronic conditions and risk factors, in addition to the PPS payment. The PMPM provides flexibility in how care is managed, but does not transform the health centers' base payment.

Defining the Population Covered by Reform

Key informants repeatedly underscored the importance of defining the population for which health centers are responsible under a payment reform model. The definition of the population is critical because it both informs the care model and approaches used by the health center, and is the population upon which payment is calculated. The model must define whether a health center is responsible to patients that are either *assigned* to them proactively (for example, within a managed care arrangement) or *attributed* to them based on historical use patterns. Regardless of the methodology selected, participants noted that there is extensive leg work involved in defining the details of the methodology, and ensuring that state and health center data sets are in agreement when identifying the patient population for which health centers are responsible.

- In Missouri, health center patients are attributed based on historical utilization patterns.
- In Oregon, initial enrollment was based on historical utilization patterns. However, now health centers identify patients to enroll in the program based on eligibility criteria developed by the state Medicaid program for ongoing enrollment.
- In California, where Medicaid is delivered primarily through MCOs, it made more sense to use the managed care assignment methodology as the basis for translating PPS into a PMPM payment. Using the existing managed care methodology helped meet the state goal of increasing alignment between the managed care system and health centers, reduces administrative burden of health centers, and allows health center to maintain and reconcile one list of patient assignments rather than two.

Pursuing Reform in a Managed Care Environment

In states where Medicaid is delivered primarily through a managed care structure, PCAs must consider whether value-based payment should flow through MCOs or be provided by the state, and the degree to which MCO payment (capitated or FFS) is consistent with the payment reform goals. Furthermore, MCOs in managed care states become an important stakeholder for PCAs and the states to work with.

- In Missouri, the state was interested in implementing 2703 to compliment the MCO model of care management, and demonstrate that care coordination is more effective at the local level through team-based care with the patient at the center of care.
- In Alabama, where the state is switching to a managed care model, the PCA has worked to ensure (as described above) that health centers will be included and ready to participate in the Regional Care Organizations (RCOs) that are being established. Most of the MCO networks that are forming are led by hospitals, so that all aspects of the RCO structure (governance, reimbursement, contracting) have a strong hospital influence. The PCA has worked to build a productive relationship with the hospital association, as well as an understanding of hospital structures and business models, and hospital expectations of health centers and the PCA. The PCA also ensured that state statute governing MCOs requires health center representation on every RCO board, an “any willing provider” requirement for MCO networks, and a reimbursement floor for health centers.

Demonstrating Outcomes from Payment Reform

All key informants were cognizant of the critical need to evaluate the success of the payment model. While most states were not far enough along to discuss specific outcomes, there were key lessons learned about the development of an evaluation. Most key informants in states that have progressed further in reform indicated that their state was primarily focused on evaluating any cost saving associated with the new payment model. Additional lessons learned included:

- PCAs play an essential role in helping to develop and monitor evaluation metrics and data collection to ensure they are relevant to the evaluation.
- While payment reform models typically include tracking of quality measures and other metrics, most payment is not yet tied to such metrics. States and PCAs anticipated that future payment would be tied to quality or other Triple Aim metrics.
- When possible, metrics should be aligned with other state and/or national measures used by health centers to streamline the evaluation process. Additional measures will likely need to be developed that are meaningful to health centers and/or specific to the evaluation of the payment change.
- Total cost savings from payment reform may be diluted due to substantial infrastructure investments.
- In California, the payment reform statute requires an external evaluation. The California PCA and their partner, the California Association of Public Hospitals and Health Systems, along with health centers from both associations, developed an outline of evaluation metrics for the state to consider. The PCA is also assessing which additional metrics health centers would be interested in monitoring as the APM is implemented.

- Oregon’s Medicaid agency is evaluating the cost, quality, and access indicators to assess the health center APM. The Oregon PCA supported the state’s development of the evaluation by helping to hone the list of meaningful touches. A state evaluation report is under development but was not available as of the release of this paper; however, the PCA and state indicated that the model was budget neutral, and the attribution method implemented was successful.
- Missouri’s state agency is assessing the cost savings resulting from the 2703 health home model. The Missouri PCA has played a significant role collecting data for all health home providers, not just health centers. Although it took 18 months to get data flowing accurately, this type of data pull is critical to the evaluation of the model. The CMS-required specific 2703 metrics (NCQA) that are disease specific and tend to be more claims based. Missouri’s state agency also tracks 14 clinical outcome performance measures supplied by the EHRs of each participating health home. To date, Missouri’s 2703 health home project has demonstrated a decline in emergency room visits and hospital re-admissions for health home members and overall good quality outcomes, including a reduction in low-density lipoprotein (LDL) for individuals with initially high LDL, and a reduction in blood pressure for individuals with initially high blood pressure.



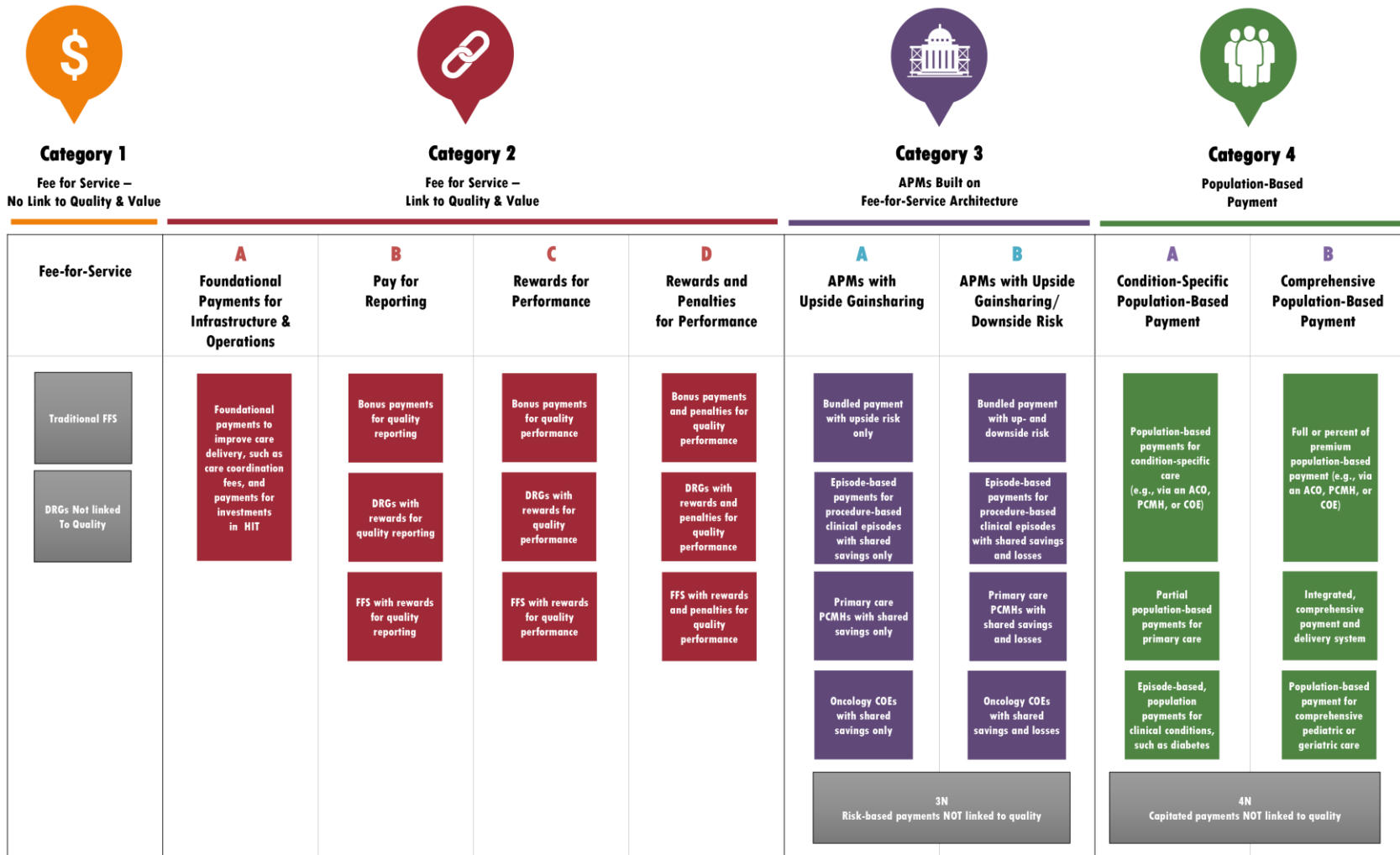
Conclusion

The changing health care environment creates an exciting and sometimes overwhelming challenge for health centers. The variety of payment reform initiatives underway offer an assortment of models to explore and pursue. Conceptualizing of payment reform as consisting of multiple payment layers allows PCAs and health centers the choice between addressing multiple payment layers at once or focusing on just one layer. The decisions about what model to pursue and the strategy for embracing that model are dependent on the state environment and, more importantly, the supports health centers have as they continue to work towards best meeting their patients’ needs. Insights and lessons learned from PCAs that are actively engaged in payment reform can help inform the efforts of health centers in other states as they navigate the myriad of delivery system and payment reform initiatives in the health care environment.

Resources: For further resources on Health Centers and Payment Reform visit the NACHC Payment Reform Community at <http://mylearning.nachc.com/diweb/community>

Appendix A. HCP LAN Alternative Payment Models Framework

Alternative Payment Models (APM) Framework



= example payment models will not count toward APM goal.

= payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

Appendix B.

State Example Health Center Payment Models

State	Payment Model Description
California	California's model to advance payment reform in health centers is a 3-year APM pilot where the PPS rate is converted to a PPS-equivalent PMPM capitation payment for assigned Medicaid members in specific aid categories. The new payment model will be piloted at between 40-80 health centers across 27 organizations who apply to participate. They will receive a PMPM payment calculated based on what the health center would have received under PPS. The funds for the PMPM amount will flow through MCOs to the pilot sites for all assigned members. The model will shift how health centers focus on the patient, allow flexibility to deliver services in innovative ways and using non-traditional providers, and to think more globally about a panel of assigned members and population health. An evaluation of the pilot will assess whether the APM yielded any improvements in access to primary care services, quality, patient experience, and health outcomes for APM beneficiaries. The evaluation will include any required health center quality metrics, the impact on other types of primary care visits and/or types of encounters and any administrative and financial implementation issues.
Oregon	Oregon's health center payment reform uses an APM that provides a capitated payment to health centers and gives health centers flexibility to provide care outside of a traditional face-to-face provider visit, while maintaining PPS as the reimbursement floor. The PMPM capitation payments are based on attribution of Medicaid members. Participating health centers are added in phases, or co-horts, with a 3-year commitment. The fourth co-hort is currently preparing for implementation. As of early 2016, ten out of 33 health centers are participating. Future plans include the inclusion of mental health in 2017, and focusing on population segmentation and Social Determinants of Health. Oregon is tracking cost, quality, and access indicators to determine any savings from the APM model with attention toward alternative visits or touches, in lieu of traditional face-to-face visits. An evaluation is still under development and will be available in the near future.
Missouri	Missouri utilizes the ACA Section 2703 health homes for patients with chronic conditions to transform how care is delivered. Missouri obtained approval for two 2703 projects: one focused on community mental health centers and the other on primary care. Twenty-one health centers are currently participating in the primary care health home initiative. To participate, organizations must meet requirements around Medicaid/uninsured patient populations, EMR use, and pursuit of NCQA PCMH recognition. Participating organizations receive a PMPM of \$61.25 for maintaining a specific set of care management staff and performing health home services and activities (touches). Participating organizations also pay a small PMPM of \$5.21 to Missouri's PCA to cover administrative costs associated with data management, training, technical and administrative support, and quality coaching. The state will assess hospital readmission rates, the management of chronic disease at participating practices, along with the coordination of care for patients with chronic diseases as part of their evaluation of the Section 2703 health home initiative. Process and outcome measures will assess quality improvement and clinical outcomes, while cost savings will be calculated by comparing inpatient hospital, emergency department, and skilled nursing facility use costs.