Safety Net APM Workgroup for Advancing Delivery & Payment Reform

Kick-off
September 26, 2018 Webcast
Advancing Delivery & Payment Reform

National Safety Net Advancement Center

The National Safety Net Advancement Center (SNAC) aims to transform the ability of U.S. safety net organizations to respond to payment and care delivery reform efforts in health care’s fast evolving financial and delivery environment. This will be accomplished by leveraging new and existing knowledge into actionable tools for safety net organizations.

SNAC is supported by the Robert Wood Johnson Foundation.
Collaborative Ventures Network (CVN) was organized in 1997 as an Arizona not for profit integrated services network under guidelines consistent with the Affiliation Policies of the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. Since inception, its Mission has been “to foster collaborative business activities which enhance Community Health Centers’ individual abilities to serve their communities to meet the needs of Arizona’s uninsured, underinsured and underserved.”
Federal & State Health Care Delivery and Payment Reform
The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”). The law has 3 primary goals:

- **Make affordable health insurance available** to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.

- **Expand the Medicaid program** to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)

- **Support innovative medical care delivery** methods designed to lower the costs of health care generally.

Source: HealthCare.gov
Access to Affordable Health Care

• About one in every ten adults (9%) – said that they either delayed or did not receive medical care due to cost in 2016
• In the U.S., most adults (90%) have health insurance and the majority (87% of adults) also report their health as at least “good” (i.e., ≥3 on a scale of 1-5)
• Adults in worse health, those with low incomes, and the uninsured are much more likely than others to delay or forgo health services due to costs.
• Nearly one in five adults in worse health (19%) said they delayed or did not receive medical care due to cost barriers, while 7% of respondents in better health reported the same
• Those in better health are less likely to report not having a usual source of care (14%) than people in worse health (9%). The uninsured, are much less likely to report not having a usual source of care (47%) than those with insurance (10%).
• Of uninsured adults who did not report having a usual source of care, the majority (65%) also said they went without preventive health care services.

Source: Kaiser Family Foundation analysis of National Health Interview Survey
The Strategic Plan describes HHS’s efforts within the context of five broad Strategic Goals:

**Strategic Goal 1:** Reform, Strengthen, and Modernize the Nation’s Healthcare System

**Strategic Goal 2:** Protect the Health of Americans Where They Live, Learn, Work, and Play

**Strategic Goal 3:** Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

**Strategic Goal 4:** Foster Sound, Sustained Advances in the Sciences

**Strategic Goal 5:** Promote Effective and Efficient Management and Stewardship

Source: US Department of Health and Human Services
HHS Strategic Plan 2018-2022
Strategic Goal 1

Reform, Strengthen, and Modernize the Nation’s Healthcare System

**Strategic Objective 1.1:*** Promote affordable healthcare, while balancing spending on premiums, deductibles, and out-of-pocket costs

**Strategic Objective 1.2:*** Expand safe, high-quality healthcare options, and encourage innovation and competition

**Strategic Objective 1.3:*** Improve Americans’ access to healthcare and expand choices of care and service options

**Strategic Objective 1.4:*** Strengthen and expand the healthcare workforce to meet America’s diverse needs

Source: US Department of Health and Human Services
CMS’ Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act).

Purpose: To test “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.

Innovation Center is currently focused on the following priorities:

• Testing new payment and service delivery models, including Quality Payment Program Advanced Alternative Payment Models
• Evaluating results and advancing best practices
• Engaging a broad range of stakeholders to develop additional models for testing

The Innovation Center is working in consultation with clinicians to increase the number and variety of models available to ensure that a wide range of clinicians, including those in small practices and rural areas, have the option to participate.

Source: www.CMS.gov
Launched in 2015 by HHS, The Health Care Payment Learning & Action Network (LAN) is a public-private partnership whose mission is to accelerate the health care system’s transition to APMs by aligning the innovation, power, and reach of the private and public sectors. The LAN’s purpose is to facilitate the shift from the fee-for-service (FFS) payment model to a model that pays providers for quality care, improved health, and lower costs.

The Goals of the LAN have included:

• Linking 50% of all healthcare payment in the U.S. to quality and value through APMs by 2018
• Increasing the alignment of APM components, such as quality measures, risk adjustment, and data sharing, within and across the public and private sectors
• Diffusing cutting-edge knowledge and promising practices on operationalizing APMs to accelerate the design, testing, and implementation of APMs
## Components of the LAN’s Primary Care Payment Models (PCPMs)

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<thead>
<tr>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td><strong>APMs Built on Fee-for-Service (FFS) Architecture</strong></td>
<td><strong>Population-Based Payment (PBP)</strong></td>
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<tr>
<td>Infrastructure Payment</td>
<td>PBP for majority of services (including behavioral health)</td>
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<tr>
<td>Upside/Downside Risk on an FFS architecture for majority of services (including behavioral health)</td>
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<td>Care Management Fee (PMPM)</td>
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<td><strong>Targeted FFS Carve Out</strong></td>
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<td></td>
<td>FFS for limited office-based services</td>
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<td><strong>Incentive Payments</strong></td>
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<td>Bonus for quality processes</td>
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<td>Bonus for quality outcomes</td>
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<tr>
<td>Fee for Primary Care Medical Home (PCMH) outcomes</td>
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Source: Health Care Payment Learning Action Network (HCP-LAN)

HealthyArizona.org
Advancing Delivery & Payment Reform
NACHC Value Transformation Framework

National Association of Community Health Centers

Founded in 1971, the National Association of Community Health Centers (NACHC) serves as the national health care advocacy organization for America’s medically underserved and uninsured and the community health centers that serve as their health care home.

NACHC works in conjunction with state and regional primary care associations, health center controlled networks and other public and private sector organizations to expand health care access to all in need.
Advancing Delivery & Payment Reform
NACHC Value Transformation Framework

• The transition towards value-based care requires health centers to simultaneously focus on improving health outcomes, improving patient and staff experience, and reducing costs as a business imperative.

• One of the greatest threats to advancement toward value-based care is not the lack of solutions but, rather, the lack of a framework that organizes proven and promising solutions into a tangible set of action steps.

• Health centers, and the staff working within the centers, have reached a point of potentially diminished return given the overwhelming volume of information, recommendations and competing improvement efforts.
Advancing Delivery & Payment Reform
NACHC Value Transformation Framework

The Value Transformation Framework addresses these challenges by translating research, proven solutions and promising practices in three domains (infrastructure, care delivery, and people) into manageable steps health centers can apply in advancing the Quadruple Aim.
The Delta Center for a Thriving Safety Net provides technical assistance to primary care associations and behavioral health state associations to build a stronger safety-net, particularly in ambulatory care settings. The Delta Center aims to inspire innovation and change in value-based care and payment, through both policy and practice.

The Delta Center is the first national center to focus exclusively on transforming payment and care for ambulatory primary care and behavioral health services. Care delivery transformation, payment reform, and sustainable learning organizations are the three main areas of focus.
Advancing Delivery & Payment Reform
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

HealthyArizona.org
Current Arizona Healthcare Landscape

- Accountable Care Organizations (ACOs) enrolling Medicare recipients have been operative in Arizona since CMS awarded Banner a Pioneer ACO designation in 2012.
- Medicare Advantage (Part C managed care) plans have increased enrollment in Arizona to 39% for 2017 (18% higher than the national average of 33%); AHCCCS has worked to align Medicare/Medicaid dual-eligible individuals under single health insurers.
- Arizona has operated the Arizona Health Care Cost Containment System (AHCCCS) under a Section 1115 (managed care) Research & Demonstration Waiver since 1982.
- AHCCCS recently awarded seven new contracts for its Complete Care Program beginning October 1, 2018 which will integrate physical and behavioral health care under managed care organizations (MCOs) representing approximately one-half of the total patients served by Arizona community health centers.
AHCCCS implemented a Payment Modernization Program in 2012 which now requires its contracted MCOs to demonstrate that at least 50% of their “medical expense” includes payments for shared savings programs, of which 25% is to be paid to primary care providers.

Proposed changes to the Alternative Payment Methodology for FQHCs under Arizona’s State Plan for Medicaid will incorporate a value-based adjustment to the Prospective Payment System (PPS) rate setting methodology as early as October 1, 2018.
Arizona Medicaid Managed Care
Current Initiatives

• The Future of Integrated Care: AHCCCS Complete Care
• Building a Health Care System: Care Coordination and Integration
• Transforming Health Care Delivery: Targeted Investments
• Incentivizing Quality: Payment Modernization
• Improving Communications: Health Information Technology
• Connecting Communities: Private Sector Partners
• Integrating Technology: Electronic Visit Verification

Source: www.azahcccs.gov/AHCCCS/Initiatives/
AHCCCS’ APM Initiatives
Aligning Contractor & Provider Incentives

Withhold and Quality Measure Performance Initiative Policy (ACOM #306)

- In order to qualify for an Earned Withhold and/or QMP Incentive payment, the MCO shall meet the APM strategies qualifying criteria
- Earned Withhold & QMP Incentive payments will be made to MCOs based on relative performance for the measurement year

Strategies & Performance-Based Payments Incentive Policy (ACOM #307)

- The MCO shall be responsible for identifying which APM strategy applies to each provider APM contract
- The MCO may use quality measures other than the measures identified in AHCCCS Policy as part of the MCO’s APM strategies.

Source: AHCCCS Contractor Operations Manual (ACOM)
### AHCCCS Quality Management Performance Measure Standards

<table>
<thead>
<tr>
<th>Quality Management Performance Measure</th>
<th>Minimum Performance Standard (MPS)</th>
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<tbody>
<tr>
<td><strong>ADULT MEASURES</strong></td>
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<tr>
<td>Emergency Department (ED) Utilization</td>
<td>&lt;=55 Visits Per 1000 Member Months</td>
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<tr>
<td>Readmissions within 30 days of discharge</td>
<td>&lt;=11%</td>
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<tr>
<td><strong>CHILDRENS MEASURES</strong></td>
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<tr>
<td>Well-Child Visits: 15 mo.</td>
<td>65%</td>
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<tr>
<td>Well-Child Visits: 3 - 6 yrs.</td>
<td>66%</td>
</tr>
<tr>
<td>Adolescent Well-Child Visits: 12–21 yrs.</td>
<td>41%</td>
</tr>
<tr>
<td>Children's Dental Visits: 2-21 yrs.</td>
<td>60%</td>
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</table>

Source: AHCCCS Contractor Operations Manual (ACOM)

HealthyArizona.org
AHCCCS APM Initiative
MCO and Provider Contracting Strategies

Figure 1: The Updated APM Framework

Source: AHCCCS Contractor Operations Manual (ACOM)
Advancing Safety Net Health Care Delivery and Payment Reform
SNAC is providing CVN funding to facilitate a collaborative effort to advance a Payment Reform Strategy for Safety Net providers in Arizona that supports

- Achievement of the Quadruple Aim in health care transformation
- Future operational/financial sustainability of patient-centered value-based primary care through these organizations

The Safety Net APM Workgroup’s approach to advancing Delivery and Payment Reform will be to identify APMs that support a Value-based Transformation Framework which interlinks value-based “Quadruple Aim” goals with four domains of primary care clinical operations: care delivery, operating infrastructure, people and funding. These APMs should support and promote patient-centered value-based primary care
Safety Net APM Workgroup
Organizational Participants and Stakeholders

Participants: Arizona Safety Net provider organizations able to participate in APM FQHCs and FQHC-LAs; Behavioral Health Organizations; and Arizona Tribal Health Organizations

Stakeholders: Other provider and non provider organizations enabling successful Delivery & Payment Reform
  • Acute Care Providers (CIPNs, Hospitals, Specialists, etc)
  • Community-based Agencies and Organizations
  • Health Plans (multiple product lines), ACOs, AHCCCS and CMS
  • Health Care Associations (e.g., AACHC, AZ Council for Behavioral Health, Arizona Tribal Health Council, AzDA, etc)
Safety Net APM Workgroup
Individual Representation

Representatives of Safety Net Providers in Arizona who:

✓ Support and facilitate the principles of a Learning Organization
✓ Are willing to participate in open dialogue regarding innovation in primary care delivery and alternative payment methodologies
✓ Receptive to enabling change management in order to meet the needs of patients and other stakeholders
✓ Engaged in health care delivery system transformation and, as necessary, the changing role of the Safety Net in value-based care
✓ Are ready to undertake the implementation of contract terms and conditions requiring Delivery and Payment Reform
Safety Net APM Workgroup
Cycle One Project Goals

• Identify the driving forces of Delivery and Payment Reform
• Define current APMs in use and available to Safety Net providers
• Discuss the challenges and barriers to Safety Net providers’ participation in Delivery and Payment Reform and strategies that may address them
• Provide tools for a self-assessment of the Safety Net organization’s readiness and adaptability to Delivery and Payment reform
• Recommend a Value-based Transformation Framework for identifying and prioritizing “next steps” toward Delivery and Payment Reform
Vision for Safety Net APMs
Value-Based Transformation Framework

Safety Net APM Workgroup
Identify and prioritize opportunities to advance integrated patient-centered value-based care through the efficient and effective application of resources across all domains of primary care operations and improve financial sustainability through alternative payment methodologies that give recognition to achievement of the Quadruple Aim.
Safety Net APM Workgroup
Cycle One Activities

• Establish Participant Baseline Data
  • Payment Reform Readiness Assessment
  • Baseline metrics
• Identify standard measures to assess transition to and improvement in each of the four goals of the Quadruple Aim
• Engage one or more health plans in
  • Discussion of value-based terms and conditions for contracts
  • Efforts to implement parallel tracking of Safety Net provider and health plan data
• Prioritize quality improvement strategies outlining the interdisciplinary impact on value-based care
## Safety Net APM Workgroup Cycle One Activities

### Webinar Series

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<th>Time</th>
<th>Topic</th>
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<tr>
<td>September 26&lt;sup&gt;th&lt;/sup&gt;</td>
<td>12:30-1:30</td>
<td>Kick-off Meeting: APM Methodology for Value Based Care</td>
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<tr>
<td>October 24&lt;sup&gt;th&lt;/sup&gt;</td>
<td>12:30-1:30</td>
<td>How Do You Assess Your Organization’s Readiness</td>
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<tr>
<td>November 14&lt;sup&gt;th&lt;/sup&gt;</td>
<td>12:30-1:30</td>
<td>Strategies and Activities to Achieve Readiness</td>
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<td>December 12&lt;sup&gt;th&lt;/sup&gt;</td>
<td>12:30-1:30</td>
<td>Measurement for Alternative Payment Methodologies</td>
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Questions?