Agenda

I. Payment Reform
   I. APM Demonstration
II. CP3
III. PCHH and 2703
CPCA Payment Reform Strategy

- Triple Aim P4P
- PCHH Supplemental
- PPS-Equivalent Capitation

- Incentive
- Investment
- Flexibility
Payment Reform

Current P4P

IP = 41%
SNF = 6%
ED = 6%
Pharma = 15%
Specialty = 11%
Other = 9%

Total Cost of Care

PPS

Savings finances, incentives, and ongoing PCHH

Non-Primary Care Costs of Care for Patient Population

Incentive tied to Triple Aim
PCHH Investment
Base Payment with Flexibility
APM Legislative Update

• Legislation
  • SB 147, Senator Hernandez
  • Co-Sponsors: CPCA, CAPH, LA Care
  • Signed by the Governor
    • Law effective January 2016
Process to Operationalize

• SPA – Fall/Winter 2015
• Implementation Detail WGs – Fall/Winter 2015
  • Rate Development
  • Contracting
  • Alternative Encounters
• Invitation/Application to all FQHCs in CA
  • Participation Criteria
• State will select FQHCs
• Rate setting
• Likely start date: Between January – July 2017
California’s APM

Most Basic

• PPS rate converted to a monthly capitation payment

• Same amount you are receiving today, just paid up front on a monthly basis rather than per visit
  • EXAMPLE: $175 PPS x 3 Avg Adult Visits = $525
  • $525/ 12 member months = $43.75 PMPM

• PPS Rules Gone- billable provider/same day visit restriction/4 walls/etc
Today- PPS

- DHCS sets rates for health plans
- Plans pay primary care capitation to health centers
- Health centers bill state a wrap-around payment
- Annual reconciliation
DHCS sets rates for health plans.

Monthly, plan would tell State how many medical members are assigned to FQHC in demonstration.

State would pay the plan an additional “Wrap Cap” for that site(s)

- Wrap around payment becomes a capitation payment that is AID Category specific
- Health center would receive 4 per member per month payments (Child, Adult, SPD, Expansion)

Rate Adjustment between FQHC and plan.

Health center receives strictly capitation for all services in their PPS rates for the four aid categories.
APM Demonstration

• Plans will have risk corridor (.75%/.75%)
  • At risk for max of .75% of wrap cap amount. State responsible for rest.
  • Can benefit up to .75% of wrap cap if FQHC had to pay back. State would get rest.

• Possible rate adjustment at end of year
  • Year 1 – Rate adjustments would be occur if traditional visits increase by more than 5% or decrease by more than 30%
  • Yr 2 – more than 7.5% or decrease of more than 30%
  • Yr 3 – more than 10% or decrease of more than 30%
APM Demonstration

• 3 year demonstration with volunteer health centers
  • Roll out will be staggered
  • 3 years starts when the county starts

• Abide by Federal APM—PPS is Floor

• Health centers will continue to:
  • Have site-specific rates
  • Have ability to do scope change (with State)
  • Receive annual MEI increases (State to pass to plans)
Goal of CP3

To demonstrate through statewide aggregated data that under the APM pilot, FQHCs can help bend the total cost of care curve, improve patient outcomes, and enhance patient experience while remaining financially robust.
• **Define** what it means to be a successful FQHC within a value-based, managed care payment system

• **Provide** technical assistance and support to demonstration sites within the Alternative Payment Methodology (APM) demonstration

• **Utilize** the lessons learned within the pilot environment to inform future payment reform transition efforts of all California FQHCs
Consultants & Coaches

- Health Management Associates
- Manatt, Phelps & Phillips
- WeiserMazars
- Capital Link
- BlueNovo
- Curt Degenfelder
- Center for Care Innovations
- Hunter Gatewood
- UCSF
- PCHH Coaches
- RAC coaches/support
CP3 Measures of Success

APM Demonstration
External Evaluation
Measures
## REVISED CP3 Measure Set

**Clinical**
1. IP Utilization: Admissions
2. IP Utilization: All cause readmissions
3. ED Visits per 1000 members
4. Controlling HTN high blood pressure
5. Diabetes Control
6. Childhood Immunization Status
7. Cervical Cancer Screening
8. Colorectal Cancer Screening
9. Frequency of Ongoing Prenatal Care
10. BMI Screening & counseling
11. TBD – Behavioral Health Integration metric

**Operational**
12. Provider/Patient Productivity
13. Staff ratio: total non-clinical/total staff
14. Member/care team ratio
15. % of patients with at least 1 “touch” in measurement year
16. **Total Member touches**
17. Continuity of Care: % of PC visits with assigned PCP org
18. Clinic staff satisfaction
19. **Patient Experience/Satisfaction**
20. Care ratings from assigned Medi-Cal members
21. TBD – Data goal around the ability to capture social determinants of health

*California Primary Care Association*
CHCC Required Capacities

Population Health Management

Data Management

Financial Management
Population Health Management

• Shifting from patients to members
• Understanding who your patients are and what needs they have
• Using care teams more effectively
• Using the appropriate visit type to manage patients’ needs
• Engaging patients effectively and meaningfully
Data Management

• Foundational Elements
  • Data leadership & strategy
  • HIT (integrated EHR, registry, PMS, accounting software)
  • Data analytic expertise

• New Elements
  • Monitoring eligibility data & payments
  • Monitoring encounter data
  • Monitoring resource use
  • Capturing risk stratification data
  • Integrating utilization data from other sources
  • Generating meaningful reports
Financial Management

• Ability/tools to plan for and manage capitated payments
• Understanding costs and revenue per site, per member, per service line, per care team/panel, etc.
• Identifying high cost/high utilizing patients
• Modeling for PMPM/budget planning for PMPM
• Ability to operate dual payment systems
Payment Reform Readiness Checklist

Being developed

November 2015 – February 2016

Assess gaps and strengths in the areas of population health management, data management, and financial management process specific to transitioning to a capitated, managed care environment
TA Priorities

• Population Health Management
  • Empanelment
  • Panel Management
  • Access
  • Stratifying Population
  • Data Collection & Mgt (SDOH)

• Managed Care
  • Monitoring eligibility data
  • Managing capitation payments
  • Understanding cost/revenue per site
  • Data collection & Mgt
Capitation Payment Preparedness Program (CP3) Training and Technical Assistance Timeline

October 2015

**2015**
- Oct: Capitation Readiness Checklist Development
- Nov: Checklist testing & roll-out
- Dec: Organizational and Site level Performance Evaluation Profiles (PEPs)
- Jan: Coach recruitment
- Feb: Coach Training
- Mar: Program Kick-Off Mtg

**2016**
- Apr: Site visits incorporated into checklist and work plan efforts
- May: Site-specific and aggregate readiness summary reports published
- June: Individual site work plan development
- July: PEP Data will feed into individual site work plan
- Aug: Coaches to facilitate workplan development

**2017**
- Sep: Technical Assistance Delivery
- Oct: Leadership & Change Mgt Forum
- Nov: Webinar #1, Learning Session #1
- Dec: Webinar #2, Learning Session #2
- Jan: Webinar #3, Learning Session #3
- Feb: Webinar #4
- Mar: Webinar #5

**Key**
- ▲: Leg. Requirement
- ☢: Checklist
- TA: Technical Assistance

Technical Trainings: 2 hours/mo coaching assistance * Site Visits
How can you stay informed?

• CPCA Weekly Update listserv
• CPCA Website: http://www.cpca.org/index.cfm/health-center-resources/capitation-payment-preparedness-program-cp3/
CPCA Staff Roles

Christina Hicks, MSOD
Deputy Director Programs & Evaluation

Tina Canupp
Associate Director of Health Center Transformation

Responsible for CP3 program development and stakeholder relations

Responsible for technical assistance implementation & consultant coordination

New/Potential positions include

Deputy Director of Health Center Transformation: Overall program management once technical assistance implementation begins

Quality Improvement Coordinator: Providing QI technical assistance to sites

Data Informatasist: Supporting APM/CP3 data collection, aggregation and analysis
California’s Health Home Program (HHP)

Section 2703

State Option to Provide Health Homes for Enrollees with Chronic Conditions as defined by each state

- Funding for 2 years and requirement to demonstrate savings
- 90% Federal/10% State funding
- The California Endowment contributing California’s 10%
HHP

What will the HHP fund?

• Comprehensive care management
• Care coordination
• Health promotion
• Comprehensive transitional care & follow-up
• Patient and family support
• Referral to community and social support services

...services not already funded by Medicaid
State Process

- State released Health Homes for Patients with Complex Needs CA Concept Paper v2.0 on April 20
- Best source of information to date on California’s HHP
<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Behavioral Health</th>
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<tbody>
<tr>
<td>Asthma / COPD</td>
<td>Substance Use Disorder</td>
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<tr>
<td>Diabetes</td>
<td>Major Depression</td>
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<tr>
<td>Traumatic Brain Injury</td>
<td>Bipolar Disorder</td>
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<tr>
<td>Hypertension</td>
<td>Anxiety Disorder</td>
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<tr>
<td>Congestive Heart Failure</td>
<td>Psychotic Disorders (including Schizophrenia)</td>
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<tr>
<td>Coronary Artery Disease</td>
<td>Personality Disorders</td>
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<tr>
<td>Chronic Liver Disease</td>
<td>Cognitive Disorders</td>
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<tr>
<td>Chronic Renal Disease</td>
<td>Post-Traumatic Stress</td>
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<td>Chronic Musculoskeletal</td>
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<td>HIV/AIDS</td>
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<tr>
<td>Seizure Disorders</td>
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<td>Cancer</td>
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Patient Eligibility

- Individuals with two or more chronic conditions
- Individuals with one chronic condition and at risk for another;
- Individuals with serious and persistent mental illness

State is focused on the 3-5% of the highest risk Medi-Cal population who can benefit from this program
LEAD ENTITY: QUALIFYING MEDICAL MANAGED CARE PLANS

- Maintains overall responsibility for the health home network, including administration, network management, health information technology and exchange (HIT/HIE)
- Receives health home payment from the state and flows to partners

COMMUNITY-BASED CARE MANAGEMENT ENTITIES: Sample orgs could include: FQHCs, hospitals, clinics, IPAs, behavioral health providers

- Responsible for providing the core health home services:
  - Comprehensive care management
  - Care coordination (physical health, behavioral health, community-based LTSS) and health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services
  - Use of HIT/HIE to link services
- Dedicated care manager is located within this entity
- Entity receives payment for health home services via a contract with the plan
- Makes referrals to community partners for non-Medicaid funded services

COMMUNITY AND SOCIAL SUPPORT SERVICES: Sample organizations could include supportive housing providers, food banks, employment assistance, social services

- Provides services that meet the enrollees’ broader needs (e.g. supportive housing services, social services and supports)
- May not necessarily receive health home funding
Logistics

- Health Home Program will run through the managed care plans
- They will certify and select organizations to be CB-CMEs (community based care management entities)
- CB-CME’s can be:
  - Community health center
  - Community mental health center
  - Hospital or hospital-based physician group or clinic
  - Local health department
  - Primary care or specialist physician or physician group
  - Substance use disorder treatment provider
  - Providers serving those that experience homelessness
  - Providers serving individuals/persons diagnosed with HIV/AIDS
  - Other entities who meet certification and qualifications of a CB-CME may serve in this capacity if selected and certified by the MCP
Qualifications for a CB-CME

1. Experience serving Medi-Cal beneficiaries;
2. Comply with all program requirements;
3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
4. Provide appropriate and timely in-person care coordination activities, as needed. If in person communication is not possible, alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the HHP beneficiary to enhance access to services for HHP beneficiaries and families where geographic or other barriers exist and according to beneficiary choice;
5. Have the capacity to accompany HHP beneficiaries to critical appointments, when necessary, to assist in achieving HAP goals;

6. Agree to accept any eligible HHP beneficiaries assigned by the MCP, according to their contract with the MCP;

7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the CB-CME on whole-person care coordination;

8. As feasible, use HIT/HIE to link health home services and share relevant information with other providers involved in the HHP beneficiary’s care, in accordance with the HIT/HIE goals noted in Section 3.
# Required Staff on Health Home team at CB CME

<table>
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<tr>
<th>Required Staff</th>
<th>Qualifications</th>
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| Dedicated Care Manager (CB-CME or by contract) | Strong background in managing multidisciplinary teams  
Paraprofessional (with appropriate training) or licensed case manager, social worker, or nurse |
| HHP Director (CB-CME)                       | Strong background in managing multidisciplinary teams                                                                                         |
| Clinical Consultant (CB-CME)                | Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional |
| CHW (CB-CME)                                | Peer professional or peer advocate; Administrative Support                                                                                     |
| Housing navigator (CB-CME)                  | For homeless beneficiaries. Paraprofessional with experience serving homeless populations.                                                     |
Payment Methodologies

- MCPs will negotiate contracts and rates with CB CMEs
- Three tier payment process based on acuity of the patients enrolled
  - First 3 months- Health Homes will receive enhanced member engagement tier rates.
  - Acknowledges intensive up front work to enroll a beneficiary
- Additional incentive payment to the Health Home upon completion of the Health Action Plan.
- At least one core health home service must be provided each quarter in order for a payment to be made to the health home.
Core Measures

- Adult Body Mass Index Assessment
- Screening for Clinical Depression and Follow-Up Plan
- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Care Transition - Timely Transmission of Transition Record
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite
Utilization Measures

- Ambulatory Care- ER Visits
- Inpatient Utilization
- Nursing Facility Utilization
Timeline

- Managed Care Plan RFI- mid October
  - Plans must submit back to state by end of October
- State Plan Amendment submission – December 31, 2015
  - Draft for comment early December
- Rates and Eligible Patients
  - Released December 2015
- Managed Care Plan Proposals- due February 2016
- TA to first counties/plans/CB CMEs – March 2016
- Go Live– July 2016
Contact

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