Emerging Issues in Payment Reform: Engagement at the State Level and Opportunities to Address the Social Determinants of Health

April 20, 2017
AAPCHO is a national not-for-profit association of 35 community-based health care organizations, 30 of which are Federally Qualified Health Centers (FQHCs). AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of medically underserved AA&NHPIs in the U.S., its territories, and its freely associated states.
*** Please submit questions in writing during the presentations by typing them in the “Questions” field. Please indicate to whom the question is directed.
Today’s Webinar Objectives

• Understand more of the national and state payment reform landscapes, considering administrative changes

• Learn about payment models that are being used in different states and why

• Learn about how some health centers are documenting SDOH, and how this could influence delivery system reform

• Find out different strategies and tools to connect with key players on the state level
Speakers

Moderator:
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Emerging Issues in Payment Reform: Engagement at the State Level and Opportunities to Address the Social Determinants of Health

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April 20, 2017

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What Are We Aiming For?

Enhancing Patient Experience

Improving Population Health

Improving Provider Work Life

Reducing System Costs
Medicare FQHC PPS

- Created in the Affordable Care Act
- **Single, bundled national PPS** rate, adjusted for geography
- Health centers are paid based on the PPS rate or their G codes, whichever is less. **CODING IS KEY**
- PPS rate is paid for a **face to face** visit with one of the following provider types:

Physician, physician’s assistant, nurse practitioner, clinical psychologist, certified nurse midwife, clinical social worker and sometimes a certified diabetes educator
Let’s Start with the Basics - Medicaid

**Medicaid FQHC PPS**
- **Single, bundled rate** covers all of the services and supplies in a single visit
- Unique to FQHCs, other providers paid on the fee schedule
- Initial FQHC PPS rate was established by **averaging reasonable costs**
- Calculated at **each health center**
- Serves as a **baseline** payment

**Medicaid FQHC Alternative Payment Methodology (FQHC APM)**
- Currently used in 23 states
- A state may implement a FQHC APM, as long as:
  1. total reimbursement is **at least equal to the PPS rate**
  2. each participating FQHC agrees
Instead of PPS, states may implement an Alternative Payment Methodology (APM) to reimburse FQHCs, as long as each affected FQHC agrees and total reimbursement is not less than it would have been under PPS.

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1Instead of PPS, states may implement an Alternative Payment Methodology (APM) to reimburse FQHCs, as long as each affected FQHC agrees and total reimbursement is not less than it would have been under PPS.
Key Steps for Health Center Engagement

1. Develop and maintain a robust understanding of payment reform efforts in the state and local environment.

2. Ensure a clear, shared vision of the organization’s role in achieving the Quadruple Aim that can be used to assess emerging payment reform opportunities.

3. Critically assess current operations and capabilities.

4. Work collaboratively with fellow health centers, stakeholders and partners to accelerate transformation of the health care delivery system.
Federal Payment Reform Landscape
CMS Initiatives

• **Affordable Care Act** gave structure to payment reform
• Created **Center for Medicare and Medicaid Innovation**
• **Broad authority to test new models**
  o Improve quality without increasing spending or decrease spending without impacting quality
• **Initiatives all over the country**
  o Accountable Care
  o Episode based payments
  o Primary care transformation
  o Medicaid and CHIP reforms
  o Delivery reform acceleration
  o Best practices
MACRA and the Quality Payment Program

• Needed a new *sustainable* update formula
• Combines several quality focused initiatives
  o PQRS, Physician Value Modifier, MediCARE Meaningful Use
• Medicare providers must choose **one of two tracks:**
  o Advanced Alternative Payment Models
  o Merit-Based Incentive Program (MIPS)
• Went live *January 1, 2017*, still much to learn
• **FQHC participation**
  o Limited to just those services billed to Part B, **NOT your Medicare FQHC PPS**
  o Option to **voluntarily report**
State Payment Reform Landscape
• **Use 1115 waivers to design system**
  - 33 states, 16 with waivers focused on payment and delivery reform

• **Provider-Based Regional Networks**
  - Examples: AL, CO, NY, OR

• **Accountable Care Organizations**
  - Examples: MA, MN, VT
PCMH-Based Approaches in Medicaid

• **Patient-Centered Medical Home Programs**
  – Directly w/ State or through MCO
  – Varying payment models

• **Section 2703 Health Homes**
  – Patients with chronic illnesses
  – Strong focus on behavioral health care, social supports and services
  – 20 states and DC

• **Multi-Payer Programs**
  – Multi-Payer Advanced Primary Care Practice (ME, MI, NY, RI, VT)
  – Comprehensive Primary Care Plus (OH)
Emerging FQHC Alternative Payment Methodologies (APMs)

- New Wave of FQHC APMs
- Intended to allow for more transformative use of the medical home and address provider burnout
- De-links payment from visit
  — PPS converted to a capitated per member per month (PMPM) rate
  — Example: OR, CA, WA, CO
AAPCHO’s APM Principles
AAPCHO’s APM Principles

• Developed in early/mid-2016
• Set of values that affirm focus and core reimbursement strategies of AAPCHO member clinics and patients.
• Principles work to ensure:
  • Health center model of care is protected
  • Health centers are adequately reimbursed for linguistically and culturally-appropriate care
  • There is room for innovations/shared savings.
AAPCHO’s APM Principles (continued)

- Protect the FQHC model of comprehensive primary care
- Innovate within the Federally Qualified Health Center (FQHC) model
- Ensure an effective bundle of culturally and linguistically appropriate services
- Include the patient in development of the model
- Pay adequately for enabling services
- Prioritize data collection
COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA USING PRAPARE TO REDUCE DISPARITIES, IMPROVE OUTCOMES AND TRANSFORM CARE

PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS’ ASSETS, RISKS, AND EXPERIENCES

© 2016. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or
1. Discuss the importance of addressing social determinants of health for improving patient and population health

2. Describe the PRAPARE protocol and how it can be used to support health center efforts in payment reform
PRAPARE WAS DESIGNED TO ACCELERATE SYSTEMIC CHANGE

- Individual level
  - Patient and Family
    - Empowered to improve health and wellbeing
  - Care Team Members
    - Better manage patient and population needs
  - Health Center
    - Design care teams and services to deliver patient/community-centered care
- Organizational level
  - Community/Local Health System
    - Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies
- System/Community level
  - Payment
    - Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)
- Payer level
  - State and National Policies
    - Ensure capacity for serving complex patients

for insured and uninsured patients
WHY COLLECT DATA ON SOCIAL DETERMINANTS OF HEALTH (SDH)?
SDH DRIVE OUTCOMES BEFORE PATIENTS RECEIVE CARE

Figure 1

A Framework for Health Equity

UPSTREAM

Discriminatory Beliefs (ISMS)
- Race
- Class
- Gender
- Immigration status
- National origin
- Sexual orientation
- Disability

Institutional Power
- Corporations & other businesses
- Government agencies
- Schools

Social Inequities
- Neighborhood conditions
  - Social
  - Physical
  - Residential segregation
  - Workplace conditions

SOCIAL FACTORS

Risk Factors & Behaviors
- Smoking
- Nutrition
- Physical activity
- Violence
- Chronic Stress

Disease & Injury
- Infectious disease
- Chronic disease
- Injury (intentional & unintentional)

HEALTH STATUS

HEALTHCARE ACCESS

GENETICS

Downstream

INDIVIDUAL HEALTH KNOWLEDGE

Medical Model

Socio-Ecological

How well do we know our patients?

Are services addressing SDH incentivized and sustainable?

Are community partnerships adequate and integrated?

WHY IS ADDRESSING SOCIAL DETERMINANTS OF HEALTH (SDH) IMPORTANT TO COMMUNITY HEALTH CENTERS?

1. Provide Better Care
2. Reduced Costs
3. Community Connection
4. Standardized data to see the big picture
**WHAT IS PRAPARE?**

**Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences:**

A *national standardized patient risk assessment protocol* designed to engage patients in assessing & addressing social determinants of health (SDH).

PRAPARE = SDH screening tool + implementation/action process

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Customizable Implementation and Action Approach

Assess Needs

→

Respond to Needs

At the Patient and Population Level
### PRAPARE DOMAINS

<table>
<thead>
<tr>
<th>Core</th>
<th>Optional</th>
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<tbody>
<tr>
<td><strong>UDS SDH Domains</strong></td>
<td><strong>1. Incarceration History</strong></td>
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<tr>
<td><strong>Non-UDS SDH Domains</strong></td>
<td><strong>3. Domestic Violence</strong></td>
</tr>
<tr>
<td><strong>(MU-3)</strong></td>
<td><strong>1. Safety</strong></td>
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<tr>
<td><strong>1. Race</strong></td>
<td><strong>2. Safety</strong></td>
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<td><strong>10. Education</strong></td>
<td><strong>4. Refugee Status</strong></td>
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<td><strong>2. Ethnicity</strong></td>
<td><strong>11. Employment</strong></td>
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<td><strong>3. Veteran Status</strong></td>
<td><strong>14. Stress</strong></td>
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<td><strong>6. Income</strong></td>
<td><strong>15. Transportation</strong></td>
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<td><strong>7. Insurance</strong></td>
<td><strong>16. Housing Stability</strong></td>
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<td><strong>8. Neighborhood</strong></td>
<td><strong>Spanish and Chinese (Mandarin) translated versions</strong></td>
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<td><strong>9. Housing Status</strong></td>
<td><strong>Find the tool at:</strong></td>
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<td><strong><a href="http://www.nachc.org/prapare">www.nachc.org/prapare</a></strong></td>
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WHAT MAKES PRAPARE UNIQUE AND FEASIBLE

- 17 core questions
  - 9 of which already collected by health centers through federal reporting (UDS)
  - All align with national initiatives

- Design
  - Vetted and stakeholder engaged development process
  - In the EHR to facilitate assessment & interventions (free templates)
  - Conversation starter and patient-centered
  - Common core yet flexible:
    - Able to make more granular and/or add questions
    - Focus on standardizing the need, not question
  - Can be used in combination with other tools/data
## PRAPARE Aligns with Other National Initiatives

<table>
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<tr>
<th>PRAPARE Domain</th>
<th>UDS</th>
<th>ICD-10</th>
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Also includes neighborhood and optional questions (incarceration history, refugee status, safety, domestic violence)
DATA ON SDH AND NON-CLINICAL INTERVENTIONS GO HAND IN HAND

**NEED**
- Standardized data on patient risk

**RESPONSE**
- Standardized data on interventions

**BOTH are necessary to demonstrate health center value**
### Enabling Services Accountability Project (ESAP)

The ONLY standardized data system to track and document non-clinical enabling services that help patients access care.

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<tr>
<th>CATEGORY</th>
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<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
<td></td>
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<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
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<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
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<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
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<td>OUTREACH</td>
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<tr>
<td>TRANSPORTATION</td>
<td>TR001</td>
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<tr>
<td>OTHER</td>
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WHAT WE’VE LEARNED FROM IMPLEMENTATION
PRAPARE PILOT TESTING
IMPLEMENTATION TEAMS AND
ELECTRONIC HEALTH RECORDS

Team 1
- OCHIN, Inc.
- La Clinica del Valle Family Health Center (OR)

Team 2
- Waianae Coast Comprehensive Health Center (HI)
- AlohaCare
- Altruista Health

Team 3
- Health Center Network of New York
- Open Door Family Medical Centers (NY)
- Hudson River Healthcare (NY)

Team 4
- Alliance of Chicago
- InConcertCare
- Iowa Primary Care Association
- Waikiki Health (HI)
- Peoples Community Health (IA)
- Siouxland Community Health Center (IA)

Other EHRs in Development or Interested:
- Greenway
- Allscripts
- Athena
- Cerner

PRAPARE templates exist for 4 common EHRs that are used by 58% of all health centers.
PILOT RESULTS

- Easy to administer
- Possible to implement using various workflows and staffing models
- Builds patient-provider relationship
- Identifies new needs
- Leads to positive changes at the patient, health center, and community/population levels
- Facilitates collaboration with community partners
PILOT DATA RESULTS

- SDH risks vary by community

- Most common risks*:
  - High stress
  - Having less than a high school education
  - Uninsured
  - Unemployed
  - Preference for language other than English

- But, patients are very socially integrated,
  - Half of patients see people they care about 5+ times a week

* Excludes low income
Patients experience multiple SDH risk factors (typically 4-7, excluding low income).

This health center pilot population had highest burden of chronic illness.

Percent of Patients with Number* of SDH “Tallies”

N = 2,694 patients for all teams

Tally Score

Alliance/Iowa: 3 CHCs
Waianae: 1 CHC
New York: 2 CHCs
Oregon: 1 CHC
Total: 7 CHCs

* Excludes low income.
POSITIVE CORRELATION BETWEEN SDH FACTORS AND HYPERTENSION: ALL TEAMS

\[ r = 0.61 \]
HOW PREPARE DATA HAS BEEN USED TO IMPROVE CARE DELIVERY AND HEALTH OUTCOMES

Better Understand INDIVIDUAL Patient’s Socioeconomic Situation

- Build services in-house for same-day use as clinic visit (children’s book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)

Better Understand Needs of Patient POPULATION

- Build partnerships with local community based organizations to offer bi-directional referrals and discounts on services (ex: Iowa transportation)

Drive STATE and NATIONAL Care Transformation

- Ensure prescriptions and treatment plan match patient’s socioeconomic situation
  - Guide work of local foundations (ex: New York housing)
  - Streamline care management plans for better resource allocation (ex: Hawaii)

- Inform both Medicaid and Medicare ACO discussions (ex: Iowa, New York)

- Create risk score to inform risk adjustment (ex: Hawaii)

- Inform payment reform and APM discussions with state agencies (e.g., Medicaid) on caring for complex patients (ex: Oregon, Hawaii)
PRAPARE IS A NATIONAL MOVEMENT

- Health centers and/or PCAs in every state have expressed interest in PRAPARE
- Health centers in over 30 states downloaded PRAPARE EHR Templates
- 7000+ hits on PRAPARE website
- Health and hospital systems are interested in PRAPARE
Chapter 1: Understand the PRAPARE Project
Chapter 2: Engage Key Stakeholders
Chapter 3: Strategize the Implementation Process

Chapter 4: Technical Implementation with EHR Templates
Chapter 5: Develop Workflow Models
Chapter 6: Develop a Data Strategy
Chapter 7: Understand and Evaluate Your Data

Chapter 8: Build Capacity to Respond to SDH Data
Chapter 9: Respond to SDH Data with Interventions
Chapter 10: Track Enabling Services
RESOURCES AVAILABLE NOW

- Visit [www.nachc.org/prapare](http://www.nachc.org/prapare)
  - PRAPARE Tool
  - PRAPARE Implementation and Action Toolkit
    - Electronic Health Record PRAPARE Templates
    - Readiness Assessment
  - Webinars
    - PRAPARE Overview
    - EHR and Workflow-specific
  - Frequently Asked Questions
  - Contact: Michelle Jester at mjester@nachc.org

- Visit [http://enablingservices.aapcho.org](http://enablingservices.aapcho.org)
  - AAPCHO’s Enabling Services Accountability Project
    - protocol for data collection of non-clinical enabling services
  - Enabling Services Data Collection Implementation Guide
  - White Papers, Best Practices, Studies
  - Contact Tuyen Tran at ttran@aapcho.org
Q&A

If you have not already submitted your questions, please do so now using the “Questions” field on your Control Panel and indicate to whom your question is directed.
Thank you!