America's Voice for Community Health Care
Lessons from the States: Oregon’s APM Model

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Poll

Which type of organization do you represent?
1. Primary Care Association
2. Health Center
3. Health Center Controlled Network
4. Other
Think Before You Jump
Why Are We Doing This?

- Our stakeholders wanted something better
  - Patients
  - Payers
  - Providers & support staff
- Recruitment getting harder
- Increased pressure
  - Transparency and accountability increasing
  - Payment moving from volume to value
Coordinated Care Organizations

- Oregon’s version of ACOs for Medicaid
  - Key elements:
    - PCMH – Needs to address cost/access/quality
    - Local control
    - Coordination
    - Health equity
    - Metrics/performance measures
    - Global budgets (pmpm), shared savings and alternative payment models
- Integrate medical, dental and mh
- Value-based pay the burning platform
2010: PCMH clinics asked OPCA for methodology to better align with model

- Current reimbursement is a barrier to medical home transformation
- Provider team retention issue

Goal of APM: De-link payment from the traditional, face-to-face, patient-provider encounter

- Not value based pay, but can serve as bridge
It’s All About The Relationship
Starting the Conversation with Medicaid

- Our missions are aligned
- Payment reform should make primary care more effective
- Value-based pay makes sense
- Must account for behavioral and socio-economic barriers
- Let’s work together on a bridge to value-based pay
Adjusting/Stratifying for Patient Complexity

- Not adjusting could increase disparities
  - Chien et.al., “Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on P4P Measures?,” *Journal of General Internal Medicine*, 12/13/11

- Paying for health homes in the safety net

- Not adjusting could penalize safety net
Medicaid Relationship Critical

- You won’t get the model right the first time, so you have to have trust to make changes
- Partnership between state, OPCA and CHCs is very strong
- Regular F2F and phone discussions
- State participation in learning community
- Mutual goal - the success of APM as measured by better cost, quality, access and patient experience is at the forefront
Legal Requirements

Federal PPS law

= or > PPS

Reconcile to PPS

SPA to CMS

Voluntary participation
Basic **Rate** Construct

PMPM payment

**Wrap** is determined from base yr

NOT VALUE BASED PAY

CCO payment like anyone else’s

Separate **bonus** payments
Reconciliation

- Required by CMS
- Quarterly with an annual settlement (if needed)
- Compares APM payments to PPS visits
- PPS is the floor, but APM revenue in excess of PPS is retained by the clinic.
APM

- Budget-neutral
- Includes:
  - Physical health services – open card, Medi-Medi, SBHC
- Carved Out:
  - Mental health services for now
  - Dental services later
  - Inpatient care & pharmacy
  - Prenatal/deliveries carved out
- Change in Scope process - similar to PPS
Clinics to provide:
- Process and outcome data to the state
- “Touches” with the patient
- Demographic data being collected
- State/CCO providing total patient utilization info
- Aligning with other state reform efforts (e.g., PCMH, CCO)
- CHCs join based on readiness
- MOU with the state is key
Payment Model Timeline

Model Development and Refinement
- Financial model development (2011)
- Financial model modifications – attribution (2013)
- Mental Health expansion (possible) (2017)

Onboarding Of Clinics
- Phase I Payment live (March 2014)
- Phase II Payment live (July 2015)
- Phase III Payment live (July 2016)
- Phase IV Payment live (possible) (July 2017)

Metrics and Evaluation
- Cost, Quality and Access (touches) defined (2012)
- Accountability Plan (touches revised) (2014)
- Optumus report and Year 1 analytics (2016)
Participation Requirements

- 3 year commitment
- 30 day emergency exit
- All sites, all Medicaid patients
- Agree to Accountability Plan and Learning Community participation
Other Commitments of APCM Participation

- Accountability Metrics
- Agreement to adjust model as needed in partnership with OHA.
- Transform model of care and participate in Learning Community
- State tracking Access through visits and “touches”
Oregon APCM Metrics and Accountability Strategy

**Data**
Track 9 CCO measures, 5 UDS measures, and ambulatory utilization. Focus on two of the clinical measures. Sustain or improve patient satisfaction.

**Quality**

**Cost of care**
Maintain or reduce adjusted per capita costs.

**Access**

Meaningful engagement
Document visits and/or engagement touches with 70% of established patients on an annual basis.

**Financial**

Severity adjustment methods
Establish tool that adjusts care for various population segments.
## APCM Core Quality Measures

### CCO Clinical Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
<th>2014 CCO/OHA Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Misuse: SBIRT - % that received brief intervention service</td>
<td>CCO</td>
<td>13%</td>
</tr>
<tr>
<td>Screening for Clinical Depression and FU plan</td>
<td>CCO</td>
<td>25%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>CCO</td>
<td>47%</td>
</tr>
<tr>
<td>Diabetes: HbA1c Poor Control, &gt; 9</td>
<td>CCO</td>
<td>34%</td>
</tr>
<tr>
<td>Controlling high blood pressure</td>
<td>CCO</td>
<td>60%</td>
</tr>
<tr>
<td>FU Care for Children Prescribed ADHD Medication</td>
<td>CCO</td>
<td>51%</td>
</tr>
<tr>
<td>Timeliness of Prenatal Care</td>
<td>CCO</td>
<td>90%</td>
</tr>
<tr>
<td>Developmental Screening in first 36 month of life</td>
<td>CCO</td>
<td>50%</td>
</tr>
<tr>
<td>Adolescent Well Care Visits</td>
<td>CCO</td>
<td>57.60%</td>
</tr>
</tbody>
</table>

### UDS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
<th>2014 CCO/OHA Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td>UDS</td>
<td>74%</td>
</tr>
<tr>
<td>Weight Control: Adults</td>
<td>UDS</td>
<td>TBD</td>
</tr>
<tr>
<td>Tobacco Screening</td>
<td>UDS</td>
<td>81%</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>UDS</td>
<td>82%</td>
</tr>
<tr>
<td>Weight Control: Kids</td>
<td>UDS</td>
<td>TBD</td>
</tr>
</tbody>
</table>

### CCO Utilization and Patient Experience Measures

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<th>Measure</th>
<th>Measure Type</th>
<th>2014 CCO/OHA Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care: Outpatient and ED Utilization</td>
<td>CCO</td>
<td>44.6/1000 MMs</td>
</tr>
<tr>
<td>CAHPS - Access to Care: Getting Care Quickly</td>
<td>CCO</td>
<td>88%</td>
</tr>
<tr>
<td>CAHPS - Satisfaction with Care and/or Internal Survey</td>
<td>CCO</td>
<td>89%</td>
</tr>
</tbody>
</table>

*Report on all these measures
Choose 2 focus measures from the list of CCO Clinical and UDS measures
## Engagement Touches

### New ‘visit’ types
- Home visit encounter
- MyChart
- Telemedicine Encounter
- Telephone Visit

### Coordination and Integration
- Information Management
- Coordinating Care
- Clinical Follow-up and Transitions
- Warm Hand-Off

### Education, Wellness and Support
- Accessing Community Resource
- Education Provided in Group Setting
- Support Group Participant
- Exercise Class Participant

### Outreach and Engagement
- Flowsheet (screening tools)
- Panel Management Outreach
- Case Management
- Health Education Supportive Counseling
# PRAPARE DOMAINS

## Core

<table>
<thead>
<tr>
<th>UDS SDH Domains</th>
<th>Non-UDS SDH Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Race</td>
<td>9. Education</td>
</tr>
<tr>
<td>2. Ethnicity</td>
<td>10. Employment</td>
</tr>
<tr>
<td>4. Farmworker Status</td>
<td>12. Social Integration</td>
</tr>
<tr>
<td>5. English Proficiency</td>
<td>13. Stress</td>
</tr>
<tr>
<td>6. Income</td>
<td></td>
</tr>
<tr>
<td>7. Insurance</td>
<td></td>
</tr>
<tr>
<td>8. Neighborhood</td>
<td></td>
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<tr>
<td>9. Housing</td>
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</tbody>
</table>

## Optional

<table>
<thead>
<tr>
<th>Non-UDS SDH Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incarceration History</td>
</tr>
<tr>
<td>2. Transportation</td>
</tr>
<tr>
<td>3. Refugee Status</td>
</tr>
<tr>
<td>4. Country of Origin</td>
</tr>
<tr>
<td>5. Safety</td>
</tr>
<tr>
<td>6. Domestic Violence</td>
</tr>
</tbody>
</table>

PRAPARE asks 15 questions to assess 14 core SDH domains.

- 9 questions already asked for UDS reporting
- 5 non-UDS questions informed by MU3

PRAPARE has 6 optional domains.
Role for PCA

- Make the case & align clinics, state
- Address political issues – state, clinics
- Convenor
- Provide fiscal expertise
- Trouble shoot issues
- Develop learning collaborative
- Spread
Advanced Care Model
The path to value

APCM timeline

2011  PCMH
2012  APM
2014  ACM
2015  ACM – Diving Deeper
2017  ACM – Going Broader

APCM activities

APCM concepts

Capacity building + care teams and data
Payment stability + change management
Advanced care strategy + Program accountability
Deep subpopulation understanding + New partnerships, roles, interactions
Community Connections + SDoH interventions
Learning Collaborative

- Doing what we know and what we don’t
  - Quarterly-ish face-to-face meetings, monthly calls
    - April – segmenting populations by SDoH
  - Incorporation of facilitation/coaching model
  - Accountability and Metrics Strategy
    - Internal, CCO partnerships, IT support
  - Strategic areas of focus
    - Merge evidence with “unknown”
Challenges/Lessons Learned
CHC Considerations for APM

- A lot of work, especially for pilots
- Is your current payment a barrier?
- Will APM free up your clinic to provide more robust, patient-centered and team-based care?
- How will you treat patients not on FFS (Medicare, private insurance)?
- Is your clinic ready (next slides)
Clinic

Financial Readiness

**Financial** stability (cash flow, stable costs)

Minimum one year **PPS** (current CiS)

Medicaid **payor mix**
Clinical Readiness

Clinical leadership

Team identified

Commitment to transformation

Medical home commitment
Operational Readiness

**Leadership** stability

**Data** capacity

Quality, cost, access and touches **data**

Know your **patients**: identify, track, stabilize

Strong **relationships**: CCO, CHCs, OHA
Payment Model Lessons

- Payment model should be hand in hand with care transformation
- Data/Outcomes should be clear, thoughtful, aligned
- This is a Partnership requiring constant refinement and trouble shooting:
  - With Medicaid
  - Between clinics
  - IT and managed care
- Don’t underestimate political issues/competing priorities
Advanced Care Model: Lessons Learned

- Don’t underestimate how hard it is to change
  - Consider competing demands
- Create less time pressure
- Plan for data collection, analytics
- Add ACM teams at all participating sites
- Keep learning (co-design is messy)
- Never separate from payment
Early Outcomes

- Model appears budget neutral per patient, per year
- APM reconciliations have not triggered payment to date.
- State monitors access
- MCO payments appear level
- Clinical quality indicators appear to be holding or improving in most cases
- Signs of improvement in total health care utilization
Elements of Risk We Shouldn’t Underestimate

- CHC work for each patient may increase while payment remains the same
- Transparency in data (cost, quality and access) shortens bridge to value-based pay
- Little time remains to adjust for behavioral and socio-economic barriers
What’s Next

- Change in Scope to be developed
- Phase IV clinics
- Mental Health integrated into APM, dental further out
- Pre-natal potentially integrated
- Capturing data on SDoH/touches and developing ROI
- Emphasis on innovation: alternative care team and visit types, including segmentation and SDoH
Questions
Thank You

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