NATIONAL ASSOCIATION OF
Community Health Centers

America's Voice for Community Health Care

NATIONAL ASSOCIATION OF
Community Health Centers

2019
Payment and Delivery Reform Summit

Thursday, August 15, 2019

11:30 AM – 4:30 PM CT

Hyatt Regency Chicago, Columbus CD

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Wi-Fi Information

Network: NACHC CONFERENCE

Password: athenahealth

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Today's Objectives

By the end of this training, participants will be able to:

- Understand key financial considerations for patient-centered care
- Discuss experiences with caring for unique patient populations
- Demonstrate how payment can drive care to impact populations
- Recognize how current topics in payment and delivery may impact their organization

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Today's Agenda

11:30 AM – 12:00 PM	Welcome and Setting the Stage
12:00 PM – 12:45 PM	Keynote Presentation : Using Payment to Drive Care and Impact the Population
12:45 PM – 1:45 PM	Update on "Hot Topics" – Taking Downside Risk
1:45 PM – 1:55 PM	Break
1:55 PM – 3:30 PM	Breakout Tracks
3:30 PM – 3:40 PM	Report Out on Breakouts
3:40 PM – 4:25 PM	Update on "Hot Topics" – Capitated APMs
4:25 PM – 4:30 PM	Wrap-Up

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Today's Theme

Financially Sustaining Patient-Centered Care For The Future

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Today's Tracks

- Behavioral Health Integration (Columbus CD
  - Aaron Williams, Senior Director of Training and Technical Assistance for Substance Use, National Council for Behavioral Health
- Caring For An Aging Population (Columbus AB)
  - Wilma Schmitz , MA, CMC, Regional Liaison & Trainer, CLAIM – Missouri's State Health Insurance Assistance Program (SHIP
  - Angela Boyer, Director, Indiana Quality Improvement Network
- Peer-To-Peer
  - What is the most pressing concern or question you have regarding health center engaging in these areas?

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Advancing Health Center Value By Strengthening PCA & HCCN Capacity

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Primary care associations (PCAs) and health center controlled networks (HCCNs) are leading strategic efforts to support and guide health centers through payment and delivery reforms intended to advance the health center mission. NACHC, in collaboration with key experts in the health care transformation space, offers several learning opportunities to support PCAs and HCCNs as they engage health centers in value-based strategies.

QUALITY CENTER

NACHC's **Quality Center** works to advance the Quadruple Aim goals of improved health outcomes, improved patient and staff experience, and lower costs through its Value Transformation Framework. The Center's resources include: action guides that distill subject-specific best practices; trainings; a quality coach self-assessment tool; and facilitated transformation projects across the country.

For PCAs

PEER LEARNING

These **Payment & Delivery Reform Peer Learning Groups** provide a structure for PCAs and HCCNs to access the collective knowledge of their peers on priority topics ranging from managed care contracting to FQHC APM development, and share common barriers and troubleshoot solutions for advancing value-based care.

Open to all PCAs and HCCNs, all levels of experience welcome

ANNUAL SUMMIT

The **Payment & Delivery Reform Summit** brings PCAs and HCCNs together for both a high-level discussion of major trends as well as in-depth peer learning to help PCAs and HCCNs navigate multiple opportunities, weigh options, and fine-tune their value-based strategies.

all levels

DELTA CENTER

The **Delta Center for a Thriving Safety Net** aims to inspire innovation in value-based care and payment by building the capacity of PCAs and Behavioral Health State Associations (BHSAs).

ACO ACADEMY

The ACO Academy focuses on the critical elements for successful participation in both informal and formal accountable care organizations (ACOs). This training helps PCA, HCCN, and health center leaders develop a deeper understanding of how to become more responsible for the total cost of care and demonstrate value through practical examples and applications.

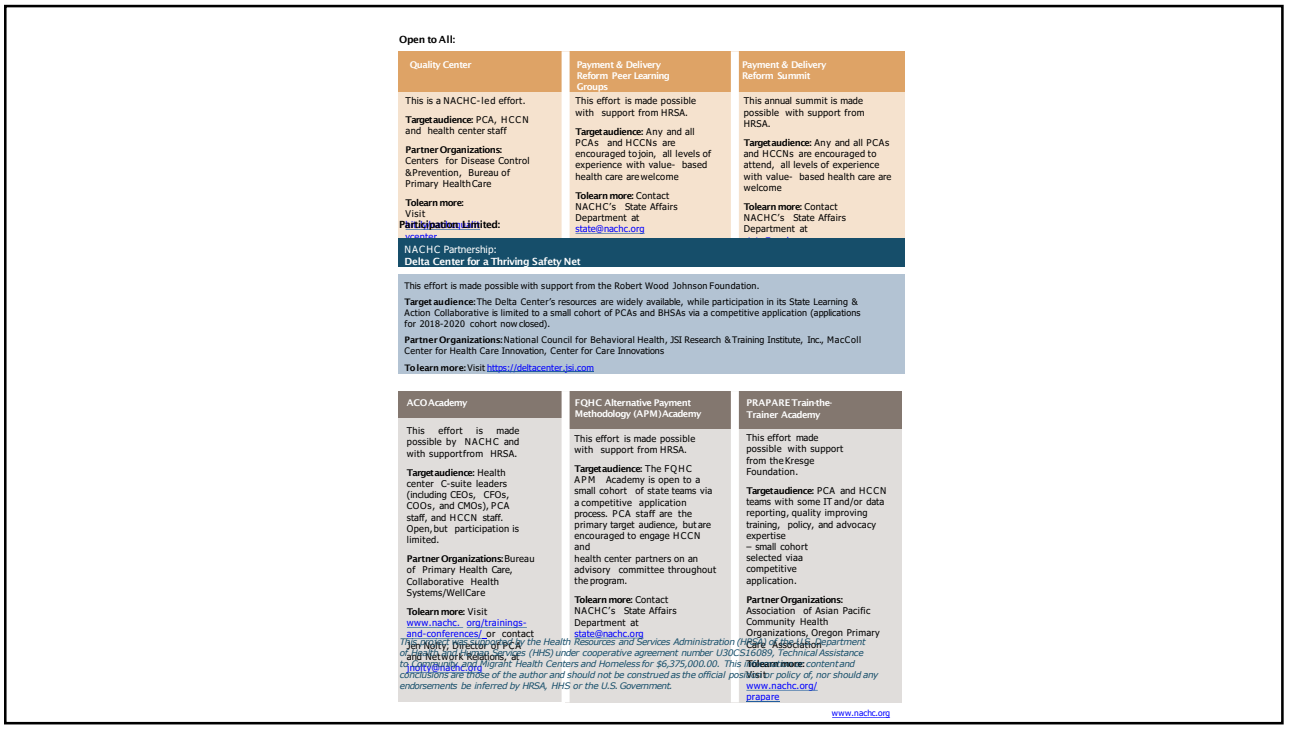
FQHC APM ACADEMY

The FQHC APM Academy guides a small cohort of state teams through the process of developing or enhancing a value-based FQHC Alternative Payment Methodology APM (FQHC APM) in Medicaid. Teams participate in structured discussions, both face-to-face and via an interactive online platform, and are also connected to industry experts.

PRAPARE TRAIN-THE-TRAINER ACADEMY

The PRAPARE Train-the-Trainer Academy helps PCAs and HCCNs build capacity to assist health centers in implementing PRAPARE, a standardized tool to collect patient-level data on the social determinants of health. The Academy also covers how to use PRAPARE data to inform state policy, payment reform, and delivery system transformation initiatives.

www.nachc.org



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Additional Resources

- Quality Center
- Peer Learning Groups
- Payment and Delivery Reform Summit
- ACO Academy
- FQHC APM Academy
- PRAPARE Train – The – Trainer
- Medicaid Resources
- Successful Practices in Accountable Care Publication Series, this and other resources are available on the Health Center Resource Clearinghouse (www.healthcenterinfo.org)
- Delta Center for a Thriving Safety Net

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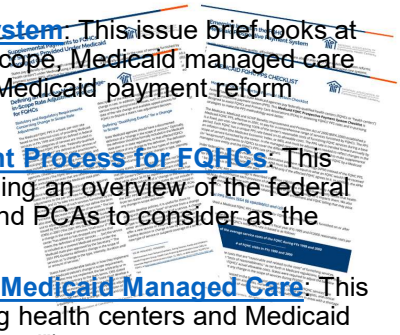
Medicaid Resources

- **Medicaid FQHC PPS Checklist**: This updated tool will help health centers and PCAs ensure that their Medicaid FQHC Prospective Payment System (PPS) is properly developed and meeting federal requirements. It includes an overview of the federal statute governing PPS as well as helpful questions for health centers to consider.
- **Emerging Issues in the FQHC Medicaid Prospective Payment System**: This issue brief looks at the top issues facing health centers and PCAs, including change in scope, Medicaid managed care and supplemental payment issues and health center participation in Medicaid payment reform initiatives.
- **Defining an Effective Medicaid Change in Scope Rate Adjustment Process for FQHCs**: This issue brief takes a closer look at the change in scope process, providing an overview of the federal statute guiding the process, as well as questions for health centers and PCAs to consider as the state is establishing the process.
- **Supplemental Payments to FQHCs for Services Provided Under Medicaid Managed Care**: This issue brief takes an in-depth look at the policy and issues surrounding health centers and Medicaid managed care supplemental payments (also known as the "wrap-around").



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Best Practices in Accountable Care

- Organizational Leadership and Partnership Development
  - *Iowa Primary Care Association*
- Financial and Operational Analysis, Management and Strategy
  - *Community Clinic Association of Los Angeles County and Capital Link*
- Robust Use of Data and Information
  - *Health Choice Network (Florida)*
- Change Management and Service Delivery
  - *Ammonoosuc Community Health Center (New Hampshire)*

All are available on www.healthcenterinfo.org!

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Looking for a Resource? We Have You Covered!

HEALTH CENTER RESOURCE CLEARINGHOUSE

www.healthcenterinfo.org

- An online repository of training and technical assistance materials for health center workforce and governing boards.
- Contains resources produced by organizations generating evidence-based, relevant assistance materials.
- Topics include finance, operations, workforce, quality improvement, capital development, HIT/data, governance, and emerging issues.

Unless otherwise noted, all projects listed are supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,375,000 with individually noted percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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Delta Center For A Thriving Safety Net

- A Robert Wood Johnson Foundation funded initiative that brings together 12 state-level organizations (6 primary care and 6 state behavioral health) to advance value-based payment and care, with a focus on ambulatory care settings. The Delta Center, led by JSI Research and Training Institute, Inc., the Center for Care Innovations (CCI), and the MacColl Center for Health Center Innovation at Kaiser Permanente Washington Health Research Institute (MacColl) seeks to leverage the strengths of state associations to spur promising payment and delivery reforms and will disseminate lessons from local, state, and national experiences to inform policy and practice. Participants have met and continue to meet in person (at events like this) and virtually to advance policy changes that benefit their members, support their members' ability to provide quality care, foster thriving partnerships within and across states, and sustain momentum toward these efforts by cultivating the practices of a learning organization.

the DELTA CENTER for a thriving safety net

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Delta Center Overarching Goals

Build internal capacity of state associations

- *VBP/C Vision & Strategy Development*
- *Board & Staff Engagement*
- *Learning Organization Practices*
- *Sustainability Planning*

Build policy and advocacy capacity to advance value-based payment & care at state level

Foster collaboration between primary care and behavioral health at state level

Build capacity to provide TA and training to advance value-based payment & care at provider level

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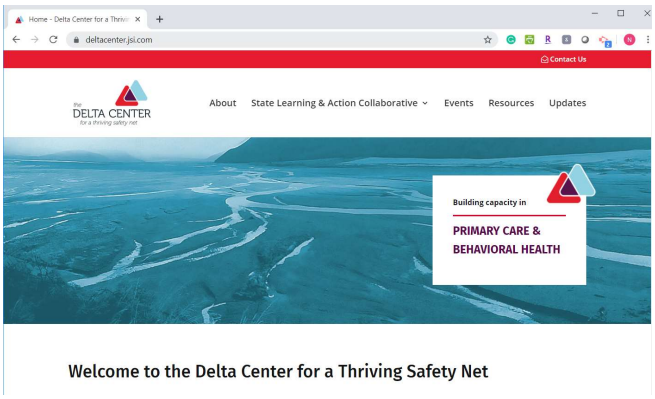
For More Information



deltacenter.jsi.com

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Keynote Presentation

Using Payment to Drive Care and Impact the Population

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Speakers:

- Nicole Kazee, Vice President of Strategy and Business Development, Erie Family Health Centers
- Denise Guerrero, Care Manager, Erie Family Health Centers

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Our Experience in a Medicaid ACO: On the Path to Value

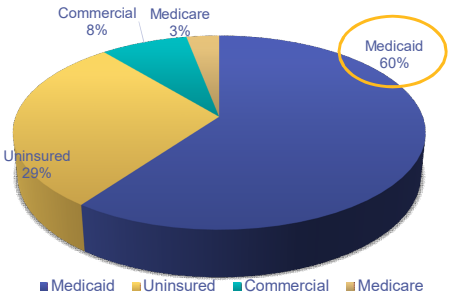
August 2019

Centros de Salud erie Family Health Centers

Erie Family Health Centers

- We provide comprehensive medical, behavioral, and oral healthcare services to 77,000+ patients each year at 13 Chicagoland locations.
- 700+ Employees (majority bilingual), 200+ Trainees
- Joint Commission and Primary Care Medical Home Accredited
- Deliver more babies (~3000 in FY19) than any other health center in Illinois

Our Patients:

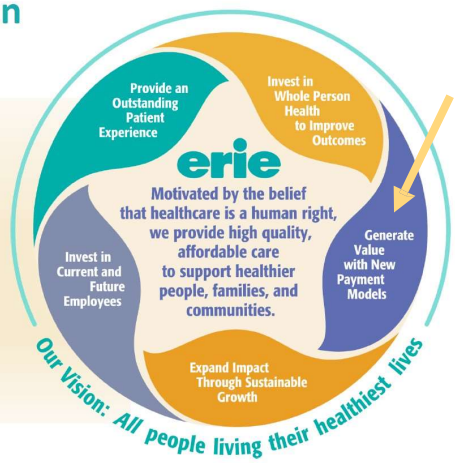


- ✓ 97% are below 200% of the federal poverty line
- ✓ 71% are Hispanic
- ✓ 45% prefer to be served in languages other than English
- ✓ 47% are under the age of 18
- ✓ 62% are female

Centros de Salud erie Family Health Centers

Strategic Plan
FY19- FY21

Our Values
- Dignity
- Impact
- Excellence
- Relationships
- Learning



MHN ACO

Medical Home Network (MHN): An accountable care organization that manages ~115K lives (Erie: 22K lives) in CountyCare, a Medicaid health plan.

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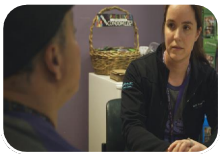
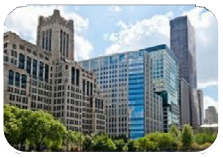
The Care Model

Services for low risk patients



Care management for high risk patients



Transitions of care

- Warm handoffs from providers to care managers
- Health Risk Assessments for all members
- Insurance and referrals navigation
- Real time hospital alerts (MHN Connect)
- Social service linkages (NowPow)
- Inpatient visiting
- ED follow-ups within 5 days
- Interdisciplinary care team meetings (including patients!)

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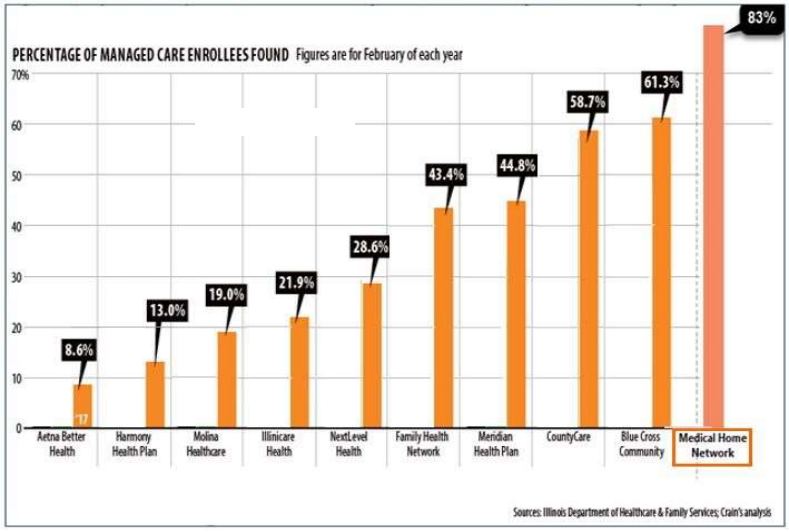
MHN Engagement

"But Insurers don't have a great track record of finding their enrollees…"



Source: *"The problem in Illinois no one is talking about."* Crain's Chicago Business (July, 2017). http://www.chicagobusiness.com/article/20170708/ISSUE01/170709929/medicaid-recipients-in-illinois-tough-to-track

MEDICAL HOME NETWORK

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Challenges:

- Double documentation
- Lots of box checking
- Patients' experiences differ depending on their
- Lags in claims data
- Interoperability (or lack thereof)

Policy Implications:

- Information about what happens outside our h
- FQHCs need stable source of revenue to fund investments. Who is willing to do this?
- ***Real change in Medicaid will only come wi Alternative Payment Model***

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Update on "Hot Topics"

Taking Downside Risk

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Speakers

- Patrick Bucknum, Chief Executive Officer, Community Clinic Contracting Network
- Lacey Clarke , Vice President of Policy, Community Health Care Association of New York State (CHCANYS)

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Community Clinic Contracting Network

Patrick Bucknum, CEO

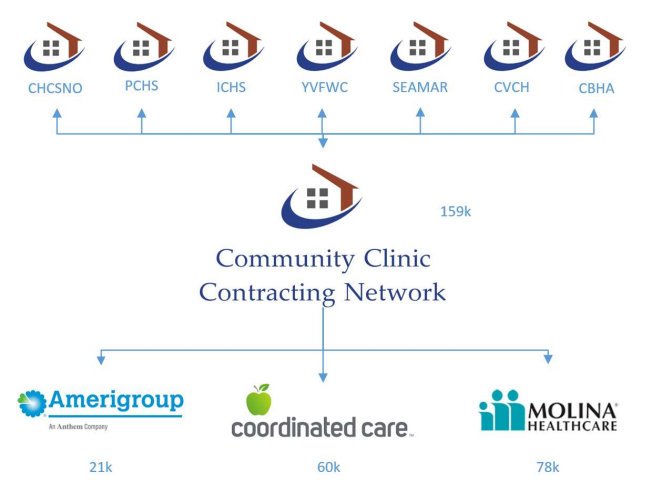
Community Clinic Contracting Network

Brief History

- FQHCs in WA State have shared upside/downside risk since the late 1990s, through a Plan created and governed by FQHCs.
- CCCN was initially incorporated in 2010 with 5 founding FQHC members.
- Started with 45k patients enrolled in July 2012.
- Today CCCN has 7 participating FQHCs sharing upside and downside risk on 159k patients enrolled in three MCOs.

Community Clinic Contracting Network

Contracting Structure – Coordinated Care



- Contracted Products
  - Apple Health (TANF)
  - Medicaid Expansion (MCE)
  - Supplemental Security Income (SSI)
  - Exchange (Ambetter)
  - Medicare Expansion
  - Foster Care

Community Clinic
Contracting Network

What We Do

- Financial Integration
  - Contract Management – Negotiate the terms, execute the contract as an agent of the participating providers.
  - Contract Management – Reconcile risk pools, contest departures from contracted terms.
  - Shared Risk – Maintain adequate reserves at the network level.
  - Shared Risk – Create additional risk pools as needed.
- Clinical Integration
  - Reconcile Care Gaps – Provide supplemental data to MCOs for patients that are compliant to contracted quality measures.
  - Build or purchase tools to enable population health management.
- Data Integration
  - Publish Operational and Clinical Balanced Scorecards using FQHC and MCO data sources.

Community Clinic
Contracting Network

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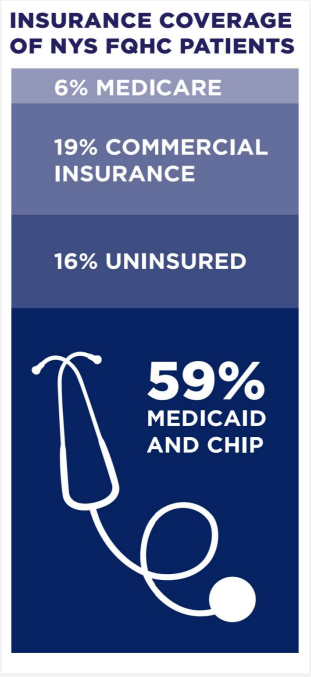
NYS HEALTH CENTERS AND DOWNSIDE RISK

NACHC Payment Reform Summit
August 15, 2019
Lacey Clarke

CHCANYS

CHCANYS 2019

New York State Health Centers



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New York State Medicaid by the Numbers

6.1 million people enrolled in Medicaid

5 million people enrolled in Medicaid Managed Care

15 Medicaid Managed Care Plans

- **1** Statewide plan
- **14** regional plans

At least **6** IPAs led by FQHCs, or including FQHCs

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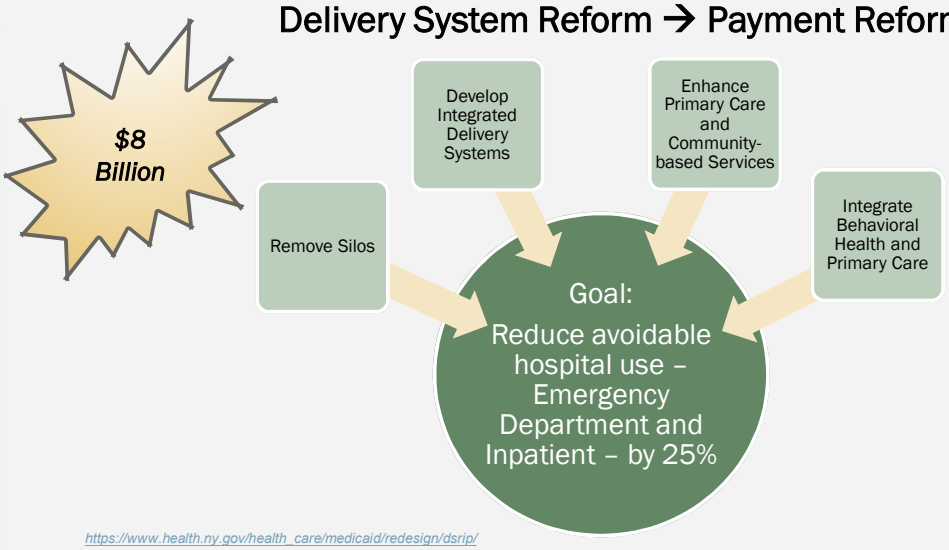
DSRIP: 2014-2020

Delivery System Reform → Payment Reform



https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

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VALUE BASED PAYMENT

CHCANYS

CHCANYS2019

The New World: Paying for *Outcomes* not *Inputs*

By DSRIP Year 5 (2020), 80%-90% of payments from MCOs to providers must employ VBP systems that reward value over volume.

Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/docs/2018-06_final_vbp_roadmap.pdf

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VBP Roadmap Categories of Arrangements

Category	Type
Population- based arrangements	Total Care for the General Population
	Total Care for Special Needs Population (HIV/AIDS, members included in a Health and Recovery Plan (HARP), Managed Long-Term Care (MLTC) members and members with significant developmental disabilities.)
Episodic-based arrangement	Maternity Care
	Integrated Primary Care (includes Chronic Care bundle)

Upside and Downide Risk Sharing Arrangements (Guideline)

Quality Targets % Met goal	Level 1 VBP Upside Only	Level 2 VBP	
		Upside when actual costs < budgeted costs	Downside when actual costs > budgeted costs
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

MCO Incentives to Move to VBP

Guaranteed $85M annual stimulus payments in 2016-17

SFY 2018-19 Transition to payment based on new Level 2 or 3

Penalties on plans began April 1, 2018

2018-19: .5% if 10% not in Level 1 or above

2019-20: 1% if 50% Level 1 or 15% Level 2 not met

2020-21: 1% if 80% Level 1 or 35% Level 2 not met

Year	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Stimulus		guaranteed	guaranteed	Contract based	Contract based		
Penalty				Begin	More stringent	Most stringent	

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Progress Toward 2020 Goal: 80-90% in VBP

(35% in level 2 or 3)

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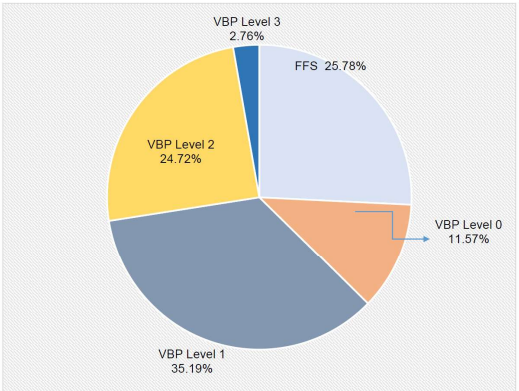
Overview of Results thru 12/31/2018 (across all Medicaid MC Lines of Business)



Current Overall VBP Progress: **62.66%**

TOTAL MA $	$22,309,553,988	
FFS	$5,750,363,457	25.78%
VBP0	$2,580,112,046	11.57%
Level 0/Quality Only	$2,255,017,678	*10.11%*
Level 0/ Cost Only	$325,094,368	*1.46%*
VBP1	$7,850,172,343	35.19%
VBP2	$5,513,812,621	24.72%
VBP3	$615,093,519	2.76%
Level 1-3	$17,051,838,452.00	*62.66%*

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NYS DOH Position on FQHCs and VBP

Proposed Roadmap Changes: **Continuing FQHCs in Level 1 VBP**

Current Language	Rationale for Change
The State must, however, ensure that there are no structural barriers to achieving the statewide goals, and the following narrow list of services and providers either *are* excluded (i.e. they cannot be included) or *may be* excluded by MCOs and VBP contractors. Services not mentioned here or elsewhere in the VBP arrangement definitions, in other words, cannot be excluded. (Pg. 36)	Federal law 42 USC 1396a (bb)(5)(A) mandates that FQHCs be reimbursed up to the PPS rate for every Medicaid visit. Any alternate payment methodology (APM) must result in payment to the FQHC of an amount which is at least equal to the PPS amount. As a result, FQHCs cannot accept risk in a VBP environment and must continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery system.

Proposed Language to be added to page 37

(Under Exclusions)
7. Federally Qualified Health Centers (FQHC)

The State's VBP model does not intend to back away from adequate reimbursements for FQHCs. NYS' model recognizes that FQHCs have a statutorily mandated rate as prescribed in Federal law 42 USC 1396a (bb)(5)(A) . For Level 2 and 3 arrangements, the NYS VBP model will accommodate the current payment structure of FQHCs in the following ways:

- FQHCs may continue to enter into Level 1 VBP arrangements as lead VBP Contractors
- FQHCs may not enter into Level 2 or Level 3 arrangements as lead VBP Contractors.
- FQHCs that have formed an IPA remain eligible to contract Level 2 and 3 arrangements, with the understanding that risk will be held by the IPA.

Statewide VBP goals and MCO specific goals will be modified as follows:

- Spend attributed to Medicaid members who have a FQHC designated as their primary care provider from total medical expense, when calculating MCO progress to level 2 & 3, will be excluded.
- Spend attributed to Medicaid members who have a FQHC designated as their primary care provider will continue to be included when calculating MCO progress toward Level 1 goals, and when calculating Statewide VBP goals.

What is the question?

Can a health center put their PPS at risk?

Does federal law require DOH to reimburse health centers for their losses in a downside risk arrangement?

How does participation in a risk sharing arrangement impact the calculation of wrap payments?

Can FQHC take risk on services outside of their scope of service?

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CMS Guidance

"Inclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provide, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO. For this reason, we have determined that the State's quarterly supplemental payment obligation should be determined using the baseline payment under the contract for services being provided, *without regard to the effects of financial incentives that are linked to utilization outcomes or other reductions in patient cost"*

State Medicaid Director Letter, September 27, 2000

https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf

How does it work?

Payment to the FQHC for its own services:

1. A health plan contracts with an FQHC to pay 30 days after the date of service a percentage of the Medicaid fee schedule or, monthly, a per member per month rate, for primary care services at an amount similar to what it pays other non-FQHC providers;
2. The state pays quarterly the FQHC Wrap-Around Payment for the difference between the PPS rate and the contracted managed care rate.

Incentive payment on the total cost of care:

1. After a 12-month period, the health plan and FQHC retrospectively reconcile the total cost for healthcare services for a patient against a budgeted amount.
2. If costs exceed the budget, the FQHC owes money to the health plan for the "deficit."
3. If costs are less than budgeted, the health plan pays a surplus to the FQHC.
4. Any money paid by the FQHC to cover any deficit is not included in that year or any subsequent years' costs for determining the Wrap-Around Payment.

Additional Potential Assurances

- ❑ "Deficit carryover" arrangement
  Deficits are applied to future surplus and there is no obligation on the part of the FQHC to repay the deficit if there is no surplus.
- ❑ Risk Corridor
  Limit amount at risk to a percentage of the total contracted amount or percentage of
- ❑ Contractual Language
  Warrant that health center has been paid their PPS rate (including wrap) and will not seek any further payment from DOH/CMS
- ❑ Reserve requirement
  Mandate that health center have a certain amount in reserves to cover any losses

Questions?

Lacey Clarke
VP of Policy
CHCANYS
lclarke@chcanys.org

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Break Time!

1:45 PM – 1:55 PM

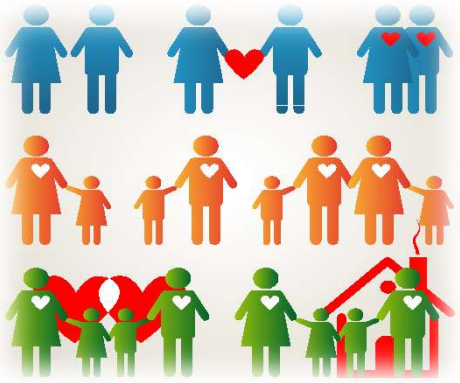
- Then, please make your way to either:
  - Columbus CD - Behavioral Health Integration
  - Columbus AB - Caring For An Aging Population

Considerations in Behavioral Health Financing

Aaron Williams, MA
Senior Director of Training and Technical Assistance for Substance Use
National Council for Behavioral Health

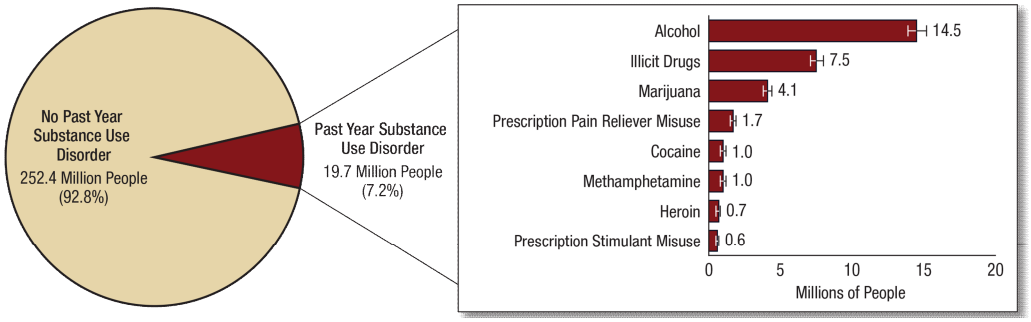
The National Council for Behavioral Health

- Serving **10 million +** adults, children and families with mental illnesses and/or addictions.
- Drive mental health and addictions policy, practice, and education initiatives that improve access to effective care



Big Tent - Mental health; addictions; children to older adults; not for profits, government, and peer run; housing, and school and employment services; hospital and community based; prevention, treatment, and recovery supports.

Numbers of People Aged 12 or Older with a Past Year Substance Use Disorder: 2017

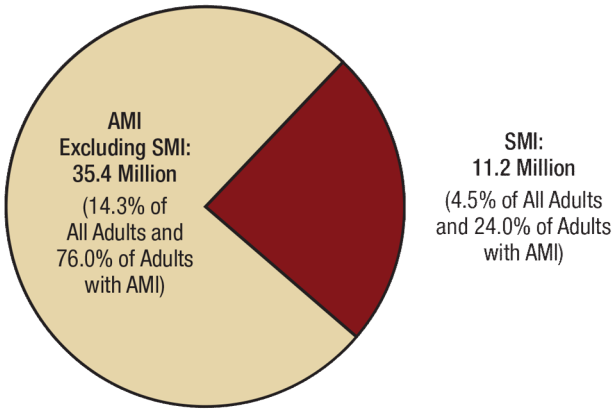


NSDUH 2017

Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term care hospitals.

Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

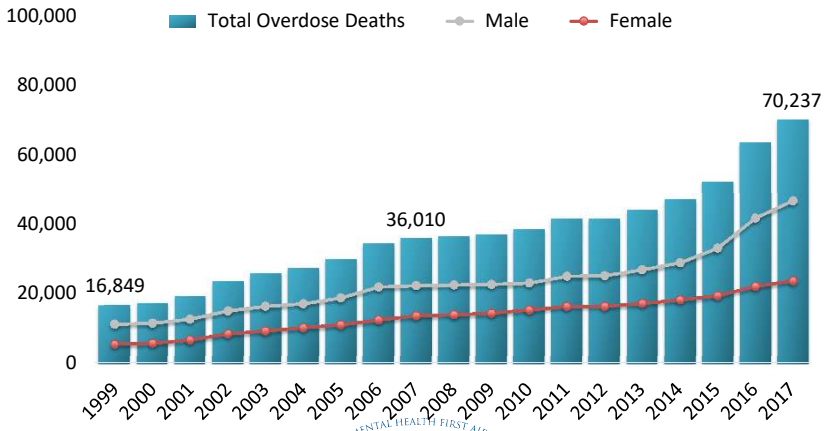
Any Mental Illness (AMI), Serious Mental Illness (SMI), and AMI Excluding SMI in the Past Year among Adults Aged 18 or Older: 2017



46.6 Million Adults with AMI in the Past Year (18.9% of All Adults)

NSDUH 2017

Figure 1. National Drug Overdose Deaths Number Among All Ages, by Gender, 1999-2017



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Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2017 on CDC WONDER Online Database, released December, 2018

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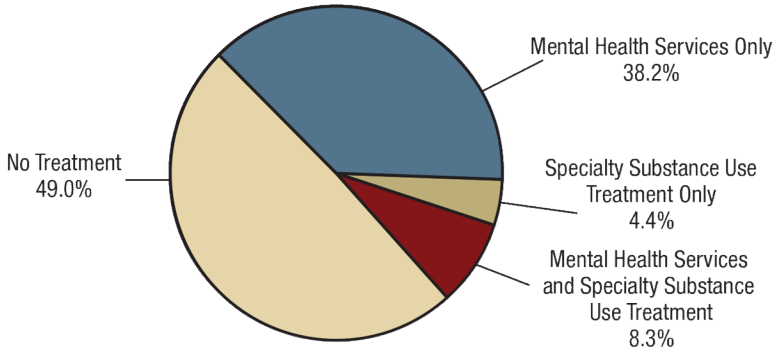
Receipt of Mental Health Services and Specialty Substance Use Treatment in the Past Year among Adults Aged 18 or Older with Past Year Mental Illness and Substance Use Disorders: Percentages, 2017



8.5 Million Adults with Co-Occurring Mental Illness and Substance Use Disorders

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Specialty substance use treatment refers to treatment at a hospital (inpatient only), drug rehab facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.
Note: The percentages do not add to 100 percent due to rounding.

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State of the Union's Behavioral Health

- Cohen Veteran's Network Survey (2018)
  - Demand for mental health services
    - Nearly 60% have sought mental health services
    - 76% believe mental health is as important as physical health
  - Availability of services must improve
    - 46% of those who have already sought services don't know where to go in the future
    - Cost is the main barrier for accessing services
    - 94 million Americans have waited >1 week for treatment
- Your work matters! Health Centers pay a valuable role in addressing behavioral health issues.

Cohen Veterans Network. (2018). America's Mental Health 2018. Retrieved from https://www.cohenveteransnetwork.org/wp-content/uploads/2018/10/CVN_Infographic_10.8.18_1045am.pdf

Health Care Today: Value-based Services

Effective Healthcare:

- Clinical & administrative processes that produce quality treat to target outcomes, staff & customer satisfaction

Efficient Healthcare:

- Clinical & administrative processes that operate within optimal time & cost specifications

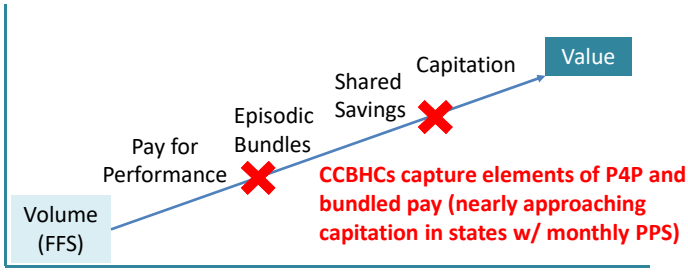
Fee-for-Service/Volume Based Care

Focus is on *Efficiency*

Value Based Services

Focuses on *Efficiency* & *Effectiveness*

Alternative payment models (APMs) shifting pay from volume to value



Incentives for health system investment in behavioral health care

- Reduce ED overcrowding
- Improve bed availability
- Reduce inpatient length of stay

- Prevent unnecessary readmissions
- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations

Key Components of Integration

Common elements highlighted across models have been summarized extensively in the policy literature and include:

- Screening for behavioral disorders using validated screening tools
- Team-based care with non-physician staff to support primary care physicians (PCPs) and co-manage treatment
- Shared information systems that facilitate coordination and communication cross providers
- Standardized use of evidence-based guidelines
- Systematic review and measurement of patient outcomes using registries and patient tracking tools
- Engagement with broader community services
- Individualized, person-centered care that incorporates family members and caregivers into the treatment plan

icer-review.org/wp-content/uploads/2016/01/BHI-CEPAC-REPORT-FINAL-VERSION-FOR-POSTING-MARCH-231.pdf

How Are Behavioral Health Services Paid For?

- Substance Abuse and Mental Health Prevention and Treatment Block Grant
- Medicaid
  - 1115 waivers
  - State plan amendment
  - 1915b waiver.
- State and local funding
- Private Partnerships
- Other federal funding
- CCBHC's

What Services to Pay for?

Model 1 Behavioral health lite

- Behavioral health screening
- Brief interventions/ Brief Therapy
- Behavioral health medication management
- Care management and referral to external behavioral health services

Model 2 Full Continuum

- Full continuum of behavioral health services
- Medication Assisted Treatment
- All (or most) ASAM levels of care
- Care management and referral to internal behavioral health services

Staffing of integrated behavioral health services

Who will provide these services?

- Primary care providers (MD,NP, PA, ETC….)
- Psychologist
- Social worker
- Psychiatrist
- Community health worker
- Peer service provider

Addiction Services

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Medications/Pharmacotherapy for Opioid Use Disorder (OUD)

Medication	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.
Buprenorphine	Daily for table or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue	Physicians, NPs and PAs with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Probuphine (buprenorphine implant)	Every 6 months	Subdermal	
Sublocade (buprenorphine injection)	Monthly	Injection (for moderate to severe OUD)	
Naltrexone	Monthly	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4893P)

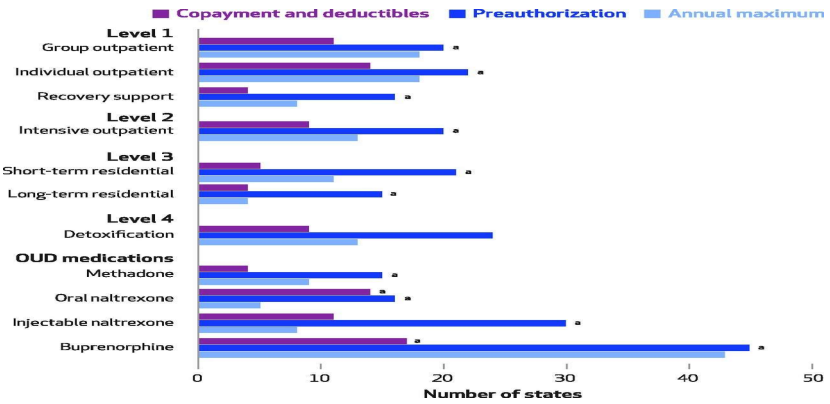
Current Challenges

Prior authorization,- Getting an agreement from the payer to cover specific services before the service is performed.

Step-therapy - Benefit design that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a branded medication.

Lifetime limit- *Insurers place* a dollar **limit** on what they would spend for your covered benefits during the entire time you were enrolled in that plan (banned under current law)

Types of limits on substance use disorder services and opioid use disorder (OUD) medications



Survey Highlights Differences In Medicaid Coverage For Substance Use Treatment And Opioid Use Disorder Medications

Colleen M. Grogan, Christina Andrews, Amanda Abraham, Keith Humphreys, Harold A. Pollack, Bikki Tran Smith, and Peter D. Friedmann Health Affairs 2016 35:12, 2289-2296

Other Challenges

Organizational Benefit Silos

One challenge to establishing a benefit design for medications to treat alcohol and opioid use disorders is that the medications can involve four different Medicaid operations

- **opioid treatment programs**
- **pharmacy benefits**
- **medical benefits**
- **pharmacy contracting**

These areas often function independently in their decision systems, staffing, and approval process (ASAM, 2013).

Some Change is happening

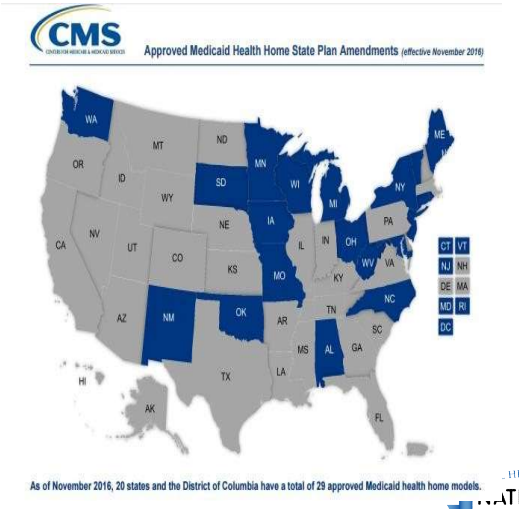
- Aetna, starting in March 2017, stopped requiring doctors to seek approval from the insurance company before they prescribe particular medications such as Suboxone.
- Anthem and Cigna also recently dropped prior authorization requirements. – These companies took the step after the New York AG investigated coverage practices that unfairly barred patients from needed treatment. The insurers adjusted their prescribing requirements as part of larger settlements.
- **As of February 2018 all fifty states covered at least 1 of the MAT medications with most covering all three.**

System Redesign

Options for States via Medicaid

Section 1115 Waiver	State Plan Amendment
Enables states to experiment with delivery system reforms	Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, requirements, etc.
Requires budget neutrality	Does not require budget neutrality
Must be renewed every 5 years	With CMS approval, can continue PPS
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in state plan)	Cannot waive statewideness, may have to certify additional CCBHCs
With CMS approval, offers opportunity to continue PPS	
Subject to CMS approval process; consider timing of request	Subject to CMS approval process; consider timing of request

Health Homes



Six Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care/follow-up
5. Patient & family support
6. Referral to community and social support services

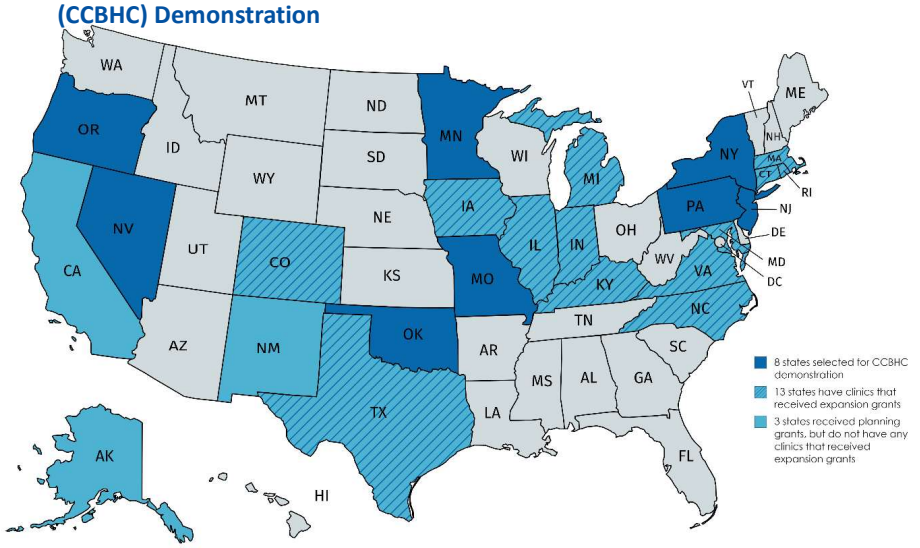
Enacted in 2014 as Section 223 of the Protecting Access to Medicare Act


Senators Roy Blunt and Debbie Stabenow


Representatives Leonard Lance and Doris Matsui

Excellence in Mental Health and Addiction Act

Status of Participation in Certified Community Behavioral Health Clinic (CCBHC) Demonstration



Note: *Demonstration ends on March 31, 2019 in OR & OK and on June 30, 2019 in the remaining 6 demonstration states*

CCBHC Certification Requirements

Scope of SUD Services

Required CCBHC Addiction Treatment Services
Crisis care: 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization
Evidence-based outpatient substance use services (e.g., addiction counseling, medication-assisted treatment, addiction technologies, assertive community treatment, cognitive behavioral therapy)
Ambulatory and medical detoxification
Treatment for co-occurring addiction and mental illness
Screening, assessment and diagnosis, including risk assessment for substance use
Brief intervention and referral to treatment for problematic substance use identified during screening
Peer recovery support and family support services
Treatment planning, including risk assessment and crisis planning
Referral to outside providers for specialized substance use services outside the expertise of the CCBHC
Targeted case management

Why pursue CCBHC status?

For many organizations, CCBHC status offers an improvement over the status quo:

- Payment **based on anticipated costs** supports hiring new staff, filling vacancies, expanding service lines
- Ability to fund **services outside the four walls** and **include expenses not traditionally billable** (like EHRs, care coordination, outreach)
- **Coverage for services** not otherwise in the Medicaid state plan (e.g. peer services)

Key staff expansions

Within the first 6 months, CCBHCs hired:

72 psychiatrists

64% hired peer recovery specialists

90% of CCBHCs have a psychiatrist on staff with an addiction specialty/focus

Within the first year:

398 **new** staff with an addiction specialty or focus

CCBHC Scope of Services

Targeted Case Management

Primary Health Screening & Monitoring

Armed Forces and Veteran's Services

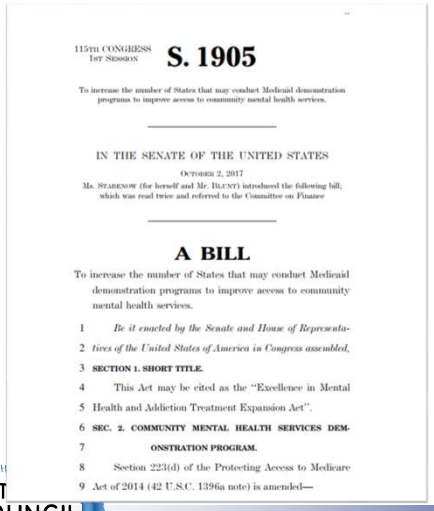
Must be delivered directly by CCBHC

Delivered by CCBHC or a Designated Collaborating Organization (DCO)

Excellence Act Expansion: S. 1905/H.R. 3931


Sens. Roy Blunt and Debbie Stabenow


Reps. Leonard Lance and Doris Matsui



115TH CONGRESS 1ST SESSION **S. 1905**

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services.

IN THE SENATE OF THE UNITED STATES

OCTOBER 2, 2017

Ms. STABENOW (for herself and Mr. BLUNT) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To increase the number of States that may conduct Medicaid demonstration programs to improve access to community mental health services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Excellence in Mental Health and Addiction Treatment Expansion Act".

SEC. 2. COMMUNITY MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM.

Section 223(d) of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 1396a note) is amended—

New FQHC Care Management Services

- FQHCs can receive payment for Chronic Care Management (CCM) or general Behavioral Health Integration (BHI) services when 20 minutes or more of CCM or general BHI services are furnished and **G0511** is billed either alone or with other payable services on an FQHC claim.

https://www.cms.gov/center/provider-type/federally-qualified-health-centers-fqhc-center.html

- FQHCs can receive payment for psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and **G0512** is billed either alone or with other payable services on an FQHC claim.

Requirements for Sustainable financing

- Understanding your Costs
- Understanding your patient populations
- Understanding your service array
- Understanding the community's resources
- Understanding your workforce requirements
- Involvement of senior leadership
- Use Data to make decisions
- Use data to make the case for financial sustainability

To Do List

- Using data create a list of the services and staff that you think are essential to maintaining your efforts going forward.
- Identify whether each of those services and staff positions has a funding source
- Create a list of community resources that could support your efforts
- Based on data, create a list of services that are absent (or in short supply) within the community
- Based on these lists prioritize those services that you believe are essential and there is a community need but no funding source or alternative mechanism for the provision of that service.
- Begin your work to seek funding for these initiatives first
- Be sure to use data to justify need for this service.

Resources

MLN Behavioral health integration services booklet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Telehealth Services Booklet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Telehealth-Services-Text-Only.pdf

Exploring Value-Based Payment *to Encourage Substance Use Disorder Treatment in Primary Care*

https://www.chcs.org/resource/exploring-value-based-payment-to-encourage-substance-use-disorder-treatment-in-primary-care/

The Business Case for Behavioral Health Care

https://www.integration.samhsa.gov/financing/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf

Questions

CONTACT INFORMATION

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NATIONAL ASSOCIATION OF Community Health Centers

Update on "Hot Topics"

Capitated APMs

NATIONAL ASSOCIATION OF Community Health Centers

Moderator:

- Rachel Tobey, Director, JSI California

Speakers:

- Marija Weeden, MSW, Alternative Payment and Care Model Manager, Colorado Community Health Network
- Ian Randall, Senior Strategy Advisor, Washington Association for Community Health

WWW.NACHC.ORG TWITTER: @NACHC

Washington Association for Community Health

Community Health Centers
Advancing Quality Care for All

FQHC Value-Based Payment in Washington State

APM4 Background

- In 2013, WA Legislature passed legislation to develop Value-Based Payment (VBP) programs for FQHCs, among other provider sectors
- The alternative payment methodology, called APM4, began July 1, 2017
- 16 out of 27 WA FQHCs are currently participating in APM4

3

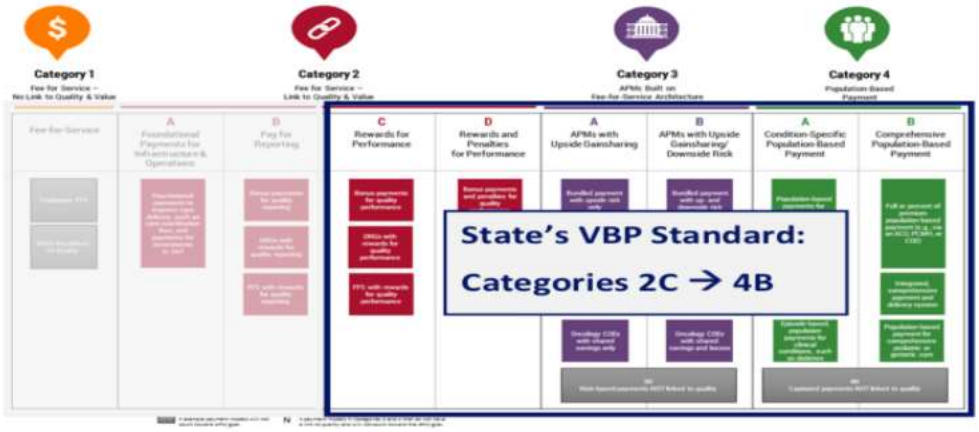
APM4 Background (con.)

- APM4 counts towards the state's 1115 waiver goal of 90% of payments for Medicaid/ in VBP structures
  - In 2017, only 43% of payments met this criterion
- For payment, APM4 converted APM3 payments to a PMPM amount using 2015 as baseline
  - 2015 is APM4 conversion year, but this has been problematic
- Washington Administrative Code says APM4 must be budget neutral, but common definition of budget neutrality has been elusive

4

HCA VBP Goals

Chart 2: Washington State's Value-based Purchasing Standard

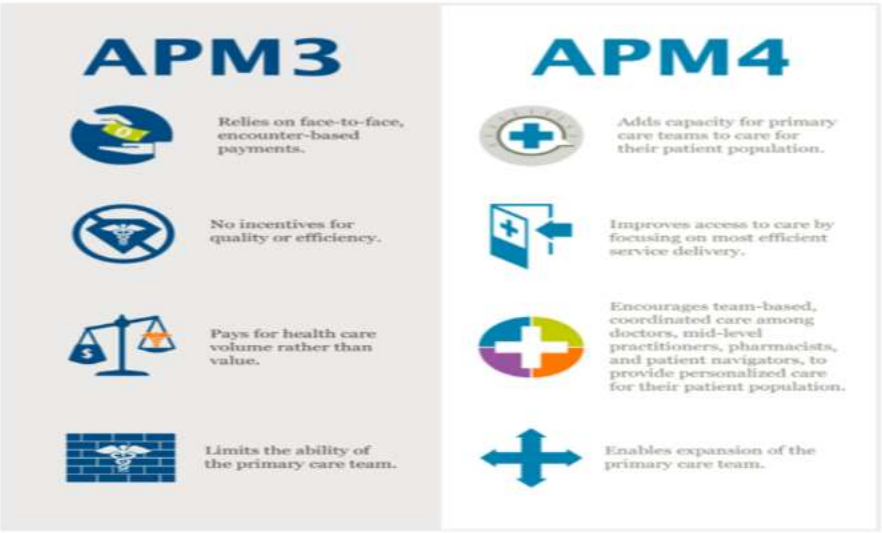


HCA aims to have 90 percent of state-financed health care payments to providers in APM Categories 2C-4B by 2021.

Source: Health Care Authority Medicaid Transformation Project Roadmap

5

APM3 vs. APM4



Source: Health Care Authority APM4 Fact Sheet

6

APM4 Construct

- Applies to Medicaid managed care enrollees only
- Does not affect current managed care organization contractual arrangements or the current flow of payments
- Converts the entire encounter-based rate to a baseline PMPM Rate
- Carries the baseline PMPM rate forward in future years

7

APM4 Construct (con.)

- Trends the PMPM rate by the Medicare Economic Index (MEI) annually
- Links the PMPM rate to quality performance measures
- Prospectively adjusts the PMPM rate based on quality performance

8

Payment Definition and Flow

APM4 RATE =

$$\frac{\text{CY2015 Encounter Rate } \$150 \times (1 + \text{CY2016 MEI } 101.1\%) \times (1 + \text{CY2017 MEI } 101.2\%) \times \text{CY2015 Encounters } 20{,}000}{\text{CY2015 Member Months } 60{,}000} = \text{Per Member, Per Month } \$51.16$$

- FQHCs contract individually with MCOs in sub-capitated or FFS arrangements
- Enhancement payments pass through the MCOs
- MCO assignment rosters are the source for determining managed care months

9

APM4 Quality Measurement

- Quality measured on a "gap-to-goal" methodology that rewards incremental improvement
- Clinics can earn a portion or all of the "APM4 Wedge" in the following APM4 CY by meeting quality targets.
  - APM4 Wedge is equal to the APM4 payment minus what would have been paid under APM3
- If FQHCs don't earn full APM4 Wedge in one year, they can earn back the full amount in the following year
- Quality Score is based on seven measures:
  1. Comprehensive diabetes care - poor HbA1c control (>9%)
  2. Comprehensive diabetes care - blood pressure control (<140/90)
  3. Controlling high blood pressure (<140/90)
  4. Antidepressant medication management
     a. Effective acute phase treatment
     b. Effective continuation phase treatment (6 months)
  5. Childhood immunization status - combo 10
  6. Well-child visits in the 3rd, 4th, 5th and 6th years of life
  7. Medication management for people with asthma: medication compliance 50%
     a. (Ages 5-11)
     b. (Ages 12-18)

10

APM4 Initial Results

- All 16 participating clinics met their APM4 Year 1 quality goals and are eligible to receive the full "APM4 wedge" payment
- Clinics made substantial investments in practice transformation to expand access and provide non-billable services
- Overall, APM4 clinics reduced average visit rates in 2017 compared to 2016, according to initial UDS data
- There are ongoing conversations related to program structure given budget issues and inability to correctly forecast program costs

11

Future Challenges

- Need to determine if and how to update baseline conversion year
- HCA faced 2017 shortfall in APM4 "authorized" budgeted vs. actual APM4 payment amounts
- HCA budget forecasting method may underestimate future expenditures
- Working to explore how to ensure future payments are predictable and FQHCs are reimbursed for VBP investments

12

Colorado's APM

Marija Weeden
marija@cchn.org

Why?

- Workforce:
  - Joy in work
  - "Get off the hamster wheel"
  - All team members at the top of their scope
- Patient outcomes
  - Meet them where they are, provide care the way they want
- Build a more efficient care model
  - Not every patient need requires an encounter

Overview – Rate Setting

$$\frac{(\text{Medical Encounter Rate} \times \text{Expected visits Per Attributed})}{12} = \text{Monthly APCM Rate}$$

Medical Encounter Rate

Same calculation as current medical rate via cost report:

$$\frac{(\text{Medical direct health care costs} + \text{Portion of Overhead})}{\text{Medical Encounters}}$$

Expected Visits

- Utilizes past history to predict utilization for the next 12 months for the APCM attributed population

- APCM Attribution:
  - APCM attribution excludes geographically attributed
  - APCM attribution includes all claims-attributed patients (no matter when they last came in)
    - Payment will be made on these patients
    - Non-encounter costs for patients are included in the cost report
    - Population based payment assumes continued non-utilization of traditional services by some patients.

Expected Visits

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Divide by 12

- Top of the equation calculates total revenue over the course of the year:
  - Visits (previous slide) are calculated through a month-by-month evaluation, summed to an annual number
  - This is multiplied by the rate to establish what the CHC would have been paid under encounters
- This accounts for changes in attribution throughout the year, so the total revenue is divided by 12 to determine the amount per patients per month that total revenue is equal to.

Relationship to Other Models

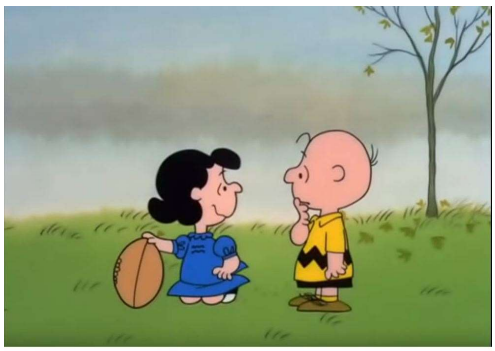
- 4% applies
  - Up to 4% of CHC payment subject to adjustment based on performance
- Dental and most behavioral health excluded at this time

Where are we now?

- Rules have been approved
- SPA looks positive, anticipate submission and approval this quarter
- If we don't launch in October, it won't be because of authorization

Challenges

- CMS
- System changes
  - So many changes in the last 12 months
  - Changes for payment
- Timeline
  - Ever extending, causing exhaustion



Screen shot from *A Charlie Brown Thanksgiving* (1973)

Advice

- Double your expected timeline
- Have a clear message of why this is needed and come back to it frequently
- Keep Medicaid in the loop on work with CHCs
  - Not just about keeping CHCs in the loop on work with Medicaid