Health Center Considerations

. . . In Federal Value-Based Care Initiatives

Audience Participation

Chat

Talk with peers

Q&A

Ask questions to panelists

Jason T. Fournier	
President & CEO	**Central Texas Community Health Centers**

Jonathan Gonzalez-Smith	
Research Associate	**Duke-Margolis Center for Health Policy (Washington, DC)**

Jessamy Taylor	
Public Health Lead	**Bureau of Primary Health Care (HRSA)**

Shannon McDevitt	
Federal Partner Lead	**Initiative to Strengthen Primary Care (HHS)**

→ → **Discussion, Questions, and Answers with all 4 Panelists**

CEO of CommUnityCare Health Centers (The Largest FQHC in Texas)

Jaeson T. Fournier DC, MPH

Prior Work

- CEO of West Side Community Health Services:
  - A not-for-profit FQHC in St. Paul, Minnesota
  - Formed and operationalize the **nation's 1st FQHC-led Medicaid ACO**
- Deputy Health Officer at the Ingham County Health Department:
  - A public sector FQHC in Lansing, Michigan
- CEO of Greater Elgin Family Care Center:
  - A not-for-profit FQHC in Elgin, Illinois
- Expert consultant for Arizona State University's RWJF-supported **National Safety Net Advancement Center**

Health Center Innovator

Value-Based Care Considerations

Jaeson T. Fournier, DC, MPH
President & CEO
Central Texas Community Health Centers
Dba CommUnityCare

Perspective from Austin, Texas

Need for Change in Health Care – Consistent with Other Markets!

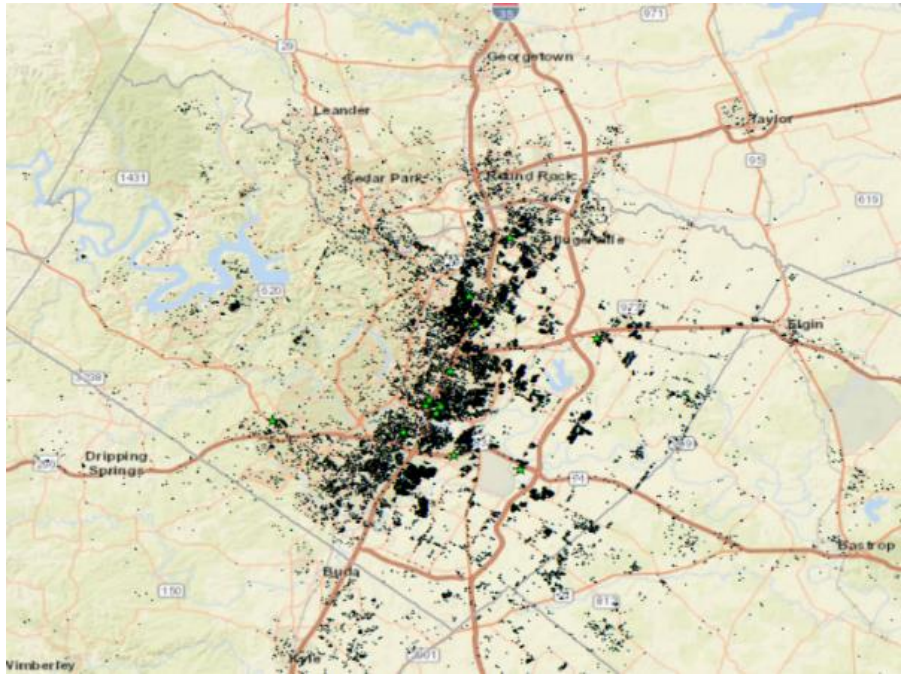
- A complex, fragmented, and confusing system
- Disparate systems challenge care coordination & care management
  - Separate funding streams and eligibility criteria for people/services combos
- Very little coordination + Very little or no incentive to limit care
- Inadequate data to assess cost-effectiveness, cost growth, or utilization trends
- Variations in care with no apparent benefits

But we, as health centers have limited resources, right!

The Why?

- Value-Based Care's (VBC) primary objective is to improve patient's health, patient satisfaction and outcomes, while lowering costs.
  - Sounds good, right?

- But what if VBC is actually a way to achieve greater **health equity** for our patients and our communities by allowing us as health centers to enhance our focus.



125,000 ≠ **210,000**

1 Year of Patients

3 Years of Patients

What is your health center's outcome time horizon?

Our Motivators as Health Centers

Extrinsic

- Increased competition – default provider to **provider of choice**.
- Increasing pressure from payers.
- Weak unadjusted clinical outcomes compared to costs/spending = Unsustainable cost growth
- Increasing disease burden

Intrinsic

- Desire to stay relevant in dynamically changing market plan
- **Care Transformation**
- Reduce health disparities and increase health equity for our patients/communities
- Opportunity to leverage needed resources for populations served.

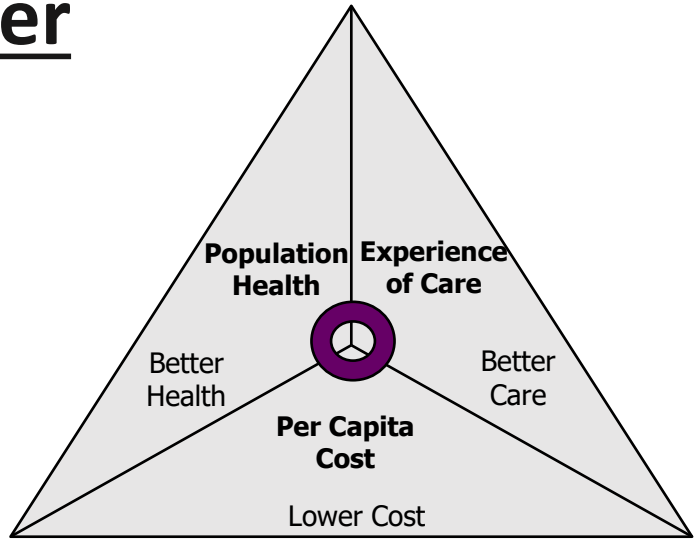
Both Extrinsic and Intrinsic

- Better access to clinical information and related insights across stakeholders leads to
  - Analyses that can identify **interventional opportunities**.
- Financial Constraints/Pressures
- Service Delivery Constraints/Pressures
- Community expectation for increased **health equity**, esp. for minority and underserved individuals

Critical Components needed for a High Value Health Center

Triple Aim + 2:

1. Reduced total cost of care
2. Improved clinical quality
3. Improved patient and family satisfaction
4. Emphasis on primary care services and relationship
5. Enhanced care coordination and patient activation



3 Key Elements for Success:

1. Population health management infrastructure and robust data analytics.
2. Performance improvement & clinical transformation that is patient centered, quality focused, and team based
3. Care coordination across care settings:

   including **care transition** and **ED follow-up**

2. Clinical transformation:
Drives measureable results

Leadership:
Drives operating discipline

1. Population health management infrastructure:
Provides clinical intelligence

3. Reinvigorated care coordination:
Manages across care settings

High Reliability Health Center = High Value

CommUnityCare HEALTH CENTERS

Key Considerations in Navigating the Path from Volume → Value

- Is the primary driver about **shifting risk** to Health Centers and our clinical care teams from payers without needed resources? Is **cost containment** the prime motivator driving "accountable / value-based care?"
- Is there **alignment** among payers about attribution, quality measurement, stratification, etc?
  - if not, this will complicate things for health centers as we move forward.
- Will value based initiatives "compensate" health centers for innovation and modeling that generates **long-term savings**?
- Data informing clinical care initiatives must be **actionable** and **timely**.
- Can you **activate your patients** further into their care?
- **Recognition of effort** to sustain savings achieved?
- Obstacle: Lack of long-term view and emphasis on population health – **time horizon**.
  - How do you approach this as part of your negotiations?
- How do you account for something that used to occur or would have occurred ***were it not for your health center's efforts*** as a result of successful VBC initiatives?

The Opportunity that Lies Beneath Medicine's "Iceberg Problem"

- Clinical Disease: Demands majority of care team's effort.
- Represents ***clinical*** epidemiology.

- Pre-clinical Disease: As much as **70%** of tomorrow's high-need, high-cost patients are not yet known
- To manage risk and achieve value, a health center should be able to identify, stay in touch with and improve the health of **rising risk patients**
- Represents ***population-based*** epidemiology

"**FFS** does not promote efficiency, nor does it promote equity."
The Case for ACOs: Why Payment Reform Remains Necessary – January 24, 2022
https://www.healthaffairs.org/do/10.1377/forefront.20220120.825396/

OR

FFS / PPS allows us to maintain our mission … maybe?

VBC rooted in population health management can accelerate achieving HEALTH EQUITY!

Which Game does your Health Center want to play?

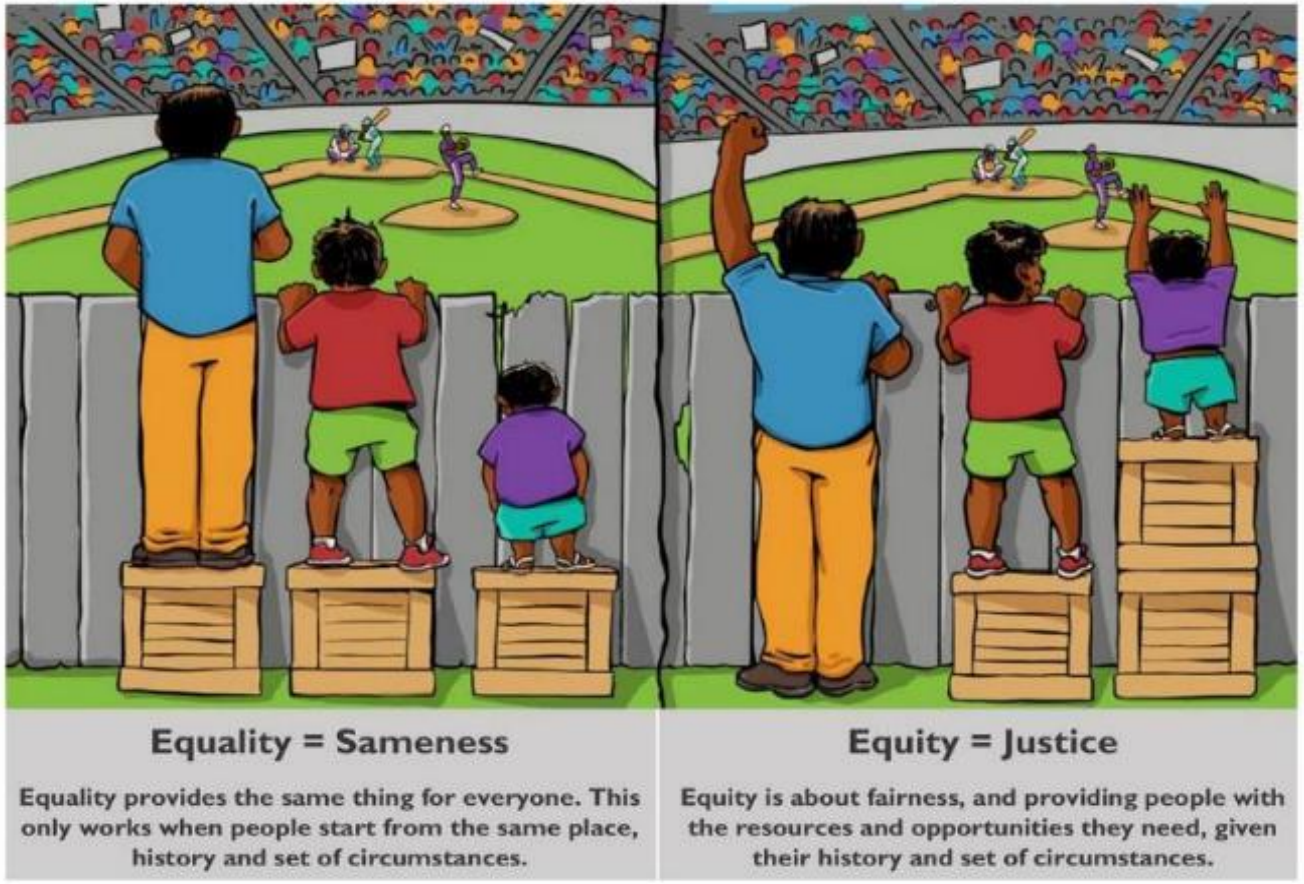
CommUnityCare HEALTH CENTERS

CommUnityCare Mission:

To strengthen the health and well-being of the communities we serve.

CommUnityCare Vision:

Striving to achieve health equity for all by: (1) being the health care home of choice; (2) being a teaching center of excellence; and (3) providing the right care, at the right time, at the right place.



Research Associate
Duke-Margolis Center for Health Policy

Jonathan Gonzalez-Smith MPAff

Helps Lead Duke-Margolis's Work on:

- Health financing
- Payment and delivery reform
- International models of accountable care

Jonathan's Research Evaluates How to:

- Support health system transformation
- Achieve better population health
- Promote efficiency, equity, and high-quality care

Recent Projects

- Analysis of domestic and global payment reform efforts to support value-based health care models in **response to COVID-19**
- The impact of CMS' value-based programs on small, physician-led **ACOs**
- Multi-stakeholder collaboratives with policymakers, health care leaders, and practitioners to identify and disseminate best practices for **advancing value-based health care models** in the U.S. and internationally

Health Financing Research

Value-Based Payment Models and Community Health Centers: Opportunities, Challenges, and Policy Directions

Jonathan Gonzalez-Smith, MPAff
Research Associate
Duke-Margolis Center for Health Policy, Washington, DC

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"America's health care safety net is a patchwork of providers, funding, and programs tenuously held together by the power of demonstrated need, community support, and political acumen."

Just like a net, the safety net has holes.

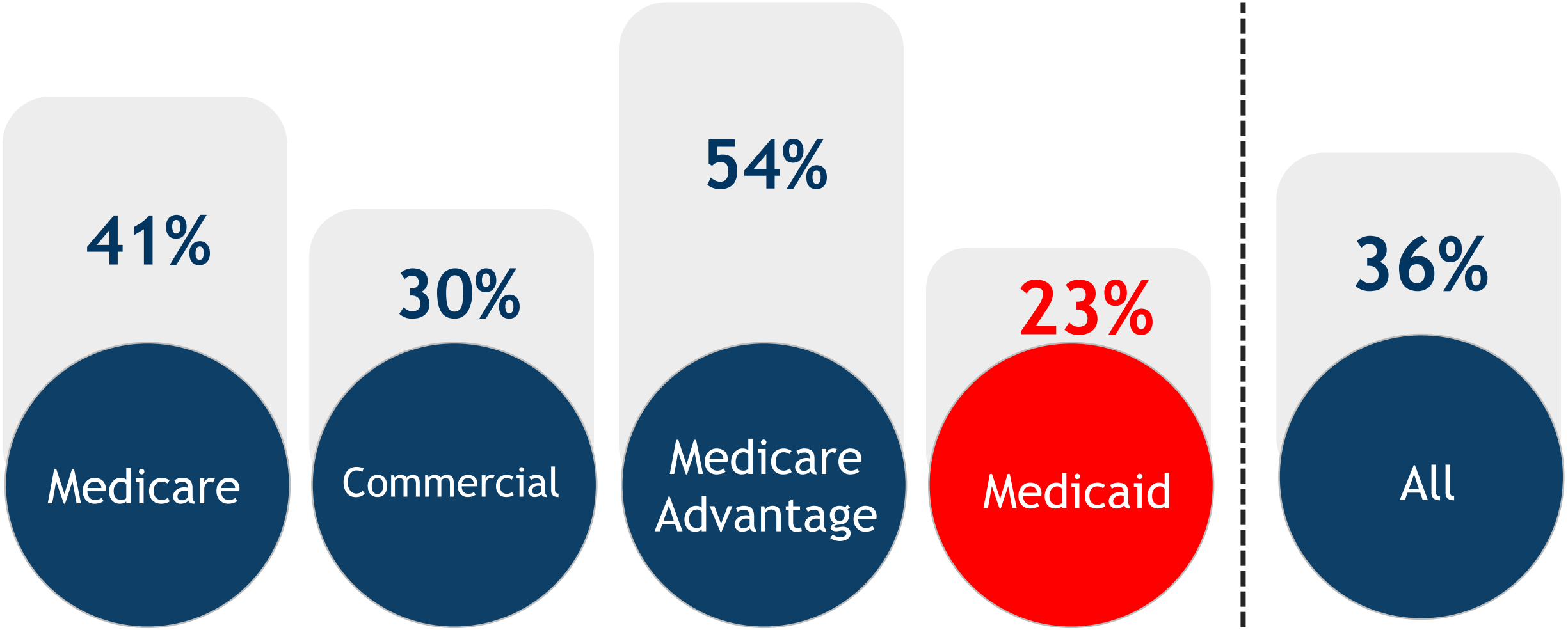
Source: Institute of Medicine. *America's Health Care Safety-Net: Intact But Endangered*. (2000)

*Slide borrowed from Dr. Pam Silberman and Dr. Becky Slifkin: "The safety net and the Indian Health Service."

Challenges with Current Payment Approach

- Existing payment models generally do not account for the unique challenges faced by safety net providers
- Current limitations:
  - ❑**What** services are offered (“medically necessary primary health services”)
  - ❑**Who** can provide those services (CHC practitioner)
  - ❑**When** those services can be offered (e.g. # of billable visits in the same-day)
- This can *impede* **access**, **care coordination**, and **integration**

Uptake of Value-Based Payment Models



HCP-LAN. 2019 APM Measurement Effort. Oct 2019. *Share of payments in "advanced" alternative payment models* (**LAN categories 3B and 4**).

Duke | MARGOLIS CENTER *for* Health Policy

Challenges With CHC VBP Adoption

CHC participation in VBP models remains limited due to:

- **Unique funding streams**
- **Regulatory Challenges**
  - States can use different systems if:
    1) No lower than PPS rate *and*
    2) Mutually agreed upon by FQHCs
- **Limited capital and resources to build infrastructure**

Biden Administration Health Policy Priorities

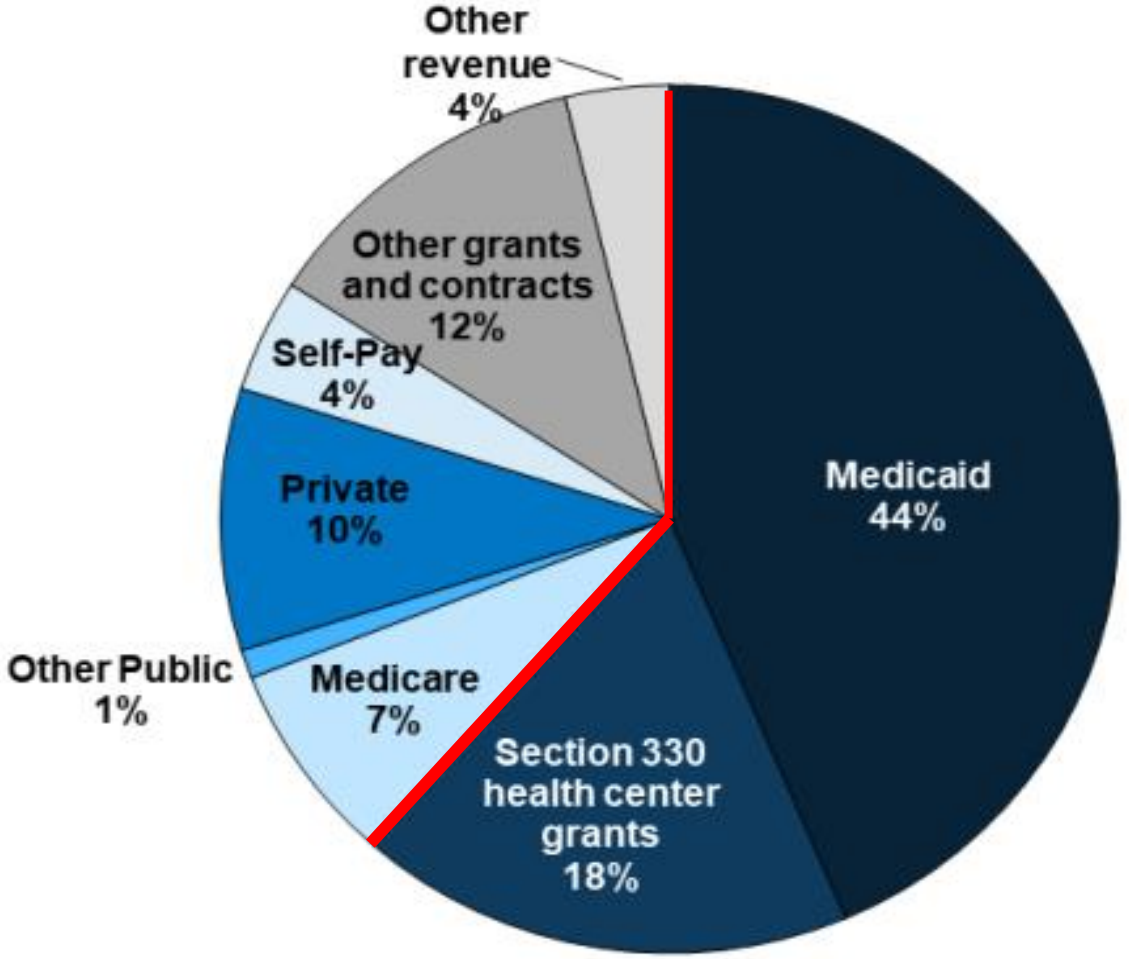
- **Medicaid reforms** that prioritize **health equity** in model development and evaluation
- Encourage **broader safety-net involvement** in value-based and patient-centered care
- **Harmonizing goals**, **metrics**, and **strategy** among health agencies
- CMS and CMMI expressed support for **integrating safety-net institutions** into **broader CMS value-based payment programs**

CMS Emphasized Commitment to Payment Reform in Its New Vision

Medicaid Is Important for Payment Reforms, But Many Sources of Funds to Integrate

- Nearly **two thirds** of revenue comes from **Medicaid** and **Section 330 grants**
- Unique payment model
  - *Medicare*: Prospective cost-based rate
  - *Medicaid:* Cost-based method or an alternative Prospective Payment System (PPS)

Sources of health center revenue, 2017



Total revenue = $26.3 billion

SOURCE: Figure from Kaiser Family Foundation. Bureau of Primary Health Care. (2018). 2017 Health Center Data: National Data. HRSA. Available at: https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief/

Opportunities for Non-Medicaid Patient Populations and FQHC-VBP Reform

While Medicare beneficiaries comprise a smaller portion of FQHC patients, their population size **continues to grow**.

FQHC Patients (National)	2017	2018	2019
Total Medicare Patients	**2.5 million**	**2.7 million**	**2.9 million**
% Medicare Patients	**9.4%**	**9.7%**	**9.8%**
Total Dual-Eligible	**1.03 million**	**1.06 million**	**1.1 million**

- Nationally **23%** of FQHC patients are uninsured, and
- 330 Grants are mostly out of scope of current VBP reform efforts

Other Activities to Advance Care Reform

- **State actions**
  - ❑ Medicaid ACOs
  - ❑ 1115 Waivers
  - ❑ Managed Care
- **Health Care Payment Learning & Action Network** - Public-Private Collaboration to Advance Payment and Care Reform
- **HRSA – Quality Improvement Awards**

Opportunities and Challenges for Implementing FQHC-VBP Models

Opportunities

- Momentum for health transformation and promoting health equity
- Aligning quality metrics and goals among payers
- Providing up-front capital to help FQHCs build infrastructure and VBP competencies

Challenges

- No “one size fits all” solution
- Patient attribution
- Risk adjustment
- Coordinating physical and behavioral health
- Confusion around whether FQHCs can legally take on downside risk
  - All payments must remain above PPS rates

Key Takeaways

- The current payment system does not support CHCs in delivering more effective care
- Value-based payment models can help lead us to a more efficient health care system
- VBP can help safety-net organizations, including CHCs
- States and the federal governments should collaborate to help move Medicaid and Medicare funded CHCs to VBP

Thank You!

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Lead Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care (HRSA)

Jessamy Taylor

Prior Work for HRSA

- Office of Planning, Analysis, and Evaluation
- Office of the Administrator
- Federal Office of Rural Health Policy (FORHP)

Prior Work for HHS

- Office of the Assistant Secretary for Program & Evaluation (ASPE)
- Office of Legislation

Policy Research and Partnership Building

- National Health Policy Forum (George Washington University)

Federal Partner

HRSA
Health Resources & Services Administration

Value-Based Care Delivery and the Health Center Program

National Association of Community Health Centers Policy & Issues Forum

February 16, 2022

Jessamy Taylor
Lead Public Health Analyst, Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People

Why Value-Based Care Delivery?

Current volume-based, face-to-face visit and payment system

- Creates vulnerabilities as seen with COVID-19
- Pays for volume of services, not quality of care
- Contributes to provider burn out

Value based payment

- Allows providers to meet the medical and social needs of patients to **advance health equity**
- **Builds provider resilience** by enabling more team-based care and time with patients
- Prepares health centers financially to **weather future public health emergencies**
- **Improves consumer experience and health outcomes**

Program Efforts to Support Health Center Participation

Health information technology and data infrastructure and capacity building

- FY 2016 Delivery System Health Information Investment
- Meaningful use participation
- Health Center Controlled Networks
- Health Information Technology, Evaluation and Quality Center (HITECH) NTTAP
- Primary Care Associations

Accreditation and Patient-Centered Medical Home Recognition Initiatives

Alignment of clinical quality and performance metrics with electronic clinical quality measures

Supporting Value through Grant Funding

- Paying for performance through **Quality Improvement Awards** (FYs 2015-2020)
- Quality Improvement Fund (FY 2022) to test new care delivery models to improve quality and equity
  - ✓ Optimizing Virtual Care one-time funding (FY 2022) to develop, implement, and evaluate innovative, evidence-based strategies
- Service Area Needs Assessment Methodology
  - ✓ Unmet Need Score and Service Area Status Score
- Advancing Health Center Excellence Framework for a holistic view of health center performance and to target support as needed
- **UDS+** patient-level data to facilitate targeting quality improvement and equity efforts
- Fund **T/TA partners** to support health centers demonstrating readiness to engage in value-based care delivery

Interagency Collaboration within HHS

CMS Innovation Center 2021 Strategy Refresh:

- ❑ Drive Accountable Care
- ❑ Advance Health Equity
  - ✓ **All new models will include safety net providers** such as community health centers
- ❑ Support Care Innovations
- ❑ Improve Access by Addressing Affordability
- ❑ Partner to Achieve System Transformation

OASH leading development of HHS Initiative tied to National Academy of Sciences, Engineering, and Medicine report "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care"

Thank You!

Jessamy Taylor

Lead Public Health Analyst, Office of Policy and Program Development

Bureau of Primary Health Care (BPHC)

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Federal Partner Lead
Initiative to Strengthen Primary Care
Office of the Assistant Secretary for Health

Shannon McDevitt, MD, MPH

Board Certified Family Physician

- Doctor of Medicine from Wayne State University School of Medicine (Detroit)
- Residency training at Moses Cone Memorial Hospital
- Fellowship at the University of Pittsburgh Medical Center-St. Margaret

Expertise

- Quality improvement
- Workforce development
- Population health

Federal Policy Experience (HRSA)

Office of Policy and Program Development (Bureau of Primary Health Care)

- Developed and led the implementation of several funding opportunities
- Advanced of numerous Administrative priorities:
  - COVID-19 response
  - HIV and the opioid epidemic
  - Health information technology and integrated practice models
  - Precision medicine
  - Healthy People 2030

Federal Policy Leader

Initiative to Strengthen Primary Health Care

National Association of Community Health Centers: Policy and Issues Forum

February 16, 2022

Shannon McDevitt, MD, MPH
Federal Partner Lead
HHS Initiative to Strengthen Primary Health Care
Immediate Office of the Assistant Secretary for Health

OASH Office of the Assistant Secretary for Health

Initiative to Strengthen Primary Health Care: Overview

Launch

- September 2021 by the Office of the Assistant Secretary for Health (OASH)
- Initiative Lead: Judith Steinberg, MD, MPH, Senior Advisor, OASH
- Strengthening primary health care is essential to achieving US Department of Health and Human Services (HHS) priorities and goals

Aim

- Provide a federal foundation to strengthen primary health care for our nation that will ensure high quality primary health care for all, improve health outcomes, and advance health equity

Initial Task

- Develop HHS Plan to Strengthen Primary Health Care
- Submit to Secretary Becerra - target delivery date in **June 2022**

Health Centers Are Important Partners

Health center model foundation is community-oriented primary care

- Community board
- Interdisciplinary teams
- Integrated services
- Screening for and addressing social determinants of health

OASH Primary Care Team engaged NACHC, PCAs, Health Centers, other stakeholders

NASEM report recommends:

- Increases in health centers and Teaching Health Centers
- Hybrid payment model
  - Provides an on-ramp to value-based care
  - Leverages positives of fee for service and capitation models

National Academies of Science, Engineering, and Medicine (NASEM) Report: *Implementing High-Quality Primary Care*

NASEM May 2021

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

NASEM Report Domain Goal States

Payment	Pay for primary care teams to care for people, not doctors, to deliver services
Access	Ensure that high-quality primary care is available to every individual and family in every community
Workforce	Train primary care teams where people live and work
Digital Health	Design information technology that serves the patient, family, and interprofessional care team
Accountability	Ensure that high-quality primary care is implemented in the United States

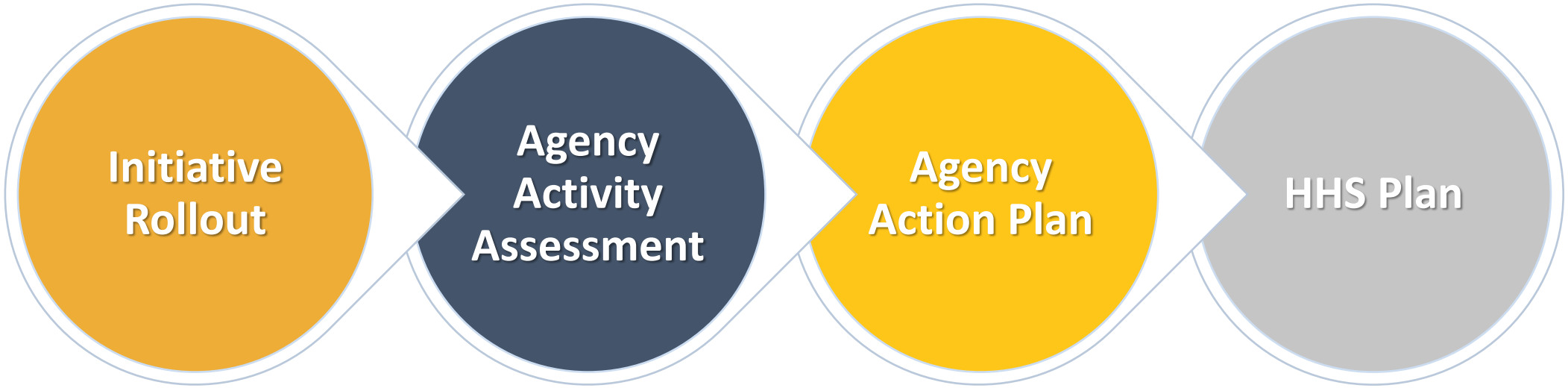
Example NASEM Report Recommendations for HHS Agencies

Agency	Example Actions from NASEM Report
AHRQ	• Expand primary care research through the National Center for Excellence in Primary Care Research
CMS	• Move to value-based, prospective payment for primary care • Increase proportion spent on primary care • Revise approach to graduate medical education funding to support community-based, interprofessional teams
HRSA	• Expand number and locations of health center sites • Expand and revise HRSA Workforce Programs – workforce shortage, interprofessional teams
IHS	• Expand number and locations of IHS sites • Workforce development, integration of care services, improving access
NIH	• Form an Office of Primary Care Research
ONC	• Advance EHR standards to support model of primary care • Expand interoperability to support patient centered coordinated care

Examples of Actions by Additional HHS Agencies

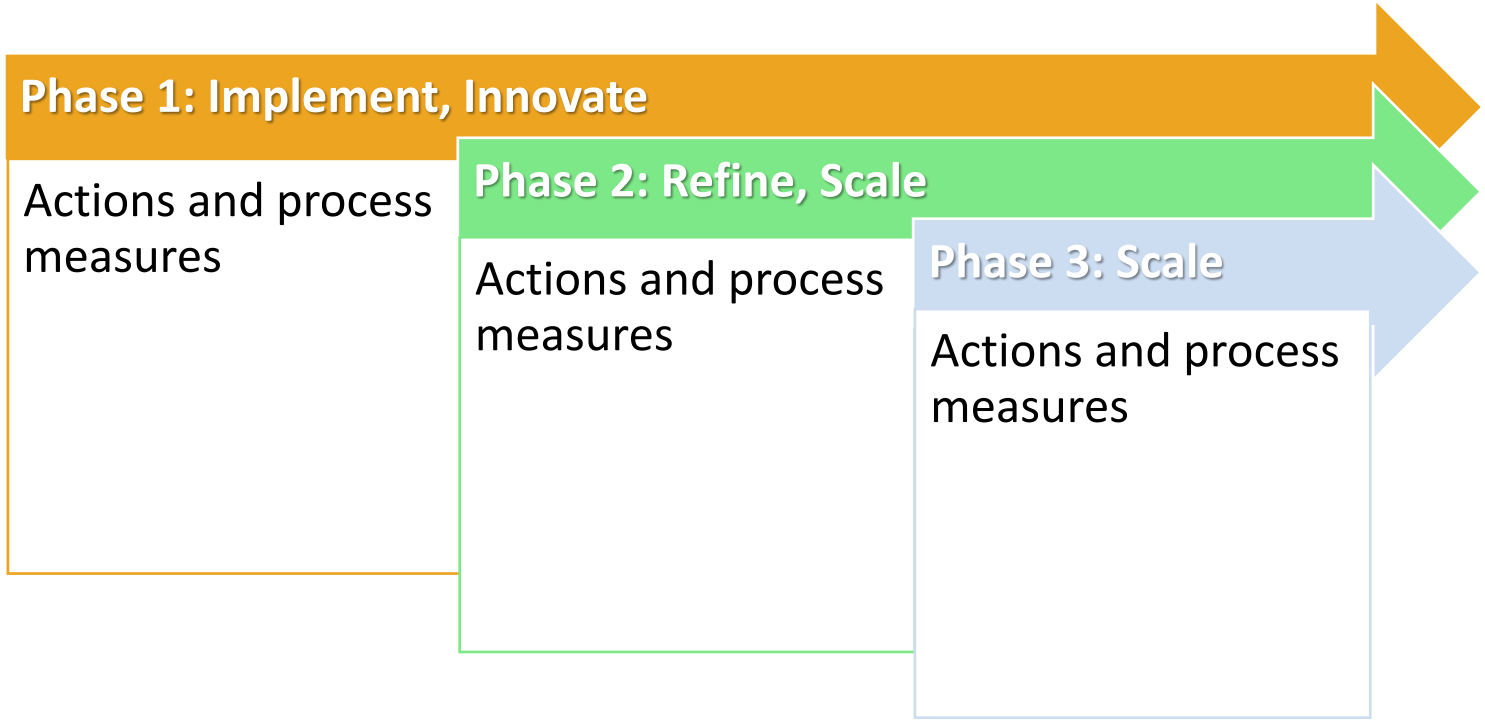
Agency	Example Actions
ACF	• Build and expand primary care partnerships to encourage strong, healthy, and supportive communities
ACL	• Build and expand primary care partnerships to encourage all individuals to live independently and participate fully in their communities
CDC	• Advance the integration of public health and primary care
SAMHSA	• Expand the integration of behavioral health and primary care

Work Plan Overview



Agency Action Plan Uses Phased Approach

2022
Current state
(baseline data, process and outcome measures)



2030
Goal state:
Federal foundation for nationally strengthened primary care (outcome measures)

Take-Aways

- Value-based care is a journey
- Health center model foundation is community-oriented primary care
- HHS Initiative to Strengthen Primary Health Care explores federal levers to help

OASH | Office of the Assistant Secretary for Health

Contact:
Shannon McDevitt, MD, MPH
smcdevitt@hrsa.gov

Office of the Assistant Secretary for Health
Department of Health and Human Services

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