AHARO HAWAII – External Discussion Paper
Value Based Care and APMs
Updated October 14, 2024

I. OVERVIEW

AHARO Hawaii Health Centers are reviewing the recently awarded State of Hawaii AHEAD grant and understand that it could be a catalyst to payment reform in Hawaii. The following document is intended to offer our community, and State leaders, AHARO's initial reaction to the "AHEAD" enabled possibilities.

It appears as if all health centers will be given the option of participating in an "Alternative Payment Model (APM)". While our PPS Plus model is appreciated by the Medicaid MCOs and Hawaii's State Medicaid Agency, there are questions remaining as to whether the "PPS Plus" model qualifies as an APM.

AHARO believes the PPS Plus Model has merit, especially if we can create validated margins that can be reinvested in community social services — a value shared by MedQUEST.

This discussion paper is intended to clarify our position on payment reform as it affects our patients. We appreciate the opportunity for a continuing discussion.

II. AREAS REQUIRING DISCUSSION

The Medicaid Director has expressed concern that while our PPS model is effective for Waianae, she is not sure it is best for others, especially health centers with less developed systems. This raises questions, "How transferrable is the model?" and even "How to best incentivize innovation?"

A key area of concern is the degree to which volume-based payments can align with value-based care and potentially an APM. Being incentivized to grow primary care visits is perceived by AHARO to be a desired goal of payment reform. In contrast, there may also be the perception by MedQUEST that "fee for service" puts undo pressure on Health Centers to produce, and in some cases, to churn visits.

The State Medicaid Director has expressed concern that there may be a "limiting factor" of qualifying certain services under Medicaid rules, and that Health Centers could be capitated for services they cannot afford to support now. From our experience within the PPS model, we have been able to add new services, not included in the PPS cost structure, when the MCO and Health Center project a positive effect these "Plus" services have on contracted outcomes (quality scores and impact on avoidable costs). We find the more limiting factor in outcomes is the contract deliverables assigned to the MCOs to address primary care inequities, particularly in rural Hawaiian communities.

In identifying an issue related to equity in telemedicine between PPS visits and fees paid private providers, the following example was used: "If you have a psychologist who works

in both private practice and for the Health Center remotely, why should the payment be different?" (Mahalo to Leinaala Kanana for a description of follow-up full FQHC services offered to our BH patients.) There is in fact, an auditable distinction as handoffs to comprehensive FQHC services are facilitated during the BH visit.

AHARO is continuing its dialogue on areas of concern. We continue to measure the relative value of Fee for Service primary care for vulnerable populations.

1. How can volume-based payments for primary care actually increase favorable outcomes?
2. Does capitation for these services disincentivize visit growth or devalue the actual delivery of care patients want/need most?
3. To what extent does a provider of episodic care to a more transient patient population, benefit disproportionately from a capitation model over those serving stable, multi-generational Hawaiian communities, especially ones historically underserved?
4. What percentage of our primary care visits are unnecessary and inconsistent with value-based services? Does churning visits actually occur and to what extent?
5. What effect has the private doc/hospital network Medicaid rate increases in 2024 had on FQHCs? Has this leveled the playing field or created new inequities?
6. In regards to the use of telemedicine, is access to full FQHC service diminished by the location of the BH provider?

It has become a realization that our substantial efforts to date to prove our relative value to payers in addressing avoidable cost and improving quality scores may not be the main goal of an APM. Some APMs may be value based while others based on different end goals.

Furthermore, there is some concern in Hawaii that some health centers will simply opt for what will pay them the most now, without the opportunity to fully consider all options available to them including the pilot project currently underway.

III. MAKING A CASE FOR PPS PLUS AS AN OPTION UNDER PAYMENT REFORM

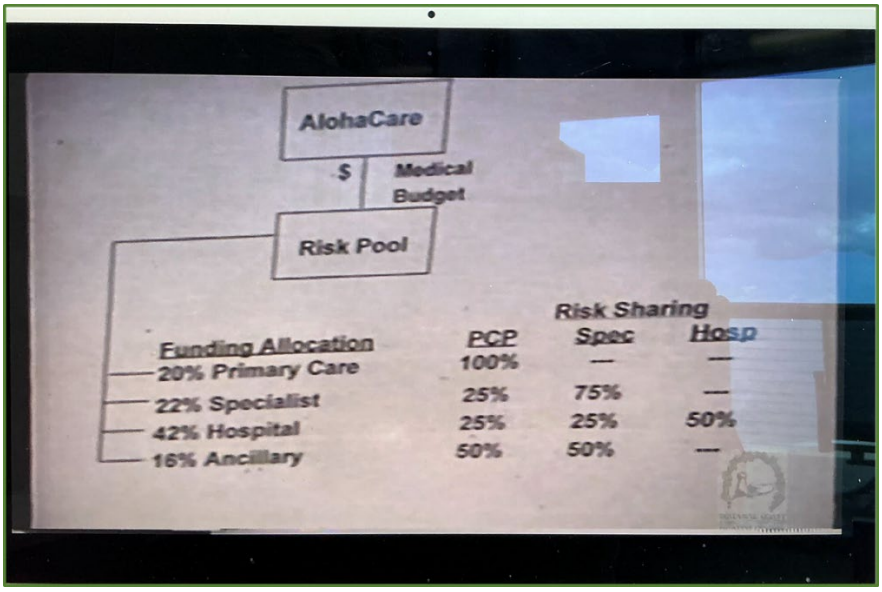
It appears the model AHARO Health Centers are pursuing is a true value-based model that levels the playing field in terms of services provided while addressing current inequities in risk adjustment and attribution of patients.

Hawaii APM is perceived by some to be a transactional offer to give up PPS for capitation in exchange for more flexibility in what services are covered. We are questioning whether this is an optimal methodology to address health equity, promote innovation and cultivate community solutions through value-based care.

We believe the single most important inequity and lack of value in health care is the long-term trend away from the relative investment in primary care and prevention.

The table below shows the proposed distribution of MedQUEST resources by functional category at the onset of QUEST. Today the allocation sits at 6-7% for primary care. Why?

From AlohaCare presentation with video available



The political issues around pharmacy benefits and hospital vested interest are far more powerful than those representing Health Centers. Our strongest empowered partners have become the Health Plans that are capable of measuring relative value. For now, PPS is the single biggest factor in assuring us some degree of equity, however, much more commitment to primary care needs to be made. This may be especially true until more precise risk adjustment is developed that recognizes broader actuarial factors including population health conditions.

We believe the keys to value-based care include trusting relationships, precision data analytics, and strategically aligned incentives. What is the case for the PPS Plus Model?

1. It removes any disincentive to reach out to the most complex and difficult patients while we wait for more precise risk adjustment.
2. It allows a floor to be set on the relative investment in primary care that is currently moving in the wrong direction.
3. The PPS Plus Model does allow Health Plans to contract for additional service not included in the cost report and support these services through capitation.
4. PPS allows Health Centers that expand scope of primary care services or new access points to know that a timely rebasing of rates will occur – it's the law.
5. The model showing success has come from within a medically underserved community and are not designed from afar.
6. And perhaps as the strongest consideration, the PPS Plus Model is actually producing documented cost savings or targeted improvement in quality scores with focus on a high-risk cohort of patients. The latest data suggests that increased performance with smaller health centers risk pools as well. Additional analysis of this initial outcome will be completed.

IV. OTHER FACTORS THAT CONTRIBUTE TO PAYMENT INEQUITY AND COULD BE CONSIDERED UNDER PAYMENT REFORM

The recent action by the State of Hawaii to increase private practice Medicaid rates to their Medicare level of payment has produced unintended consequences in the workforce market with the potential for many health centers losing providers to private networks that can offer higher salaries. While this may present a positive opportunity for improved primary care access there needs to be a companion program that enables underserved communities to train a replacement workforce. While hospital networks have work force support built into their Medicare reimbursement, Health Centers do not.

Access to behavioral health requires additional support whether a Center uses an APM model or a PPS Plus model. Not extending remote BH provider options is of immediate concern. This issue will be covered in a future correspondence.

The algorithm that assigns patients from AHARO service areas that do not select a plan to the Kaiser plan, based on national quality scores, is another form of inequity. National quality scores may not correlate to local quality scores and may not be adequately risk adjusted.

V. CONCLUSION AND RECOMMENDATIONS

AHARO Hawaii appreciates the transparency and willingness of the Hawaii State Medicaid Agency and the State Health Planning and Development Agency to engage in open dialogue around the topics of Alternative Payment Models (APM) and Value Based Payment.

AHARO Hawaii believes that value-based care should incentivize increased access to comprehensive primary care. Converting primary care visits to capitation does not incentivize growing primary care in communities not historically acculturated or enabled to fully access primary care, or in Native Hawaiian communities that are typically less transient that others.

The Value Based Care (PPS Plus) approach being tested by 3 AHARO Centers focuses on a high-risk cohort thereby neutralizing attribution and risk adjustment inequities. The approach targets the highest level of avoidable costs or contributing to lower that achievable quality scores. This model may be an interim solution to inequities in the attribution of patients to risk pools and the lack of adequate risk adjustment for Native Hawaiians including chronic disease onset variances.

Ultimately, if the State of Hawaii wants to use the AHEAD grant to facilitate change it should structure contracts with Health Plans to require a substantial proportionate increase in Plan investment in primary care and prevention. The current practice of requiring Health Plans to address social determinants has been successful increasing the investments in addition to social and preventive services is an admirable goal.

VI. ADDITIONAL RECOMMENDATIONS

1. AHARO should engage Foresight Health Solutions to validate AHARO assumptions that access to primary care and prevention in Hawaii's MUA communities is essential in addressing avoidable costs and quality outcomes and provide such evidence to MedQUEST. The relative value of primary care access can be measured.

2. The MedQUEST Agency should specify what is the qualifying criteria to recognize what is an "Alternative Payment Model" and whether relinquishing PPS is a necessary requirement. If the current PPS Plus model does not qualify, it should not preclude additional support for primary care for Health Centers fully engaged in this form of value-based care.

3. Given the evidence available to date, MedQUEST should support more than one model under payment reform when they demonstrate desired goals of payment reform. This would allow health centers to choose between the proposed APM model and one based on "enhanced" value-based care. The enhanced value option should be based on contractual deliverables beyond those supported by PPS and as a joint deliverable with Medicaid MCOs.

4. As the goal of moving back to a higher level of investment in primary care Medicaid MCOs should be contracted to expand investment in PPS Plus capitation for services such as "food as medicine", Native Hawaiian traditional practices, school-based services, workforce development including "Teaching Health Centers", and expanded behavioral health integration. The cost of behavioral health group treatment, substance and workforce initiatives not currently included in the PPS cost rate could be capitated as a value-added service in both the APM and the "PPS Plus" (Value-Based) Model.

5. To further align incentives, MCO Health Centers will develop, cooperatively with the Health Centers, work plans on non-PPS supported services and continuing support will be performance based as continued funding support need not be continued if plan objectives are not achieved.

6. MedQUEST should immediately extend the full payment for remote behavioral health service providers when there are protocols in place that assure the BH patient the same level of access to full scope FQHC services as those receiving care, face to face, at an FQHC site.

7. To access any disparities in system proficiencies, AHARO Hawaii has proposed definitions for tiered proficiency levels in data aggregation and asked Health Plans to support stages of adoption tied to deliverables. These proficiencies are available upon request.

Mahalo!