

ENGAGING IN ACCOUNTABLE CARE: A PCA/HCCN TOOLKIT



NATIONAL ASSOCIATION OF
Community Health Centers



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PCA AND NETWORK RELATIONS DEPARTMENT

Shawn Frick

Associate Vice President

sfrick@nachc.com

301-347-0447

Jennifer Nolty

Director, Innovative Primary Care

jnolty@nachc.com

301-347-0437

Dick Bohrer

Director, Network Relations

dbohrer@nachc.com

301-347-0401



HOW TO USE THIS TOOLKIT

The delivery and payment for health care services is rapidly changing. Health Centers across the country are building new capacity, skills, and partnerships to meet the challenges and opportunities of the Accountable Care Act. This toolkit is intended to provide information and resources to support Health Centers seeking to engage with Qualified Health Plans. These same strategies and resources can be utilized for any type of managed care contract, including Commercial, Medicaid and Medicare managed care, ACOs and IPAs. Embedded in this document are several links to web resources, so it may be most effective to review the content from the Toolkit in an electronic format.

The Toolkit is organized into five modules:

Module 1 discusses the current trends in healthcare delivery and reimbursement that impact the way that Health Centers and payers engage to meet the needs of patients.

Module 2 highlights the various capacity and capabilities that Qualified Health Plans will expect of their Health Center partners.

Module 3 focuses on the positive impact of collaborations among Health Centers, Primary Care Associations, and Health Center Controlled Networks in strengthening partnerships with payers.

Module 4 identifies important tools and competencies that Health Centers should develop in order to function as strong partners with Qualified Health Plans and other payers.

Module 5 focuses on ways that Health Centers can evaluate their ability to respond to state and regional market opportunities to work with Qualified Health Plans and other payers.

The Toolkit includes a number of features to help Health Centers practically apply the information into their planning efforts. These include:

- **Information** and **examples** about how Health Centers, safety net providers, and others have built their ability to engage with Qualified Health Plans and other payers in order to respond to changes in the healthcare system
- **Weblinks** embedded throughout the document for Toolkit users to hyperlink directly to reports, references, and resources where additional information can be easily accessed
- **Checklists** and **worksheets** to assist Health Centers in thinking through their current level of capacity to identify current areas of strength or weakness



MODULE 1: TRENDS IMPACTING HEALTH CENTERS AND PAYERS

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) has ushered in a number of systems, payment, and care delivery changes in United States health care system. Long supported through federal programs and grants, Health Centers, Health Center Control Networks (HCCNs) and Primary Care Associations (PCAs) must consider how their historical care delivery and funding models are being impacted by both the challenges and opportunities that lie ahead. More than ever, the primary care provided through health centers will play an important role in linking communities, patients, and providers as health systems around the country seek to achieve the three goals of the Triple Aim: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

Just as providers and Health Centers are impacted by these changes, payers of health services are impacted as well. Medicaid Managed Care, commercial, and other payers operating on the health insurance marketplaces also face a number of changes that impact how they work with patients and interact with all types of healthcare providers.

For many years, Health Centers, Primary Care Associations (PCAs) and Health Center Control Networks (HCCNs) have benefited from partnerships that supported the goals of expanding high-quality primary care for underserved areas. As the dynamic has begun to shift as a result of the ACA, these organizations are seeking innovative ways to deepen and strengthen their historical collaborations.

In order for Health Centers, PCAs, and HCCNs to leverage their position as these opportunities emerge, Health Centers and networks of Health Centers will need to form new formal partnerships. These new relationships will evolve over time but will create the need for new business practices and competencies to engage payers, patients, and providers. Health Centers that choose to “go it alone” without partnering with other Health Centers, payers or health systems, may forego critical opportunities to secure both strategic positioning and advantageous payment terms in the future. Health Centers that work collectively with payers may be able to leverage economies of scale and pool enough patient lives to increase their competitive standing during negotiations around payment and other terms. Health Center CEOs should carefully consider these options and weigh the potential opportunity costs of deciding not to collaborate with other organizations.



TRENDS INFLUENCING NEW PARTNERSHIP AND NETWORK DEVELOPMENT

In a post-ACA reality, Health Centers face environmental factors and trends that put pressure on their existing business models. Health Centers have traditionally built partnerships at the regional level to meet the needs of their patients and communities. As a result of ACA-implementation, Health Centers are expanding upon these in many different ways. Many Health Centers are coming to the conclusion working collectively with other providers better facilitates the ability to create economies of scale, invest in needed data management platforms, risk management, and efficiencies necessary to meet these challenges. By working in partnership, Health Centers are often better positioned to respond to the following trends.

Trend 1: Shifting Payer Mix

Historically, Health Centers have served a high proportion of uninsured and Medicaid patients. As a result of the ACA's priority of expanding health insurance coverage to uninsured Americans, Health Centers will experience a shift in their uninsured patient pools. As more patients gain coverage, many uninsured patients will become eligible for new health coverage programs either through state efforts that expand Medicaid eligibility or through the Health Insurance Marketplace plans. In addition, Health Centers are generally experiencing an increase in demand for primary care services as previously uninsured individuals gain coverage.

In several states, newly Medicaid-covered patients are being enrolled in Medicaid Managed Care plans. These Managed Care plans often parallel commercial-style payer contracts and typically include reporting on performance metrics and new payment models that present different terms than Health Centers have traditionally experienced. As a result of this change, Health Centers are examining how these changes impact their financial, operational, and clinical operations and workflows.

Additionally, as more commercial-style contracting occurs, Health Centers may seek to participate with *contracting entities* to create more influence with Medicaid Managed Care, Medicare Advantage, and commercial plans.

Trend 2: Operationalizing the Triple Aim

Originally developed by the Institute for Healthcare Improvement (IHI), the *Triple Aim*¹ is a framework that describes an approach to optimizing health system performance. The Centers for Medicare and Medicaid (CMS), as a result of the ACA, adopted the goals of the *Triple Aim* defined as:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

Many of the Bureau of Primary Health Care's nineteen program requirements² for Health Centers build a foundation for supporting the Triple Aim. For example, Health Centers have long focused on providing high quality, patient-centered care. However, in order to respond to the Triple Aim's charter of improving the health of populations, Health Centers are being tasked to analyze population-level clinical and cost data to identify opportunities for clinical interventions and programs, all while assuring that quality and the experience of the patient do not suffer. Specifically, Health Centers will need to respond to the following:

- Using clinical and cost data to implement models of care that jointly manage the **total medical expense** of their patients
- Focusing on the quality of care at both the patient and population level
- Collaborate with other providers to isolate “hot spots” of expense growth and clinical need that require intervention
- Implement data-driven decision making to support these goals.

*Although different payers define it slightly differently, a good way to think about **Total Medical Expense** is that it is the sum total of all the expenses related to all the claims paid on behalf of a patient—primary care, pharmacy, labs, radiology, hospitals (inpatient, outpatient, and ER), and specialists.*

1 <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>
2 <http://bphc.hrsa.gov/about/requirements/hcpreqs.pdf>



Reflection Questions

What are some of the barriers your Health Center, HCCN, or PCA would face in trying to manage the health of a particular population? Based upon current relationships with payers, are there any patient populations that could be an effective pilot group for this type of effort?



Trend 3: Engaging Patients and Beneficiaries in New Ways

Health Centers historically have established an important role within the communities they serve. As mission-driven organizations with consumer boards, Health Centers are leaders in providing culturally appropriate, holistic, patient-centered care. This background affords them a strategic advantage under health reform initiatives emphasizing patient engagement and satisfaction. New models of care require patients not only to participate in the strategic governance of new entities (i.e. Accountable Care Organizations) but they are also set to play a more active role in their own healthcare through self-management activities and enhanced communication with their providers. As a result, Health Centers should explore ways to enhance and expand their current patient engagement strategies. Strategies such as patient portals, patient-led outreach and peer education, telehealth and remote monitoring, patient education, and even financial incentives for patients will likely be more effective and efficient when developed and managed through a network of Health Centers.

Patient Engagement strategies will adapt to meet the changing ways patients want to communicate and interact with their healthcare provider.

Stories from the Field: Medi-Cal Incentives to Quit Project (California)

Medicaid beneficiaries who smoke are offered a \$20 incentive to call a telephone counseling hotline, complete an intake protocol, and participate in counseling sessions. Incentives are also provided when a patient relapses but re-engages for support.

Trend 4: Increased Competition for Health Center Patients

The ACA places more emphasis on the importance of primary care in an effort to increase coordination and prevention, and decrease care in more expensive settings. One important signal was the ACA's increase in overall Medicaid payments, a move designed to expand the number of primary care providers willing to serve Medicaid and Medicaid expansion patients. In addition, many risk arrangements define patient populations by their primary care provider. As a result health systems are looking to add primary care capacity in order to expand their patient pools. Thus, affiliating with primary care providers will become a prominent network growth strategy as health systems seek to expand their patient base to minimize risk.

Health Centers and other primary care providers, will be expected to provide care management services for chronic diseases, but will also be tasked to expand coordination with mental health, substance abuse, care transitions between institutions, and other areas. For patients that require more specialized care, these primary care providers will be incentivized to keep these patients in network where cost and quality can be better managed.

As the role of primary care becomes more prominent, more capacity and infrastructure, including mid-level primary care provider staff, will be needed to fill this role. Networks of existing primary care providers, hospitals, health systems, and other organizations will be looking to develop this capacity so that it integrates with their existing infrastructure to maximize the opportunities, positioning, and influence of primary care providers. More and more, Health Centers are experiencing the impact of these groups building their own primary care capacity instead of partnering with Health Centers. This could ultimately diminish the influence of Health Centers with both payers and existing and/or emerging patient populations. By coming together to form formal primary care networks, Health Centers can create both *scale and influence*.



Reflection Questions

Has your Health Center experienced any competition for your patients? If so, what steps have you taken to address this?



Trend 5: Providers Organizing Under New Network Models

Redesigning the healthcare system and delivering on the promises of the ACA relies upon providers, patients and payers to interact with each other in new ways. More than ever, close collaborations, shared accountability, and standardization of clinical and business operations are creating new opportunities for these partnerships.

Health Centers and PCAs around the country are gravitating towards three main models of networks to formalize their partnerships (below). Deciding to participate in these types of partnership models depends on the type of capacity that Health Centers need to meet the challenges of health reform in their region or state. In many cases, Health Centers may already participate in formal networks or partnerships (i.e. Health Center Controlled Networks or group purchasing organizations). However, many are finding that by coming together through newly developed entities will provide additional support for shared business services, payer contracting, and other key functions.

*Accountable Care Organizations (refer to the 'Accountable Care Organizations: Health Center Strategies for Success' white paper via https://mylearning.nachc.com/diweb/gateway/init/1/f/catalog*2Fitem*2Feid*2FPB0814PCA5 found on the NACHC website)*

Accountable Care Organizations (ACOs) are provider-led organizations that come together to manage the quality of care and costs of a specific population of patients. Providers who come together in ACOs collaborate to manage the clinical care of attributed patients and manage the costs against the total medical expenses for the population. By working together to coordinate the care of these patients, they are able to create efficiencies, minimize duplication, and target specific clinical interventions. When the ACO achieves both the required clinical and cost outcomes, it can share in the savings generated.

The number of ACOs is expanding rapidly. As of January 2014, the Medicaid Shared Savings Program included 341 ACOs. In addition, approximately 250 ACOs have been developed in response to ACO Medicaid pilots and commercial health insurance programs³. Health Centers are increasingly leveraging opportunities to participate in ACOs. In some cases Health Centers have joined with other provider types and health systems in the formation of ACOs, while in other instances they have found it more advantageous to form new, Health Center-led entities.

Stories from the Field: Community Health Accountable Care (Vermont)

In 2013, seven FQHCs along with Bi-State Primary Care Association formed a new primary care centric ACO entity to integrate and coordinate population based care across Vermont among and between vertical and horizontal health care providers. By coming together under the ACO, the Health Centers have created an entity to engage with Medicare, Medicaid and Commercial payers.”

Independent Practice Associations

An independent practice association (IPA) is an association of independent practices providing services to managed care organizations under negotiated financial terms. By joining an IPA, a Health Center can maintain its independence and autonomy, while receiving favorable payment terms and other terms from payers. The IPA, however, may require the practice to use a shared business infrastructure and adhere to other standards. Health Centers that create their own or join an existing IPA remain separate and free-standing organizations, and maintain autonomy over their business governance and operations. Participating in an IPA does not preclude a Health Center from participating in other health systems, ACOs, or other formal partnerships.

Managed Services Organizations

A management services organization (MSO) is an entity that, under contract, provides services such as a facility, equipment, staffing, vendor contract negotiation, administration, and marketing. Services may be provided to independent practices through a fee-based arrangement paid by the Health Center or another entity such as an insurer. An MSO creates a shared infrastructure for co-management of functions to create economies of scale.

³ <http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/>

NEW PAYMENT MODELS AND TERMS PRESENTED TO HEALTH CENTERS BY QUALIFIED HEALTH PLANS AND OTHER PAYERS

A key tenet of the ACA is the shifting focus of reimbursement in healthcare from volume (number of services delivered) to **value** (quality of the care services delivered per unit of cost). These **value-based payments** acknowledge the fact that improving quality of care requires some upfront investment. If these investments prove effective, the payer (i.e. Medicare, a health plan) will share savings with the providers in the system, compensating them for their investments. It should be noted that value-based contracts are concerned with the **cost to the payer**, not the **cost to the care provider** to produce the service. Therefore, cost reduction under value-based reimbursement models either take the form of reduction in the volume of services based on a set **patient population** (i.e. CT scans/1000 patients per year), or a reduction in the reimbursement the care provider receives for these services from the payer.

Reimbursement Models in the Marketplace: Value-based Reimbursement and Total Expense

As more Health Center patients become eligible for health coverage through expanded State Medicaid benefits or coverage through the Health Insurance Marketplace, innovations in reimbursement are being tested and implemented throughout health care services. Health Center reimbursement has historically focused on encounter-based payments, often perceived as “expensive” in comparison to other fee schedules and payment structures for other primary care providers. As a result, both public and commercial payers *may* approach Health Centers and their networks about testing or implementing new models of reimbursement. More and more, this emphasis on **value-based payments** to compensate healthcare providers delivering higher quality, more effective care is becoming pervasive. These value-based reimbursement models put a portion of the reimbursement “at risk” based upon a set of performance measures. As the provider takes on more risk, more opportunities arise for higher levels of reimbursement. Health Centers should carefully consider strategic and financial thresholds for the riskier models of payment.

Typically, Health Centers do not start out in the riskier payment arrangements but over time may choose to evolve to these as they become more adept at managing the risk of their patient populations. In addition, for the most risky reimbursement models, pooling risk through some type of **clinically integrated network** such as an Accountable Care Organization or Independent Practice Association provides a critical safeguard for a Health Center’s individual financial position. Essentially, the network absorbs the financial impact that might occur as a result of failing to meet specific benchmarks and performance measures set as part of the payment agreements. Finally, Health Centers engaging with these new models should strive to maintain the base payments afforded them through the Prospective Payment System (PPS) or other encounter-based reimbursement arrangements. Many Health Centers have been able to build these rates into other payment models as new strategies have been tested or implemented.

Clinically Integrated Networks demonstrate that by sharing clinical, financial, and operational infrastructure, the network performs more efficiently and effectively than the providers could independently.

As Health Centers consider these new arrangements, it is important to understand the differences among the reimbursement models that are emerging.

Quality Incentives – These are payments made for achievement of certain quality goals. Typically, these are provided in addition to base payment arrangements. These have traditionally mirrored the Healthcare Effectiveness Data and Information Set (HEDIS) measures on effectiveness of care. These incentives can be put into place regardless of the number of a QHP’s patients a Health Center cares for.

Cost of Care Incentives – These are incentive models where provider organizations are incentivized to reduce the cost of care they deliver compared to some target. These are typically paired with a quality incentive to ensure quality is not adversely affected by any reductions in cost.

Below are several forms of cost incentives in order of least risk to most risk borne by the provider organization. These models generally have some minimum number of QHP patients the provider organization cares for. Five thousand patients is a typical minimum for these programs.

Shared Savings – These are payments that represent a portion of savings against total medical expense (TME) that are shared among providers and, depending upon the model and payers. The comparison group for measuring the amount of savings can take several forms, or can be a set target based on the expected economic growth.

Bundled Payments – These are a single payment that must cover all services for a patient for a specific medical event or condition. Provider groups that can provide services for the medical event below the price of the bundled payment book the difference as profit,



but any overages are booked as losses. The distribution of these gains or losses can be highly contentious and should be thought out before a contract takes effect. An unwillingness to share in gains and losses under bundled payments likely indicates a larger unwillingness to collaborate.

Full or Partial Capitation – These are single payments that must cover all services for a patient over a given time period, typically distributed after a risk-adjustment model has been applied. Providers usually receive payments through a per member per month (PMPM) allocation. Providers must then attempt to deliver care within the cost of the PMPM allocation and are financially responsible for any variance from this number.

The examples above highlight some of the current examples of changes in reimbursement that Health Centers are experiencing. Other models may emerge as well. Regardless of the type of incentive, healthcare providers must carefully design programs to target populations to help meet quality standards and control high rates of cost growth. The ability to adequately manage these programs requires a broad range of data and competencies; value-based reimbursement may provide the financial incentive to invest in these competencies that may not exist under fee-for-service.

CONCLUSION

The delivery of healthcare under the Affordable Care Act is fundamentally changing the way Health Centers and PCAs interact with health systems, other providers, payers, and patients. In order to respond to these changes, take advantage of new opportunities, and stay positioned to provide high-quality primary care, Health Centers will need to develop new competencies and partnerships. In some cases, joining an existing network or developing a new Health Center-led network may offer an opportunity to build upon existing resources and competencies to adapt to this changing environment. Health Center and PCA staff should be aware of the opportunities and challenges that these new partnerships and networks may offer.



WORKSHEET 1: TRENDS INFLUENCING THE DEVELOPMENT OF HEALTH CENTER NETWORKS AND PARTNERSHIPS

Directions

As you consider the various dynamics occurring as a result of the ACA, think about how the trends and environmental shifts are impacting your Health Center's ability to respond and engage.

Complete this checklist as a way to identify areas where your Health Center may want to strengthen its position or competencies.

IMPACT OF HEALTH CARE TRENDS CHECKLIST

- My Health Center has been approached by new payers (i.e. Qualified Health Plans) about becoming a contracted provider in their network.
- My Health Center has analyzed how a changing payer mix could impact our financial bottom line.
- My Health Center has been involved in building partnerships with local hospitals to enable our organization to provide cost effective care to an integrated patient population.
- My Health Center has experienced a loss in patients as their healthcare coverage status changed.
- My Health Center is exploring new ways to engage patients and improve patient experience.
- My Health Center has been approached about participating in formal, integrated networks like ACOS or IPAs.
- My Health Center has been approached about and has begun to test new models of reimbursement that emphasizes value over volume.



MODULE 1 RESOURCES AND LINKS

Information on the Triple Aim

The Institute for Healthcare Improvement originated the concept of the Triple Aim. They have several valuable resources and materials available in this content area. These include:

1. [Are you ready to pursue the Triple Aim?](#)
2. [The Improvement Guide: A Practical Approach to Enhancing Organizational Performance \(2nd Edition\)](#)
3. [High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs](#)

The Center for Medicaid and Medicare Services (CMS) Innovations Center promotes, tracks, and catalogs a number of Triple Aim and other innovative practices that may be useful for Health Centers, PCAs, and other safety net stakeholders. A number of resources can be found at the Innovations Center [website](#).

Several foundations and research organizations have produced reports and resources accountable care and health reform:

1. [Organizing the U.S. Health Care Delivery System For High Performance](#)
2. [Better Ways to Pay for Health Care](#)
3. [Implementing the Affordable Care Act: The State of the States](#)

Patient Engagement

1. [Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies](#)
2. [Financial Incentives, Patient portals, UnitedHealth Group Rewards for Health Program](#)
3. [California: Medi-Cal Quits Program](#)
4. [Person- and Family-Centered Care Options \(IHI weblinks\)](#)
5. [Clinical Management Apps: Creating Partnerships Between Providers and Patients](#)

Value Based Health Care

1. [Quality, Cost, and Value \(IHI weblinks\)](#)
2. [Value Based Reimbursement Models \(AHRQ Links\)](#)
3. [From Volume To Value: Better Ways To Pay For Health Care \(Health Affairs\)](#)
4. [Moving Payment from Volume to Value: What Role for Performance Measurement? \(Urban Institute\)](#)
5. [Curbing Costs, Improving Quality \(Robert Wood Johnson Foundation weblinks\)](#)
6. [State-Based Approaches to Health Care Value](#)

MODULE 2: EMERGING EXPECTATIONS OF QHPs AND OTHER PAYERS: WHAT HEALTH CENTERS CAN ANTICIPATE

INTRODUCTION

As more Health Center patients gain access to insurance coverage, the ability—and necessity—of Health Centers and payers to form relationships with QHPs and other payers will expand. Whether engaging with Medicaid Managed Care plans or commercial payers, Health Centers will enter these relationships by carefully considering their local markets, risk-tolerance, and strategic aspirations.

While building these relationships, Health Centers should consider the operating requirements payers will expect as part of these partnerships. In particular, QHP and other payers will look to Health Centers to provide the following:

- Scale and Patient Volume
- Quality and Consistency of Healthcare Services
- Cost Management

QHPs Seek Scale and Patient Volume

The concept of *scale* is critical in post-ACA healthcare delivery. The most basic definition of scale is “the relative size of a group of providers” or, more specifically, “the relative size of the population of patients a group of providers can provide care for.” Both of these issues are important as QHPs and other payers, including Medicaid and Medicare, seek contracts or partnerships with Health Centers. Scale provides a number of advantages to both Health Centers and payers. Understanding how payers define these advantages from the payer’s perspective will strengthen the ability of Health Centers to engage with them. In addition, QHPs are required to meet a minimum threshold for contracting with “essential community providers,” a designation that includes Health Centers. As such, QHPs are often incented to work with Health Centers to fulfill this requirement.

Scale plays an important role for QHPs by increasing the size of their provider group as well as providing access to patients and effective clinical programs.

QHPs and other payers define scale through five key constructs:

1. Patient Volume
2. Network Adequacy and Access
3. Geography
4. Expanded and Effective Clinical Programs
5. Risk Management



Defining Scale	
Patient Volume	<ul style="list-style-type: none"> • Payers seek to enroll as many patients as possible • Payers will look to Health Centers for help steering patients to their plans • Health Centers can bring continuity in coverage and clinical coordination to the newly covered patients
Network Adequacy and Access	<ul style="list-style-type: none"> • The overall size of a Health Center (or network of Health Centers) is more valuable to payers if the primary care provided is comprehensive and based upon a Medical Home model • Health Centers will need to demonstrate the ability to add additional patient access • QHPs are required by law to meet minimum network adequacy requirements⁴
Geography	<ul style="list-style-type: none"> • Payers seek to demonstrate an adequate network in a broad geographic region. QHPs need to demonstrate an adequate network to qualify for selling their products on the Marketplace. • Most individual Health Centers are not well positioned to expand their geographic reach quickly. Therefore, Health Centers may appeal to payers more if they work together in networks.
Expanding Effective Clinical Programs	<ul style="list-style-type: none"> • QHPs need to provide behavioral health and substance abuse treatment options. • QHPs will look to their contracted providers to implement effective care coordination, disease management, and prevention programs that are broadly operational.
Risk Management	<ul style="list-style-type: none"> • More patients provide a greater distribution of risk by decreasing the impact of riskier/more expensive patients • QHPs will seek contracts with larger organizations that can attract more patients.

Reflection Questions

How might your Health Center support a QHP looking to expand its scale? Where would your Health Center be able to provide more scale; access, geography, expanding clinical programs such as behavioral health, or risk management? Which areas is your Health Center weakest?

⁴ In the March 27, 2012, Federal Register, the Secretary of HHS published the final rules, “Exchange Establishment Standards and Other Related Standards under the Affordable Care Act.” The final rules set out the minimum requirements for network adequacy that a plan must meet to be certified as a QHP. Subpart C – Qualified Health Plan Minimum Certification Standards, section 156.230 Network Adequacy standards, states that a QHP issuer must ensure that the provider network of each of its QHPs meets these standards: http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf

*Stories from the Field:
Minnesota Community Quality Measures (Minnesota)*

Since 2008, healthcare providers, health plans, Health Centers and the Minnesota Health Department have partnered on a statewide, public reporting of hospital, clinic, and medical group clinical performance management. The Minnesota Community Measures are widely used and required for many programs, including QHP provider reporting requirements.

QHPs Seek Quality and Consistency

The QHP marketplace is slowly maturing. Over time, Health Centers should anticipate QHPs and other payers will evaluate their contracted providers by evaluating the quality and consistency of clinical practice. This means that QHPs will seek relationships with providers who are able to maintain a level of healthcare performance regardless of the size or scope of its services. For example, a Health Center that can add access by hiring additional clinicians, as well as demonstrate very high performance in common diabetes population health metrics, is considered to have greater scale than one that cannot. QHPs seek to work with providers who can provide additional access to care through growth of services, but will be considerably more interested if they are also capable of maintaining or improving quality at the same time.

QHPs and other payers will look for Health Centers to leverage several assets that support quality and consistency in health care delivery:

- Performance Management
- Accountability for Outcomes
- Adherence to Evidence-based Guidelines
- Care Coordination
- Integrated Models Across Provider Settings

Performance Management

Performance management is not a new concept for Health Centers. The Bureau of Primary Health Care defines performance management as:

“the regular collection of data to assess whether the correct processes are being performed and desired results are being achieved.”⁵

Performance management provides a mechanism to measure the progress towards the intended clinical, operational, and financial goals.

Most Health Centers have historical experience reporting on UDS, Meaningful Use, PCMH, HEDIS, and other clinical measures. In addition, new payment contracts and options, including the Medicare Shared Savings Program, have put additional performance management requirements on Health Centers that currently participate. While there is much alignment of the current performance management and reporting, Health Centers can anticipate clinical measures will be further combined with financial and operational measures as QHPs and other payers seek ways to maximize the efficiency and effectiveness of the providers with whom they partner. This is not totally new territory for Health Centers, many of whom have some experience with quality-based incentive payments. However, QHPs will expand upon this even further for several reasons:

- Based on federal requirements, Qualified Health Plans will soon (in 2016) be required to meet their own quality requirements, and will expect providers working with them to assist in meeting these measures.⁶

⁵ Performance Management and Measurement, Bureau of Primary Health Care <http://www.hrsa.gov/quality/toolbox/methodology/performancemanagement/index.html>
⁶ <http://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf>



- QHPs have a limited amount of financial resources to direct at patient care. Thus, they will seek relationships with providers who are effective in helping them manage tight budgets.
- Since many patients who enter QHPs may not have had insurance before, they are likely to have uncontrolled conditions. Quality measures assist the QHP in determining the effectiveness of the provider in taking a potentially uncontrolled population and turning it into a controlled one.

*Stories from the Field:
St. Louis Integrated Health Network*

The St. Louis Integrated Health Network (collaborative of CHCs, medical schools, and public health partners) operates a program available to be contracted by hospitals or other clients that require targeted care coordination and regional strategic planning around transitions of care. The IHN has staff located in multiple hospitals that ensure primary care follow-up, communication, and continuity of care that aid hospitals and CHCs in hitting meaningful use metrics, addressing readmissions, and engaging difficult populations in care management. In addition to the direct staffing component, the IHN provides a neutral convening table for sharing of best practices, collaboratively addressing population health metrics, and improving access to care across the regions they operate in.

More information at:

<http://www.stlouisihn.org/community-referral-coordinator-program>

- Performance measures and management will become more sophisticated over time as Health Centers and their payer partners increase their capacity for collecting and benchmarking metrics.

As Health Centers look to form partnerships with QHPs and other payers, there are several steps they can take to maximize their ability to collect, analyze, and manage these performance measures.

Establish Effective Data and Reporting Mechanisms Health Centers will need to build or leverage their data and reporting resources to provide the information required to effectively manage their performance.

Evaluate Performance Health Centers should evaluate pre- and post-QHP contract performance against high-priority quality measures. This will provide Health Centers with the ability to target under-performing measures for improvement efforts.

Prioritize Quality Improvement Efforts Health Centers should base their quality programs, both at the Health Center and at the network or collaborative level, on adopting consistent approaches to impacting high-priority QHP measures.

Compare Performance across Contracts Health Centers should develop the ability to track quality performance by contract, and study the performance of each QHP population over time.

Target High-need Patients Health Centers should consider outreach programs that bring high-priority QHP patients into the practice quickly for assessment and treatment planning (e.g. chronic disease patients.) If clinical data is not available through the Health Center's EHR, QHPs can provide information about high-need patients by sharing claims and other data with the Health Centers.

Reflection Questions

What are some of challenges your Health Center faces with implementing effective clinical, operational, and financial performance management? What are some steps you could take to improve your capacity in this area?

Accountability for Outcomes

More and more, Health Centers are feeling the impact of **accountability** for performance measures and clinical outcomes. As Health Centers build relationships with payers, accountability will become a cornerstone of these efforts. Health Centers can expect accountability to be built into the following:

- Payment terms in contracts with both public (i.e. Medicaid and Medicare) and private payers
- Public reporting requirements as part of integrated network participation (i.e. IPAs and ACOs)
- Standards of participation in new programs or provider networks

Adherence to Evidence-based Guidelines

Increasingly, primary care physicians are being asked to practice using Evidence-Based Guidelines, or Clinical Practice Guidelines. In 1990, the Institute of Medicine defined Clinical Practice Guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.”⁷

QHPs and other payers will look to their provider partners to implement and maintain these types of consistent clinical approaches when managing their patient populations. Clinical decision support, enabled through EHR data, for both care teams and patient self-management are integral to Health Center clinical practices. QHPs and other payers will look to their provider partners to implement and maintain these types of consistent clinical approaches when managing their patient populations. For many Health Centers, adherence to evidence-based practice or guidelines is already included in their clinical care programs that build upon the PCMH model. Payers may require that specific tools or documentation be used to implement these strategies.

Quick Links: Evidence Based Guidelines

The Agency for Healthcare Research and Quality maintains a large clearinghouse of Evidence Based Guidelines at <http://www.guideline.gov/index.aspx>

Another valuable resource of guidelines for Internal Medicine is the American College of Physicians http://www.acponline.org/clinical_information/guidelines/guidelines/

7 Lohr, MJ, Field, MJ. Eds. Clinical practice guidelines. Directions for a new program. IOM - Institute of Medicine; National Academy Press, Washington DC: pg 8, 1990.



Care Coordination

While no single definition of **care coordination** exists, the Agency for Healthcare Quality and Research created this working definition based on input from forty experts:

“Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.”⁸

Care coordination of patients will take on increased importance as QHPs and other payers provide financial incentives to reduce the cost of care and seek stronger clinical outcomes from their provider partners. Health Centers will find most incentive payments will strongly suggest they utilize care coordination models that improve both clinical and financial outcomes and fully engage the patient in these efforts. This will require collaboration with care providers outside of the Primary Care patient centered medical home, emphasizing the need for data exchange.

Health Centers that develop capacity to provide care coordination services will benefit from strengthened relationships with other providers in their communities and with Health Plans. In some cases, Health Centers may participate in a network, such as a Health Center Controlled Network (HCCN) or a contracting network like an ACO or IPA, which provides care coordination and health information exchange services. In other situations, Health Centers may choose to take this on at the individual Health Center level. Given the complexity associated with bridging the information gap across provider settings, Health Centers are finding that collaborating through networks has been an effective way of developing and delivering care coordination services.

Quick Links: Care Coordination

Information from the Agency for Healthcare Research and Quality on Care Coordination:

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

Integrated Models across Care Settings

QHPs and other payers will be looking at all the providers in their networks to demonstrate an effective implementation of integration across care settings. In some cases, this integration will be required for participation in the plan or program (i.e. Medicare Shared Savings Program). There are two main types of integration that Health Centers can expect to demonstrate: **clinical** and **financial**.

Clinical integration is used to describe certain types of collaboration among otherwise independent health care providers to improve quality and contain costs. This type of integration is fundamental to any effort to manage patients as they transition from one site of care to another, implement chronic disease management programs across multiple sites of care, or make investments for enhanced IT services. Clinically integrated organizations gain new clinical capabilities from the network. For example, Health Centers are able to benchmark their performance against the performance of similar organizations, providing them the capacity to plan enhanced quality improvement activities. QHPs will require clinical integration from their contracted providers.

Financial integration is the creation of a shared financial model and incentives across organizations. Common plans to distribute shared savings, and quality and performance bonuses, are all forms of financial integration. Groups of providers demonstrate financial integration through a pooling of risk. This sort of integration is required to share in the financial benefits generated by clinical integration. Financial integration plays an important role in provider networks that span across different health delivery sectors (primary care, acute care, post-acute, etc.). Developing a common set of financial incentives is vital to moving the entire network in one direction.

Stories from the Field: Missouri Health Plus

In 2013, 23 Health Centers came together to form MissouriHealth+. These Health Centers agreed to set standards of care for all patients seen throughout the network. They have data measurement systems to analyze performance and a governance model designed to hold each other accountable for outcomes. Through this integration, MissouriHealth+ can negotiate payor contracts on behalf of its member Health Centers.

⁸ McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

These two types of integration can be achieved through a variety of methods. Shared EHRs, clinical messaging, and data exchanges provide high tech examples of demonstrating clinical integration, but it need not exclusively be technology based. For example, primary care teams across a provider network can receive financial incentives for meeting quality targets under the terms of a value-based contract. Shared methods for recording and managing progress towards achieving quality goals can combine with programs targeted towards patients with certain conditions to show clinical integration as well. Documenting clinical policies and procedures, and adopting them across multiple organizations will also accomplish this task.

Clinical and financial integration also provides quality and consistency to scale through *accountability*. Provider networks may be able to band together to make shared investments, but if the quality and patient experience of the services offered vary wildly from one group to the next, the focus or the value of the whole network may fall apart. Large differences in quality can create challenges between “high quality” and “low quality” groups. Clinical integration with a clear set of guidelines and standards helps to reduce this variation and supports all providers in delivering the same quality of care.

QHPs Seek Cost Management

QHPs and other health plans are capable of evaluating the primary care providers in their network based on cost. Plans will look at how the cost of patient care varies across primary care settings and will compare primary care settings to each other based on this information. Health Centers will be more desirable partners, and thus perform better in negotiations with QHPs if they are able to demonstrate *cost efficiency* and *cost effectiveness*.

Cost efficiency is the measure of how efficiently the Health Center uses its own resources to deliver care. There are a variety of ways that cost efficiency can be measured, including provider panel size, number of patients seen in a given period of time, or through the use of “Relative Value Units” or “RVUs.”⁹

On the other hand, *cost effectiveness* is the measure of the magnitude of the total financial resources that Health Center patients utilize in order to manage their overall care. The most common measure of cost effectiveness is “Total Medical Expense.” Cost efficient providers will always have an advantage in contracting with QHPs and other Health Plans, but a much greater influence is being placed on the ability of a primary care provider to be cost effective. This is evidenced by the growing prevalence of incentive models tied to Total Medical Expense.

In order to address their cost effectiveness, Health Centers are using population health data and information on their patients to identify ways of reducing costs while improving patient experience of care and clinical outcomes. Some common areas of focus include:

- Emergency department utilization for ambulatory sensitive conditions
- Duplicative or redundant diagnostic testing
- Pharmacy cost management
- Preventing avoidable hospital admissions and readmissions

Maintaining the strongest possible relationship with QHPs and other Health Plans will require Health Centers to understand, and find effective means of managing cost.

9 The National Health Policy Forum has a good primer, despite being published in 2009, on RVUs here: http://www.nhp.org/library/the-basics/basics_rvus_02-12-09.pdf

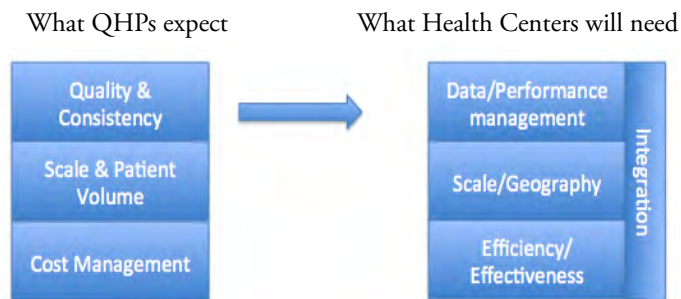


Reflection Questions

How does your Health Center measure and demonstrate its effectiveness and efficiency? Could you clearly articulate these to a QHP?

CONCLUSION

As QHPs and other payers seek relationships with Health Centers, much will be expected. It will be imperative Health Centers not only understand what will be expected of them, but also how they might work together with others to help create the type of scale, efficiencies, and effectiveness to make them competitive, attractive partners to payers. In general, Health Centers need to understand how they can meet the needs of their emerging payer partners.





WORKSHEET 2: MEETING THE EXPECTATIONS OF PAYERS: WHAT CAN YOUR HEALTH CENTER DO?

Directions

Think about the strengths and challenges your Health Center faces in creating value for QHPs and other payers. In the table below, identify where your Health Center can support a QHP's goals and where your Health Center needs to build capacity.

QHP's Area of Need	Health Center Strengths	Health Center Challenges
Scale and Patient Volume		
Quality and Consistency of Services		
Cost Management		



MODULE 2: RESOURCES AND LINKS

Qualified Health Plan and ACO Requirements

The following links provide guidance and information on key requirements for QHPs and ACOs.

1. [Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System \(QRS\), Framework Measures and Methodology \(From the Federal Register\)](#)
2. [Network Adequacy & Exchanges \(NCQA white paper\)](#)
3. [Leveraging Economies of Scale Opportunities in the Accountable Care Organization \(ACO\)](#)
4. [Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations \(From the Federal Register\)](#)
5. [Plan Management Function: Network Adequacy White Paper](#)

Performance Management

A number of organizations have created tools, resources, and reports related to performance management in healthcare.

1. [HRSA Toolkit: Performance Management & Measurement](#)
2. [Measuring and Benchmarking Clinical Performance \(AHRQ Resources\)](#)
3. [Minnesota 2013 Health Care Quality Report: Compare Clinic, Medical Group and Hospital Performance](#)
4. [Accountable Care Organization 2013 Program Analysis: Quality Performance Standards Narrative Measure Specifications](#)
5. [HEDIS and Quality Measure Improvement](#)

Evidence Based Guidelines and Practice

1. [AHRQ's National Guideline Clearinghouse](#)
2. [American College of Physicians Clinical Practice Guidelines](#)
3. [Clinical Practice Guidelines for a New Program \(Institutes of Medicine\)](#)
4. [Western Clinicians Network and the California Primary Care Association Clinic Library](#)

Clinical Integration

1. [American Hospital Association \(weblinks and resources\)](#)
2. [Federal Trade Commission \(weblinks and resources\)](#)
3. [Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative](#)



Efficiency and Effectiveness in Health Center Service Delivery

1. [Relative Value Units \(RVUs\)](#)
2. [Identifying, Categorizing, and Evaluating Health Care Efficiency Measures \(AHRQ weblinks and resources\)](#)
3. [Improving Access and Efficiency in Primary Care at HealthServe Community Health Center \(IHI white paper and weblinks\)](#)
4. [Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year \(IHI white paper and weblinks\)](#)



MODULE 3: COLLABORATIONS AMONG HEALTH CENTERS, HCCNs, AND PCAs FOR QHP PARTNERSHIPS

Redesigning the healthcare system and delivering on the promises of the ACA rely upon providers, patients and payers interacting with each other in new ways. More than ever, close collaborations, shared accountability, and standardization of clinical and business operations are creating new opportunities for these partnerships. This is particularly true as Health Centers begin to build relationships with QHPs and other payers. Once these opportunities have been identified, a structured, centrally coordinated effort to manage the development of these activities creates the highest likelihood of success. In many cases, Primary Care Associations or Health Center Controlled Networks are uniquely positioned to help facilitate and support these activities.

The Case for Collaboration

Partnerships among Health Centers and PCAs offer many advantages to those who participate:

1. ***When Health Centers come together, they can combine their cumulative clinical outcomes.*** By working collaboratively, they can create a story or measure a patient population by a number of key clinical metrics including population health and patient experience. This can provide Health Centers scale and legitimacy when working with payers, policy makers, funders, and others. In addition, by working together on clinical quality, Health Centers can implement collaborative strategies for targeted clinical interventions and raise the overall quality of care at all participating Health Centers. PCAs may play a role in providing the technical or administrative backbone for these collaborations.
2. ***Formal collaborations can create economies of scale for investments in infrastructure and staff.*** Formal partnerships and networks may provide cost effective ways for Health Centers to reduce the individual cost of building the capacity they need for responding to the demands of health reform. The number of areas where Health Centers could collaborate is almost limitless and is bounded only by the needs of particular Health Centers who choose to come together. Examples include: credentialing, recruiting, revenue cycle management, data analytics capacity, compliance, care coordination, and many others. In some cases, PCAs or HCCNs may already be positioned to provide the administration or contract management of key vendor relationships to facilitate these efforts.
3. ***Integrated networks may provide an important structure for pooling risk.*** As Health Centers enter into new reimbursement models, they will need to take steps to minimize their risk of financial losses. Integrated networks can provide a larger patient pool and more programmatic freedom to manage downside risk.
4. ***Integrated networks may provide legal protections required for negotiating reimbursement terms.*** In order to avoid the legal pitfalls related to anti-trust and price-fixing, Health Centers may have to organize into clinically integrated networks. These networks must demonstrate that the participating providers gain new clinical capabilities from the network and share risk together in ways their participants could not do alone.

Missed Opportunities of Failing to Collaborate

Many Health Centers are concerned about the financial, time commitment, and political costs of creating or joining a new collaboration and building new partnerships. Nearly all Health Centers are concerned with the investments of both financial and staff resources. Health Centers face a myriad of fast-changing environmental dynamics and it is often very challenging to prioritize. Some may feel the level of quality and cost effectiveness at which they perform would be diminished by joining a network, effectively being diluted by what they perceive to be at “low performing Health Centers.” Others may be concerned that participation in new partnerships may negatively impact existing relationships they hold with other providers (i.e. hospital systems) or payers. Finally, some entities, such as public FQHCs, may be concerned that their inability to participate in active contracting with payers may negatively impact their overall influence within a new network. While these concerns and challenges are significant, it is important Health Centers carefully consider the missed opportunities they may not be presented if they decide against collaboration.

Individually, most health centers do not have the scale necessary to command an advantageous negotiating position with payers or vendors. Typically, a single payer will not consider alternative payment terms with an entity that has less than 5,000 lives. Alternative payment terms typically require this level of scale to prove actuarially that the provider is in fact the reason for improvements in cost or quality outcomes. This is an important point for Health Centers to understand, because it Accountable Care Organizations could mean that they are precluded from certain payment term options if they attempt to contract individually.

By pooling lives through a network, Health Centers are able to create a concentration of patients that are of greater significance to a payer as well as reduce the impact of expensive outlier patients with complex conditions (i.e. end stage renal disease). Although 5,000 lives is a typical minimum, it is always better to have a larger pool of patients when considering payment terms that have any level of risk factor. It eliminates the likelihood that a few of these outlier patients can have a very large negative effect on cost and quality outcomes used to determine payments.

The same is true of vendors who provide important services that can support health center operational efficiencies and effectiveness (i.e. revenue cycle management, etc.). By collaborating, a network can negotiate much more cost effective vendor contracts.

Health Centers cannot risk appearing unwilling to change. Failing to demonstrate a willingness to operate in a clinically and financially integrated network may signal to external stakeholders—whether or not it is true—the Health Center is not legitimately willing to take on the challenges of the Triple Aim. This could harm Health Centers at an individual level as well as question their credibility as a whole with State Medicaid departments, payers, and others.

Potential Roles for Partners

Health Centers, Primary Care Associations, and Health Center Controlled Networks have a long history of building collaborations that strengthen the overall core functions of all three organization types. These existing collaborations can be expanded to support Health Centers as they begin to build relationships with QHPs and other payers. Depending on the strengths and assets of each type of organization, various roles within the collaboration may be filled by one or more of the partners.

Convening and Coordination

Both PCAs and HCCNs have significant experience bringing their member Health Centers and other stakeholders together to build new programs, initiatives, and create policy agendas. These strengths and resources can be supportive to building new partnerships with QHPs and other payers. PCAs are typically asked by their members or other stakeholders (i.e. payers) to bring groups together to discuss risks and opportunities of new partnerships. PCAs can help support this by providing logistical coordination, physical meeting space, identification of subject matter experts or external participants, project management, and tracking of follow up items. Often, in order to maximize participation, the PCA is able to leverage the convening of network development planning sessions in conjuncture with existing meetings (i.e. annual conferences, advocacy days, Board meetings). This helps to minimize travel and other costs for both the PCA and the Health Center participants.

PCAs may also play the role of serving as the primary contact with **strategy consultants** or **legal counsel** who is engaged to help facilitate the planning and implementation of new partnerships or networks. This can be an important function to play helping manage the budget for consultants and keep their work focused. To avoid a “too many cooks in the kitchen” scenario, PCA staff can coordinate the time, effort, and activities of consultants and attorneys to ensure the resources they bring to the process are properly focused and managed.

Education

Similar to the role of convening, providing education is a critical component of building new relationships. PCAs and HCCNs can build upon their existing training and technical assistance programs to bring subject matter experts to the Health Centers to increase the overall understanding of key concepts and practices. This could include education to Health Center Boards and staff on topics such as new payment models, new workforce models, data analytics, financial operations, payer contract management, and patient engagement and navigation.

Infrastructure Support

The following table details many of the ways that a PCA or HCCN may provide infrastructure support for newly forming Health Center partnerships. Review the types of support and denote whether your PCA or HCCN might be in a position to assist the process through infrastructure support.



Table 4.1 Leveraging Existing PCA and HCCN Relationships

Type of Support	Explanation	Available Through Your PCA? Y/N	Next Steps or Additional Considerations
Executive or Lead Staff Project Sponsorship	High-level staff that oversee the centralized coordination of activities and facilitates member participation.		
Administrative Support	Assists with meeting coordination, materials preparation, and tracking of activities.		
Data and Reporting Capacity	Assists with the data collection and analysis necessary to: 1) determine the capacity of a potential new primary care partnership; 2) build the business plan for the new partnership; 3) provide <i>ongoing</i> support to the partnership for new contracting and service opportunities.		
Financial Administration	Provides initial accounting and banking support as capitalization and/or funding of the collaboration begins; prepares, manages, and reports upon budget updates.		

In addition to the areas noted in Table 4.1, PCAs or HCCNs may be in a position to assist with the *fund development* goals of a new collaboration. As established nonprofit organizations, PCAs may have the ability to provide “seed funding” to support the initial development activities of new Health Center collaborations. In some cases, PCA’s may have discretionary budgets or their Boards may have the ability to allocate funding to engage planning consultants and offset other costs associated with convening partners and developing additional fund development strategies. PCAs may also be able to leverage external funding through grant opportunities or negotiate financial support with other entities (i.e. health systems, government agencies, payers, private foundations, etc.) that have a vested interest in Health Centers collaborating in new networks or partnerships. This may have additional advantages to PCAs or HCCNs that may be able to help cover operating or other costs as partners in these funding arrangements.

PCA’s may find that providing infrastructure support to new partnerships has advantages both in the short and long term. In the short term, it allows the PCA to participate in innovative new models of care delivery and payment pilots, thus exposing the PCA to emerging opportunities that may lead to future funding and strategic positioning of the PCA with its external stakeholders. In the long term, infrastructure support to the new network may convert to an ongoing service contract for support back to the collaborative, thus providing a new revenue stream to the PCA.

Relationship Cultivation

PCA’s can play an important role in bringing new stakeholders to the table with Health Centers who are seeking to leverage new partnership models or networks. As the representative of either statewide or regional primary care networks, PCAs often have access to subject matter experts, consultants, funders, vendors, other provider groups, policy makers, and payers who are looking to build new relationships with Health Centers. PCAs can leverage these and help facilitate effective relationships among these stakeholder groups and their Health Centers.

Building and cultivating these relationships can provide both strategic advantages as well as risks to PCAs. As with earlier examples, by positioning themselves as key players in these opportunities, PCAs and HCCNs may strengthen their strategic positioning among external stakeholders. Similarly, PCAs should demonstrate caution and thoughtfulness when engaging emerging partners to weigh the political tradeoffs that could occur by developing formal partnerships. For example, certain payers may be concerned if a PCA



or a network is too strongly aligning with payers who are competitive in the current market. PCAs and Health Centers should make every effort to consider the relative opportunity costs and benefits as these prospects present themselves.

Reflection Questions:

Which formal and informal relationships does your PCA have that might strengthen new networks or partnerships for Health Centers? What are the opportunities and risks that are associated with expanding these relationships?



Types of Collaborations

Collaborations among Health Centers, PCAs, and HCCNs to support partnerships with QHPs can range from the informal peer-to-peer sharing to formal participation in newly created free-standing entities. The function, structure, and degree of formality will be dictated by the regional and statewide dynamics at play. In some cases, existing capacity for key services, infrastructure or competencies may already be in place, reducing the need to create new formal partnerships. In other situations, Health Centers may decide to come together to create new entities to meet a specific purpose (i.e. shared services) or participate in a particular program or payer contracting arrangements. Health Centers seeking to engage in partnerships that formally leverage shared services or create shared risk through integrated models will need to carefully consider the risks and benefits of forming new formal partnerships that can support these goals.

[Module 1](#) discusses the purpose, structure, and opportunities for three such formal partnerships: *Managed Service Organizations*, *Accountable Care Organizations*, and *Independent Practice Associations*.

Accountable Care Organizations

The ACO model fosters creativity and innovation, and therefore there is much variation in the models that are emerging. However, they generally share several common functions.

Key Functions of ACOs	
Contract Management and Administration	<ul style="list-style-type: none"> • Assist members in managing contract terms • Ensure payer honors contractual commitments
Data Analytics	<ul style="list-style-type: none"> • Collect data necessary to support contract administration • Identify areas to maximize performance under contracts • Standardize and coordinate reporting to members on agreed upon timeframes
Standards Setting and Enforcement	<ul style="list-style-type: none"> • Set standards for members to improve the value and impact of the ACO • Create accountability programs for non-performing members • Require clinical and financial integration

ACOs also share common attributes including:

- ✓ Reward reductions in “total medical expense”
- ✓ Require performance against quality measures in order to receive compensation
- ✓ Require a clearly defined patient population, and adequate scale (usually at least 5,000 patients from across all providers participating in the ACO)
- ✓ Patients are attributed to the ACO based upon their relationship with a primary care provider
- ✓ Allow patients to seek care where they choose – ACOs do not restrict patient choice
- ✓ Organized as a distinct legal entity from its participants
- ✓ Include other specific requirements (i.e. compliance programs, data reporting, annual reattribution of patients)

It is a common misconception ACOs must be led by vertical health systems and hospitals. In reality, many different models have emerged. Practically, the primary determinant of eligibility for an ACO lies in the requirement that an ACO must take accountability for 5,000 lives with an ACO payer in order to enter their contract.

There are three models that health centers should be aware of:

- The Hospital or Health-System Centered ACO
- The “Primary Care Only” ACO
- The Primary Care Led ACO

Each of these ACO models present advantages and challenges for Health Centers and should be considered carefully. (Please refer to NACHC’s “Accountable Care Organizations: Health Center Strategies for Success” document located at: https://mylearning.nachc.com/diweb/gateway/init/1/ffcatalog*2Fitem*2Fid*2FPB0814PCA5)

An Integrated Network Provides Legal Protections from Anti-Trust by demonstrating the network brings value to patients and the marketplace would otherwise not be possible if the participating provider were acting individually.

Independent Practice Associations

For all practical purposes, IPAs and ACOs share many of the same functions, structures, and capacities. As clinically integrated networks, both IPAs and ACOs provide legal protection from Anti-Trust for its members. ***Anti-Trust Protections*** are critical to prevent Health Centers from being subjected to prosecution from the Federal Trade Commission for price fixing and collusion. In order to avoid this, networks must demonstrate their presence does not create harm to patients or competition in the marketplace.

In addition to offering legal protection from Anti-Trust during contract negotiation, IPAs may also offer a number of clinical and operational infrastructure supports such as clinical decision support, data and analytics, capacity, and payer contract management. IPAs may be led by Health Centers or other groups of providers.

The primary difference between the two network models focuses on the fact that IPAs function as a joint contracting entity on behalf of all and any payers its members seek to engage, and largely focuses on garnering the best contract terms (payment and otherwise) for the participating members. Like ACOs, IPAs will require and monitor a number of clinical, financial, and operational metrics to demonstrate the value of the network as a whole. Without demonstrating this value, the IPA may fail to exhibit the necessary indicators that a clinically integrated network exists, thus jeopardizing its ability to provide Anti-Trust protections. Further, the inability to show the effectiveness of the network as a whole may diminish its negotiating platform with payers.

The advantages and disadvantages of IPAs are similar to those of ACOs. However, developing and managing the competencies and performance management in order to secure effective payer contract negotiation provide special challenges to Health Centers for the IPA model. Because Health Centers have historically had fewer commercial or commercial-style contracts, including managed care contracts, they have far less experience in this area than other healthcare providers. Establishing these practices can be challenging and confusing. Health Centers may also suffer from a lack of “brand recognition” among payers with whom they seek to engage. Overcoming these challenges takes time and a high level of focus to build a broad strategy to communicate and demonstrate the value proposition of Health Centers.

Managed Services Organizations

Unlike the clinically integrated networks (ACOs and IPAs), MSOs ***do not*** pool the risk of patient populations to secure payment for the provision of healthcare services. As such, MSOs are unlikely to be required to hold participants accountable to performance standards. Instead, the services purchased through an MSO provide services to Health Centers that can increase their performance and effectiveness. In essence, an MSO operates as a sophisticated “group purchasing organization” for services that cannot be typically purchased on the open market. For example, if all Health Centers want to hire a Chief Medical Information Officer but do not have the resources to do so, they might share one through an MSO. Structurally, MSOs may be established as sub entities of a PCA or other Health Center networks (i.e. Health Center Controlled Network or a quality improvement collaborative), or they may exist as separate and distinct organizations newly formed by Health Centers to provide support for competencies missing in current business operations.

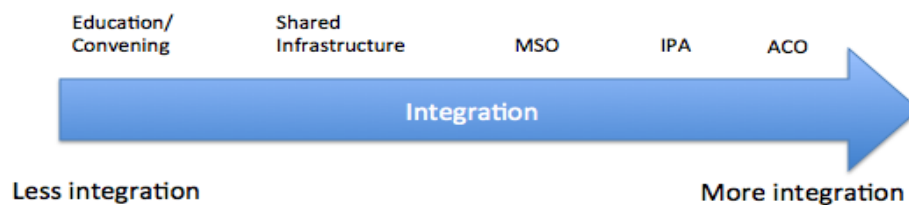
The types of services an MSO may offer are virtually unlimited. Health Centers who participate in the development of these networks will prioritize the service lines based upon emerging needs.



Examples of MSO Services	
Clinical Support	<ul style="list-style-type: none"> • Quality Improvement • Care Coordination • Medically necessary services (e.g. pre-authorizations) • Reporting of quality metrics • Clinical Performance Benchmarking • Patient Registries
Financial Services	<ul style="list-style-type: none"> • Revenue Cycle Management • Coding and Compliance • Credentialing of providers for billing purposes • Reporting on cost metrics
Operational Services	<ul style="list-style-type: none"> • Revenue Cycle Management • Coding and Compliance • Credentialing of providers for billing purposes • Reporting on operational items (i.e. patient rosters)
Human Resources	<ul style="list-style-type: none"> • HR and Payroll • Recruitment and retention • Continuing Education and ongoing provider communication

CONCLUSION

More and more, Health Centers are seeking formal and informal partnerships and collaboration with others. In many situations, building upon historical efforts with other Health Centers, PCAs, and HCCNs may provide the critical infrastructure and support needed. However, in other cases it may be necessary to create new relationships with health systems, other providers, and medical groups. In still other situations, it may be necessary for Health Centers to come together to build entirely new, free-standing entities. The degree and depth of these collaborations will largely depend upon the existing regional and statewide resources and competencies. However, it is typically true Health Centers will benefit by pooling their collective experience and resources to meet the needs of the patients and communities they serve.





MODULE 3 RESOURCES AND LINKS

Partnership Development

1. [High Value Healthcare Collaborative](#)
2. [ACO Learning Network](#)
3. [Arranged Marriages: The Evolution of ACO Partnerships in California](#)
4. [Catalyst Fund for Nonprofits](#)
5. [Safety Net Accountable Care Organization Readiness Assessment Tool](#)
6. [Strategic Restructuring for California Community Clinics: Self-Assessment Workbook](#)



MODULE 4: TOOLS AND COMPETENCIES FOR HEALTH CENTER SUCCESS

INTRODUCTION

The ACA encourages QHPs to contract with provider organizations to promote value (value-based contracting) over volume. Provider organizations, including Health Centers, will need to restructure the way they are organized and provide care in order to succeed under these new types of agreements. This section identifies the core business, care delivery competencies and tools Health Centers will need to succeed in these new relationships and contract models. By reviewing these competencies, Health Centers can assess their preparedness in these areas. These competencies include:

- Data Analytics
- Data Exchange
- High Performing Medical Homes
- Care Coordination
- Continuous Operational Improvement
- Engaging Patients

It may be necessary for Health Centers to partner with Health Center Controlled Networks (HCCNs), Primary Care Associations (PCAs), or other care providers to develop all of the competencies needed to manage performance in these new types of contracts. Health Centers that choose to “go it alone” without partnering with others may not be able to independently develop all the competencies necessary to excel in these new contracts and could be financially penalized as a result. Health Center leadership (CEOs, CFOs, COOs, CMOs, and CIOs) should carefully consider these options collectively and weigh the potential opportunity costs of deciding not to participate in broader partnerships.

Competency 1 – Data Analytics

The aggregation, measurement, and benchmarking of reliable data collectively creates the data infrastructure required to make informed management decisions necessary to drive performance against new style insurance contracts. This is easier said than done.

Increased amounts of financial risk, particularly risk taken on the cost of care delivered, require a greater amount of data integration. Certain types of payment models, such as full or partial capitation, will require data from claims and internal operations. Health Centers testing these models will need the capacity to collect and analyze this data as well as integrate them with clinical data. Perfect integration of this data is likely impossible in most organizations, but carefully linking data and learning the shortcomings particular to your organization, can vastly improve your ability to manage risk.

In addition to the task of data aggregation, Health Center leadership must be able to measure performance in a timely fashion, pinpoint negative trends in performance, compare these trends to similar organizations, and create action plans to address meaningful changes in performance. Some of these activities require data infrastructure while others require strong managerial practices. Without both sets of competencies, healthcare organizations will be hard pressed to manage performance against financial incentives in value-based contracts.

Competency 2 – Data Exchange

As the ACA intensifies, with an emphasis on primary care as the focus of care management, data exchange between sites of care will become increasingly important. This data exchange is in addition to the sharing of insurance claims data with care providers mentioned in the above section.

As patients move across various sites of care (home health services, Health Centers, acute inpatient facilities, etc.) they generate and frequently leave data at each location. This data is valuable to all caregivers and would ideally be shared freely across all organizations.



Regulatory issues create some barriers to the ideal form of data sharing, and technological limitations inhibit sharing where it is permitted.

Whenever possible, health information exchanges (HIEs) should be used to share information across organizations. HIEs can improve data integrity and timeliness and can integrate into a care provider's electronic health record (EHR). When an HIE is not available, an alternative form of data exchange should occur as a patient is transferred across care settings. This communication can be as simple as a phone call or a faxed discharge form. Regardless of the form this communication takes, it should be incorporated in the clinical record as soon as possible.

Competency 3 – Creating High Performing Medical Homes

The related white papers (found on the NACHC website) and earlier modules all reference the increasing importance of primary care in a health system where providers take on additional risk as part of contracting with insurers. Key to this increased influence is the creation of patient centered medical homes for patients. These medical homes must not only meet a set of checkbox criteria, coordinate care efficiently, but have to become the foundation for an expanded set of services to be delivered alongside traditional primary care. Health Centers have been providing these services for decades and are uniquely positioned to become high performing medical homes.

Core to the concept of a patient centered medical home is an expanded care team to address a variety of patient needs. These care teams will triage patient needs to the most efficient team member, allowing physicians to focus on the tasks that best match their level of expertise. Nurse practitioners, physician assistants, nurses, social workers, medical assistants, and front desk staff are all core members of the care team. In addition to this core, nutritionists, therapists, financial counselors, and community health workers may all be part of the medical home. Once this expanded team is functioning, other services can be mapped onto the primary care practice. Mental health counseling, dental services, pharmacy, and financial counseling can all improve a patient's ability to address their overarching health needs.

High functioning teams require high functioning data that informs clinical, financial, and operational decision-making. Medical homes must also be able to track their patients and develop tools to manage their health outside of the clinical visit. This is particularly important for insurance contracts that have a quality incentive, as there is a defined patient population that must meet certain criteria. A high functioning tool not only lists patients who are part of a population (ex. diabetics) and their compliance with a specified measure (ex. blood pressure performance), but also allows the care team to contact patients who are not in compliance so that targeted care can be delivered.

Patient centered medical homes appeal to QHPs for several of the reasons discussed in Module 2. A high performing medical home provides **service diversity** as services not traditionally delivered in conjunction with primary care are mapped onto the care team. It also improves patient **access**. Established patients can have many of their care needs addressed by a member of the care team other than the physician, allowing this team member to focus on the sickest established patients and patients new to the Health Center.

Competency 4 – Care Coordination

Medical home care management will take on increased importance as QHPs provide financial incentives to reduce the cost of care. All forms of cost of care incentives require care coordination services to manage patient care, making this competency a vitally important one. This competency also requires collaboration with care providers outside of the patient centered medical home, emphasizing the need for data exchange.

Care management can take on several forms with the level of intensity matched to the needs of a specific patient population. Patients with multiple chronic illnesses, mental health concerns, and complex medication needs will benefit from dedicated care managers. These are typically nurses with case management training who remain in close contact with patients and their care team, help manage transitions between sites of care, and avail patients of evidence based education on their specific needs. The Centers for Medicare and Medicaid Innovation (CMMI) has conducted a series of demonstrations projects and evaluated care management programs.¹⁰

While the primary care medical home is the hub for most care management efforts, other sites of care could have more specialized care management activities. Organ transplant programs, cancer centers, and dialysis centers may all make use of care managers of some form. If this occurs, clear roles should be negotiated to reduce overlaps in work and potential slips due to unclear responsibilities.

¹⁰ <http://content.healthaffairs.org/content/31/6/1156.short>



In addition to these parallel programs, care managers can also be consulted when a patient presents to a different site of care. Some health systems generate notifications to the care manager when one of his or her patients shows up in an affiliated emergency department or is admitted to a post-acute care site. These notifications allow the care manager to provide detailed information on the care of a patient in a situation where care providers would have otherwise gone without this specialized knowledge.

Competency 5 – Continuous Operational Improvement

A shift to value-based contracting and accountability does not diminish the need for efficient operations that have been emphasized in a fee-for-service world. As QHPs seek relationships with providers with high quality to cost ratios, health systems with low overhead costs can offer lower contracted pricing, therefore increasing their value.

Managing from data is perhaps the defining characteristic of efficient operations. Health Center managers must be able to balance the costs to produce services (space, personnel, equipment) with capacity (access to care providers) and assess their ability to recognize reimbursement for services provided (revenue cycle management). QHPs will contract in a fashion that resembles traditional commercial practices. Health Centers will be pressed to develop capacities in coding and billing for commercial payers to maintain cash flow as patients transition to QHPs.

Other operational functions that Health Centers should consider emphasizing continuous improvement include:

- Billing and coding
- Revenue cycle management
- Claims, authorizations, and credentialing
- Expanded access
- Compliance
- Staff training

Additionally, managers must make sure that personnel are being used in an efficient fashion as medical homes and care management services are being developed. These resources represent an upfront investment and generate overhead for the care provider. They must be able to reach patients effectively, deliver their particular services, and see measurable results within a relatively short period of time. Clear data allows managers to address shortcomings in these programs and retarget initiatives to more efficiently use resources or drive stronger results. An inability to do so will actually result in increased overhead costs, enhancing pressure to negotiate higher reimbursement rates with QHPs or face operating losses.

Competency 6 – Patient Engagement

Patient Engagement is the final competency for value-based contracting. Patients and their families collectively become a team member in a high performing medical home, engaging in care decisions, helping develop care plans, and participating in a range of educational opportunities. In order for this to take place, patients and their families must have the opportunity to engage with the medical home through a number of mechanisms.

Patient engagement takes on several forms depending on the type of patient and service in which the medical home hopes to engage them. The first step may be simply notifying patients of the expanded set of services now available to them, introducing them to the various members of the care team, and telling them of their responsibility as a member of the care team. This can be accomplished via a variety of media and need not be a high tech outreach project.

More complex patients may need additional “touches” to fully involve them in the new services being offered. Their physician may need to provide in person introductions to care managers and social workers, patient support groups may have to host mini-sessions to get patients and families to attend full-length discussions, and text reminders may be necessary to ensure patients stay on medication regimens. Some of the high tech solutions available in this area may not be applicable to the patient segments typically cared for by Health Centers, however technology solutions have been shown to be quite effective in reaching the medically underserved. Patient portals typically require computer access or a Smartphone and English literacy, requirements that may or may not be met by patients of Health Centers. While these types of tools may represent best in class solutions, they are not the only way of developing a patient engagement competency. Any contact with the medical home care team should be used to involve patients in their own care, inform them of new service offerings, and solicit feedback as to their experience with their care team.



Patients can also be engaged in the management of the organization itself. Patient Advisory Councils can be formed to address specific topics or patients can be included in setting the strategic priorities of the organization. Health Centers are required to have consumer majority on the Board of Directors and these board members could be used to engage a broader spectrum of patients, engaging them independently of their care team.

CONCLUSION

Health Centers will need to develop six key business and clinical delivery competencies to begin to effectively manage cost and quality under value-based contracts. A broad spectrum of tools can be leveraged to create success under contracts with QHPs, this list represents a few foundational competencies off of which many other programs can and should be built.

1. Reliable **data analytics** that enable data-driven management
2. **Data exchange** processes to make clinical data accessible across the organization
3. **High Performing medical homes** that deliver diverse services through team-based care

*Stories from the Field:
Texting for Better Care Project (California)*

In 2014, the Center for Care Innovations conducted an evaluation on the effectiveness of the use of text messaging with safety net patients. While the evaluation surfaced limitation, successful practice was noted in the use of text with appointment reminders, disease management, care coordination, and outreach. For more information click [here](#).

4. Integrated **care coordination** to support care teams in the management of high risk patients
5. Improved **operating efficiency** to keep operating costs down and reduce pressure to raise prices
6. Diverse **patient engagement** strategies to involve patients in the management of their own care

Reflection Questions

How confident are you in your ability to take on risk under value-based contracts with QHPs? How many of these competencies does your health center, HCCN, or PCA currently possess? What are the barriers preventing you from developing the remainder? Could these barriers be more efficiently overcome by partnering with other organizations?



WORKSHEET 3: YOUR HEALTH CENTER'S COMPETENCIES FOR SUCCESS

Directions

Think about your Health Center's experiences with the six competencies discussed in Module 3. Rate your Health Center's individual capacity with each of the competencies from 1-5 (5 being highest). Then note what steps you could take to improve upon these.

Health Center Competency	Rating (1-5)	Opportunities to Improve
Data Analytics		
Data Exchange		
High Performing Medical Homes		
Care Coordination		
Continuous Operational Improvement		
Engaging Patients		

MODULE 4 RESOURCES AND LINKS

Data Analytics

1. [Data and Analytics Key to Health Reform, but Challenges Stand in Way](#)
2. [America Health Insurance Plans \(weblinks and whitepapers\)](#)
3. [Numbers, Numbers and More Numbers](#)

Data Exchange

1. [What is HIE?](#)
2. [HealthIT.gov \(weblinks and resources\)](#)
3. [HIE & the Safety Net](#)
4. [Health Information Exchange: The Role of Safety-Net Providers](#)

High Performing Medical Homes

1. [The 10 Building Blocks of High-Performing Primary Care](#)
2. [The Building Blocks of High-Performing Primary Care](#)
3. [Safety Net Medical Home Initiative](#)
4. [NCQA Patient-Centered Medical Home](#)

Care Coordination

1. [Community Referral Coordinator Program](#)
2. [Care Coordination Atlas \(AHRQ weblinks and resources\)](#)
3. [Safety Net Medical Home \(weblinks and resources\)](#)
4. [Institute for Healthcare Improvement \(weblinks and resources\)](#)
5. [Improving Chronic Care Illness \(weblinks and resources\)](#)
6. [Care Management for Medicaid Enrollees Through Community Health Teams](#)

Continuous Operational Improvement

1. [IHI 7 Rules for Engaging Clinicians in Quality Improvement](#)
2. [BPHC Website: Health Center Operations \(weblinks and resources\)](#)



MODULE 5: TAKING NEXT STEPS: EVALUATING YOUR PROGRESS AND PREPARING FOR FUTURE OPPORTUNITIES

INTRODUCTION

With the many changing dynamics currently applying pressure to the healthcare system, Health Centers will likely have several opportunities to build or join new partnerships. Health Centers will be impacted by a variety of Federal, State, and local changes in how health care is paid for, how insurance is obtained by patients, and how other health care providers in their region respond to the Affordable Care Act.

The first four modules identified trends and environmental factors impacting Health Centers. This module focuses on how Health Centers can evaluate their ability to respond to and engage these changes.

Health Centers should evaluate three key factors:

- State-level Health Reform activities and how these impact Health Center patients
- The impact of healthcare delivery on the changing local partnerships
- Options and methods Health Centers are utilizing to successfully position themselves in response to these changes

Assessing Your State-Level Environmental Factors

There are several major, identifiable, state-level factors that will determine the impact on Health Centers:

1. Expansion of Medicaid
2. Existence of a CMS State Innovations Model Initiatives program
3. Expansion of Medicaid Managed Care
4. Number and type of Qualified Health Plans selling insurance in local markets
5. Presence of a functional Statewide Health Information Exchange

The following table provides a high-level overview of the impact of these factors:

1. Expansion of Medicaid	
What is it?	The health care law provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 who make up to 133% of the federal poverty level. ¹¹
If your state is expanding Medicaid...	<ul style="list-style-type: none"> • All uninsured patients should be re-evaluated for Medicaid eligibility • Health Centers will likely see a net increase in revenue as patients move from uninsured status to Medicaid • Health Centers may face increased competition from Health Systems that wish to serve these newly insured patients
If your state is not expanding Medicaid...	<ul style="list-style-type: none"> • Those with incomes above 100% of the Federal Poverty Level, and who do not qualify for Medicaid, will not be eligible for subsidies.

¹¹ Healthcare.gov

2. Existence of a CMS State Innovations Model Initiatives Program	
What is it?	The State Innovation Models (SIM) Initiative is providing support to states for the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. ¹²
If your state has a SIM Award...	<ul style="list-style-type: none"> Your state is likely convening a broad group of stakeholders to discuss changes in payment for Medicaid and other payers States who have these awards are testing shared savings payment models, bundled or episode payment models, and other advanced payment models This increases the likelihood of the introduction waivers that may attempt to create alternative payment methodologies for Health Centers
If your state does not have a SIM Award...	<ul style="list-style-type: none"> Introduction of new potential payment models for Medicaid are less likely Health Plans will have more latitude to design their own payment models, should the desire to do so

3. Expansion of Medicaid Managed Care	
What is it?	State policymakers are increasingly looking to Medicaid managed care as a key strategy to manage costs and encourage innovation in health care delivery. ¹³
If your state is expanding Medicaid Managed Care...	<ul style="list-style-type: none"> You may have new Health Plan partners to interact with, as your state may look to procure the services of Managed Care Plans through an RFP process. New populations may move from traditional Medicaid into Managed Care Plans. Existing Managed Care Plans may be allowed to serve patients in new geographic regions of your State.
If your state does not expand Managed Care...	<ul style="list-style-type: none"> Your state is more likely to look to create new payment models within traditional Medicaid.

¹² From CMS.gov

¹³ <http://www.commonwealthfund.org/publications/fund-reports/2014/apr/role-of-medicaid-managed-care-in-health-delivery-system-innovation>



4. Number and type of QHPs selling insurance in your region	
What is it?	Under the Affordable Care Act, starting in 2014, an insurance plan certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will be certified by each Marketplace in which it is sold. ¹⁴
Your market may have many QHPs...	<ul style="list-style-type: none"> • In some markets, there will be many QHPs selling insurance on the Insurance Marketplace. • Some of these QHPs could be new products offered by existing Medicaid Managed Care or Commercial Health Plans in your region. Your existing contracts with these QHPs may define your payment terms for the Marketplace population. • In markets with many QHPs, Health Centers will want to seek contracts with as many as possible, so they can avoid losing patients who opt for QHPs with which they have no contract.
Your market may have few QHPs...	<ul style="list-style-type: none"> • Some markets will have very few, or even just one QHP. • Health Centers must ensure they have contracts with the limited number of QHPs in these markets so as to be able to continue to see their patients who qualify and purchase insurance on the Marketplace.

5. Existence of a functional Statewide Health Information Exchange	
What is it?	The State HIE Cooperative Agreement Program funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states. ¹⁵ Each state has had the opportunity to create a HIE, but some are more mature and functional than others.
If your state has a functional HIE...	<ul style="list-style-type: none"> • QHPs and other Health Plans may require you to participate in the HIE. • Obtaining information about your patients when they seek care elsewhere should be enhanced. • You should strongly consider joining the HIE if you have not already. • Your Health Center should learn about how the information in the HIE might effectively support new payment models from QHPs and other Health Plans.
If your state does not have a functional HIE...	<ul style="list-style-type: none"> • In states without a functional HIE, there are more likely to be similar functions supported by local Health Systems or Hospitals. • Your Health Center must learn about and consider getting involved with these initiatives. • If there is no locally sponsored HIE initiative, the Health Center itself may need to explore options for obtaining information from key healthcare provider partners in their community.

¹⁴ <https://www.healthcare.gov/glossary/qualified-health-plan/>

¹⁵ <http://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange>

Assessing Local Partnerships

The role your state plays in formulating a statewide Health Reform strategy will certainly influence local organization of healthcare providers. Ultimately, each Health Center must evaluate and determine how best to position itself within its local market.

The options available to Health Centers will be impacted and influenced by the following factors:

1. The number of competing Health Systems in your local market
2. The “physician engagement” strategy of local Health Systems
3. Your local Health Systems’ perception of Health Centers
4. Options for Health Centers to collaborate in a local market

1. The number of Health Systems in your local market	
What is it?	Health Centers have historically had to maintain relationships with most or all specialists and hospitals in their local market. Reform is increasing competition between Health Systems, and depending on the number of Systems in your market, it can impact your Health Center.
If you have no Health Systems in your local market...	<ul style="list-style-type: none"> • If your Health Center is situated in a market where there is limited access to hospitals, you will likely wish to collaborate with QHPs and other Health Plans to understand their strategy for obtaining access for their patients.
If you have a single Health System in your local market...	<ul style="list-style-type: none"> • It is likely a good strategy to seek formal relationships with this Health System, while maintaining autonomy of your Health Centers decision-making processes. • Every situation is unique, but this could include: <ul style="list-style-type: none"> ○ Developing programs with this Health System for better transition of patients between Health Center and Hospitals. ○ Sharing data about shared patients through a Statewide or local HIE. ○ Participating in contracts with QHPs and other Health Plans with this Health System. ○ Participating in an ACO sponsored by this Health System.
If you have more than one Health System in your local market...	<ul style="list-style-type: none"> • It may not be possible to participate in contracts or ACOs with any one Health System, because the perception could be the Health System might expect an exclusive relationship. • Health Centers must look at options that allow them to remain neutral in their alignment with any one System. These can include: <ul style="list-style-type: none"> ○ Contracting directly with QHPs and other Health Plans, rather than with a System. ○ Forming a Health Center ACO, independent from the ACOs formed by local Health Systems. ○ Not participating in ACOs or other Health Systems networks.



2. The physician engagement strategy of Health Systems in your market

What is it?	<p>Health Systems engage physicians in a variety of different ways, and each could have an impact on Health Centers in their local market. These include:</p> <ul style="list-style-type: none"> • Acquisition • Joint contracting • Care coordination programs
If Health Systems in your market are acquiring practices...	<ul style="list-style-type: none"> • Be cautious of recruitment strategies that could lure providers away. • Be cautious of initiatives to market to QHP patients directly • Consider marketing directly to QHP patients.
If Health Systems in your market engage physicians through joint contracting...	<ul style="list-style-type: none"> • This could take the form of a PHO (Physician Hospital Organization), an IPA (Independent Practice Association), or an ACO (Accountable Care Organization.) • Your Health Center will want to understand its options and the associated risks of participating in joint contracting with a local Health System. • Be cautious of exclusive arrangements, particularly in markets with multiple Health Systems.
If Health Systems in your market engage physicians through care coordination programs...	<ul style="list-style-type: none"> • Some Health Systems will look to engage physicians in your community through care coordination programs that do not require contracting together. • This could take a variety of forms: <ul style="list-style-type: none"> ○ Shared Health IT, like EHR or HIE ○ Care coordinators based at the hospital ○ Referral programs to Health Center services • In this case, you must ensure the Health System is educated on the Health Center's programs and capacity, and they make reasonable accommodations for engaging with Health Center staff on shared patients.

3. Health System perception of Health Centers

What is it?	<p>Health Systems in some markets understand and value the contributions of Health Centers. In other markets, they may know little about Health Centers and the value they may bring.</p>
Regardless of the current perception...	<ul style="list-style-type: none"> • Health Center leaders should focus on continually educating Health System leaders on the value the Health Center can bring. • New opportunities exist for which Health Centers are well positioned, including: <ul style="list-style-type: none"> ○ Providing access for recently discharged hospital patients ○ Empanelment to the Health Center for patients recently seen in the Health System emergency department ○ Development of transition of care programs that include data-sharing arrangements for shared patients

4. Options for Health Centers to Collaborate in the local market	
What is it?	As Health Systems organize to respond to QHP and other Health Plan needs, so too can Health Centers. In some local markets, Health Centers have organized amongst themselves to serve as stronger local partners.
Options Health Centers may have...	<ul style="list-style-type: none"> • Health Centers may build capacity that is shared across multiple Health Centers. For example, a referral coordinator program that helps to get patients leaving a hospital following an inpatient stay or ER visit, into a visit at a Health Center. • Health Centers may consider options for contracting with QHPs and other Health Plans as a group, with specific focus on improving quality and cost outcomes.

Evaluating and Positioning for Future Opportunities

Each of the state and local trends can independently impact what Health Centers must do to prepare to be the most effective in serving QHPs and other Health Plans. It is the interplay of multiple trends that will determine what approaches will have the greatest impact. While not possible to evaluate every possible combination of trend factors, there are three very common themes that have emerged.

Theme #1: Aggressive state reform agenda, little to no Medicaid Managed Care expansion, multiple QHPs and Health Systems	
Characteristics...	<ul style="list-style-type: none"> • Medicaid expansion to 133% of FPL • Likely to have a CMS SIM Model grant • Utilizing SIM process to influence payment terms in Medicaid and QHPs • Unlikely to expand Managed Care • Several QHPs selling insurance products • Likely to have functional statewide HIE
Impact on Health Centers...	<p>When the state expands Medicaid and is utilizing the CMS SIM Innovations model funding, Health Centers should expect:</p> <ul style="list-style-type: none"> • Potential for new payment options in Medicaid and through QHPs. • Alignment of quality measures and payment terms across multiple payers, including QHPs • Participating meaningfully in new payment options will require participation in the HIE
Potential Health Center response...	<ul style="list-style-type: none"> • Connect to the statewide HIE, and create meaningful programs to utilize HIE data to improve quality and cost outcomes • Participate actively in the SIM process, which should allow for contributions from Health Centers • Consider all options to collaborate with local Health Systems under new payment options • Consider options to integrate clinically or financially with other Health Centers in order to gain scale and improve outcomes



Theme #2: Slow state reform agenda, aggressive Medicaid Managed Care expansion, multiple QHPs and Health Systems

Characteristics...	<ul style="list-style-type: none"> • Unlikely to be expanding Medicaid to 133% FPL at this time • Unlikely to have a SIM grant • Very likely to be expanding Managed Care: <ul style="list-style-type: none"> ○ New plans ○ New geographies ○ New patient populations • Several QHPs selling insurance products • Unlikely to have functional statewide HIE
Impact on Health Centers...	<p>When the state expands Managed Care ahead of expanding Medicaid, Health Centers should expect:</p> <ul style="list-style-type: none"> • Opportunities to create relationships with Medicaid Managed Care plans that are new to their market • Lower uptake of Marketplace plans by uninsured patients, given decreased availability of subsidies. • Health Centers will have to find ways of creating meaningful data exchange with local Health System and other providers
Potential Health Center response...	<ul style="list-style-type: none"> • Evaluate options to contract with Medicaid Managed Care plans either independently, as a group with Health Systems, or as a group with other Health Centers <ul style="list-style-type: none"> ○ Focus on options to provide care coordination services to Medicaid Managed Care patients, with a focus on improving quality and cost outcomes • Facilitate conversations with Health Systems about stronger collaborations and local data sharing arrangements

Theme #3: Slow state reform agenda, no Medicaid Managed Care expansion, few QHPs and few Health Systems

Characteristics...	<ul style="list-style-type: none"> • Unlikely to be expanding Medicaid to 133% FPL at this time • Unlikely to have a SIM grant • Little to no Medicaid Managed Care • Few QHPs selling insurance products • Unlikely to have functional statewide HIE
Impact on Health Centers...	<p>Common in very rural states with a very widely distributed population:</p> <ul style="list-style-type: none"> • Health Centers in these regions/states will see Health Reform related changes occurring much more slowly • Lower uptake of Marketplace plans by uninsured patients, given decreased availability of subsidies.
Potential Health Center response...	<ul style="list-style-type: none"> • Health Centers may have an ability to collaborate with their state to create alternative options for uninsured patients • Health Centers should weigh the option of seeking a SIM Model grant, in partnership with their state • Health Centers must seek contracts with QHPs to avoid having their patients be ineligible to continue receiving care at the Health Center

Reflection Questions:

Which of the themes is most like your current environment? How does your current environment differ, based on the key trends? How has your response been similar or different from the theme that most resembles your environment?

CONCLUSION

If your state is moving slowly, you have more time to be thoughtful and develop a meaningful response to changes in your environment. If your state is moving more quickly, time may be of the essence related to how you intend to respond.

Regardless of the pace at which your local market is changing in response to Health Reform, there are common activities every Health Center should be doing to improve the value they bring to QHPs and other Health Plans and payers:

- Continually build upon Quality Improvement processes to improve quality and better manage cost
- Seek increasingly effective models for working with Health System and Hospital partners
- Understand the dynamic in the local market regarding number of QHPs participating
- Ensure all stakeholders including QHPs, other Health Plans, the state, health systems, hospitals, other providers, and patients have a firm understanding of the Health Center and the value it brings to each

New best practices are emerging, and identifying Health Centers that are operating in markets similar to your own can be a valuable opportunity to educate yourself on how certain aspects of Health Reform have played out for Health Centers. Further, understanding how your state and local markets might move forward, if they have not done so already, can help you identify which models might work best going forward.



WORKSHEET 5: EVALUATING YOUR PROGRESS AND PREPARING FOR FUTURE OPPORTUNITIES

Directions

As you consider the various dynamics occurring as a result of the ACA, think how market opportunities and challenges impact your Health Center.

Complete this checklist as a way to identify areas where your Health Center may want to strengthen its position to respond to state and local market forces.

IMPACT OF STATE AND LOCAL MARKET FORCES CHECKLIST

- My local market has many local health systems and hospitals that our current patients interact with for their care.
- My Health Center has at least some relationships with local health systems and hospitals that it can build upon for future partnerships.
- My Health Center's patients gain coverage as a result of our state's approach to Medicaid Expansion.
- My Health Center is aware of and, involved in, the state's State Innovation Model program.
- My Health Center is successful in tracking QHP participation and activities in our state. We understand where opportunities exist for us to build these relationships.
- My Health Center is considering working with other Health Centers to pool some of clinical (i.e. referral coordination) or operational (i.e. IT, RCM) services to improve efficiencies.
- The Medicaid Department in our state is considering new payment models for all or part of the Medicaid population.

MODULE 5 RESOURCES AND LINKS

Medicaid Expansion

1. [The Role of Medicaid Managed Care in Health Delivery System Innovation](#)
2. [High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid](#)
3. [Medicaid Expansion](#)

State Innovation Model (SIM)

1. [State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform](#)
2. [State Innovation Models Initiative: General Information \(CMS weblinks and resources\)](#)







