Introduction

- Who am I?
- Who are you?

Nice to meet you!
What are we going to cover?

- Why are we talking about APMs?
- How do we get paid today?
- How do we get paid tomorrow?
- What does that mean for my center?

Goal:
- a better understanding of what APMs are
- how they could affect your center
Why are we talking about this?

► 1/26/2015: Secretary Burwell set measurable goals for payment reform in Medicare (1st time ever!)

► Traditional/fee for service payments will be tied to quality or value in some fashion

  ► 85% by 2016
  ► 90% by 2018

► Traditional/fee for service payments will be tied to quality or value through alternative payment models (APM)

  ► 30% by 2016
  ► 50% by end of 2018
“I want you to find a bold and innovative way to do everything exactly the same way it’s been done for 25 years.”
Is payment reform just 1990s Managed Care repackaged?

While payment reform in many states is being implemented within a managed care environment, it differs from prior iterations of managed care in significant ways. These include:

- A focus on value over cost containment
- A recognition that vertical and horizontal alignment of the system is needed to provide the right care in the right place at the right time
- Widespread use of health information technology to support population health management and patient care, as well as system integration.
- Expectation that patients and providers be active
- Increasing efforts to improve the health care system

From Health Centers and Payment Reform: A Primer
How do we get paid today?

- Timing concerns
- Rather predictable
- Inflexible

### 3rd Party Payors
- MCD, MCR, Private, uninsured
- TOS, monthly, quarterly, annually
- Quality incentives

### Other Models
- PCMH
- Meaningful Use
- Demonstration Models

### Grants
- Federal
- State
- City
- Local

### Agreements
- Leasing co-located providers
- Rent

### Donations
- Fundraising, capital projects
- Benefactors

### $
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How do we get paid tomorrow?

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
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<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<td>🧐</td>
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- **Category 1**
  - A: Foundational Payments for Infrastructure & Operations
  - B: Pay for Reporting
  - C: Rewards for Performance
  - D: Rewards and Penalties for Performance

- **Category 2**
  - A: APMs with Upside Gainsharing
  - B: APMs with Upside Gainsharing/Downside Risk

- **Category 3**
  - A: Condition-Specific Population-Based Payment
  - B: Comprehensive Population-Based Payment

85% by 2016/ 90% by 2018
30% by 2016/ 50% by 2018
How do we get paid tomorrow?

**Category 1**  
Fee for Service – No Link to Quality & Value  
Payments are based on volume of services and not linked to quality or efficiency

**Category 2**  
Fee for Service – Link to Quality & Value  
At least a portion of payments vary based on the quality of efficiency of health care delivery

**Category 3**  
APMs Built on Fee-for-Service Architecture  
Some payment is linked to the effective management of a population or episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk

**Category 4**  
Population-Based Payment  
Payment is not directly triggered by service delivery so volume is not linked to payment. Payment tied to long term care of a beneficiary (>1 yr)

85% by 2016/ 90% by 2018
30% by 2016/ 50% by 2018
How do we get paid tomorrow?

Category 1
Fee for Service – No Link to Quality & Value

Payments are based on volume of services and not linked to quality or efficiency

- FFS payment from MDHHS

Category 2
Fee for Service – Link to Quality & Value

At least a portion of payments vary based on the quality of efficiency of health care delivery

- FFS + Incentive payments from QHPs
- PCMH uplifts

Category 3
APMs Built on Fee-for-Service Architecture

Some payment is linked to the effective management of a population or episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk

- ACOs
- Bundled payments

Category 4
Population-Based Payment

Payment is not directly triggered by service delivery so volume is not linked to payment. Payment tied to long term care of a beneficiary (>1 yr)

- Eligible Pioneer ACOs (?)

85% by 2016/ 90% by 2018
30% by 2016/ 50% by 2018
What does this mean to my health center?
Advantages

- Flexibility to deliver the care our patients need
- Which should lead to happier and healthier patients
- Better value
- Lower cost

Sound familiar?!

*(Triple Aim - patient experience, population health, per capita cost)*
Expected Shifts

• Providers (our most expensive resource) will be allowed to practice at the top of their license and tend to the patients who need it most (high utilizers).
• Payments will be driven by panel size and population statistics
• Data and its analysis will become incredibly important, much more so than today. Interoperability becomes necessary instead of nice.
• Budgeting revenue and expenses will look drastically different
Example - NYS VBP Roadmap

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

- Maternity Care (including first month of baby)
- Acute Stroke (incl. post-acute phase)
- Depression
- ...

Episodic

- Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression...)
- Hemophilia
- Chronic Kidney Disease
- AIDS/HIV
- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the Developmentally Disabled

Continuous

began June 2015

Source: “Value Based Payment in NYS Medicaid; The FQHC/Primary Care perspective”, DOH - August 10, 2015
# The Shift from Visit to Patient

<table>
<thead>
<tr>
<th></th>
<th>Fee-For-Service</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Model</strong></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><strong>Revenue Equation</strong></td>
<td># of units × rate = revenue</td>
<td># of patients × rate PMPM × 12 months = revenue</td>
</tr>
<tr>
<td><strong>Financial Success</strong></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 → More patients = Increased revenue

Source: Peter Epp of CohnReznick, VBP Learning Lab FOMIT 2015
## Evaluating Capitation Primary Care Payment 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><strong>Provider &quot;capacity&quot; (visits)</strong></td>
<td>3,000</td>
<td>3,500</td>
<td>4,000</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Average Visits per Patient</strong></td>
<td>3.50</td>
<td>3.50</td>
<td>3.50</td>
<td>3.00</td>
</tr>
<tr>
<td><strong>Panel Size (Members)</strong></td>
<td>857</td>
<td>1,000</td>
<td>1,143</td>
<td>1,333</td>
</tr>
<tr>
<td><strong>Number of Member Months</strong></td>
<td>10,286</td>
<td>12,000</td>
<td>13,714</td>
<td>16,000</td>
</tr>
<tr>
<td>(Members x 12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capitation Revenue PMPM</strong></td>
<td>$42.50</td>
<td>$42.50</td>
<td>$42.50</td>
<td>$42.50</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>437,143</td>
<td>510,000</td>
<td>582,857</td>
<td>680,000</td>
</tr>
<tr>
<td><strong>Total Expenses (driven by volume)</strong></td>
<td>506,250</td>
<td>512,500</td>
<td>518,750</td>
<td>518,750</td>
</tr>
<tr>
<td><strong>Surplus/(Loss)</strong></td>
<td>($69,107)</td>
<td>($2,500)</td>
<td>$64,107</td>
<td>$161,250</td>
</tr>
</tbody>
</table>

Source: Peter Epp of CohnReznick, VBP Learning Lab FOMIT 2015
### 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>$75 per patient</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total Direct Care</strong></td>
<td></td>
<td></td>
<td><strong>700</strong></td>
</tr>
<tr>
<td>Administration/HIT</td>
<td></td>
<td>20% of direct</td>
<td>140</td>
</tr>
<tr>
<td><strong>Total Cost PMPY</strong></td>
<td></td>
<td></td>
<td><strong>$ 840</strong></td>
</tr>
<tr>
<td><strong>Total Cost PMPM</strong></td>
<td></td>
<td></td>
<td><strong>$ 70</strong></td>
</tr>
</tbody>
</table>

- **This example highlights the importance of understanding patient utilization of services on a high level!**
- **The analysis would be further enhanced if utilization and cost were analyzed on a per procedure basis (use of a cost-based charge structure)!**

Source: Peter Epp of CohnReznick, VBP Learning Lab FOMIT 2015

Utilization varies by health condition of patient!
Are we ready?

- Michigan NACHC Readiness Assessment
Core Capacities to Participate
From Health Centers and Payment Reform: A Primer

- Keeping a pulse on Broad Reform Environment
- Analytic Capabilities - “Demonstrate with data...system savings, improved access and quality that accrue to the system from their care”
  - Document the Value of Enabling Services
    - Scope
    - Intensity
    - Impact
    - Cost/Savings
  - Assess Impact on Social Determinants of Health (community, education, health, neighborhood, economic)
- Use Data from Design, Monitoring, and Evaluation
Core Capacities to Participate
From Health Centers and Payment Reform: A Primer

► Analytic Capabilities (cont.)
  ► Use Data for Design, Monitoring, and Evaluation
    ► Need technical capability to:
      1. Evaluate data accuracy
      2. Identify how the data reveals opportunities for improved care
      3. Ensure data elements are sufficient to measure performance (see following)
Core Capacities to Participate
From Health Centers and Payment Reform: A Primer

3. Ensure data elements are sufficient to measure performance (cont.)
   a. Evaluate proposed risk tiers and benchmarks
   b. Evaluate feasibility and desirability of payment arrangements
   c. Provide information to compare with payers’ data
   d. Evaluate proposed changes in payment models
   e. Identify potential impact of financial risk via payment withholds or penalties
Challenges/Hurdles

- Achieving care transformation- PCMH (maybe)
- Competing policies and regulations
  - BCBS PCMH uplifts up to 140% of fee schedule in conflict with Sliding Fee PIN dictating charges must be built on cost
  - MOA/PPS
- Ability to get an invite to the table
  - What knowledge will we be able to bring?
- Cash flow!
- Budgeting and forecasting
- Data informatics and analysis
Resources

- MPCA Payment reform webpage
  - [http://www.mpca.net/page/ERC_paymentreform](http://www.mpca.net/page/ERC_paymentreform)
  - Webinar Series
  - NACHC’s Health Centers and Payment Reform: A Primer
Questions (and Answers?)

“A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.”
— Winston S. Churchill

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