



How Health Centers Can Improve Patient Care Through Value-Based Payment Models

Patients in Federally Qualified Health Centers (FQHCs) across the country are benefiting from state-led value-based payment (VBP) models. VBP encompasses activities that move away from the traditional fee-for-service payment system, which rewards the volume of services provided, to models that reward high-quality, cost-effective care. The VBP models described in this brief aim to provide patients with coordinated, team-based health care that is convenient to access and best meets their needs. VBP supports opportunities to identify and address patients' health-related social needs at health centers by care coordinators who can provide links to community resources.

FQHCs are an essential part of the nation's health care safety net, providing primary care, as well as diagnostic lab, radiologic, preventive health, cancer screening, family planning, oral health, and patient case management services. Because FQHCs are deeply embedded in the community, they are uniquely positioned to impact care across the health care system and form long-lasting, trusting relationships with the patients they serve.

Under the traditional Prospective Payment System (PPS), FQHCs are paid for face-to-face encounters. Payment is based on volume of encounters rather than value, which stifles innovation and limits ways providers can care for their patients. In addition, health centers often lack the data and data management systems to monitor where patients get their care, which results in poor care coordination as patients receive disjointed care from providers at multiple locations. Under PPS, FQHCs are not paid to address the health-related social needs of patients, such as housing insecurity, even though they have a substantial impact on outcomes and costs.

VBP arrangements have the potential to remedy some of these issues in five meaningful ways. VBP can accomplish the following:

- ▶ Give health centers flexibility to provide care in the ways patients need and want.
- ▶ Allow health centers to make critical infrastructure improvements.
- ▶ Help improve patient outcomes.
- ▶ Help deliver holistic, patient-centered care.
- ▶ Improve accountability by rewarding health centers that improve quality of care.

A significant number of VBP programs are underway for FQHCs, and many are showing results. Four of these successful FQHC VBP models are (1) Oregon's Alternative Payment and Advanced Care Model (APCM), (2) Washington State's Alternative Payment Methodology 4 (APM4), (3) Illinois' Medical Home Network (MHN), and (4) Minnesota's FQHC Urban Health Network (FUHN). Because of the flexibility and opportunities for expanded infrastructure under VBP, each of these models has

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achieved success in improving quality and cost outcomes and demonstrated improved value to patients. The structure of these programs, including their payment models and quality metrics, is outlined in Table 1.

In the wake of the COVID-19 pandemic, the need for FQHCs to transition to VBP has taken on increased urgency. The examples highlighted in this brief show that this transition is possible and has the potential to substantially benefit patients.

Table 1. Overview of FQHC Value-Based Payment Models

MODEL/DESCRIPTION	PAYMENT MODEL	QUALITY METRICS
<p>Oregon’s Alternative Payment and Advanced Care Model <i>Start date:</i> 2013 <i>Participation:</i> 18 of the state’s 32 health centers¹</p> <p>The Oregon Primary Care Association (OPCA) worked with the Oregon Health Authority (OHA) to develop the Alternative Payment and Advanced Care Model (APCM), which was launched in 2013 as a pilot with three participating health centers.</p>	<p>Health centers receive a base encounter payment from the health plan and an up-front supplemental capitated PMPM (per member per month) wrap payment from the state. Health centers submit reconciliation reports quarterly, with settlements paid on an annual basis. A portion of the payment is tied to meeting five quality benchmarks.</p>	<p>FQHCs are accountable for five metrics that align with the coordinated care organization (CCO) incentive measures:</p> <ul style="list-style-type: none"> ▶ Colorectal cancer screening ▶ Depression screening ▶ Diabetes HbA1c >9% ▶ Weight assessment and counseling in children and adolescents ▶ Controlling high blood pressure
<p>Washington State’s Alternative Payment Methodology 4 <i>Start date:</i> 2017 <i>Participation:</i> 16 of the state’s 27 health centers² <i>Patients served:</i> 183,563³</p> <p>Washington State’s Alternative Payment Methodology 4 (APM4) initiative expands that state’s previous APM3 model, which was implemented in 2011. APM3 allowed FQHCs to choose between being reimbursed under the traditional encounter-based PPS or receiving an APM payment.</p>	<p>Health centers receive an up-front PMPM payment from the health plan as well as a monthly “enhancement payment” from the state. The rate is then prospectively adjusted annually by the state to reflect the FQHC’s performance on five quality targets. FQHCs continue annual reconciliation to ensure PPS equivalency. In lieu of a settlement process, adjustments are made prospectively to future rates.</p>	<p>The following five process and outcome measures, which were selected from the state’s common measure set, are tracked:</p> <ul style="list-style-type: none"> ▶ Antidepressant medication management ▶ Childhood immunization status ▶ Well-child visits ▶ Controlling high blood pressure ▶ Comprehensive diabetes care, including HbA1c >9%
<p>Illinois’ Medical Home Network ACO <i>Start date:</i> 2014 <i>Participation:</i> 9 FQHCs <i>Patients served:</i> 180,000⁴</p> <p>The Medical Home Network (MHN) accountable care organization (ACO) includes nine FQHCs, three hospital systems, and their physician practices, which came together to “improve health care delivery in the safety net, enhance quality of care, and reduce medical costs” in Chicago’s south and southwest neighborhoods.⁵ The ACO grew out of a two-year pilot with the state Medicaid agency. The ACO is operated by Medical Home Network, a nonprofit health care organization founded in 2009 by the Comer Family Foundation. MHN ACO partners with CountyCare, a Medicaid health plan run by Cook County Health and Hospitals System.</p>	<p>Health centers receive an up-front PMPM payment from the ACO to deliver care coordination. Health centers also receive a shared savings payment from the ACO based on each one’s total cost of care and its performance on quality measures.</p>	<p>MHN performance measures include⁶:</p> <ul style="list-style-type: none"> ▶ 30-day all-cause readmissions ▶ 7-day primary care provider (PCP) follow-up ▶ 7-day PCP follow-up after emergency department (ED) admissions ▶ New-patient visits within 90 days ▶ Care plans with timely updates ▶ Patient Health Questionnaire-2 (PHQ-2) positives with completed PHQ-9 ▶ ED utilization

Table 1. Overview of FQHC Value-Based Payment Models, continued

MODEL/DESCRIPTION	PAYMENT MODEL	QUALITY METRICS
<p>Minnesota’s FQHC Urban Health Network</p> <p><i>Start date:</i> 2013</p> <p><i>Participation:</i> 10 FQHCs with 30 health center sites</p> <p><i>Patients served:</i> 100,000⁷</p> <p>In 2013, Minnesota launched its Medicaid Health Care Delivery System initiative, creating an ACO program now known as the Integrated Health Partnership (IHP) program. Under this program, 10 FQHCs in the Minneapolis–St. Paul area came together to form the Federally Qualified Health Center Urban Health Network (FUHN) to enhance the health care of its Medicaid patients and improve primary care access for vulnerable populations.⁸</p>	<p>If FUHN earns shared savings through its state contract, member health centers receive a portion of shared savings based on a total-cost-of-care calculation for a core set of Medicaid services, and for achieving quality targets.</p>	<p>Measures for the IHP program include 32 quality measures, which are scored as nine aggregate measures.⁹ Measures are determined through the contract negotiation between the state and FUHN, drawing from a core set of quality measures from the MN Department of Health’s Statewide Quality Reporting and Measurement System, Medicaid, Healthcare Effectiveness Data and Information Set (HEDIS), and the Medicaid Electronic Health Records incentive program.¹⁰</p>

Value-based payment can give health centers flexibility to provide care in the ways patients need and want.

The nature of VBP arrangements allows FQHCs flexibility to deliver, and be paid for, services outside traditional health care services, which are often referred to as alternative encounters or touches.¹¹

For example, by continuing the move away from traditional encounter-based reimbursement, Washington’s APM4 model provides additional flexibility in delivering primary care services, expands primary care capacity, taps into a broader workforce, and creates financial incentives for improved health care.¹² Examples include health centers that are providing nutrition and exercise counseling and classes, integrating behavioral health, expanding supports for pregnant women, and conducting outreach to jail-involved patients.

Health centers that participate in Oregon’s APCM model have the flexibility to offer “nontraditional services” that were previously not paid for. Under this model, these services are referred to as a Care STEP, which is a direct interaction between the health center staff and the patient, the patient’s family, or authorized representative(s) through in-person, digital, group visits, or telephonic means.¹³ Care STEPs may include home visits, telemedicine and telephone visits, information

management, clinical follow-up and transitions, dental care coordination, transportation assistance, health education and supportive counseling, support group participation, group education, exercise classes, panel outreach, and case management.¹⁴

Examples of Alternative Encounters

- ▶ Home visits
- ▶ Telemedicine encounters and telephone visits
- ▶ Patient outreach, clinical follow-up, transitions
- ▶ Dental care coordination
- ▶ Transportation assistance
- ▶ Health education and supportive counseling
- ▶ Support group participation and education
- ▶ Exercise classes
- ▶ Nutrition counseling and medically tailored meals

Value-based payment can allow health centers to make critical infrastructure improvements.

The flexibility that FQHCs receive from VBP programs, including up-front PMPM payments for patient care or care coordination and shared savings distributions, can allow FQHCs to invest in infrastructure improvements to better serve their patients and improve operational efficiencies. In Minnesota, for example, health centers used their resources to develop a data analytics infrastructure that includes a data warehouse that receives real-time clinical data from the FQHCs' electronic medical records, payer claims data, and admission and transfer data from hospital partners. This infrastructure allowed FUHN to gain deeper insights into their patients' conditions and utilization patterns, which can be used to improve patient care. Additionally, FUHN was able to support on-site care coordinators and other health care staff to use these data to coordinate care and manage costs.

Similarly, to advance its care coordination efforts, the MHN ACO in Illinois used its up-front funding to create MHNConnect, a data-sharing portal that integrates data from the ACO providers, area hospitals from within and outside of the ACO, and claims and pharmacy data. This system allows providers access to real-time, actionable data to support care coordination activities and transitions of care.¹⁵

Expanding the Care Team

The traditional PPS payment methodology restricts billable encounters to physicians, physician assistants, and nurse practitioners. VBP allows health centers to use additional staff, including the following:

- ▶ Behavioral health and peer counselors
- ▶ Community health workers
- ▶ Dietitians
- ▶ Nurse care managers
- ▶ Pharmacists
- ▶ Physical therapists
- ▶ Social workers

Value-based payment can help improve patient outcomes.

The FQHC VBP models in Illinois, Minnesota, and Oregon have shown positive outcomes to date (Washington's APM4 model was recently implemented, so statistical data are not yet available). Significant positive impacts have been seen in preventive screening rates and patient engagement efforts, but most importantly, there have been impressive reductions in patients' social risk factors and hospital utilization (including inpatient admissions and ED visits). These improvements have also contributed to substantial cost savings for payers (state Medicaid agencies and health plans) as well as significant shared savings distributions to the FQHCs in these arrangements (see Table 2).

Table 2. Patient Outcomes of FQHC Value-Based Payment Models

Patient engagement

- ▶ Patient engagement with the care team beyond traditional visits has more than tripled since 2013 (OR APCM)¹⁶
- ▶ 30% reduction in appointment cancellations (MHN ACO)¹⁷

Prevention and screening

- ▶ 15% increase in colorectal cancer screening rates (OR APCM)¹⁸
- ▶ 21% increase in depression screening with follow-up (OR APCM)¹⁹
- ▶ 89% of patients completed Health Risk Assessments (MHN ACO)²⁰

Health-related social needs

- ▶ Care teams' focus on social determinants of health has resulted in a 37.4% reduction in total social risk factors impacting health, for example, helping patients to access transportation to go to medical appointments (MHN ACO)²¹

Hospital utilization

- ▶ 26% reduction in inpatient admissions (FUHN)²²
- ▶ 34% reduction in ED visits (FUHN)²³
- ▶ 15% reduction in in-patient days (MHN ACO)²⁴

Cost savings

- ▶ State analysis of OR APCM showed \$17 million in Medicaid costs avoided over the first three years²⁵
- ▶ \$23.6 million in shared savings earned, from 2013 to 2017 (FUHN)²⁶
- ▶ In its first year (July 2014–July 2015), MHN ACO earned \$17.7 million in shared savings²⁷

Value-based payment can help deliver holistic, patient-centered care.

FQHCs that implement VBP programs are able to improve patient experience by enhancing care coordination services, increasing access to care through alternative modalities such as telehealth, and addressing health-related social needs such as food insecurity, housing instability, and lack of transportation. The sidebar “APM4 Health Centers Share Their Experiences” describes changes that health centers participating in VBP have been able to make to improve care for their patients.

Value-based payment models can allow FQHCs flexibility to use alternative visits/touches and more provider types, as well as providing more convenient care. These changes can directly benefit patients, both clinically and through greater satisfaction with their interactions with the care team.

Enhancing Care Coordination

- ▶ Patients receive more coordinated care because providers have access to real-time data on ED visits and hospital admissions, allowing them to target outreach to at-risk patients, link them to community providers, and better support their care.
- ▶ Patients are connected with care coordinators who help them manage their health by developing treatment plans, making appointments, and accessing prescriptions.
- ▶ Patients who transition from hospitals and specialty care receive follow-up care from providers who help meet their needs to prevent readmissions and ED visits.

APM4 Health Centers Share Their Experiences

Peninsula Community Health Services

- ▶ “[We] revamped our care model to provide patient-centered care and engagement where patients live and spend time, and when they need it.”
- ▶ “[Our center] has a patient navigator that spends time at local drug court and local veterans drug court and makes sure that justice-involved individuals and their family members have access to Medicaid, and facilitates scheduling for these people.”

Community Health Association of Spokane (CHAS)

- ▶ “[Our health center] has created a Utilization and Care Management team dedicated to improving the health and lives of patients who often seek primary care in urgent and/or emergency care settings.”
- ▶ “This [new] mix of providers enables access to comprehensive, on-site behavioral health services, including mental health counseling, substance use counseling, behavioral health prescribing, medication counseling, and nutrition counseling, all in an environment equipped to also counsel patients experiencing co-occurring physical chronic disease and behavioral health disorders.”
- ▶ “[The health center] has recently undertaken a systemwide initiative around primary care transformation. Through patient registries, enabling technology, and preplanned interactions, CHAS Health will proactively support the success of each patient’s care plan. This includes doing what we can to keep patients engaged even when they are not in our clinics.”

Columbia Valley Community Health:

- ▶ “[Our health center] recognizes ... that pregnancy could be a time when a young mother creates lifelong healthy habits, with lifelong impacts for both herself and the rest of her family.”
- ▶ “Certified midwives will be partnering with licensed dietitians and personal trainers ... offering exercise classes, nutritional monitoring and classes, free access to gyms, and a proven exercise-tracking social-media platform to make all the changes fun and engaging.”

For more information, view www.youtube.com.

Increasing Access to Care

- ▶ Patients have access to providers through alternative modalities, such as telehealth, which means patients don't have to take time off from work to travel to appointments.
- ▶ Patients receive transportation assistance to help them attend appointments.

Addressing Health-Related Social Needs

- ▶ Health center staff have the time to become knowledgeable about community resources and develop partnerships with organizations that can address patients' health-related social needs that lead to improved health. Patients have access to community health workers whom they trust to help navigate the health care system and connect them to community resources that they may not know about.
- ▶ Patients receive on-site health education, nutrition counseling, and exercise classes from staff they know and trust, and which doesn't require extra traveling outside their neighborhoods.

Value-based payment can improve accountability by rewarding health centers that improve quality of care.

Providers at health centers that are accountable for patient outcomes are motivated to deliver coordinated, quality care and address the health-related social needs of their patients. Traditional per-visit payments do not encourage prevention and screening, coordinating care to address chronic conditions, conducting outreach, or addressing the underlying social needs of patients. VBP allows providers to focus on the best interests of their patients. VBP includes built-in financial incentives and penalties to help improve quality and reduce costs, such as those in the capitated and shared savings payment models and quality metrics described in Table 1, which are designed to improve the way care is delivered. As patients' health improves and their experiences are enhanced by holistic, team-based care, providers also benefit from increased confidence in seeing better outcomes.

Conclusion

Across the country, FQHCs are finding success in moving away from fee-for-service payments and toward value-based payment arrangements. These payment arrangements, developed through partnerships with state Medicaid agencies and health plans, reward providers for improving quality and decreasing health care costs, while offering greater flexibility to deliver care in innovative ways. The examples in this brief provide ideas for states and their stakeholders to develop models that better align the financing and delivery of health services at FQHCs to provide the best possible care for patients.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

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