Payment
&
Delivery Reform
A Deeper Dive

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October, 2019

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What Drove Us To APM?

- Healthcare transformation…
- Affordable care act 3/2010 → 1/2014
- Oregon Medicaid expansion → fall/2013 964k; up 338k
- Oregon healthcare payment reform → 1/2014
  https://www.Oregon.Gov/oha/ERD/documents/2015-0526-apm-cover-letter-report.Pdf
- Triple aim / quadruple aim → cost
- Accountable Care Organizations (ACO)/Oregon Community Care Organizations (CCO)
- Patient Centered Primary Care Home (PCPCH) certification
- Value based pay / pay for performance

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The Basic Premise

- Payment is detached from the visit
- Payment is attached to the patient/client
- Eliminate the incentive of overutilization and resource inefficiency
- Eliminate undervaluation of preventative services and overvaluation of procedural services
- Introduce incentives for collaboration
- Introduce incentives for cost reduction
- Introduce incentives for improved health outcomes
- Grants providers the freedom to utilize alternative methods of delivery, allow providers to work at the top of their license

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Oregon APM

State Alternative Payment for Wrap/PPS

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Financial Basics of the OR APM

- Establishes a PMPM rate for the wrap-around portion the state pays to make FQHC's whole to their PPS rate.
- PMPM made on 'engaged' patients
- One 'up front' monthly payment, adjusted weekly for additions and deletions
- One PMPM rate, no risk stratification
- FQHC's held financially harmless
- Quarterly reconciliations (APM vs. PPS encounter rate)
- Annual close-out reconciliation

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Implementation – Main Contributors

Terms and conditions a joint effort

- Oregon Health Authority
- OPCA
- Broad group of Oregon FQHC's
- Three early adaptor FQHC's
- Paid outside consultant

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Implementation - Initial Obstacles

- Process is NOT quick
  - Started with high level goals (guide posts)
- Most difficult decisions
  - What services were in and which were out?
  - Who was in and who was out from the clinic's list
  - Attribution and effect on PMPM rate
  - Defining care steps (touches) and how these would be measured and justify funding

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Mechanics of Setting the PMPM Rate

- Look back to the last full year of activity adjudicated and closed by DMAP
- Strip out all non-APM activity (OB/BH/Dental/PH)
- Identify eligible total amount paid by DMAP for the 12 months
- Identify total patients seen to make up that paid amount
- Identify total member months for those patients
- Divide total payment by total member months to obtain PMPM rate
- Multiply PMPM rate * engaged members to obtain monthly payment, paid up front

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Go-Live – What Went Well?

- Intended effect realized
  - Clinics paid up front
  - Payment detached from the visit
    - Stabilized cash flow
  - Different/creative/more effective care teams (positive care delivery changes)
  - All rate calculations well considered
    - Result in positive gains for FQHC's over PPS model
- Enhanced bond between all stakeholders
    - "A strong partnership with all parties based on trust and fairness is essential"

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Go-Live – What Went Wrong?

- Changes to program policy did not go well
  - Required better documentation of decisions
  - Required defined process on how to reach decisions
- Did not address how a PPS change in scope would effect the APM rate from the beginning
  - Retro decisions painful & emotion filled
- Time/Resource commitment under estimated
  - Impact financially material for all parties involved
- State covered many patients it should not have & made APM payments on non-engaged patients
  - Now doing take backs

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Implementation - Lessons Learned

- Better define and document the roles of
  - State / Clinics / OPCA
- Determine up front how agreement would be reached on changes to the program
- The body of work involved is HUGE
  - OHA and OPCA struggle financially with sustainability
- OB services should have been in, not out
  - Excluded over concern how to attribute, if PC at one FQHC w/o OB so OB at a different FQHC that did. (Same concern with specialty behavioral health)
- Turnover of key contributors happens and hurts

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Benton County Experience

- Before APM
  - Bill primary payer
  - Wait 6-7 months to ensure most primary payments were realized
  - Bill the State for the WRAP portion
  - Wait an additional month for WRAP payment
  - Suffer financially with visit volume reductions resulting from provider turnover/vacancy

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Benton County Experience

- After APM
  - Payment received up front
  - 8 month windfall of double WRAP collection
  - Increased reimbursement
  - Stabilized/Predictable cash flow
  - Financial risk with provider turnover abated
  - Freedom to innovate
  - Increased administrative tasks
    - Payment tracking & recording changes
    - Assignment & attrition reconciliations
    - Quarterly reconciliations
    - Panel management & Navigation

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Benton County Specific Advice

- Being first can be painful
  - We are grateful we waited until phase II
- Being last can be stupid
  - Overcome your fears and go early
    - perfect is the enemy of the good, and in order to get an innovative program off the ground, you have to move forward without everything completely buttoned up.
- Know your data going in
  - Past payments under PPS that will be replaced
  - The patients & visits making up these payments

NOTE: You will likely have to trust the State for 'member months' of these identified patients as typically, you won't have access to that information.
(Member Months is a key factor in the PMPM rate calculation)

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Benton County Experience Quantified

4 ½ year experience - (1/2014 – 6/2018)

(same patients / same time period)

	Pre APM	Post APM	Variance	% Variance
OR State APM	$ 13,300,000	$ 16,000,000.00	$ 2,700,000.00	20%

Payer Mix – was 30%; is 46%; highest 57%

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State of Oregon Experience

- Cost of primary care has increased
- We "think" total cost of care and quality has improved
  - "An early study of the pilot seemed to bear out reduction in ED and hospital utilization for clinic patients in the program in the early stages. However, neither the state, OPCA nor the clinics have resources to track this well over time. It was a resource intensive effort to get that point in time study, and it is a challenge to repeat. Also a huge challenge to unwind what is due to APCM; what was due to ACA expansion; CCO contracts, etc. Almost impossible in my mind to get to a distinct impact of this program without the influence of those other factors. But I think most clinics would say that it was a strong contributing factor to their ability to be successful in that environment of CCOs and VBP, becoming leaders in transforming their care."

Benton County Total Cost of Care Experience Quantified

- 2018 vs. 2017
  - Benton County APM  .6%
  - Hospital Utilization  1.2%
  - ED Utilization  0%
  - Total Cost of Care  .3%

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Where Things Stand Today

- January 24, 2018…Oregon approved taxes on hospitals, health insurers and managed care companies in an unusual special election Tuesday that asked voters and not lawmakers how to pay for Medicaid costs that now include coverage of hundreds of thousands of low-income residents added to the program's rolls under the Affordable Care Act.
- "It's become a huge challenge for all (clinics, OHA and OPCA) to manage the details of the program and find a process that works well to reach agreement when changes are proposed."
  - For example, our quality metrics are tied to CCO metrics, several of which were just DROPPED by the CCO metrics committee, so back to the drawing board to determine what to measure.
- CCO 2.0 is at our door step

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CCO 2.0 Summary

GOALS:

1. Improve the behavioral health system
2. Increase value and pay for performance
3. Focus on social determinants of health and health equity, and
4. Maintain sustainable cost growth.

POLICIES:

- Require CCOs be fully accountable for the behavioral health benefit
- Assess capacity of comprehensive services
- Address prior authorization and network adequacy issues that limit member choice and timely access to providers
- Use metrics to incentivize behavioral health and oral health integration
- Expand programs that integrate primary care into behavioral health settings
- Require CCOs to support electronic health record adoption and access to electronic health information exchange
- Develop a diverse and culturally responsive workforce, and
- Ensure children have behavioral health needs met with access to appropriate services.

Local APM

APM with CCO

Financial Basics of the CCO APM

- Establishes a PMPM rate for the initial Medicaid portion the CCO pays before the State makes FQHC's whole to their PPS rate.
- PMPM made on 'assigned' medical patients
  - No dental, public health, behavioral health
- One 'up front' monthly payment, adjustments the following month
- Individual patient PMPM is risk stratified
  - 6 levels ($15 - $60)
  - Defined and assigned by CCO, no FQHC control
- FQHC's not held financially harmless
- No quarterly reconciliations
- No annual close-out reconciliation

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Mechanics of Setting the PMPM Rate

- Analyzed our historical data
- Came prepared for negotiation battles
- Had an estimated/desired PMPM rate in mind
- CCO laid out their plan and proposed their rate
- We sat silently, listened and said YES!

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Benton County Experience

- Before APM
  - Initial payment delayed by billing, denials, rebilling, and slow adjudication
  - Poor visit fee
- After APM
  - Same benefits to cash flow
  - Same protection against provider turnover
  - Reduced administrative costs
  - Increased reimbursement
    - NOTE: State APM rate calculated using poor visit fee, then came CCO's enhanced PMPM rate. State rate never recalculated

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Benton County Experience Quantified

	Before	After	Change	% Change
2015	985,300	1,842,900	857,600	87.0%
2016	999,600	1,745,100	745,500	74.6%
2017	904,100	1,451,000	546,900	60.5%
2018	851,400	1,527,200	675,800	79.4%
Est 2019	824,400	1,666,400	842,000	102.1%
Global Increase	**4,564,800**	**8,232,600**	**3,667,800**	**80.3%**

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CCO Reports

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Benton County PCP - 2019 Financial Report
CCO Capitation vs. Clinic Capitation

	CAPITATION PAID				IHN-CCO NON-PCP CLAIMS VS. CLINIC CAPITATION (Paid amounts exclude any claims that are capitated and any that are MH-related)				
Year - Month	Assigned Members	Total Approx. IHN-CCO Capitation for Professional and Institutional Services	Benton County - PCP Capitation	Amount Available for Non-PCP Services	Total Claims Paid by IHN-CCO for Non-PCP Services	Professional Claims Paid by IHN-CCO for Services Outside APM Clinic	Institutional Claims Paid by IHN-CCO	Monthly Retained Balance for Future Non-Capitated Claims Outside APM Clinic	Carry-Over Balance for Future Non-PCP Claims
2019-01	[redacted]								
2019-02									
2019-03									
2019-04									
2019-05									
2019-06									
2019-07									
2019-08									
2019-09									
2019-10									
2019-11									
2019-12									
A	*B*	*C*	*D*	*E = C - D*	*F*	*G*	*H = F - G*	*I = E - F*	*J = I + previous month's balance*

Claims data reflects processing status as of 07/11/2019

Each month's claims data corresponds to IHN patients who were assigned to the clinic at the time of the service.

Overview:
For the purpose of transparency, this page shows the total premium amount IHN received from the State for all medical services. It then breaks the payments out to show the amount of capitation paid to BCHC-PCP, and then what is leftover for IHN to pay for all other non-BCHC-PCP services.

Key Points:
1. Carry-Over Balance - Year-to-date balance of money available.
2. Monthly Retained Balance - Did IHN have enough $ to cover all costs including capitation?
3. Has membership at clinic increased or decreased?

- Monthly PMPM Patient Details are packaged with monthly payment.

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Benton County PCP - 2019 Financial Report

Clinic Capitation vs. Claim Billed Amount

	NON-BILLABLE SERVICES BY CLINIC		BILLABLE SERVICES BY CLINIC (Claims include only those that are capitated and not MH-related)					COMBINED SERVICES BY CLINIC					
Year - Month	Count of Care Coordination Touches	Value of Care Coordination Activity (assuming $30/touch)	Count of Claim Lines Submitted	Count of Rejected Claim Lines	Reject Rate (%) *Goal is 7% or less*	Total FFS Claim Billed Amounts	Clinic Capitation	Total Value of Clinic Services (Billed Amounts & Touches)	Total Business Value % (Billed Amounts & Touches/Capitation)	Total Service Count	Assigned Members	Distinct Members Touched or Seen by the Clinic	% Penetration Rate (Distinct Members/ Member Assigned)
2019-01	[redacted]												
2019-02													
2019-03													
2019-04													
2019-05													
2019-06													
2019-07													
2019-08													
2019-09													
2019-10													
2019-11													
2019-12													
A	*B*	*C = B X $30/touch*	*D*	*E*	*F = E / D*	*G*	*H*	*I = C + G*	*J = I / H*	*K = B + D*	*L*	*M*	*N = M / L*

Claims data reflects processing status as of 07/11/2019

Overview:
This page shows the value of your services for the clinic and the % of members assigned to the clinic that are receiving PCP services.

Key Points:
1. Is the Provider connecting with as many members as you think they should be?
2. Is the Provider providing enough services to justify the capitation?

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Benton County PCP - 2019 Financial Report

Costs Among Service Categories for Paneled Members

	INPATIENT VISITS (HOSPITAL, E&M, & SNF)			OFFICE VISITS - PCP LEAKAGE			EMERGENCY DEPARTMENT(ED)					
Year - Month	Paid Amount	Distinct Episode	Distinct Member Count on Paid>0 Claims	Paid Amount	Distinct Episode	Distinct Member Count on Paid>0 Claims	Paid Amount Non MH Dx	Paid Amount MH Dx	Distinct Episode Non MH Dx	Distinct Episode MH Dx	Distinct Member Count on Paid>0 Claims Non MH Dx	Distinct Member Count on Paid>0 Claims MH Dx
2019-01	[redacted]											
2019-02												
2019-03												
2019-04												
2019-05												
2019-06												
2019-07												
2019-08												
2019-09												
2019-10												
2019-11												
2019-12												

All data reflects claims processing status as of 07/11/2019

In this analysis, a distinct episode is based on claim date of service and member ID.

Overview:
This page shows the utilization of the members assigned to Benton County - PCP for which IHN-CCO pays each month outside of Benton County - PCP.

Key Points:
Is there any room for improvement where Benton County - PCP might be able to control costs:
1. Are there increases or decreases in high cost services, such as inpatient visits or ED visits?
2. Are members getting in to see their assigned PCP?

- Quarterly patient details are packaged with this high cost utilization report to be used for patient outreach

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Benton County (IHN) - Scorecard (FINAL)

Report Date: 2018 FINAL
Report Period: Qtr.4

Quality Measure	Achieved	Members to be Seen	Eligible Member Count *(Denominator)*	Improvement Target *	Improvement Target Count	Desired Direction	Actual	Actual Count *(Numerator)*	% of Funds Available	% Earned
Adolescent Well-Care Visits	YES	0	430	43.9%	189	↑	49%	210	25%	25%
Ambulatory Care: Emergency Department Utilization	YES	0	57,974 member months	49.7 ED visits per 1000 member months	2881 ED visits	↓	47.3 ED visits per 1000 member months	2740 ED visits	25%	25%
Colorectal Cancer Screening	NO	18	588	54.0%	318	↑	51%	300	10%	0%
Controlling High Blood Pressure	YES	0	270	70.6%	191	↑	79%	212	15%	15%
Dental Sealants on Permanent Molars for Children	YES	0	373	22.9%	86	↑	24%	91	25%	25%
Diabetes Care: HbA1c Poor Control Challenge Pool	NO	31	254	23.8%	60	↓	36%	91	Challenge	0%
Total Performance								Total	100%	90%

Tier 1 (0%-49%) Anything below 50% performance = $0 available

Tier 2 (50-79%) The percentage of performance met is equivalent to amount of funds earned (e.g. 60% performance = 60% of funds available)

Tier 3 (80%) Receive 100% of the [redacted] Quality Pool earned

Challenge Pool Receive an additional [redacted] when 80% (or higher) of the weighted Quality Metrics are achieved, and 100% of the Diabetes Care: HbA1c Poor Control Metric's Improvement Target is met

NOTES:

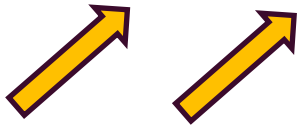
Year 2018: Provider clinics must be 100% EHR certified using either the 2014 or 2015 Edition

Year 2019: Provider clinics must be 100% EHR certified using the 2015 Edition

Provider clinics must be working toward becoming a 4 Tier or 5 Star PCPCH certified by December 31, 2018

* Improvement Targets have been updated with OHA's 2018 targets and benchmarks

Benton County (IHN) | Measure Specifications | Value Sets



- Monthly Gap lists at the patient level (all gaps per patient) are packaged with monthly scorecard

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Future Changes

- Include Behavioral Health in APM
- Greater impact of value based pay/pay for performance on overall compensation
- Share upside and downside risk

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Questions ?

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