APCM 2.0
Informational Sessions
April 13, 14 and 19, 2022
Welcome!

• In the chat box, please introduce yourself:
  » Your name
  » Health center
  » Role and,

  » Either what your favorite CareSTEP is (to bill or do) or,

your favorite memory/experience in the APCM program...
< 10 years of APCM in Oregon

2011 – 2022
## 8 Years of Growth: 20 CHCs + 2 RHCs Participate in Oregon’s APCM

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<tbody>
<tr>
<td>Mosaic Medical</td>
<td>Benton County</td>
<td>Clackamas County</td>
<td>Neighborhood Health</td>
<td>La Clinica</td>
<td>Lane County</td>
<td>ADAPT</td>
<td>Aviva</td>
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<tr>
<td>OHSU-Richmond</td>
<td>Multnomah County</td>
<td>Rinehart Clinic</td>
<td>Northwest Human Services</td>
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<td>OHSU-Scappoose</td>
<td>OHSU-Scappoose</td>
<td>Rogue Community</td>
<td>Winding Waters</td>
<td>Wallace Medical Concern</td>
<td>Valley Family</td>
<td>Waterfall Clinic</td>
<td>One Community Health</td>
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<tr>
<td>Virginia Garcia</td>
<td>Yakima Valley</td>
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<td>Orchid Health</td>
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Behind the Scenes

• OCPA Staff
  » Danielle Sobel, Sr. Director of Policy and Government Affairs
  » Torie Baldwin, APCM Specialist
  » VBP Strategies Director, TBD
  » Simon Parker Shames, Data Director
  » Brandon Lane, Data Analyst
  » Brooke Linn, Transformation Director
  » Stephanie Castano, Transformation Sr. Manager
  » Marty Carty, Government Affairs Director
  » Jason Bell, Quality Improvement Manager

• Members + Consultants
  » APCM Steering Committee, 7 members
  » Value-Based Pay Committee (Board)
  » CedarBridge Consulting
  » Curt Degenfelder
  » Hostetler Group
  » Community Health Center Network of Oregon (CHCNO)

• OHA
  » Donald Jardine
  » Jennifer Smith
  » Adrienne Cook
1. **Accountability for Outcomes**: OHA’s goal, aligned with their vision for health reform that established the CCO model, was to move towards increased accountability for Triple Aim outcomes - Improved quality, improved patient experience and reduced cost. It was particularly appealing to OHA that under a new methodology they would report tracking quality outcomes when heretofore they had not received any such data from health centers.

2. **No Additional Funding**: OHA stated explicitly that they were unwilling to pay *more* for health center services, but they were willing to pay differently. OPCA found common ground in the ask of Health Centers, which proposed equal payment on a per patient basis, with flexibility to serve those patients differently.

3. **Maintain Access**: OHA’s biggest concern about unintended consequences was that patients would see constricted access. This concern was primary for OHA because of their required accountability for Medicaid access and the experience that many had under Medicaid managed care models during the 90’s.
1. **Off the Face-to-Face Visit**: The foundation of health center’s ask was to create a methodology that would maintain their level of payment on a per patient basis and allow them to move off of the face-to-face visit with a billable provider.

2. **Formal APM**: OPCA required that the methodology be established as a formal Alternative Payment Methodology (APM), allowed for under federal PPS law. OPCA saw the PPS law as both protective of health centers by limiting the potential downside to the model as well as addressing concern that the APM would set a PPS-damaging precedent.

3. **Bridge to Value Based Payment**: Health centers were willing to share quality and access data for maintaining or improving outcomes but were not willing at the outset to put money at risk for improving outcomes. In particular, OPCA cautioned that until adequate social risk adjustment would become a reality, the playing field between providers is not level. The payment methodology was intended to “bridge to value-based payment”, because CHCs were not willing to go fully at risk for outcomes without improved medical and social risk adjustment.
APCM Program Successes

- Highest performing PCPCHs
- Significant and measurable increases in CareSTEPs
- Improvements in quality metric performance
- Cost savings demonstrated through reductions in hospital/ER utilization
- Countless local level clinical and community health innovations enabled by movement to population-health payment
APCM Challenges

- Limited staffing at OHA to administer APCM
- Increased complexities with new and existing reporting requirements
- APCM focus shifted to reporting requirements instead of original intent (care model advancements and innovations)
- Scaling up to meet need of larger number of FQHCs on the model is a major challenge
- Lack of automated operations/staffing stretches OHA, OPCA resources; FQHCs experience significant delays
Opportunities
Equity and Payment landscape

1. OHA strategic goal: Eliminating health inequities by the year 2030

2. CCO incentive metric: 70% of all primary care payment in VBP model by 2024 (LAN category 2C)

3. SDoH Incentive Metric (2023 planned)

4. CMMI and future of APMs (2026)
VBP Bridge(s)

<table>
<thead>
<tr>
<th>Element</th>
<th>FFS</th>
<th>APCM</th>
<th>VBP</th>
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<tbody>
<tr>
<td>Attribution</td>
<td>Visit-based</td>
<td>Services-based</td>
<td>Annual assignment + patient preference</td>
</tr>
<tr>
<td>Accountability</td>
<td>Documentation</td>
<td>CareSTEPs</td>
<td>Outcomes: Total cost + quality</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>None</td>
<td>None</td>
<td>Claims-based</td>
</tr>
<tr>
<td>Risk Stratification</td>
<td>None</td>
<td>None</td>
<td>Different levels of intensity</td>
</tr>
<tr>
<td>Quality</td>
<td>In-patient Universe (UDS)</td>
<td>In-patient Universe (UDS + Medicaid)</td>
<td>Assigned patient universe (CCO)</td>
</tr>
<tr>
<td>Race Adjustment</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>SDoH Adjustment</td>
<td>None</td>
<td>None</td>
<td>None</td>
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Setting the stage: Priorities

• Leverage the current state environment without jeopardizing program gains though:
  1. Risk adjustment includes: SDoH adjustment and race adjustment
  2. Streamline and automate data collection and evaluate outcomes
  3. Promote and be recognized as trainers in care model transformation and transitional mindset

• We can do this by iterating the following areas of APCM:
  » Accountability: Quality outcomes, Total Cost of Care analysis, assess current accountabilities
  » Attribution: align with CCO attribution?
    » Quality: CCO metrics, attributed universe of claims-based
    » SDoH: Z-codes collaborative
  » Technology: new platforms/modules at OPCA and OHA
The Vision for APCM 2.0

- Re-centering on equity and clinical innovation
- Automating program requirements & data exchange
- Showcasing FQHC Community Health Excellence
*DRAFT*
APCM 2.0 Framework
Reengineered for equity and innovation
OPCA develops draft framework for evolving APCM program

Draft framework reviewed by APCM Steering Committee in January. Presented at APCM forum in February, with focus groups through April, for clinic feedback.

OPCA and FQHC champions meet with OHA to gain buy-in on APCM 2.0 in May and June. New participation agreements signed in June/July.

APCM 2.0 launches in July
Structure of APCM 2.0 Framework

Goal 1
Renovate and redesign APCM operations to promote efficiencies through automated data exchange and reporting requirements

Goal 2
Maximize interoperability using federal funds to advance Medicaid systems and promote sharing of health and community information

Goal 3
Accelerate health equity by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions

Goal 4
Bridge to value-based care through alignment with CCOs and exploration of new innovative performance incentives

• Including:
  ✓ Timelines
  ✓ Milestones
  ✓ Cost Estimates
  ✓ Success Metrics
Goal 1

*Renovate and redesign APCM operations to promote efficiencies through automated data exchange and reporting requirements*
Goal 1

Renovate and redesign APCM operations to promote efficiencies through automated data exchange and reporting requirements.

Cost Estimate*

$910K

*Estimate of state general fund required for 10% portion of $1.1 million cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities (FFY 23-24). Add $400,000 annually for process automation contractor over 2 years ($800,000 total).
Maximize interoperability using federal funds to advance Medicaid systems and promote sharing of health and community information
Goal 2
Maximize interoperability using federal funds to advance Medicaid systems and promote sharing of health and community information.

**Implementation Timeline & Milestones**

**Jan 2023**
Evaluate existing systems and initiatives for health and community information exchange in Oregon. Assess data sources OHA / DHS that may assist with client care.

**Aug 2023**
Pilot workflows for utilizing community information exchange (CIE) to screen for patients’ social risk factors, query for social risks, refer to community-based organizations, track and monitor the status of referrals, and/or analyze population data on social risk factors at the community-level.

**Oct 2023**
In accordance with the MMIS IAPD in Goal 1, include funding for OHA to support FQHCs with onboarding and technical assistance to CIE technology infrastructures.

**Aug 2024**
Publish an annual report on FQHC CIE pilot activities with measurable outcomes and preliminary findings.

**Success Metrics**
- Assessment of FQHCs data infrastructure and community landscape for health and community information sharing by March 2023
- Each FQHC implements a pilot for CIE-type activities by August 2023
- OHA begins support for CIE activities by March 2024
- Report on FQHC CIE pilots including preliminary findings and community health outcomes by August 2024

**Cost Estimate**
$50K

*Estimate of state general fund required for 10% portion of $500,000 cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities.*
Goal 3

*Accelerate health equity* by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions.
Accelerate health equity by integrating REALD and SOGI data with clinical and social risk data to identify disparities and pilot community interventions.

**Goal 3**

**Success Metrics**

- FQHCs report predominant health disparities identified by June 2023
- FQHCs focus disparities and intervention methods by December 2023
- FQHCs design and implement the community health intervention(s) by Mar 2024
- Report progress and success stories by December 2024

**Cost Estimate**

$0

*Scope proposed does not impact state general fund budget.*
Goal 4

*Bridge to value-based care* through alignment with CCOs and exploration of new innovative performance incentives
**Goal 4**

*Bridge to value-based care* through alignment with CCOs and exploration of new innovative performance incentives

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**Jul 2022**

Pause and remove previous VBPs (accountability plan and non-engaged closure report). Engage FQHCs, OHA, and CCOs on menu of HCP-LAN VBPs methods. Explore new risk scoring based on REALD, SOGI, and social risk data.

**Oct 2022**

Reach agreement with FQHCs. Present a proposal to OHA to get buy-in. Assist OHA with applying for necessary federal authority to introduce new risk and/or reward components to APCM. Prioritize shared savings from total cost of care measurement.

**Jan 2023**

Plan and design Medicaid system changes necessary to efficiently administer VRP, including savings from aggregate total cost of care measurement. Assist OHA with design and development discussions with MMIS VBPs.

**Dec 2023**

Launch the new VBPs component of APCM 2.0. Facilitate engagement and technical assistance for participating FQHCs. Implement capabilities to monitor shared savings accrual in near real-time.

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**Success Metrics**

- Reach agreement with FQHCs on preferred HCP-LAN VBPs components by Jan 2023.
- UAT testing of new Medicaid VBPs module by Oct 2023.
- Launch the new APCM 2.0 VBPs (risk adjusted for REALD, SOGI, and SDOH) shared savings model using total cost of care by Dec 2023.

**Cost Estimate**

$250K

*Estimate of state general fund required for 10% portion of $2.5 million cost within an MMIS Implementation Advanced Planning Document (IAPD) submitted to CMS for 90% federal funds for design, development, and implementation activities (FFY 23-24).*
REMEMBER...

• This is a DRAFT framework...with planned implementation over next 2 years
• Your feedback matters and will improve the proposal
• OHA’s continued partnership is key
• Framework agreed upon will remain iterative and will build upon current successes
Discussion

What did you like in the framework?

What is working well in your APCM program?

What is missing in this framework?

Are you interested in joining future workgroups as each area moves forward? Please send Torie or Danielle a note or drop in chat here today.
Thank you!

Danielle Sobel, dsobel@orpca.org
Torie Baldwin, tbaldwin@orpca.org
Next steps for this group

Next Forum will be in Summer 2022 (July-August)

In-person networking event TBD (and as gatherings resume)

Workgroups/feedback opportunities on APCM 2.0

If you have questions or want to connect about anything APCM, please contact us anytime!
Torie (tbaldwin@orpca.org) or Danielle (dsobel@orpca.org)
Thanks very much!

Hang in there!