Integrating Performance Incentives into Financial Management

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Overview

- Summary of Value Based Payment (VBP) Initiatives
- Underlying VBP Payment Methodologies and Keys to Success
  - Base Compensation Models
  - Quality Incentive Payments
  - Total Cost of Care – Global Budgets/Payments
  - Care Coordination Payments
- New Core Competencies
- Overview of ACOs/IPAs
- Financial and Operational Considerations

All Payors Are Moving Towards an Evolving Definition of "Value"

Value =

↑ Health Outcomes

+

↓ Total Healthcare Spend

+

↑ Access

VBP Is Taking the Nation by Storm

- Medicare expects to have 90% of all payment tied to value and quality by 2018
- State Medicaid agencies are implementing VBP initiatives at lightening speed
  - California (APM)
  - Massachusetts (coupled with DSRIP)
  - New York (coupled with DSRIP)
  - Oregon (APM)
  - Tennessee (TennCare) – *New for 2017*
  - Others…..

TennCare's Patient Centered Medical Home Initiative

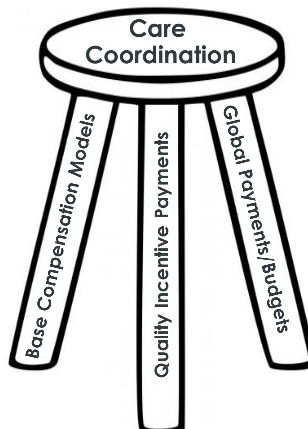
- TennCare's 3 MCOs will launch a statewide PCMH program, in waves, starting with 20 practices on January 1, 2017
- It is expected that by 2020, approximately 65% of TennCare members will have joined the PCMH program
- There are specific PCMH eligibility requirements
- Required services
  - Team-based care and practice organization
  - Knowing and managing your patients
  - Patient-centered access and continuity
  - Care management and support
  - Care coordination and transitions
  - Performance measurement and quality improvement
- Use of a statewide Care Coordination Tool

TennCare's Patient Centered Medical Home Initiative

- TennCare's 3 MCOs will launch a statewide PCMH program, in waves, starting with 20 practices on January 1, 2017
  - Current fee-for-service payment for delivery of services remains
  - Practice support payments (monthly payment, per member per month (PMPM) based on PCP assignment by MCO
    - "Practice Transformation Payment" - $1 PMPM for first year only
    - "Activity Payment" – risk-adjusted $ PMPM for duration of program ($4 PMPM average)
      - Beginning in 2019, portion goes "at-risk" based on quality and efficiency scores
  - Outcome payments :
    - Total Cost of Care (TCOC) for PCMH practices with greater than 5,000 members
    - Efficiency Metric Improvement for practices with fewer than 5,000 members
    - *To receive either type of outcome payment, must earn a minimum # of quality stars and show improved efficiency*

VBP Arrangements – "The 3-Legged Stool"

- VBP arrangements contain a hybrid of several different payment methodologies to incentivize and tie together desired behaviors
- The key components of VBP arrangements include:
  - Base Compensation Models
    - Fee-for-service
    - Partial capitation
  - Care Coordination Fee PMPM
  - Quality Incentive Payments
  - Global Payments/Budgets
    - Surplus-sharing/Risk-sharing
    - Global capitation



VBP Arrangements

- Preparation for VBP requires an understanding of the key metrics that drives each payment methodology
  - Quality and risk-adjusting embedded through-out

Payment Model	Key Metric
Base Compensation	Move from "per visit" to "per patient" (capitation)
Care Coordination	New core competencies and cost
Quality Incentive Payments	Measuring performance metrics
Global Budgets/Payment	Monitoring the total health care spend (and quality)

Base Compensation Payment Models (In-House Services)

- As VBP arrangements evolve, payments to FQHCs will change away from the traditional "per visit" model
- Payment will be moving towards quality outcomes and patient-centeredness
- Medicare's VBP initiative includes base compensation payments "being linked to quality"
  - A % of a provider's Medicare FFS payments are withheld and redistributed based on performance/quality

Revenue/Cost "Per Visit"

Revenue/Cost "Per Patient"

Primary Care Capitation Models

- Partial Capitation Arrangements

	Patient A	Patient B
Annual Revenue	Rate ($25 PMPM) × 12 months = $300	Rate ($25 PMPM) × 12 months = $300
Annual Cost:		
Cost per visit	$125/visit	$125/visit
# of visits per year	2 visits/year	3 visits/year
Annual Cost	$250	$375
Financial Success	$50	$(75)

How does a health center manage financial risk? One patient with unusually high utilization can have a dramatic downward impact on financial performance!

Primary Care Capitation Models

- The paradigm shift in managing primary care capitation

	Fee-For-Service	Capitation
Payment Model	Payment based on the # of units (visits) provided	Payment based on the # of patients assigned to the Center
Revenue Equation	# of units × rate = revenue	# of patients × rate PMPM × 12 months = revenue
Financial Success	Increase productivity and the # of units to increase revenue	Reduce the cost per unit, manage patient utilization and minimize risk through increased # of patients and improved health outcomes

Increased Provider Productivity …	*More visits = Increased revenue*	*More capacity → More patients = Increased revenue*

Improving Efficiencies And Reducing The Cost Per Visit

- All-inclusive cost per visit analysis
  - The following variables impact the all-inclusive cost per visit and must be managed to improve financial performance:
    - Salary levels and staffing mix
    - Support staff ratios (direct care versus patient support)
    - Amount of enabling and ancillary services
    - Administrative/overhead infrastructure
    - Provider productivity/clinician capacity

$$\frac{\$\ 1{,}542{,}100}{10{,}000\text{ visits}} = \$\ 154.21\text{ per visit}$$

Center's will continue to monitor/manage these cost/operating metrics as they move to Value Based Payment!

Primary Care Capitation Models

- Impact of Productivity – Capitation Models

	Provider A	Provider B	Provider C	Provider D
Provider "capacity" (visits)	3,000	3,500	4,000	4,000
Average Visits per Patient	3.50	3.50	3.50	3.00
Panel Size (Members)	857	1,000	1,143	1,333
Number of Member Months (Members x 12)	10,286	12,000	13,714	16,000
Capitation Revenue PMPM	$42.50	$42.50	$42.50	$42.50
Total Revenue	437,143	510,000	582,857	680,000
Total Expenses (driven by volume)	506,250	512,500	518,750	518,750
Surplus/(Loss)	**($69,107)**	**($2,500)**	**$64,107**	**$161,250**

Today – Evaluating Cost Per Patient

Utilization varies by health condition of patient!

Simple Cost PMPM Calculation – Per Visit per Patient Basis:

Service Description	Patient Utilization	Unit Cost	Annual Cost per Patient
Primary Care	3 visits PMPY	$175 per visit	$ 525
Behavioral Health Care	1 visit PMPY	$100 per visit	100
Care Management (PCMH)	1 patient	$75 per patient	75
?????			
Total Direct Care			700
Administration/HIT		20% of direct	140
Total Cost PMPY			$ 840
Total Cost PMPM			**$ 70**

- *Payors risk-adjust capitation payments and generally pay more for more complex patients*
- *The analysis would be further enhanced if utilization and cost were analyzed on a per procedure basis (use of a cost-based charge structure)*

VBP – Quality Metrics & Incentive Payments

- "Value-inspired" metrics, of late, revolve around the following areas: measures
  - Patient quality measures
  - Process measures
  - Population health metrics
  - Patient satisfaction measures
  - Access
  - Care coordination
- Measurement and payment thresholds include -
  - Event based
  - Population based
    - Maintenance
    - Improvement

VBP – Quality Metrics & Incentive Payments

- Understand metrics being measured
  - Discussion of metrics selected
  - Calculation of the metric (including data elements)
  - Identify benchmarks
  - Evaluate current performance and anticipated future performance
- Project revenue based on anticipated performance and benchmarks
  - Fixed payment per measure for improvement
  - Fixed payment per measure for maintenance
  - Incremental bonus based on movement of metric
  - Composite scoring across multiple metrics
  - Amount of surplus-sharing/risk-sharing payments earned

VBP – Quality Metrics & Incentive Payments

- Types and how payment determined

Type of Payment	Formula to Earn Payment	Examples
Fixed amount paid for improvement of metric	Improvement of metric from one quartile to another	Various HEDIS measures
Fixed amount paid for maintenance of metric	Maintain metric that currently exceeds the specific percentile	Various HEDIS measures
Incremental bonus based on size of movement in metric	Amount of payment increases incrementally based on size of % change	Reduction in urgent/non-emergent ER use
Composite scoring across multiple metrics	Negotiated set of metrics assigned points; % earned based on number of points scored versus total points available	Numerous HEDIS measures defined that, as a group, determine payment

VBP – Quality Metrics & Incentive Payments

- Understand the total pool of funding available assuming all metrics met
- Method for projecting quality incentive payments
  1. Identify current actual performance of metric
  2. Project improvement/reduction in metric over time
  3. Compare to benchmark(s)
  4. Determine amount of projected payment based on payment formula
  5. Reserve %

VBP – Quality Metrics & Incentive Payments

- Example of composite scoring formula
  - Analysis of metric

Measure	Current Actual	Year One		Year Two	
		Improve %	Metric	Improve %	Metric
Cervical Cancer Screening	40.00%	25%	50.00%	15%	57.50%

  - Comparison to benchmark

Measure	Benchmarks			Projected Score	
	25th %-tile	50th %-tile	75th %-tile	Year One	Year Two
Cervical Cancer Screening	50.00%	60.00%	70.00%	2	2
	2 points	4 points	6 points		

VBP – Quality Metrics & Incentive Payments

- Example of composite scoring formula (continued)
  - Composite scoring and amount of payment

	Year One	Year Two
Total Points – all measures	15	30
Total Available Points (10 metrics)	60	60
% of Total Attained	**25%**	**50%**
QIP $ Available PMPM	$ 5.00	$ 5.00
# of Member Months	100,000	100,000
Maximum QIP Pool Available	**$ 500,000**	**$ 500,000**
Total Projected QIP	**$ 125,000**	**$ 250,000**

Success in VBP Arrangements for In-House Services

- As Centers move away from fee-for-service payment arrangements to VBP, patient-centered care, the drivers of success expand:
  - Proper coding of services provided required for appropriate risk-stratification of patients
  - Managing provider productivity impacts panel size and thereby revenue
  - Managing the cost per patient
    - Improving cost efficiencies (per visit or per unit)
    - Monitoring clinical staff capacity and panel sizes
    - Managing patient utilization and health condition
  - Actuarial mix of patients including cost and utilization patterns
  - Unusual utilization patterns and drilling down to the patient level and identifying high utilizers of services
  - Improving quality metrics and accessing incentive payments

VBP – Surplus/Risk-Sharing

- Revenue projection – complicated and various assumptions
  - Targeted Spend/Benchmark – Use of historic claims versus Medical Loss Ratio (MLR)
  - Projection of actual spend
  - Surplus-sharing and risk-sharing %s
  - Impact of quality scores on distribution amount
  - Timing of payments – interim versus annual

VBP – Surplus/Risk-Sharing

- Example revenue projection

	$ PMPM	# of Member Months	Total Amount
Targeted Spend/Benchmark	$500.00	100,000	$50,000,000
Actual Spend (Projected)	$475.00	100,000	$47,500,000
Projected Surplus (Deficit)	$25.00		$2,500,000
Surplus-Sharing %			50%
Amount Available for Distribution			$1,250,000
Quality Score			75%
Adjusted Distribution for Quality Score			**$937,500**

Surplus/Risk-Sharing – Key Considerations

Key items which impact success:

- Panel formation
  - Enrollment
  - Attribution
- Development of overall budget
  - Utilization assumption based (bottom up) – “Paid Claims”
  - Historic baseline or revenue based (top down) – “Medical Loss Ratio”
- Protections against outliers
  - Stop Loss
  - Carve-Outs
  - Risk Corridors
  - Reserves

Budget/Benchmark Setting

Differs based on Health Condition of Patient

- Setting a Budget Target – "Bottom-Up" Approach:

Service Description	Expected Utilization	Unit Cost	Cost Per Patient Per Year
Inpatient Care	1	$3,000 per discharge	$ 3,000
Emergency Services	1	$500 per visit	500
Specialty Care	2	$150 per visit	300
Primary Care*	3	$125 per visit	375
Behavioral Health Care*	1	$100 per visit	100
Laboratory	8	$25 per lab test	200
Radiology	2	$100 per xray	200
Pharmacy	12	$25 per script	300
PCMH Services*			170
Administration/HIT			855
TOTAL – Per Member per Year			**$6,000**

Understand "look-back" periods!

Using Third-Party Claims Data

- Analyze the high cost and high utilizing members
- Combine Claims data files
  - Determine the Total Cost of Care by patient and PMPM
  - Determine Total Cost of Care for patients with like conditions (e.g., all diabetic patients regardless of comorbidities)
- Stratify the high cost/high utilizing members and develop plans to better manage care and reduce the Total Spend
  - Clinical interventions to manage utilization
  - Outreach efforts/patient engagement
  - Specialty referral practices and high cost specialists
- Link to EHR/PMS, ED Use and High Risk Member Reports
- Analyze "systemic" anomalies
  - Physician practice patterns – cost and outcomes
  - Specialty referral practices and high cost/low quality specialists
  - Care locations

Surplus/Risk-Sharing – Key Considerations

Keys to Success:

- Monitor the cost and utilization of services provided by other providers:
  - Analyze total cost PMPM by actuarial class
  - Cost per unit (visit or procedure)
  - Utilization trends
  - Identify high cost patients
  - Identify high utilizers of services
  - Analyze high cost providers (unit cost)
  - Further analyze by health condition
  - Ensure quality measures are met
- Health information exchange systems
- Quality partners have been identified and arrangements executed
- Informatics and data reporting systems to manage all services provided to the patient
- Benchmarks and expected utilization patterns identified

Care Coordination Fees

- One of the foundational elements of most, if not all, VBP arrangements is the need for effective care coordination and management
- Third party payors are sometimes including care coordination fees in their VBP arrangements, however health centers need to sell the value of the care coordination proposal
  - Stand-alone fee PMPM
  - Advance against future shared-savings distributions
- Development of a proposed care coordination fee:
  - What services are required?
  - What services should be provided at the health center sites versus reside at the ACO/IPA level?
  - How to “cost-out” care coordination services?

Care Coordination Services

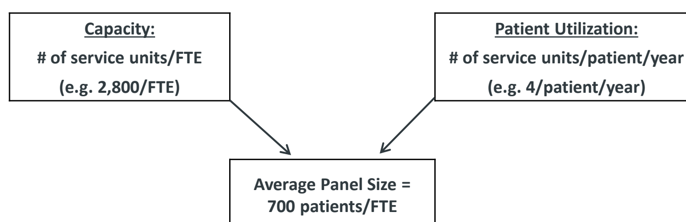
- What care coordination/management services are required to be successful under VBP?

Service Type	Health Center	ACO/IPA
Care Managers	√	
Care Management Central Support and Technology		√
Data Analytics Technology and Support	√*	√
Health Informatics	√*	√
Quality Improvement	√	√
Others	???	???

* May be provided by the ACO/IPA

Care Coordination Costs – Health Center

- Costs must be assigned to care coordination services identified
- Example - care managers
  - Care manager capacity (productivity)
  - Patient utilization



  - Number of care managers required = # of patients ÷ average panel size
    - Panel sizes may be impacted based on risk-stratification of patients

Care Coordination Costs – Health Center

- Example calculation of cost of care coordination services –
  - Total cost and PMPM

Service Type	Costing Methodology	Cost Estimate
Care Managers	4.00 FTE X $60,000	$ 240,000
Quality Improvement	1.00 FTE X $75,000	75,000
Health Informatics	1.00 FTE X $75,000	75,000
Support Staff	1.00 FTE X $30,000	30,000
Care Management/Data Analytics Technology Solutions	Covered by ACO/IPA (charged to the center?)	???
Others	TBD	???
TOTAL ANNUAL COSTS		**$ 420,000**
Number of Member Months	10,000 members X 12 mos.	120,000
COST PMPM		**$ 3.50**

Summary of VBP Arrangements

- Moving towards managing care on a capitation basis

	Patient A	Patient B
Revenue Per Member Per Year: *Fee-for-service* *Capitation* *Care Management Fee* *Quality Incentive Payments* *Surplus/Risk-Sharing*	$ 4,000	$ 4,250
Cost Per Member Per Year (PMPY)	$ 4,500	$ 4,750
Financial Success	$ 500	$ (500)

VBP – New Core Competencies

- Improved coding and clinical documentation
  - Traditional coding (claims)
  - Enhanced coding and documentation (EHR)
- Managing patient centered care (per patient)
- Data analytics (including business intelligence)
- Care management/delivery
  - HIT/HIE
- Partnerships and collaboration
- MCO contracting
- Financial management systems

Clinical Documentation and Coding – Uber Important!

- The importance of properly coding what is performed in the electronic health record and claim forms increases exponentially as we move up the VBP food chain

Traditional Coding (claims) Enhanced Coding & Documentation (EHR)

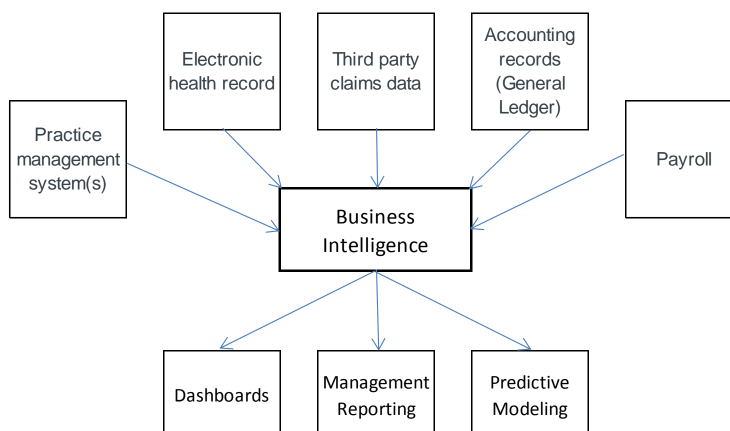
- The Coding Escalator to Better Outcomes:
  - Today (fee-for-service) – essential to be properly paid by 3rd party payors
  - Transition to PC capitation – critical to understanding patient utilization patterns, risk adjusting payments and accessing quality incentive payments
  - Tomorrow (global budgets) – required for proper risk stratification and benchmarking, creating clinical treatment plans, and attaining population health outcomes

Managing Patient-Centered Care

- Managing the total cost of care (fixed price per patient)
  - Cost per unit
  - Utilization of services
- Internal services (PC capitation)
  - Improve cost efficiencies – reduce the cost per unit (visit, RVU)
  - Monitor/manage service utilization – linked to complexity of patient
- External services (global budgets)
  - Manage referrals – lower cost at the same/better quality
  - Monitor/manage service utilization – linked to complexity
- Identify and manage high cost and high utilizing patients
- Need for data analytics and business intelligence

Data Analytics

- Ability to merge data from disparate systems and report in a meaningful way



Data Analytics

- Ability to merge data from disparate systems and report in a meaningful way ("Business Intelligence" applications)
  - Electronic health records/practice management systems
  - 3rd party claims data
  - Accounting records/payroll system
- Reporting and dashboards
  - Identify high cost and high utilizing patients (and drill-down)
  - Manage quality measures/metrics
  - Identify attributed members whom have not been seen by the center
  - Utilization review and management
  - Monitor provider productivity
  - Compliance with VBP arrangements
  - Predictive modeling

Care Management/Delivery

- Outreach and engagement
- Risk stratification of patients and care plans
  - Screenings/risk assessments
  - Social determinants of health
- Care coordination and multi-disciplinary care teams
- 24-hour nurse triage/hot-line
- Required technology to support care management/delivery embedded into EHR or web-based solutions
- Health information exchange
  - Real-time alerts
  - Interconnectivity with other healthcare organizations (e.g. hospitals)

Partnerships and Collaboration

- Partnerships with other healthcare provider types
  - Behavioral health organizations
  - Hospitals
  - Home health agencies
  - Nursing homes/long-term care providers
  - Community based organizations
- Formation of integrated care networks
  - Accountable care organizations (ACOs)
  - Independent practice associations (IPAs)

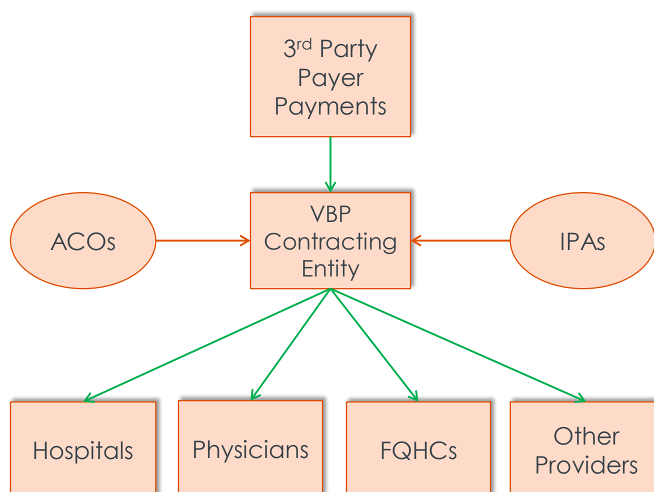
MCO Contracting

- Cost and utilization data required for negotiations
- Payment terms are negotiable
  - Base compensation and care management fees
  - Pay-for-performance/quality incentive payments
  - Global budgets
- Business case linked to social determinants of health
- Risk adjustment/mitigation
- Credentialing
- Referral management
- Utilization review and management
- Management of performance measures/metrics
- Compliance with contract terms

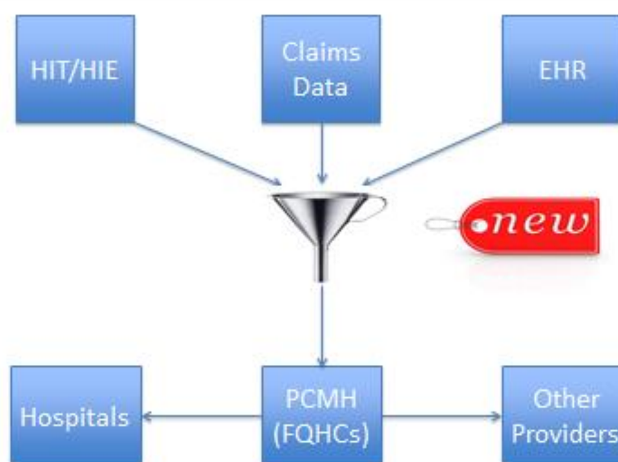
Why Form an ACO/IPA?

- Share infrastructure and realize cost efficiencies
- Quality improvements through sharing of best practices
- Pool resources to attract talent
- Expansion of geographic reach/market share
- Pool members to spread insurance risk in VBP arrangements and improve bargaining position with third party payors
- Expansion of service offerings and improve care coordination

VBP Contracting Entities: ACOs/IPAs



VBP – New Demands on Infrastructure



Funds Flow Within the ACO/IPA

- ACO/IPAs cash flow projections
  - What services will the ACO/IPA provide on behalf of its members?
  - Reserves?
    - Working capital
    - VBP reserve requirements
  - What revenue sources are available to the ACO/IPA to defray the cash needs?
  - Distribution methodology of surpluses to members
- Payments to ACO/IPA members
  - Pass-through of care coordination/quality incentive payments?
  - Surplus-sharing/Risk-sharing allocations
    - Attributed lives
    - Quality scores
    - Participation and engagement
    - Other

The VBP Dilemma

- The timing of potential new revenue streams under VBP are not aligned with the costs for successful participation in VBP

Payment Model	Timing of Cost		Timing of Revenue
	One-time, Upfront	On-going, Operational	
Base Compensation		√	Through-out the year as services are provided
Care Coordination	√	√	Through-out the year as services are provided
Quality Incentive Payments	√	√	6-9 months after the end of the measurement period
Global Budgets/Payment	√	√	6-9 months after the end of the measurement period

VBP – Financial and Operational Considerations

- What is this going to cost?
  - Identify new services to be provided
  - Evaluate whether to "go this alone" versus "join forces"
  - Develop a financial model
  - Quantify a range of capital requirements
  - Identify outside funding sources to offset capital needs and reserves
- What is the return on investment
  - Understand financial requirements of participation in VBP arrangements
  - Develop sound assumptions based on available data
  - Utilize financial model to inform VBP negotiations

VBP – New Core Competencies

New Care Coordination & Core Competencies = New Cost

- Initial, one-time infrastructure requirements
- On-going operating costs
  - Fixed versus variable (PMPM)
- Potential for joining an ACO/IPA – share new core competencies and cost
- Capital requirements
  - One-time costs plus working capital until break-even

Financial & Operational Key Considerations

- Develop a financial model
  - Decide on the services required to be provided for success under VBP
    - In-house (personnel) versus contracted ("Build Or Buy")
    - Short-term versus long-term
  - Organize member and covered lives data and develop phase-in strategy for VBP negotiations
  - Project potential revenues under VBP arrangements
    - Understand and develop "best estimates" for key assumptions
    - Retained by ACO versus paid directly/passed-through to members/providers
  - Prepare 3-5 year financial model including cash flow
    - Estimate potential capital requirements
    - Estimate potential distributions
    - Research need for reserves

Financial & Operational Key Considerations

- Working capital generally required to cover –
  - Start-up costs through execution of initial VBP arrangement
  - Deficiency in operating revenue over expenses until VBP surplus-sharing distributions are received
- Evaluate need for capitalization of the ACO
  - Organization/Start-up costs
  - Working capital required until break-even
  - Reserves for risk-sharing arrangements
- Deficiency in operating revenue over expenses during start-up driven by -
  - Negotiated “infrastructure” fee PMPM paid under VBP to cover “new” infrastructure costs
  - Operating cost PMPM (Personnel, MSO services, technology, other)
- Identify outside funding sources to offset capital requirements
  - Government (e.g. DSRIP)
  - Foundations
  - Third party payors

Financial & Operational Key Considerations

- Use financial model to inform VBP negotiations
  - Utilize key assumptions in financial model around surplus-sharing and risk-sharing arrangements when developing negotiation strategies
    - Monthly care management/infrastructure fee (PMPM)
    - Benchmarks
      - Use of historic claims data versus Medical Loss Ratios (MLRs)
      - Future adjustments to benchmarks
    - Surplus-sharing and risk-sharing %s
      - Transitioning from surplus- to risk-sharing
    - Risk mitigating factors
      - Reserves versus risk corridors, carve-outs and stop-loss
    - Timing of payments
      - Interim versus final distributions

Financial Management Systems

- Current financial health and positive operating performance
  - Reserves
- Strong financial systems and internal controls
- Financial modeling
  - What are the new services and infrastructure required?
  - What will it cost – upfront versus ongoing?
  - What resources are available to fund these costs?
  - What potential revenue streams are available?
  - What are the key assumptions that drive success?
  - What are the working capital needs?
  - What is the ROI?

Utilize the financial model to inform VBP negotiations!

How To Engage Staff?

- Success in VBP requires a multi-disciplinary approach
  - CEO + CMO + CFO + COO + others…..
- Need to educate all staff on VBP to create a level playing field
  - Requires educating clinical staff on how future revenue streams under VBP are impacted by what they do
- Requires input from clinical/operational staff on the resources required for financial success
- Once the required services are identified, CFO can cost out and prepare the financial model to determine an ROI

VBP Moves Quality to the Forefront in Revenue Generation

- Base Compensation payments: Moving towards Value Based Purchasing – providers with better quality scores receive higher payments than those with lower scores
- Care Coordination payments: Payors beginning to put care coordination PMPM payments "at risk" in the out years
- Quality Incentive payments: Providers may have access to additional payments by improving/maintaining quality metrics for patient attributed to the center
- Surplus Sharing Distributions: Payors are applying quality gates or adjustments to shared savings amounts thereby rewarding higher quality providers at the expense of low performers

Questions

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