Using Data to Measure Performance
Advancing Value-Based Payment Methodologies for FQHCs and RHCs
Art Jones, MD
Accountable Care Institute
FQHC/RHC Variable Revenue = PPS Rate X Face-to-face Billable Encounters

“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity”

- George Bernard Shaw, 1911
# APM Framework

## Category 1: Fee for Service – No Link to Quality & Value
- **A**: Foundational Payments for Infrastructure & Operations
  - Traditional FFS
  - DRGs Not linked to Quality

## Category 2: Fee for Service – Link to Quality & Value
- **B**: Pay for Reporting
  - Bonus payments for quality reporting
- **C**: Rewards for Performance
  - DRGs with rewards for quality performance
  - FFS with rewards for quality reporting
- **D**: Rewards and Penalties for Performance
  - DRGs with rewards and penalties for quality performance
  - FFS with rewards and penalties for quality performance

## Category 3: APMs Built on Fee-for-Service Architecture
- **A**: APMs with Upside Gainsharing
  - Bundled payment with upside risk only
- **B**: APMs with Upside Gainsharing/Downside Risk
  - Bundled payment with up and downside risk

## Category 4: Population-Based Payment
- **A**: Condition-Specific Population-Based Payment
  - Population-based payments for specialty, condition, and facility-specific care (e.g., via an ACO, PCMH, or CCD)
- **B**: Comprehensive Population-Based Payment
  - Full or percent of premium population-based payments, e.g., via an ACO, PCMH, or CCD
  - Integrated, comprehensive payment and delivery system
  - Payment for comprehensive pediatric or senior care

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*Example payment models will not count toward APM goal. Models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.*
Reasons to Pursue a FQHC/RHC APM

• Retain or increase PCP network adequacy for the Medicaid population
• Improve the value (quality and resource use) of primary care service delivery at FQHCs and RHCs including reducing the overuse of services that are not evidence-based
• Expand FQHC and RHC focus on managing the full continuum of care including managing transitions of care and controlling total cost of care
VBP Clinical Focus

• Improving transitions of care
• Care Management of high risk patients
• Behavioral and physical health integration
• Reducing low value medical practices
• Performance on Quality Parameters
• Becoming more member centric
High Value, Consumer-facing Practice Transformation

• Team-based care with non-billable providers
• Enhanced access to primary care
  – Urgent care center level of access
  – Expanded hours
  – Nurse triage
  – Phone consultation
  – Management over the patient portal
• E-consults for specialty care
• Structured care management at the PCP practice level informed by analytics fed by multiple data sources including real time hospital ADT alerts and impactable social risk factors
• Home and nursing facility visits
• Telemedicine
Assumptions for Illustration Purposes

• Market PCP cap $18 PMPM or FFS equivalency
• APM 3 $180/visit
• PCP productivity 3500 visits/yr.
• % Medicaid 70%
• Preventive visits 1 PMPY
• Replace non-preventive, face-to-face encounters 2.5 — 2.2 — 2.0
• Total PCP visits 3.5 — 3.2 — 3.0
• Demand for PCPs willing to serve Medicaid recipients allows panel expansion to fill resultant capacity
**Example: Non-preventive PCP visits progressively replaced under APM**

<table>
<thead>
<tr>
<th></th>
<th>Baseline Year</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per FTE PCP</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PCP Visits PMPY</td>
<td>3.5</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>PCP Panel Size</td>
<td>1,000</td>
<td>1,094</td>
<td>1,167</td>
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<tr>
<td>% Medicaid</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
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<tr>
<td>PCP Medicaid Panel Size</td>
<td>700</td>
<td>768</td>
<td>817</td>
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<tr>
<td><strong>State Wrap Payment PMPM</strong></td>
<td>$ 34.50</td>
<td>$ 30.00 current</td>
<td>$ 27.00 current</td>
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<tr>
<td></td>
<td></td>
<td>$ 34.50 proposed</td>
<td>$ 34.50 proposed</td>
</tr>
<tr>
<td>PCP Panel Medicaid Rev</td>
<td>$441,000</td>
<td>$441,000 current</td>
<td>$441,000 current</td>
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<tr>
<td></td>
<td></td>
<td>$482,344 proposed</td>
<td>$514,500 proposed</td>
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<tr>
<td>Increase PCP Panel Revenue</td>
<td></td>
<td>$ 0 current</td>
<td>$ 0 current</td>
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<tr>
<td></td>
<td></td>
<td>$41,344 proposed</td>
<td>$73,500 proposed</td>
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</table>
The Ideal Building Blocks for Delivery System Transformation & Population Management

Medical Home Network’s Path

Organizational Structure
- Shared vision & culture of accountability
- Established governance
- Competent leadership

Connectivity
- MHNConnect Portal
  - Real-time alerts
  - Information exchange between 17 hospitals and 150 primary care sites
  - Bridge to social service agencies

Actionable Reporting & Analytics
- Timely & actionable reporting based on integrated historical & real-time data
- Advanced analytics to support high-risk population management
- Transparent provider-performance reporting that drives improvement

Practice Transformation
- Team-based model of care implemented
- Pertinent patient information available at point of care
- Integration of BH and LTSS into model

Workforce Development
- Develop education & training around the new model of care
- Create pipeline of allied health professionals prepared to work in underserved communities

Value-Based Payment
- Active pay-for-performance program that rewards reductions in utilization, improvements in quality, as well as program implementation

Patient Engagement
- Fostering the accountable patient
- Remote home monitoring for CHF & hypertension patients
- E-consults & virtual visits

Complex Care Coordination Capability

Redesign Delivery to Achieve Triple Aim
- Better Health
- Better Healthcare
- Lower Cost

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It’s About Total Transformation

Practice transformation without a financial model is not sustainable.

AccountableCareInstitute.com
Quality Gates for FQHC/RHC APMs

• APM must pay participating health centers at least what they would have been paid under the PPS which does not have a quality gate
• PCP capitation models must be monitored for access to care adequacy
• Shared savings/risk on total cost of care are routinely tied to quality metrics and thresholds
Measures should be patient-centered and outcome-oriented whenever possible. Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures.
Considerations in Choosing Metrics

• Implementation challenges:
  – Prospective or retrospective attribution
  – Source of data
  – Data repository
  – Reporting burden and cost
  – Timeliness of data sharing and reporting to facilitate rapid cycle improvement
  – Eligibility and attribution
  – Case mix adjustment
  – Standardization with benchmarks
  – Ability to stratify for different populations or conditions
Considerations in Choosing Metrics

- FQHC and RHC engagement
  - Manageable number of metrics
  - Address actionable activities
  - Facilitate fair comparisons
    - appropriate case-mix adjustment
    - establishing appropriate peer groups for comparison
  - Voluntary groupings of small volume providers
  - Use a core set of measures, along with a menu of optional measures
  - Frequency of resetting the metrics
  - Consultation with FQHC and RHC stakeholders
  - Offer rewards based on improvement and achievement beyond the norm
Considerations in Choosing Metrics

• Impact considerations
  – Disparity in care; opportunity for improvement
  – Impactable variation in performance
  – Sufficient sample size; use of composite scores
  – Be evidence-based; supported by empirical evidence demonstrating clinical effectiveness and a link to desired health outcomes
  – Reliable in discerning meaningful differences in performance between low and high performers
  – Alignment with metrics for other populations
  – Inclusion of multi-payer performance data
  – Minimize gaming opportunities
  – Avoiding unintended consequences
Recommendations

• Capitated APM monitored by access to care metrics
  – PCP engagement
  – Preventive services that require a face-to-face visit with a “billable provider”
  – Potentially avoidable ED visits
Recommendations

• Shared savings/shared risk on total cost of care savings
  – Chronic care clinical quality tied to chronic PQIs (Diabetes, COPD/asthma, Heart Failure)
  – Acute conditions PQI composite and chronic conditions PQI composite (not reliable for practices with <10 PCPs)
  – PCP follow-up post hospital discharge
  – Reducing impactable barriers to compliance with treatment plans
  – Reducing potentially avoidable utilization and cost
Identification of utilization flashpoints allows care managers to:

- Detect rising risk that claims-based risk stratification misses
- Identify and address modifiable medical and social risks
- Initiate primary care disease management
- Connect to public health and community-based social service supports
- Gauge care management effectiveness as ability to address and resolve risks

*Focusing exclusively on High Cost Utilizers doesn’t prevent them in the first place*

*Denver Health Health Affairs, 34, no.8 (2015):1312-1319*
Integrating Disparate Entities *Across the Delivery System to Enhance Patient Care, Value & Outcomes*

### Medical Home Network ACO

<table>
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<tr>
<th>CountyCare</th>
<th>ACO Subset</th>
<th>ACO % of Total</th>
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<tbody>
<tr>
<td>ACA</td>
<td>71,862</td>
<td>24,347</td>
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<tr>
<td>FHP</td>
<td>86,470</td>
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<tr>
<td>SPD</td>
<td>3,840</td>
<td>1,589</td>
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<tr>
<td>Total</td>
<td>162,172</td>
<td>81,106</td>
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</table>

### MHN ACO Providers

- 9 FQHCs
- 3 Hospital Systems
- 86 Medical Homes
- 375 PCPs
- 150 Care Managers
- 1,200 Specialists
- 5 Hospitals
## PROSPECTIVE ANALYSIS FINDINGS

1. MHN’s risk stratification algorithm accurately correlates with subsequent cost of care

2. Presence of impactable risk factors even in the absence of historical high inpatient or emergency room utilization predicts increased subsequent hospital utilization and total cost of care

### Source: MHNConnect & CountyCare Claims Data

<table>
<thead>
<tr>
<th>HRA Risk Profile</th>
<th>Count</th>
<th>% Members with No Claims</th>
<th>ER Visits /1000</th>
<th>Inpatient Admits /1000</th>
<th>Medical &amp; Rx Cost</th>
<th>Relative Cost</th>
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</thead>
<tbody>
<tr>
<td>Low by Utilization without any Impactable Risk Factors</td>
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<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
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<tr>
<td>Low by Impactable Risk Factors</td>
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<tr>
<td>High by Utilization +/- Impactable Risk Factors</td>
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<tr>
<td>High by Impactable Risk Factors</td>
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MHN judges effective care management by its ability to resolve impactable patient risk factors.
Medical Home Network’s Proven Ability to Impact Cost, Engagement, and Outcomes

**Total Cost of Care**

The difference in cost of care for MHN versus other Medicaid patients in IL is **3.5%** in Year 1 and **5%** in Year 2

![Bar chart showing the difference in cost of care between MHN and Non-MHN risk adjusted cohorts.](chart)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care.

*Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population*

**ACA Readmission**

MHN 13% vs External Network 11%

15% BETTER OUTCOME

Period: July 1, 2014 – May 19, 2015

**ACA Utilization**

<table>
<thead>
<tr>
<th>Inpatient Days/1000</th>
<th>ED Visits/1000</th>
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</thead>
<tbody>
<tr>
<td>External Network</td>
<td>MHN</td>
</tr>
<tr>
<td>742</td>
<td>613</td>
</tr>
<tr>
<td>901</td>
<td>747</td>
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</tbody>
</table>

17% BETTER OUTCOME

Period: July 1, 2014 – May 19, 2015

**Patient Engagement**

MHN’s engagement efforts reach almost **2½ times** as many patients other Medicaid providers

MHN ACO: 71% COMPLETE

External Network: 31% COMPLETE

130% BETTER OUTCOME

Period: July 1, 2014 – May 19, 2015
Shift in Payment Mechanisms NYS DSRIP

MIPS-Merit Based Incentive Payment System

Combines parts of:

- Physicians Quality Reporting System (PQRS)
- Value Modifier (VM or Value Based Payment Modifier)
- Medicare Electronic Health Record (EHR)/Meaningful Use incentive programs into one single program

Based on:

- Quality
- Resource use
- Meaningful use of certified EHR technology
- Clinical practice improvement

2016 is the final reporting period for these stand alone programs; their infrastructure will be used for MIPS beginning in 2017
Data Submission Mechanisms

• Administrative claims
• Qualified clinical data registry
• EHR
• Web interface
• Patient-Reported Outcome Measures such as CMS-approved survey vendor for CAHPS
MIPS for PCPs

• We are proposing to allow individual MIPS eligible clinicians and groups the flexibility to determine the most meaningful measures and reporting mechanisms for their practice.

• To create a more comprehensive picture of the practice performance, we are also proposing to use all-payer data where possible.

• Report at least six measures including one cross-cutting measure and including at least one outcome measure

• No longer require reporting across multiple NQS domains

• Analysis of the quality performance category may include quality measure data from other payers; “We believe that aligning Medicaid and Medicare measures is in the interest of all providers and will help drive quality improvement for our beneficiaries.”