blue of california
foundation

issue brief

transforming california's healthcare safety net through value-based care

The Patient Protection and Affordable Care Act (ACA) continues to provide California with an extraordinary opportunity to transform and improve the state's healthcare system. Thus far, California has been a national leader in taking bold steps to increase access to care for the uninsured or underinsured. Since 2010, the state has cut its uninsured rate in half. More than one million people have signed up for health insurance through Covered California, and Medi-Cal has expanded to include more than 2.7 million newly-eligible Californians. In fact, total Medi-Cal enrollment in 2015 is expected to top 12 million – almost a third of the state's total population.

While significant progress has been made, increasing healthcare coverage is not enough. We must pay equal attention to how care is being delivered in our communities. A transformed system is one in which health care is provided efficiently and effectively so that it is affordable for all Californians. This requires an emphasis on high *value* care, not high volume.

To improve quality while holding down costs, California must look for opportunities to change the way healthcare providers are reimbursed and rewarded. The old adage, "you get what you pay for" aptly describes how payment currently dictates the way our health system operates. We must move away from a reimbursement model that pays organizations based on the number of patients providers see, towards a model that incentivizes better care by paying for improved patient outcomes.

This policy brief provides key insights and recommendations for modernizing healthcare payment in California. It also highlights the opportunity to test a new model in federally qualified health centers (FQHCs) across the state.

An Outdated Payment Model

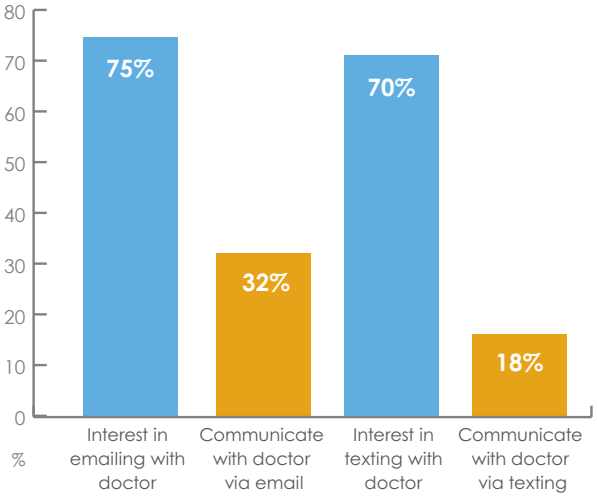
Healthcare providers, policymakers, and even patients themselves recognize that our healthcare system needs to change. Even after reform, access to timely, effective, and affordable care is still a challenge for many Californians. The current system is complex and often difficult to navigate. Especially for low-income individuals covered by Medi-Cal, the system can be even more overwhelming given the limited number of doctors accepting new Medi-Cal patients.

FQHCs, which encompass both county and community health centers, are a critical component of California's healthcare delivery system for low-income patients. In 2013 alone, California community health centers recorded over 5 million patient visits. To reimburse FQHCs for Medi-Cal patient visits, the state of California currently uses a payment method known as the Prospective Payment System (PPS). Under federal law, the PPS payment formula sets a minimum per-visit payment for Medi-Cal patients seen by an FQHC provider. Each FQHC has a different PPS rate based on its historical cost of providing care. Although the PPS method has been very important in stabilizing FQHC finances and enabling health centers to expand services for the newly insured, it does not account for whether a patient's health is improving, or reward providers for the quality and coordination of care. Instead, FQHCs are reimbursed every time a Medi-Cal patient comes into the health center for care.

This model inhibits FQHCs from focusing on the needs of individual patients. Instead, providers are incentivized to have as many visits per day as possible. Even for basic services, overcrowded provider schedules cause long wait times and backlogs. In some cases, visits are unnecessary and frustrating for both the patient (who has to worry about transportation and the time it takes to travel and wait) and the provider (who cannot focus on the patients who truly need extended and in-person attention).

Despite these ongoing challenges, the PPS formula has not changed to support new and more efficient ways of delivering care. For example, it does not reimburse providers for telephone consultations or for communicating with patients through email. According to recent research by Langer Research Associates, just 32 percent of low-income patients in California communicate with their providers by e-mail, though 75 percent express an interest in being able to do so. And just 18 percent of low-income patients in California communicate with their providers via text, though 70 percent express an interest in being able to do so. Clearly, low-income Californians want the convenience of connecting with their doctors online and through mobile devices, but current payment methodology discourages providers at FQHCs from embracing these strategies.

Interest vs. Use of New Communication Methods (Among Low-Income Californians)



In some cases, important preventative services and support systems that help patients manage chronic disease, such as nutritionists or promotoras, do not qualify for reimbursement under PPS.

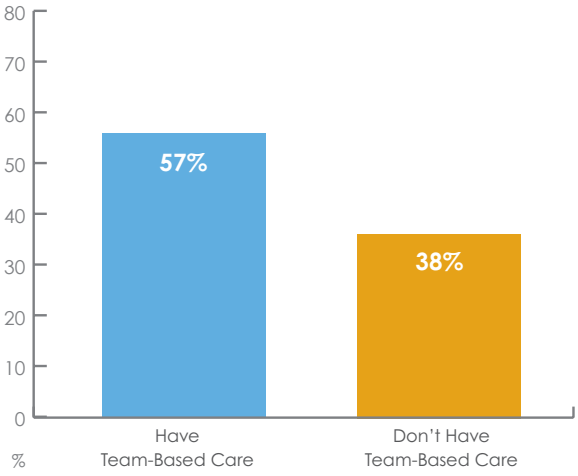
The PPS formula also does not pay for behavioral health services if a patient has already seen their primary provider in the same day. This means that if a patient is identified as having a mental health issue during a primary care visit, they might be told to return on a different date to get their behavioral health needs addressed. Alternatively, some FQHCs will see the patient on the same day and not get reimbursed for their services to ensure the well being and safety of the client and community they seek to serve.

Paying for Better Value

California has an opportunity to address these shortcomings and incentivize better care. Rather than continuing to reward the volume of visits, Medi-Cal could test an approach that pays a capitated rate, or a small consistent amount per patient every month. Such an approach would further allow FQHCs to deliver high-quality, patient-centered services, while reducing hospital readmissions, preventing unnecessary emergency room use, and ultimately improving health outcomes for low-income Californians. All of these lead to cost savings for patients, providers, and the Medi-Cal Program.

In addition to healthier patients and lower costs, an approach that pays for value would also lead to better patient experiences. We know from our research on the healthcare preferences of low-income Californians that patient satisfaction requires consistent access to a team of providers working together to successfully support patients' health and coordinate care. Data shows that 57 percent of patients who have team-based care (provided by an assigned group of caregivers) feel very informed about their health, compared to just 38 percent among patients who lack team-based care.

Percentage Who Feel Informed About Their Health (Among Low-Income Californians)



Federally qualified health centers are ideally suited and well-positioned to test new models that pay for better value. These providers have a demonstrated record of delivering high-quality care, a unique understanding of the cultural and linguistic diversity of low-income Californians, and the ability to tailor their services to best meet the needs of these patients. In many cases, FQHCs already deliver preventive and social services consistent with value-based health care, despite not being reimbursed. This idea is not novel for these providers. However, the opportunity to create a payment system that encourages and rewards them for delivering this type of care is new.

Paying for Better Value in FQHCs:

A Pilot Project

Federal law allows states to test new payment methods for services provided to Medi-Cal enrollees at FQHCs. To take advantage of this opportunity, The California Primary Care Association, California Association of Public Hospitals and Health Systems, LA Care Health Plan, and the Department of Health Care Services are actively working to develop such a pilot project.

The pilot aims to demonstrate that changing payment methodology will help patients receive the right kind of care and treatment in the most effective and convenient way possible. FQHC providers will be measured by the health and wellbeing of their patients, rather than by the number of patients they see in a day.

Under this new system, health centers will have greater ability to choose how they deploy a broader array of services and supports to improve patient health. The pilot also offers more support for new approaches and technologies that enable care to be delivered at the right time and in the right setting.

Key components and benefits of the pilot include:

- **More effectively meeting the needs of patients** – The pilot will enable patients to receive more comprehensive services from a wider range of health professionals (such as community health workers, social workers, and family counselors). They will also be able to receive mental health and primary care services on the same day, which leads to greater coordination between behavioral health providers and doctors. These changes will begin to shift the conversation from "What's the matter?" to "What matters to you?"
- **Greater efficiency in care delivery** – Under the pilot, providers will have greater ability to use virtual or telephonic visits to support patient interaction. By realigning incentives to encourage innovative models, doctors will be able to assess patient needs and provide treatment without requiring patients to travel or wait for in-person consultations. Through these efficiencies, patients will get more consistent and convenient access to care, and doctors will be able to spend more time with the patients that need it most.
- **Better use of healthcare dollars** – Through this pilot project, the state can maximize Medi-Cal funds by enhancing flexibility in the provision of care and allowing resources to be focused on what best serves the patient. This will not only minimize costly and unnecessary emergency department visits, it will also incentivize providers to keep their patients healthy – which has the potential to reduce the burden that chronic disease, obesity, and other illnesses continue to place on our healthcare system.

End Goal: Patients Leading Healthier Lives

California is making an enormous investment in providing primary care to low-income Californians, so it is important that we spend every dollar wisely. A shift away from a volume-based approach will begin to allow safety net providers to deliver a wider array of services that provide the most value for the patient in the most efficient way. Through this pilot, and other models that transform healthcare payment in California, we can improve quality, manage costs, and ultimately help patients lead healthier lives.

This issue brief was prepared by Blue Shield of California Foundation. The data and conclusions presented here are drawn from a series of statewide surveys on the healthcare experiences of low-income Californians conducted for the Foundation annually since 2011.

For details and the full reports see blueshieldcafoundation.org.

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