FQHCs Are Expected to Participate in VBP: Are You Ready?

NACHC
FOM-IT
October 20, 2020

HOSTETLER GROUP

Why are VBP & VBC Gaining Traction?

HOSTETLER GROUP

FEE-FOR-SERVICE IS FLAWED

- Rewards volume without accountability to quality or cost
- Focuses work on the billable provider instead of the work of the team
- Doesn't reward continuity between the patient and provider
- Doesn't incentivize proactively managing patients
- Doesn't support improving care through risk stratification
- Doesn't incentivize provider organizations to work together
- Doesn't incentivize efficiencies in the health care system
- Hasn't sufficiently supported primary care and behavioral health integration
- However, FFS does track access to services and will have a role in VBP/VBC

Health Center Trend Summary

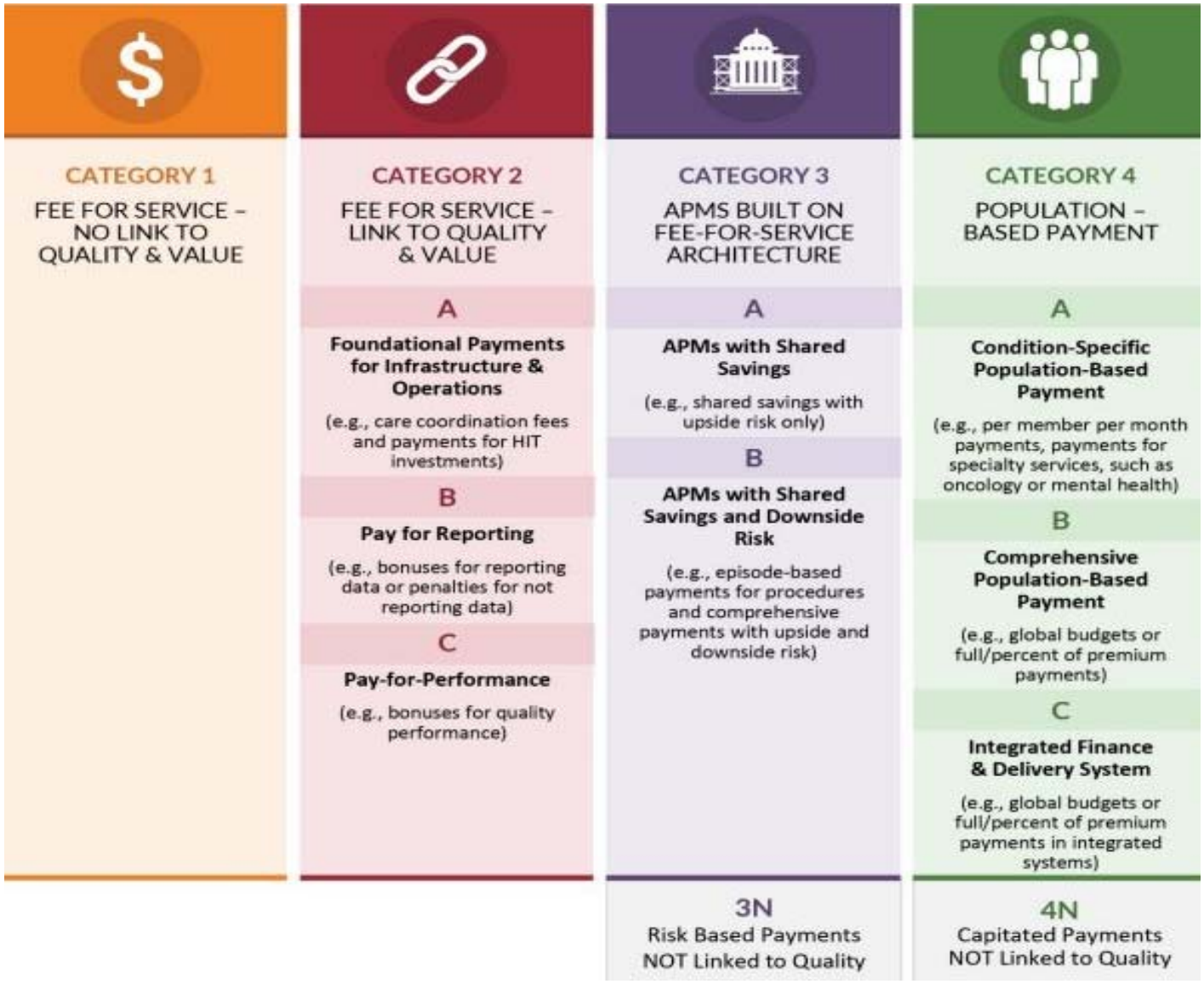
- It is hard to recruit providers, and not enough providers lowers revenue from visits
- Visits per provider per day and per year are declining, and lower provider productivity lowers revenue from visits
- Medicare & Medicaid rate increases of approximately 1.2% per year are not enough to keep up with provider compensation increases (10%), staff raises (3%), and inflation (2.2 %)
- Not enough pay for performance revenue to offset the decline in patient service revenue
- 330 grant is a constant dollar amount
- The financial benefit of Medicaid expansion has already occurred

Health Center Trend Summary

- Our electronic health record (EHR) specifically, and technology generally, keeps eating up a greater portion of our budget
- New staff (health coaches, referral coordinators) for better patient management are not billable
- Loan repayment program more difficult to qualify for

THERE IS A BETTER WAY

- Value-based pay (VBP) can align payment to support and reward better care
- Otherwise, there is no point to changing payment
- Although there are many pitfalls to current VBP arrangements, there is energy behind continuing to move from volume to value
- Capitation can offer flexibility to advance the care model and prepare for VBP…22 states are implementing or looking into capitated APMs for FQHCs
- There are some success stories in VBP of reducing costs and improving quality


CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE
CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)
B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance
(e.g., bonuses for quality performance)
CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE
A
APMs with Shared Savings
(e.g., shared savings with upside risk only)
B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N
Risk Based Payments NOT Linked to Quality
CATEGORY 4
POPULATION – BASED PAYMENT
A
Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)
C
Integrated Finance & Delivery System
(e.g., global budgets or full/percent of premium payments in integrated systems)
4N
Capitated Payments NOT Linked to Quality

Value-Based Pay Is Evolving

HOSTETLER GROUP

VBP is in the Eye of the Beholder

- Some define VBP as providers accepting downside risk
- Others count quality payment on top of FFS as achieving VBP
- HCP-LAN has provided some structure, but there is variation within each of the defined categories
- Many payers are starting with lower VBP categories with the intent of evolving towards higher levels

Barriers to VBP

- Attribution of patients
- Lack of resources to invest in transformation
- Data analytics capability at the clinic level
- Interoperability
- Lack of staff time
- Insufficient transparency between payers and providers
- Different numerators and denominators for performance measures among payers
- Whether performance measures can be impacted by primary care
- Unrealistic timeframes to move metrics
- **Lack of adequate risk adjustment for behavioral health and SDoH barriers**

DESPITE VBP ISSUES, IT WILL BE COMING TO A THEATRE NEAR YOU

Implement	States want to implement VBP, but often short on specifics
Targets	Some are setting targets for a % of provider payment in VBP
SDoH	Many want more SDoH interventions
Behavioral Health	There is increasing interest for VBP in behavioral health
Participate	States are/were participating in DSRIP, SIM, PCMH… with an emphasis on VBP/VBC
Focus on High Risk	Payors are becoming more interested in VBP for high risk populations

CMS Payment Reform Letter 9-15-20

- Promotes use of capitated payments, citing this shift during the pandemic
- Providers taking on down-side risk is critical, although CMS was concerned that some providers didn't have the capacity to take on risk
- Encouraged states to shift from voluntary to mandatory VBP models
- Used HCP-LAN definitions
- CMS acknowledged that what works for one state doesn't necessarily work for another

HOW WILL COVID IMPACT VBP/VBC

- A lot of flexibility for FQHCs getting paid for alternative visits - telehealth video visits and telephone visits
- MCOs and states are working with FQHCs on temporary capitated payments or paying revenue equivalent to 2019
- The impact on state VBP efforts are yet to be seen
  - CMS flexibility, the recent CMS letter to Medicaid Directors and State FFS views could lead to acceleration of VBP
  - Countered by COVID-19 focus and fiscal impact on the State/providers & quality and cost metrics are skewed in 2020

Capabilities Needed for VBP

HOSTETLER GROUP

CAPABILITIES NEEDED FOR VBP

- Patient-centered, team-based care has become the baseline
- Population health approaches to care delivery, whole person care
- Integration of medical, behavioral health and oral health services
- Evidence-based & innovation (e.g., testing SDoH interventions)
- Care coordination/care management, particularly for high risk pts
- Tracking and moving cost, quality and access metrics
- Open access
- Better data, including SDoH & data analytics
- Finance departments know costs, evaluate VBP opportunities and risk
- Culture of quality

FFS with Link to Quality and Capabilities Needed

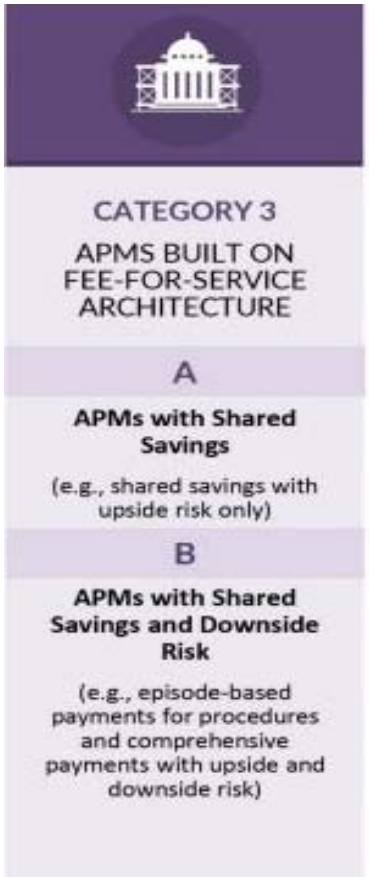
2A
- **Time to play**: build PCMH & BHH capabilities, like care coordination, IT capabilities, data & analytics, leadership

2B
- Ability to capture and report data, usually quality metrics. SDoH is important for vulnerable populations, think about data for risk adjustment

2C
- QI & chronic disease management programs
- Registries and performance dashboards
- Patient experience performance reporting
- Data security infrastructure
- Financial and payment performance modelling
- Aligned incentive performance payment programs
- Cultural alignment with quality
- Change management expertise
- Adaptive reserve

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

APMs Built on FFS Architecture and Capabilities Needed

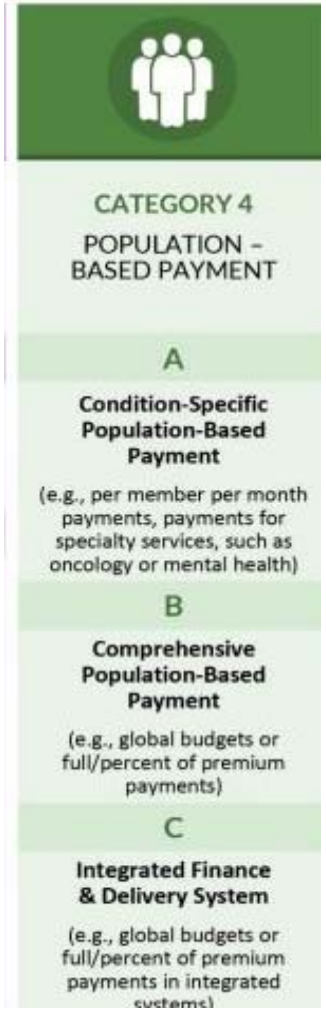


3A
- Master care coordination
- Set quality and utilization benchmarks and standards
- Establish clinical protocols and coordinated workflow processes
- Population health capabilities (e.g., risk stratification)
- Alternative visits

3B
- Care management capabilities, especially high risk
- Targeted disease management
- Medical oversight of coordinated care and disease management programs

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

Population-Based Payment and Capabilities Needed



In 4B & 4C, you need

- Utilization management and review
- Pharmacy benefits management
- Prevention and wellness programs
- Actuarial analytics & predictive modelling
- Payment processing and claims adjudication
- Underwriting
- Reinsurance
- Reserves maintenance

4N isn't VBP, but can offer flexibility to evolve care transformation. Need to know your costs.

Utilized information from the AHA TrendsWatch report & RevCycle Intelligence, Value-Based Care News

Change care and listen for the effects.

- Whole person and family care
- New team roles, including response to social factors
- Team members work at top of license
- Integrated and trauma-informed approach
- New workflows and clinical processes that integrate new team members

- Care management infrastructure for complex care needs
- Community and public health partnerships
- Trauma-informed approaches that integrate behavioral, medical and social services
- Partner with patients to educate on PCPCH access and services

- Therapeutic alliance to understand whole person priorities
- Motivational interviewing to empower and support patients
- Human-centered design to create patient-driven care transformation
- Focus on and document patient medical, behavioral and social priorities and strengths, as well as needs

- Access to wellness care, not just sick care
- New models for group and technology supported interactions
- Care and services offered outside of clinic walls
- Team-based approach to providing continuity
- Reportable documentation of all access and enabling services
- Co-design new access models with patients

- Team-level
- Population health management that reflects whole person priorities
- Identify disparities and use QI to improve equity
- Trauma-informed and patient-centered approach to social determinants of health data collection and use
- Organizational data analytics strategy and capacity

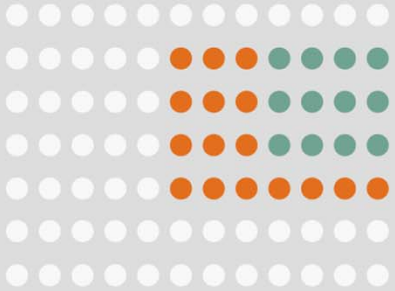
Listen to your data.

10,000 PEOPLE
POPULATION

Use analytics to piece together target population characteristics.

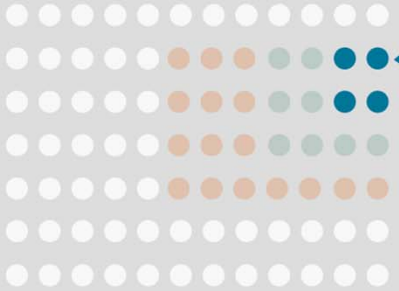
May require multiple data sources and analytic processes.

SUB-POPULATION(S)



- 834 diabetics
- 223 with HbA1c >9

TARGET POPULATION



- 56 out of the 223 diabetics with HbA1c >9 who also:
  - Missed 2 appointments in the last 6 months
  - Live below 100% FPL
  - Are non-native English speaker
  - Have a co-occurring mental health diagnosis
  - Did not graduate from high school

Understanding Their Needs

- Empathic inquiry and community data ***(PRAPARE)***

Responding to Their Needs

- Redesigning care teams
- Developing strong community partnerships
- Expanding social determinants of health/upstream interventions

Demonstrating Impact

- Metrics of success
- Understanding cost and ROI

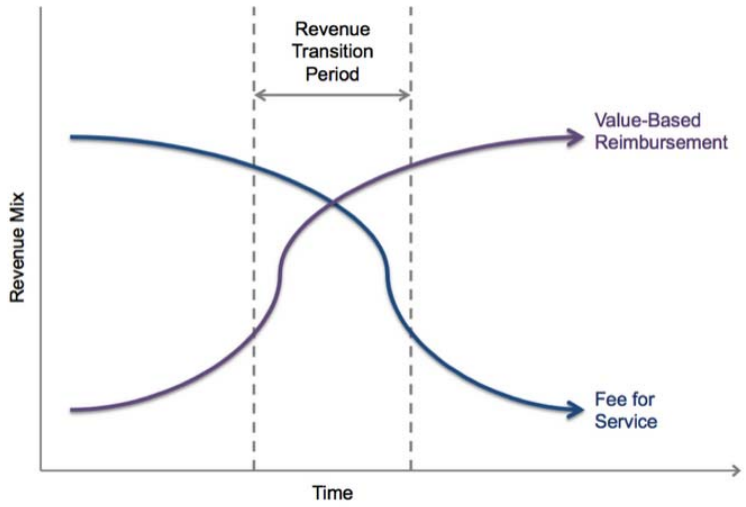
Transitioning Payment

HOSTETLER GROUP

OPCA
Oregon Primary Care Association

TRANSITIONING TO VALUE-BASED REIMBURSEMENTS

- This graph makes this transition process look simple, but it belies the complexity in moving to payment for value.
- It is critical to address the complexity appropriately in order to:
  - » Improve outcomes instead of maintaining the status quo.
  - » Avoid creating scenarios that continue to incentivize visit-based medicine.
  - » Avoid destabilizing the delivery of critical health care services to vulnerable population.

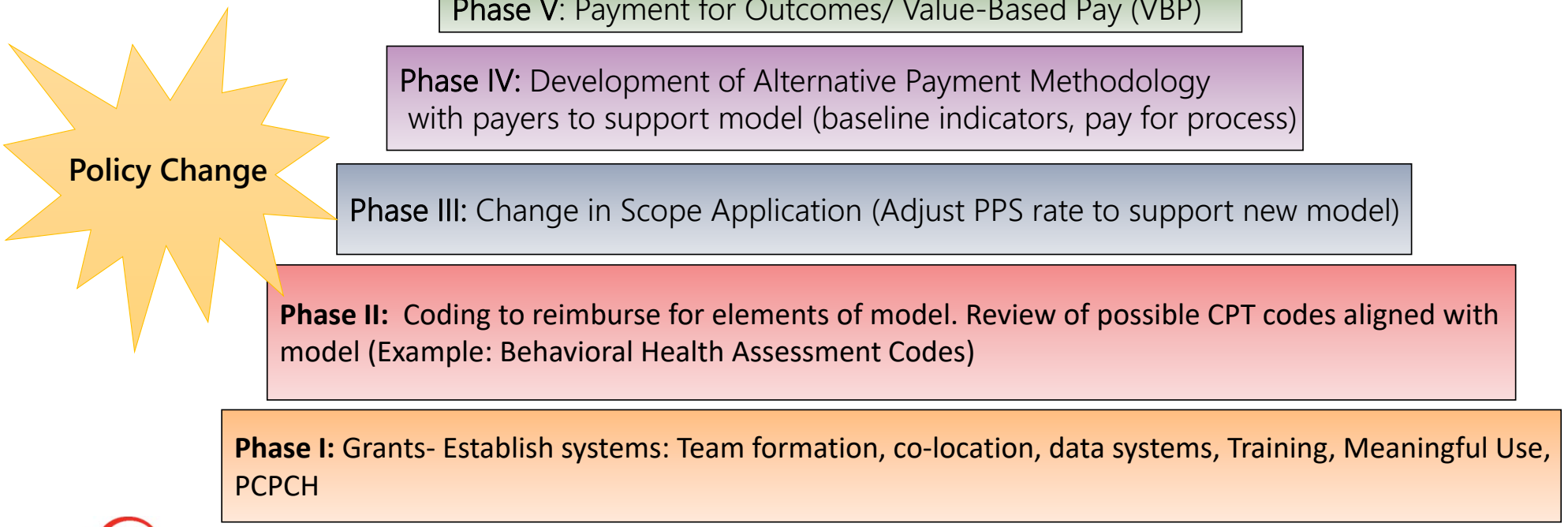


Source: https://www.healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements

BALANCING BETTER CARE WITH BOTTOM LINE

- Providers that move too quickly into VBC can impact viability by
  - Decreasing FFS revenue
  - Investing more in care transformation than payers are willing to reimburse for
- VBC is different depending on the populations you serve
  - Payers are starting to understand this and talk about flexibility

BUILDING THE FINANCIAL FOUNDATION FOR PATIENT-CENTERED PRIMARY CARE



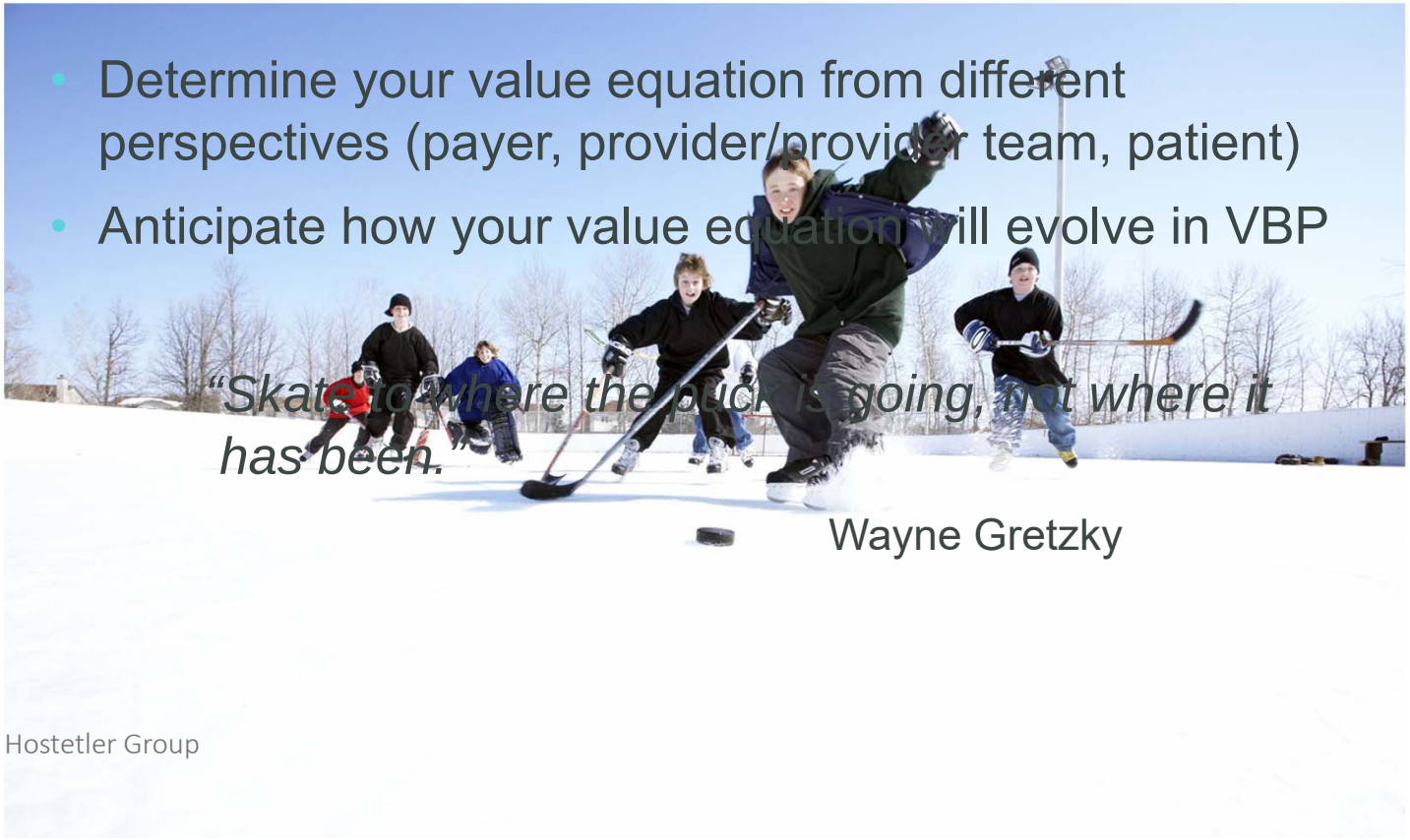
Preparing for VBP

HOSTETLER GROUP

DEVELOP A GAME PLAN

- Establish a high-level strategy and process for preparing FQHCs for payment reform and practice transformation
- Take the lead in shaping VBP for the populations HCs serv
- Not a static document, it should evolve over time as the health care environment changes
- Become part of HC staff work plans in order to sustain momentum

DEFINE YOUR VALUE EQUATION



- Determine your value equation from different perspectives (payer, provider/provider team, patient)
- Anticipate how your value equation will evolve in VBP

"Skate to where the puck is going, not where it has been."

Wayne Gretzky

Know Your Data

- Services
  - Billable and non-billable
  - Accurate coding
  - Medical, dental, behavioral health (incl
- Patients
  - Medical, dental, behavioral health nee
  - SDoH barriers
- Innovation
  - New forms of access (e.g., e-consults,
  - SDoH interventions

IMPROVE CARE

- Data analytics & actionable data at the team level
- PCMH has become the baseline
- Integrate medical, behavioral health, oral health
- Population health approaches to care delivery
  - Segment Populations
  - Test SDoH interventions
  - Care management
  - Holistic customer orientation
- Move cost, quality and access metrics important to payers, providers, patients (TCOC data hardest to get)

EXAMPLES OF THE CHANGING FINANCE ROLE UNDER VBP

- Understand your costs for billable and non-billable services
- Be able to identify costs associated with VBP opportunities
- Evaluate risk tolerance
- Move from budgeting/tracking visits/day to value metrics
- Provider team performance incentives move from volume to value
- CFOs and CMOs goals should be better aligned
- Navigate FFS and VBP payment methodologies
- Attribution is key and will impact revenue in VBP & PMPM arrangements

BUILD A BRIDGE TO VBP

- Assess your health center's readiness for payment reform
- Develop flexibility through capitation
- Improve care and populate your HC value equation with data
- Align payment to support care transformation
- Determine the right level of risk to support your care transformation goals
- Collect data to make your case for risk adjustment for behavioral health and SDoH

Opportunity

- VBP seems to be here to stay
- However, VBP is evolving
- You have an opportunity to lead

QUESTIONS?

Craig Hostetler, Principal
Hostetler Group, LLC
503-913-6916
craig@hostetler-group.com

HOSTETLER GROUP