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

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Key Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Compensation</td>
<td>Move from &quot;per visit&quot; to &quot;per patient&quot; (capitation)</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>New core competencies and cost</td>
</tr>
<tr>
<td>Quality Incentive Payments</td>
<td>Measuring performance metrics</td>
</tr>
<tr>
<td>Global Budgets/Payment</td>
<td>Monitoring the total health care spend (and quality)</td>
</tr>
</tbody>
</table>
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

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

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

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

**Increased Provider Productivity …**

| More visits = Increased revenue       | More capacity \( \rightarrow \) 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

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

Today – Evaluating Cost Per Patient

Simple Cost PMPM Calculation – Per Visit per Patient Basis:

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

- 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

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

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 |
    |-----------------------|----------------|----------|----------|
    |                       | Percent Improve | Metric   | Percent Improve | Metric   |
    | Cervical Cancer       | 40.00%          | 25%      | 50.00%    | 15%      |
    | Screening             |                |          |           | 57.50%   |

  - Comparison to benchmark
    
    | Measure               | Percent | 25th %-tile | 50th %-tile | 75th %-tile | Projected Score |
    |-----------------------|---------|-------------|-------------|-------------|-----------------|
    |                       | Metric  |             |             |             |                 |
    | Cervical Cancer       | 50.00%  | 60.00%      | 70.00%      |             | 2               |
    | Screening             | 2 points| 4 points    | 6 points    |             | 2               |

VBP – Quality Metrics & Incentive Payments

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Points – all measures</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Total Available Points (10 metrics)</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>% of Total Attained</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>QIP $ Available PMPM</td>
<td>$ 5.00</td>
<td>$ 5.00</td>
</tr>
<tr>
<td># of Member Months</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Maximum QIP Pool Available</td>
<td>$ 500,000</td>
<td>$ 500,000</td>
</tr>
<tr>
<td>Total Projected QIP</td>
<td>$ 125,000</td>
<td>$ 250,000</td>
</tr>
</tbody>
</table>
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

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

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

- Setting a Budget Target – “Bottom-Up” Approach:

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

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?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Health Center</th>
<th>ACO/IPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Managers</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Care Management Central Support and Technology</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Data Analytics Technology and Support</td>
<td>√*</td>
<td>√</td>
</tr>
<tr>
<td>Health Informatics</td>
<td>√*</td>
<td></td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Others</td>
<td>???</td>
<td>???</td>
</tr>
</tbody>
</table>

* 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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Costing Methodology</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Managers</td>
<td>4.00 FTE X $60,000</td>
<td>$ 240,000</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>1.00 FTE X $75,000</td>
<td>75,000</td>
</tr>
<tr>
<td>Health Informatics</td>
<td>1.00 FTE X $75,000</td>
<td>75,000</td>
</tr>
<tr>
<td>Support Staff</td>
<td>1.00 FTE X $30,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Care Management/Data Analytics Technology</td>
<td>Covered by ACO/IPA</td>
<td>???</td>
</tr>
<tr>
<td>Others</td>
<td>TBD</td>
<td>???</td>
</tr>
<tr>
<td>TOTAL ANNUAL COSTS</td>
<td></td>
<td>$ 420,000</td>
</tr>
</tbody>
</table>

Number of Member Months 10,000 members X 12 mos. 120,000

COST PMPM 10,000 members X 12 mos. $ 3.50

Summary of VBP Arrangements

- Moving towards managing care on a capitation basis

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

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**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

<table>
<thead>
<tr>
<th>Traditional Coding (claims)</th>
<th>Enhanced Coding &amp; Documentation (EHR)</th>
</tr>
</thead>
</table>

- 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

- Practice management system(s)
- Electronic health record
- Third party claims data
- Accounting records (General Ledger)
- Payroll
- Dashboards
- Management Reporting
- Predictive Modeling

Business Intelligence
**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

- HIT/HIE
- Claims Data
- EHR
- Hospitals
- PCMH (FQHCs)
- Other Providers

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

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Timing of Cost</th>
<th>Timing of Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One-time, Upfront</td>
<td>On-going, Operational</td>
</tr>
<tr>
<td>Base Compensation</td>
<td></td>
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<tr>
<td>Care Coordination</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Quality Incentive Payments</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Global Budgets/Payment</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

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

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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