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TRANSFORMING HEALTHCARE: A PATH TOWARDS VALUE BASED PAYMENT

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OVERVIEW

- FQHC Medicaid PPS Rate Requirements
- Transition to Value Based Care
- Alternative Payment Models
- Clinically Integrated Networks
- Future – Advanced Value Based Care Arrangements
- Transitioning to Tomorrow

FQHC MEDICAID PPS RATE REQUIREMENTS

Beginning January 1, 2001, and each succeeding fiscal year, States shall reimburse FQHCs for FQHC covered services as follows:

- For 2001, payment shall be made in an amount equal to 100% of the average of costs of the center during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing FQHC covered services
- For fiscal years 2002 forward, payment shall be equal to the per visit amount from the prior year –
  - Increased by the % increase in the Medicare Economic Index (MEI) for primary care services, and
  - Adjusted to take into account any increase or decrease in the scope of services
- Centers that first qualify as FQHCs after 2000 shall have their rates set based on the rates established for other centers located in the same geographic area with a similar case load

FQHC MEDICAID PPS RATE REQUIREMENTS

(Continued)

- For services provided pursuant to a contract with a Medicaid managed care plan, the State shall provide a supplemental payment to the FQHC equal to the amount by which the FQHC PPS rate exceeds payments received from the plan
  - Payments to be made no less frequently than every 4 months
- The state may provide for an alternative payment methodology for FQHC covered services as long as -
  - It is agreed to by the State and the center, and
  - It results in payment to the center of an amount at least equal to the FQHC PPS rate

OTHER FQHC PPS RATE PROTECTIONS

State Medicaid Director Letter (September 27, 2000)

- Section 1902(a)(13)(C)(ii) of the Act requires States to make supplemental payments (at least quarterly) to FQHCs/RHCs that subcontract with MCOs representing the difference, if any, between the MCO's payment to the subcontracting FQHC/RHC and the payment to which the FQHC/RHC would be entitled for the ‘services under the Act”.
- MCOs frequently use their own funds to include financial incentives in their contracts with subcontracting providers.
- Financial incentives provide the subcontractor with an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs.

OTHER FQHC PPS RATE PROTECTIONS

State Medicaid Director Letter (September 27, 2000) – *continued*

- Inclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provide, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO.
- “For this reason, we have determined that the State's quarterly supplemental payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives that are linked to utilization outcomes or other reductions in patient costs.”

OTHER FQHC PPS RATE PROTECTIONS

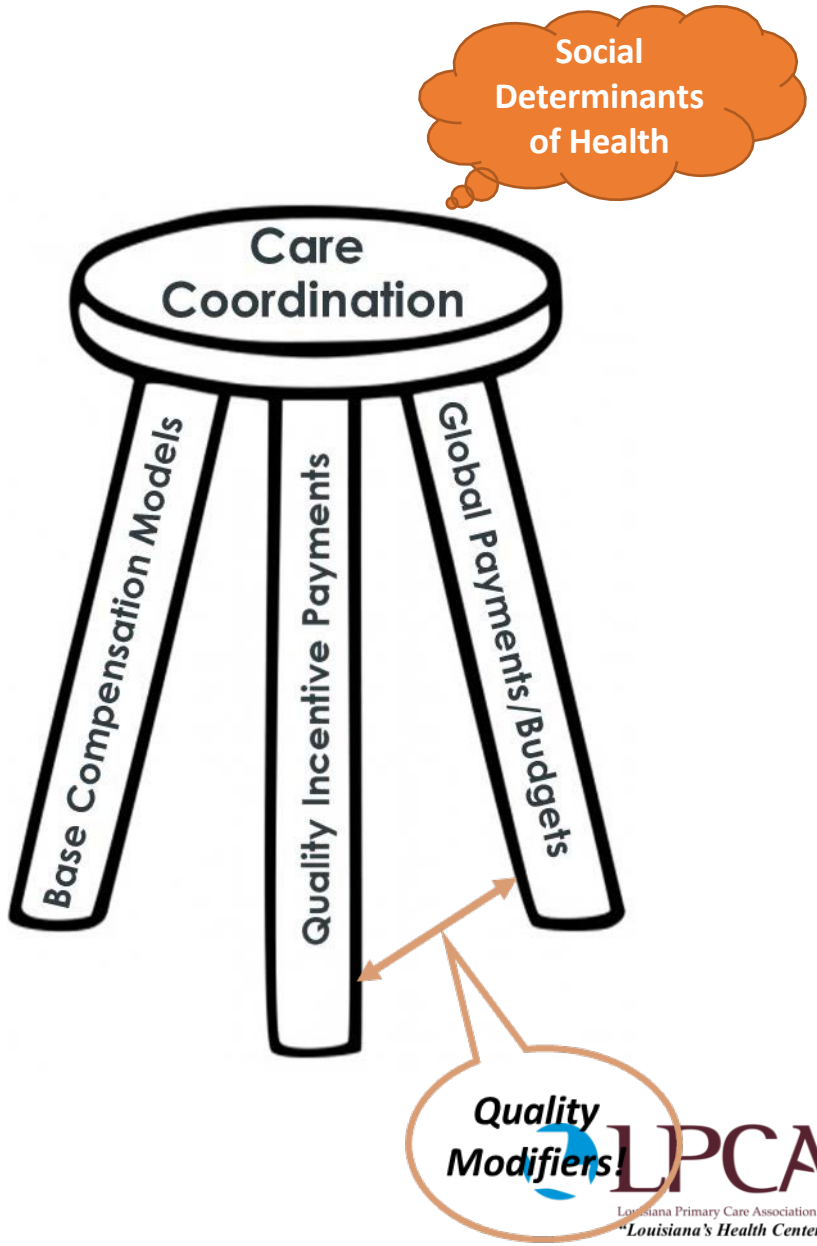
- When Value-Based Payment began, payers were concerned with moving payment from volume to value
- Patient advocates were successful in adding the “patient” to the center of the value equation
- The “silver lining” of the COVID pandemic has been a heightened concern with health equity and social care needs for inclusion in value-based arrangements
- “Value-Based Payment” (VBP) has evolved to “Value-Based Care” (VBC)

ELEMENTS OF A TRADITIONAL VALUE-BASED PAYMENT MODEL

- A VBP Contracting Entity (e.g., CIN/IPA) manages the total cost of care (global budget) for patients "attributed" to the VBP Contracting Entity
- Beneficiaries are assigned to the VBP Contracting Entity based on a specified attribution algorithm
- Third party payer reimburses providers directly within the VBP Contracting Entity for services provided and monitors the global budget
  - Base compensation – fee-for-service versus bundled payments/partial capitation
  - Case management fees (per member per month)
- Providers may also be eligible for quality incentive payments
- Surplus-sharing/Risk-sharing arrangements:
  - Surpluses/losses shared amongst providers based on an algorithm established by the governing body of VBP Contracting Entity
  - *Amount of surpluses/losses shared are often impacted by performance against specified performance metrics!*

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 (Total Cost of Care)
    - Surplus-sharing/Risk-sharing
  - Support of Social Determinants of Health



CARE MANAGEMENT/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 payers are often including care management/coordination fees in their VBP arrangements, however health centers need to sell the value of the care coordination proposal and the services to be provided
  - Stand-alone fee PMPM (most common)
  - Advance against future shared-savings distributions
- *Negotiating care management/coordination payments into VBP will create a revenue stream to support these care management activities*

# of Attributed Members	×	**Rate PMPM**	=	**Amount of Payment**
10,000 Members		**$ 3.00 PMPM**		**$ 30,000**

VBP – QUALITY METRICS AND INCENTIVES

- Understand metrics being measured
  - Understand types of metrics and their calculation (including data elements)
  - Identify/**Negotiate** 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
  - Adjustment of the amount of surplus/risk-sharing distributions earned
- *Understanding how performance against quality metrics impact payment can create incentives to improve quality and generate additional funds to cover staff responsible for quality improvement*

VBP – GLOBAL BUDGETS/PAYMENTS

- Setting a global budget target – "Bottom-up Approach"

- Keys to success in managing the total budget (total cost of care
  - Managing utilization
  - Managing unit cost
- *Dedicating staff to monitoring utilization and access to data for services provided outside the 4 walls of the center is critical for success in managing financial performance under surplus/risk-sharing arrangements*

Differs based on Health Condition of Patient

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**

VBP – GLOBAL BUDGETS/PAYMENTS

- Example Calculation of Surplus-Sharing/Risk-Sharing Amounts:

Actual Expense vs. Benchmark	Scenario A	Scenario B
Actual Expenses:		
Fee for Service	$42,500,000	$47,500,000
Capitation (Health Center)	$5,000,000	$4,000,000
Total Actual Expense	$47,500,000	$51,500,000
Target Spend/Benchmark	$50,000,000	$50,000,000
Surplus/(Loss)	**$2,500,000**	**($1,500,000)**
Shared-Surplus Arrangement (50%)	*$1,250,000*	*N/A*
Risk-Sharing Arrangement (60% upside; 30% downside)	*$1,500,000*	*($450,000)*

EXAMPLE – ACCESSING SURPLUS DISTRIBUTIONS

Jan 1 - Dec 31, 2019	TANF Kids	TANF Adult	SSI	Total
Member Months	105,223	128,165	16,692	250,080
Actual Revenue (PMPM)	$ 216.99	$ 507.11	$ 1,105.66	$ 424.99
Actual Medical Expenses (PMPM)	$ 202.94	$ 451.98	$ 975.83	$ 382.16
PMPM Difference	$ 14.05	$ 55.13	$ 129.83	$ 42.83

Jul 2017 - Jun 2018	TANF Kids	TANF Adult	SSI	Total
Member Months	107,938	124,469	18,691	251,098
Actual Revenue (PMPM)	$ 212.87	$ 506.92	$ 1,078.93	$ 423.10
Actual Medical Expenses (PMPM)	$ 201.21	$ 468.21	$ 1,029.66	$ 395.23
PMPM Difference	$ 11.66	$ 38.71	$ 49.27	$ 27.87
YoY PMPM Savings/(Loss)	$ 2.39	$ 16.42	$ 80.56	$ 14.96
YoY Savings/(Loss)	$ 251,483	$ 2,104,469	$ 1,344,708	$ 3,741,197
Shared Savings %age	50%	50%	50%	50%
Total Shared Savings/(Loss)	$ 125,741	$ 1,052,235	$ 672,354	$ 1,870,598

IMPACT – QUALITY METRICS ON SURPLUS DISTRIBUTIONS

Prevention Quality Measures (3)	Prior CY Actual Performance	Expected Target in Measurement Year	Actual Measurement Performance	Variance to Expected	YOY Improvement	Score Allocation	Weighting	Score
PPR (potentially preventable re-admissions)	5.23	5.42	5.82	0.40	0.60	0.00%	33.0%	0.0%
PPA (potentially preventable admissions)	9.06	9.58	9.76	0.18	0.70	0.00%	33.0%	0.0%
PPV (potentially preventable ER-visits)	386.24	308.00	346.93	38.93	-39.32	0.00%	34.0%	0.0%
PPE Total								**0%**

PRODUCT: MEDICAID		PERCENTILE			01/2019- 12/2019 YTD Performance			
MEASURE	SOURCE	50TH	75TH	90TH	Denominator	Numerator	Performance Rate	Scoring
1. Breast Cancer Screening	NCQA HEDIS®	68.42%	70.83%	73.72%	762	502	65.88%	**0.00**
2. Cervical Cancer Screening	NCQA HEDIS®	71.35%	72.75%	74.45%	4345	2991	68.84%	**0.00**
3. Comprehensive Diabetes Care: Poor Control	NCQA HEDIS®	31.14%	29.44%	26.28%	794	453	57.05%	**0.00**
4. Controlling High Blood Pressure	NCQA HEDIS®	60.83%	70.40%	71.53%	1393	819	58.79%	**0.00**
5. Medication Management for People with Asthma	NCQA HEDIS®	47.95%	50.42%	53.46%	772	353	45.73%	**0.00**
6. Statin Therapy for Patients with Cardiovascular D	NCQA HEDIS®	66.00%	69.51%	71.43%	50	24	48.00%	**0.00**
7. HIV Viral Load Suppression	NYS QARR	76.81%	83.41%	83.97%	TBD	TBD	TBD	
8. Adherence to Antipsychotic Medications for Indivi	NCQA HEDIS®	60.90%	63.49%	67.69%	54	35	64.81%	**0.75**
9. Pharmacotherapy for Opioid Use Disorder (POD)	NYS QARR	35.78%	40.15%	41.45%	61	15	24.59	**0.00**
10. Prenatal and Postpartum Care (Postpartum Care)	NCQA HEDIS	68.86%	72.25%	73.72%	316	158	50.00%	**0.00**
11. Well-Child Visits in the First 15 Months of Life - 5	NCQA HEDIS	81.32%	84.28%	85.85%	243	204	83.95%	**0.50**
12. Use of Spirometry Testing in the Assessment and D	NCQA HEDIS®	49.74%	56.21%	59.09%	24	6	25.00%	**0.00**

Total	1.25

Quality Total	11%

IMPACT OF QUALITY METRICS ON SURPLUS DISTRIBUTIONS

- *Poor performance on quality measures resulted in lost revenue of $1.8M!*
  - Total savings at 50%, $1,870,000
  - After adjustment for quality metrics, reduced to $85,000

	Score	Weighting	Final Score
PPE Total	0%	60%	0%
Quality Total	11%	40%	5%
Total Quality Performance			**5%**

QUALITY MODIFIER ACHIEVED = 5/100	**5%**
% of Gain Met (>50%)	**100%**

Total Savings	$	3,741,196.80
Contracted Share Percentage		50%
Quality Modifier		5%
Share of Savings	**$**	**85,027.20**
Total Share of Savings Due:	**$**	**85,027.20**

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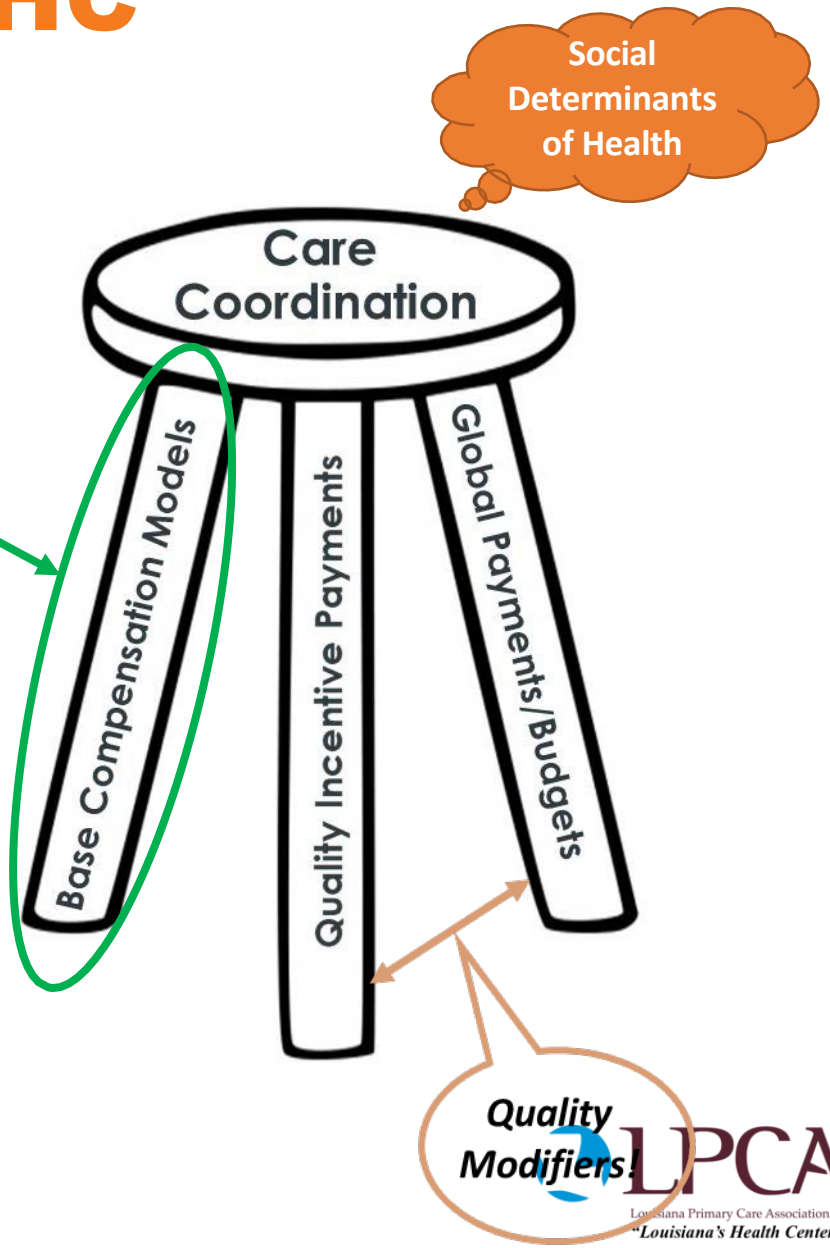
VBP ARRANGEMENTS & FQHC MEDICAID PPS

- **FQHC Medicaid PPS reimbursement regulation pertain to the Base Compensation leg of the stool**
- FQHCs receive the following reimbursements over and above the FQHC Medicaid PPS rate:
  - Care coordination payments (e.g., PCMH)
  - Quality incentive payments
  - Global payments/budgets (total cost of care)
- FQHC Alternative Payment Models (APMs) focus on transitioning the FQHC Base Compensation from a “fee-for-service” model to a capitated model



TRANSITIONING FROM FFS TO 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
Policy Makers..…	Dislike – Medicaid at-risk for volume fluctuations	Preferred – Utilization risk shifted to providers

OVERVIEW – ALTERNATIVE PAYMENT MODELS (APM)

- Current FQHC Medicaid reimbursement received (on a per patient basis):
  - In a managed care environment, combined reimbursement received from both Medicaid managed care plans and Medicaid "wraparound" payments equals the FQHC Medicaid PPS rate

# of billable visits per year	3.00
FQHC Medicaid Wraparound rate per visit	$150.00
Annual Medicaid Wraparound revenue per patient per year	$450.00

- If we convert the FQHC Medicaid PPS reimbursement system from a "per visit" to a "per member per month" (PMPM) payment model, based on historical FQHC PPS reimbursement, it would allow FQHCs to transform and move away from the billable visit conundrum
  - FQHC Medicaid PMPM Payment = ($450.00 PMPY ÷ 12 months) = $37.50 PMPM

WHY AN APM?

- The original premise for transitioning to an APM was clinical practice models have traditionally been structured around the billable provider/visit definition which is not supportive of new clinical care models (e.g. team-based care)
- If payments from Medicaid under both the fee-for-service and managed care programs (including “wraparound” payments paid by the State) were paid based on a per member per month (PMPM) basis, Medicaid revenue received during the Public Health Emergency (PHE) would not have fluctuated by visit volume/different PPS rates and held constant based on the FQHC’s members
  - Would have protected against drops in fee-for-service volume
  - Would have protected shifts to telehealth and variation in payment rates (PPS threshold visit rates versus lower telehealth rates), if applicable

WHY AN APM?

- Potential to push care management services (e.g., Patient Centered Medical Home) and/or other infrastructure costs as an add-on into the APM
  - Would be excluded from the PPS hold-harmless calculation
- Consider transitioning from a model based on current FQHC Medicaid PPS rates to the current actual cost per visit to reflect costs incurred today not included in the base years utilized to develop current PPS rates
  - Costs required to participate in Value Based Payment arrangements
  - Costs to support Social Determinants of Health initiatives
- If an FQHC participates in the APM and there is no change in clinical workflows/practice plans, actual Medicaid revenue received remains the same
  - Cash flow is improved as Medicaid reimbursement is received on a monthly basis versus fluctuating based on visit volume
- *And there is the Hold Harmless protection!*

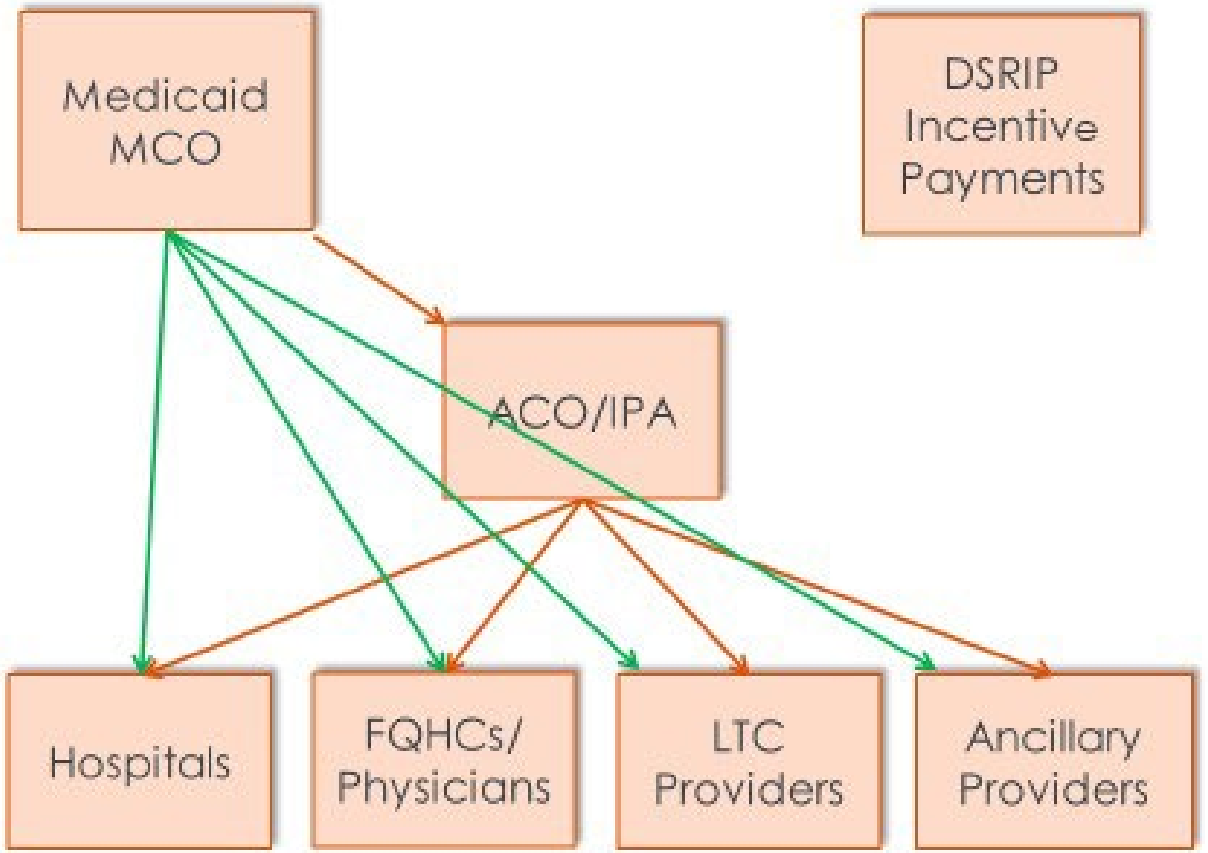
APM & PRACTICE TRANSFORMATION

- *Practice transformation requires enhanced technology supports*
  - Collaborative care model for managing chronic conditions
  - Integration of physical and behavioral health care
  - Managing patients with chronic conditions
  - Managing complex patients with behavioral health conditions
  - Enhanced triaging of patients calling for an appointment
  - Pushing care down to team members to work at the top of their licenses
  - eConsultations
  - NCQA-Certified approach to care management
  - Risk assessments - screening and reporting
  - Team meetings focused on high-risk patients
  - Others…..

WHY A CLINICALLY INTEGRATED NETWORK (CIN)/IPA?

- Most VBP arrangements require a minimum of 3,000 – 5,000 attributed members for participation
- 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 payers
- Improve care coordination

Funds Flow Within the ACO/IPA



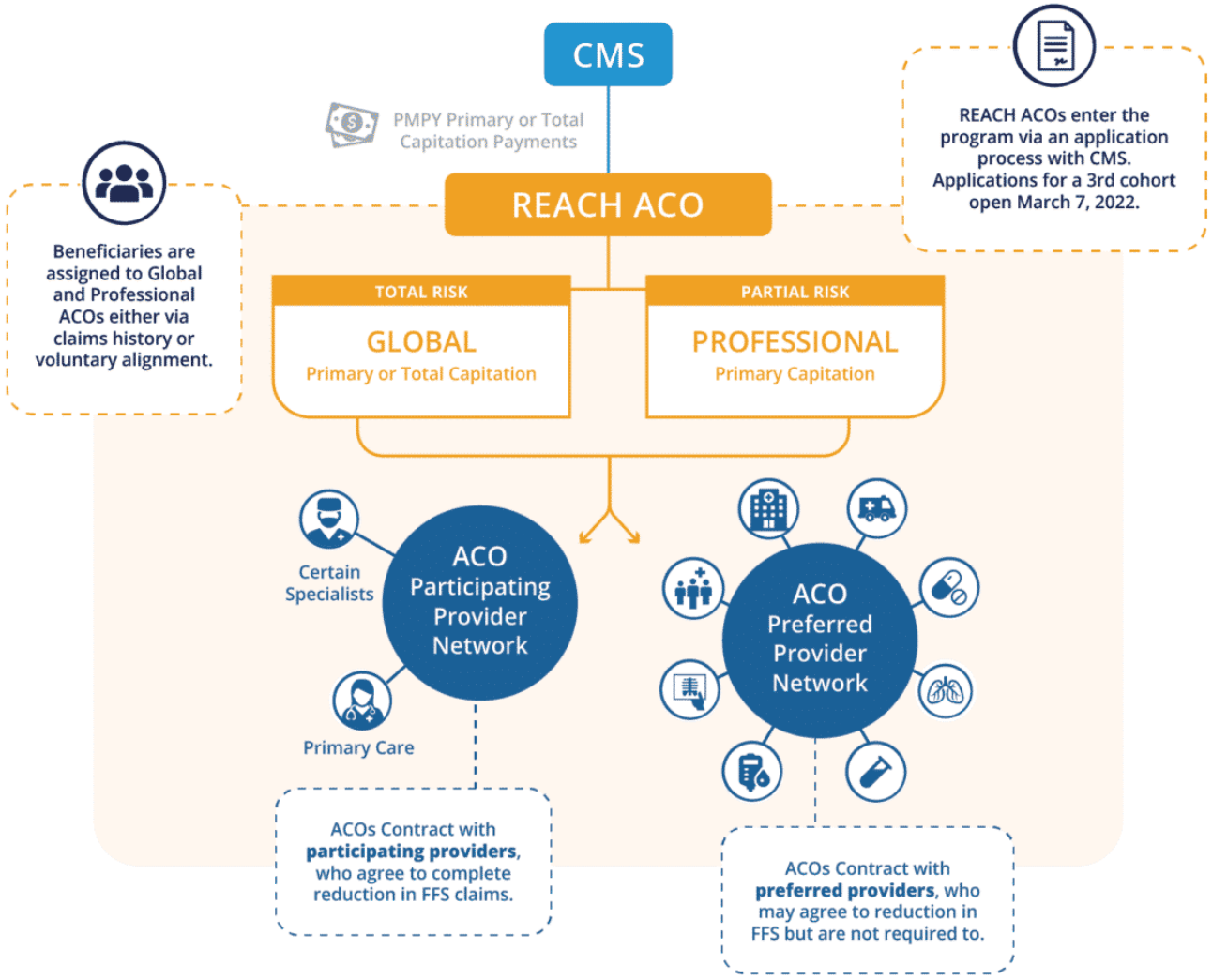
DISTRIBUTIONS FROM A CLINICALLY INTEGRATED NETWORK (CIN)/IPA?

- Surplus distributions received by a CIN/IPA may be distributed to its members based on a distribution methodology approved by the governing board
- General components of a distribution methodology:
  - Retain dollars to fund infrastructure and risk reserves
  - Distributions to CIN/IPA members may take multiple forms generally taking into account members, quality and performance against total cost of care targets

Pool	Year 1	Year 2	Year 3	Notes - Data
Participation	100%	60%	33%	Data readily available; encourages providers to attribute members to CHIPA
Quality	0%	20%	33%	Data by provider very granular; hard to interpret; differ by plan
Cost Efficiency	0%	20%	33%	
TOTALS	**100%**	**100%**	**100%**	

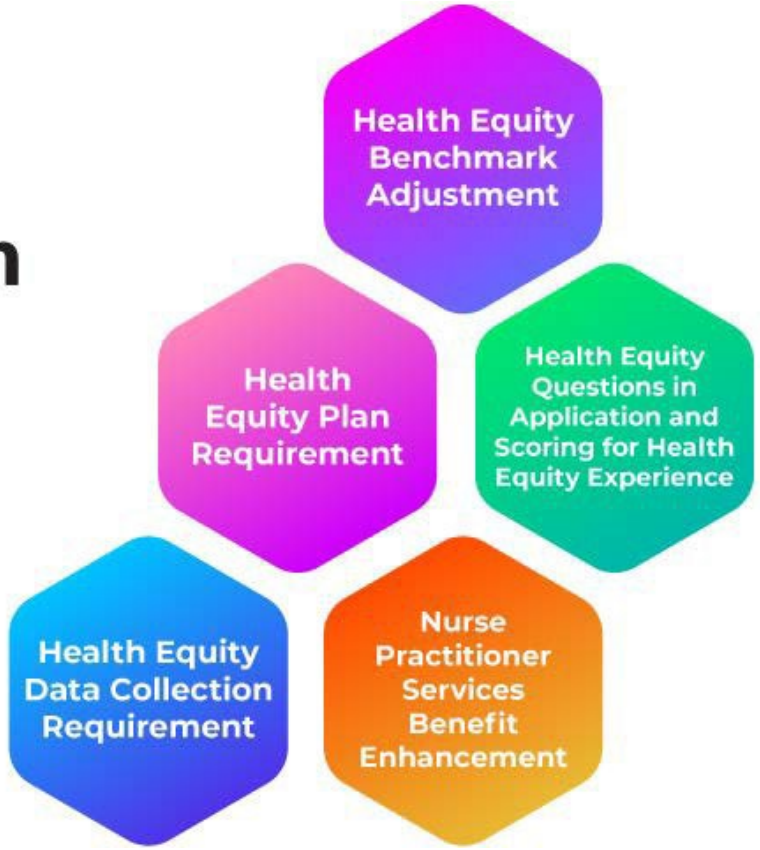
CMMI – ACO REACH DEMONSTRATION

- The ACO Realizing Equity, Access, and Community Health (REACH) Model is the Center for Medicare and Medication Innovation's (CMMI) redesigned Global and Professional Direct Contract Model (GPDC)
- Goals:
  - Promotes Physician Leadership and Governance: At least 75% control of each ACO's governing body must be held by participating physicians
  - Requires at least two beneficiary advocates on the governing board
  - Protects Beneficiaries by enhancing the participant vetting, monitoring, and transparency
  - Stronger protections against inappropriate coding and risk score growth



CMMI – ACO REACH DEMONSTRATION

How will ACO REACH focus on Health Equity



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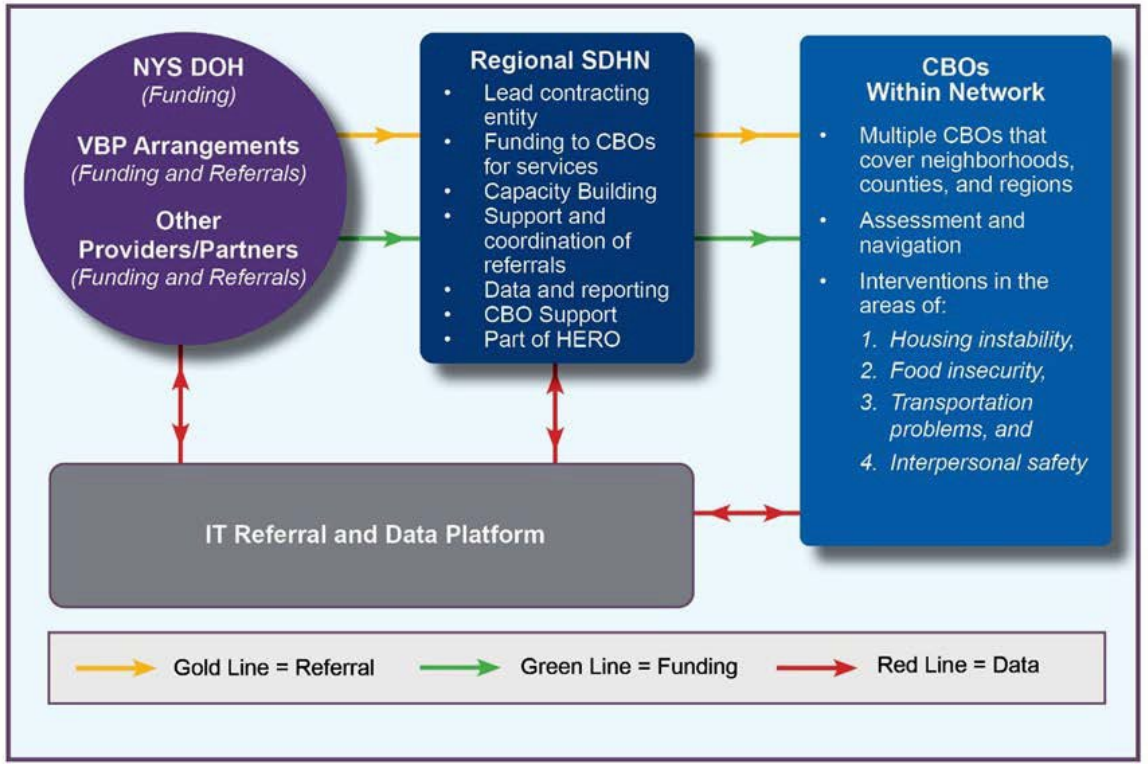
NEW VBP MODELS & HEALTH EQUITY

- Example - New York Medicaid Waiver Request:
  - *"HEROs would build regional consensus around a retooled VBP approach and design for services integration and care management with a focus on specific target populations (e.g., SMI, SUD, SED, I/DD), and the more successful braiding of health, behavioral health, and social care, including evidence-based approaches to collaborative care in primary care"*
  - *"A global prepayment payment model would allow for the necessary upfront investments in the care delivery model to improve population health and provide value-based care. Global budgets would include expenditures beyond utilization of services to account for* needed investments to improve health outcomes*, including strengthening or developing new outpatient and community- based services, providing integrating the full spectrum of behavioral health and SUD services in settings traditionally focused on physical health in a financially sustainable manner, providing non- medical SCN services that improve health outcomes and are not traditionally covered by Medicaid, and investing in a sustainable workforce for new care models"*

NEW VBP MODELS AND HEALTH EQUITY

- Exhibit 2 – SDHN Structural and Funding Diagrams*
  - Each SDHN would consist of a network of Community Based Organizations (CBOs) to provide evidence-based interventions that address a range of Social Care Needs (SCNs)
  - SDHNs to be funded through VBP arrangements and Medicaid waiver funding



* Source: New York State MRT Waiver Amendment

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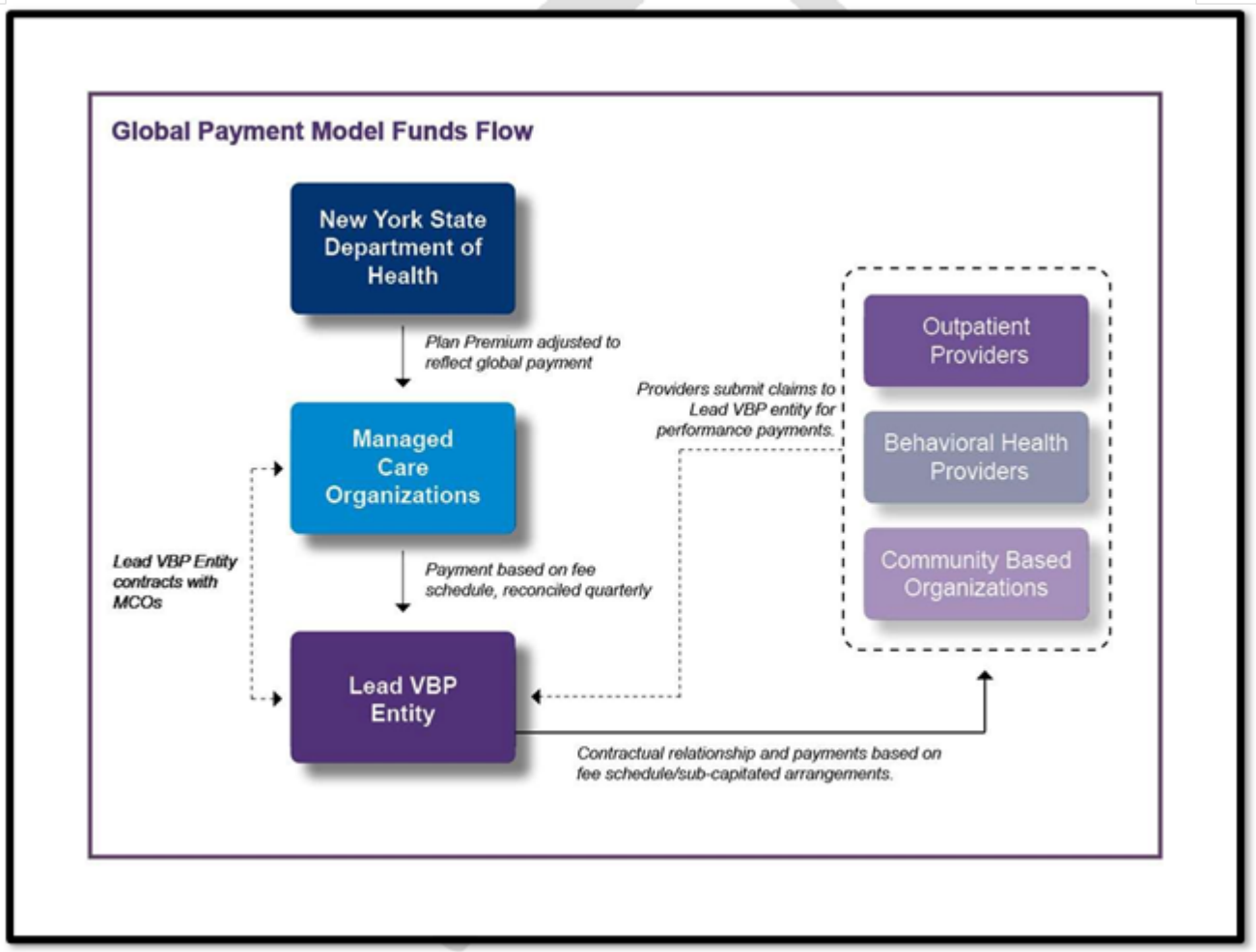
NEW VBP MODELS & HEALTH EQUITY

- *"The lead VBP entity would bring together providers across the continuum of care and health plans across all payors to improve population health in the target region. The lead VBP entity would be responsible for managing the total cost of care, establishing provider-payor relationships, negotiating and effectuating contracts, and providing data and analytics for performance measurement and continuous improvement around established quality measures."*



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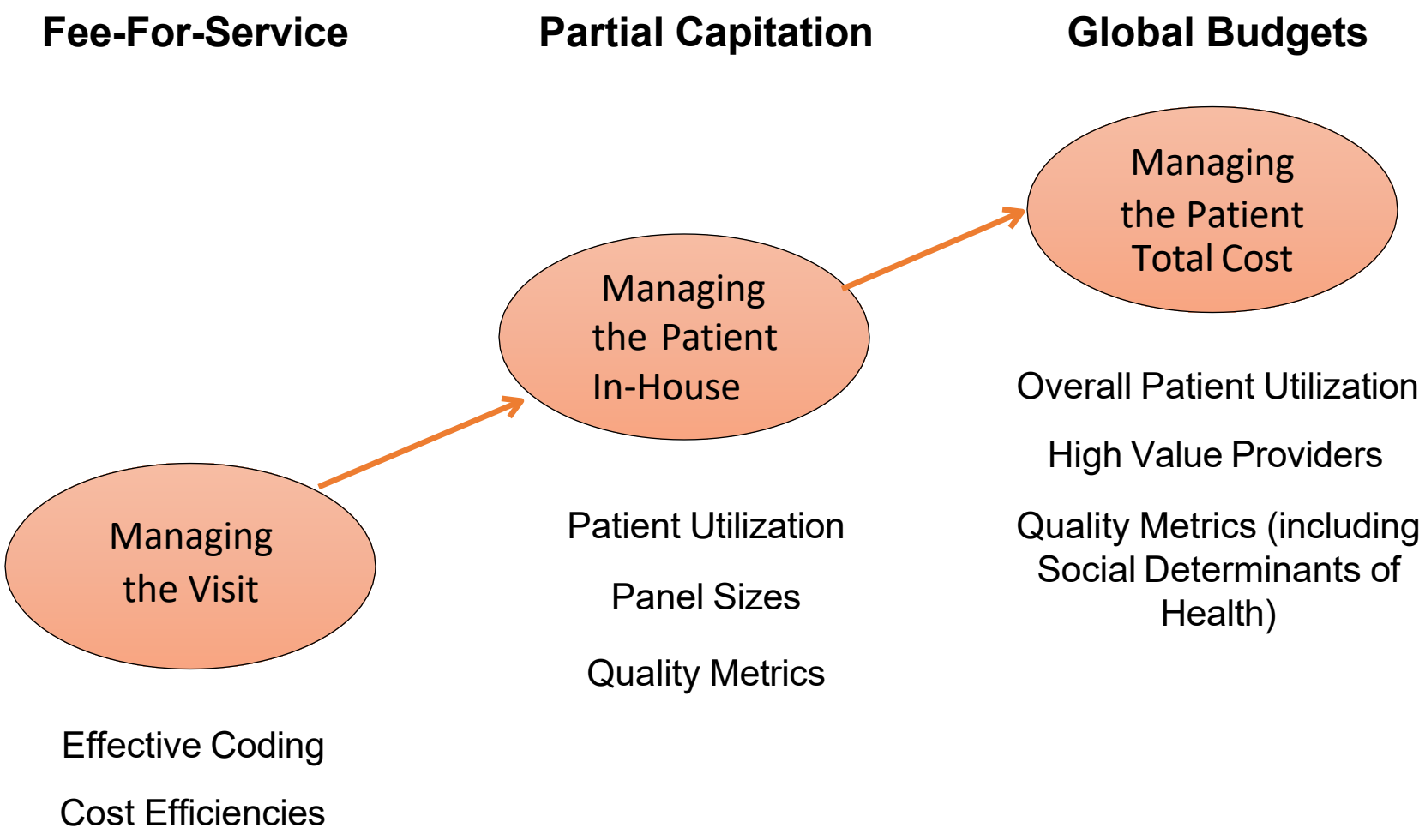
TRANSITIONING TO TOMORROW…



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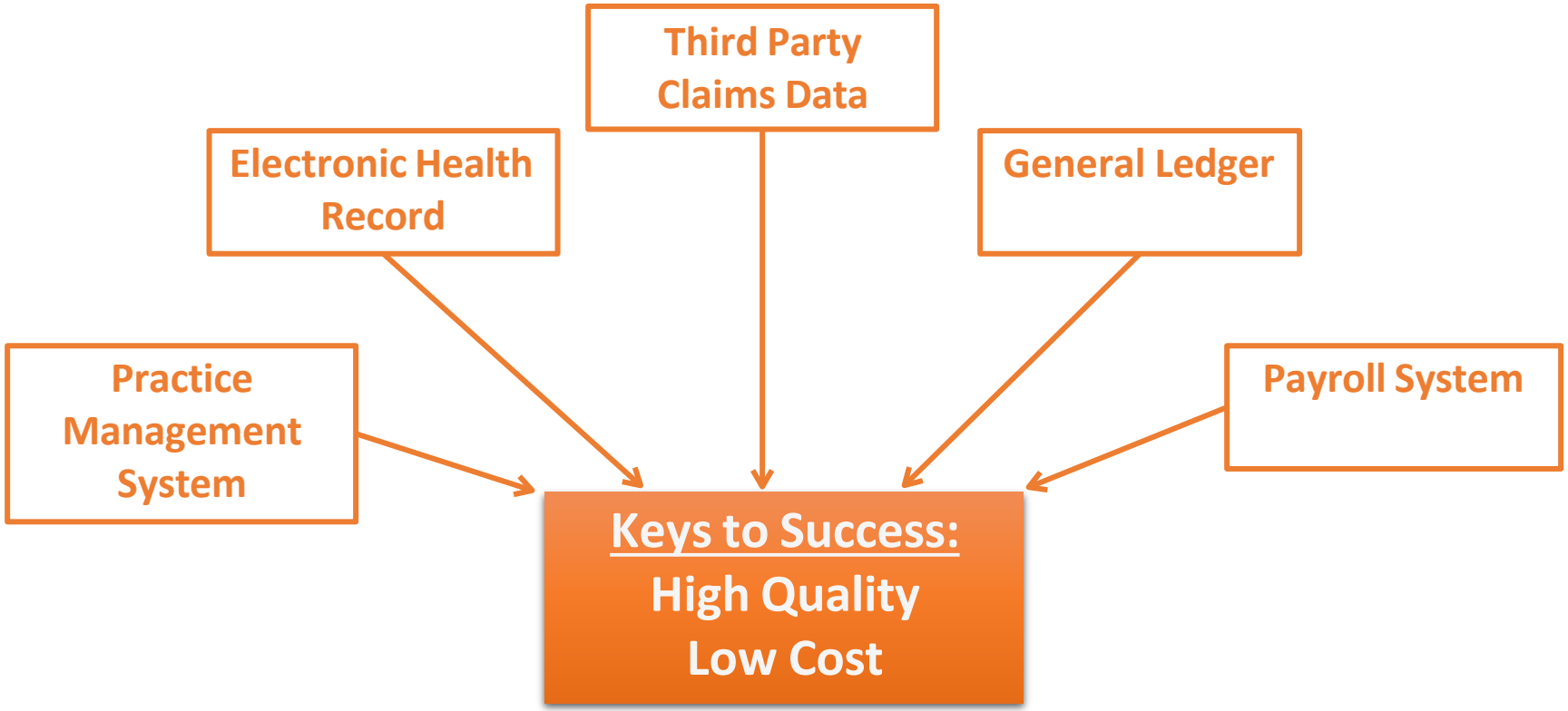
TRANSITIONING TO TOMORROW…

	TODAY	TOMORROW
Proper coding for services provided	★	★
Monitor/improve provider productivity	★	★
Provision of services in a cost-efficient manner	★	★
Manage and improve quality metrics, including social determinants of health		★
Manage/monitor patient utilization – in-house		★
Manage/monitor the total cost of care		★
New skill requirements, communication & technology		★

NEED FOR BUSINESS INTELLIGENCE

- To be financially successful, health centers will need to manage financial operations by merging information from disparate systems



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TRANSITIONING TO TOMORROW…

Success in the future is dependent on the effective use of data

- Improving quality outcomes and managing utilization to reduce the total cost of care will drive revenue
  - Value-Based Care arrangements
  - Distributions from CINs/IPAs
- Support for practice transformation
  - Care teams and managing patient-specific health conditions
- Intersection of Social Determinants of Health (SDoH) and VBC arrangements
  - Capturing/Reporting on SDoH data
  - Exchanging SDoH data amongst all participants in the health care delivery system including Community Based Organizations (CBOs)
- Managing rosters, attribution and utilizing versus non-utilizing members
- Real-time health information exchange across the delivery system

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