CURRENT DEVELOPMENTS IN VALUE BASED PAYMENT (VBP):
Part 1 – Recent Initiatives

Presented by: Peter R. Epp, CPA

September 29, 2016

Introduction

One of the overarching objectives of Health Reform

- Transform the Medicare and Medicaid reimbursement systems and drive delivery system reform

Fee-for-service  →  Bundled Payments

“Value-based” Purchasing

- To prepare for payment reform, health centers must:
  - Improve cost efficiencies today and generate reserves
  - Create business processes and reporting necessary for success in the future
Medicare’s Payment Reform Goals

- On January 26, 2015, DHHS announced its goals and timeline for shifting Medicare reimbursement from volume to value
- Goal for shifting Medicare fee-for-service reimbursement to alternative payment models (e.g. ACOs and/or bundled payment models)
  - 30% by 2016
  - 50% by 2018
- Additional goal of tying traditional Medicare payments (fee-for-service) to quality and value (e.g. Hospital Value Based Purchasing and Hospital Readmissions Reduction programs)
  - 85% by 2016
  - 90% by 2018
- DHHS will also intensify its work with states and private payers to support adoption of alternative payment models, attempting to exceed the goals/timeline set by Medicare

Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment is based on volume of service and not linked to quality or efficiency</td>
<td>At least a portion of payment vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payment still triggered by delivery of services, but opportunities for shared savings or (e.g. ACOs)</td>
<td>Payment is not directly triggered by service delivery to volume is not linked to payment. Citizens and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. a LTPA)</td>
</tr>
</tbody>
</table>

- Fee-for-service linked to quality = Categories 2 though 4
- Alternative Payment Models = Categories 3 and 4

- Eligible Pioneer accountable care organizations in years 1-5
Medicare’s Payment Reform Goals

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 35%
- 50%

2018
- 90%

Medicare and Value-Based Purchasing

- Value-Based Purchasing (“VBP”) is part of the effort to link the payment system to a value-based system to improve healthcare quality
- Category 2: A % of a provider’s Medicare FFS payments are withheld and redistributed based on performance/quality
  - Hospital Value-Based Purchasing initiative
  - Physician Value-Based Modifier
- Category 3: Bundled payments/Population health initiatives
  - Comprehensive Primary Care Initiative (CPCI) – Population-based care management fee with shared savings opportunity
  - Bundled Payment for Care Improvement (BPCI) – Bundled payment for selected episodes of care triggered by an inpatient stay
  - Medicare’s ACO and Shared Savings innovation
**What is a Bundled Payment?**

- The Bundled Payments initiative is comprised of broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care.

**What Is an Accountable Care Organization?**

**ACO Operating Model**

What role can a CHC play in an ACO?
Elements of a Traditional Value-Based Payment Model

- An ACO/IPA manages the total cost of care (global budget) for patients “attributed” to the ACO/IPA
- Beneficiaries are assigned to an ACO/IPA based on a specified attribution algorithm
- MCO pays providers within the ACO/IPA for services provided and monitors the global budget.
- MCOs/IPAs pay providers for specific services (Base Compensation)
  - Fee-for-service versus partial capitation
  - PMPM case management fee
- 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
  - 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 models to incentivize and tie together desired behaviors
- The key components of VBP arrangements include:
  - Base Compensation Models
    • Fee-for-service
    • Partial capitation
    • Care management PMPM
  - Quality Incentive Payments
  - Global Payments/Budgets
    • Surplus-sharing/Risk-sharing
    • Global capitation
Medicare’s Shared Savings Program

- ACO providers and suppliers are paid for specific items and services as it currently does under the Fee-for-service payment systems
- ACOs may choose 1 of 3 program tracks –
  - Track 1: ACO to operate on a shared savings only arrangement for the duration of their first agreement (or 3 years)
  - Tracks 2 & 3: ACO to share in savings and losses for the duration of the agreement, in return for a higher share of any savings it generates
- CMS establishes a benchmark for each ACO using the most recent available 3 years of per-beneficiary expenditures for Medicare Fee-for-service beneficiaries assigned to the ACO
- The amount of an ACO’s shared savings or losses depends on its performance on quality measures.
- An ACO that meets the program’s quality performance standards will be eligible to receive a share of the savings if its assigned beneficiary expenditures are below its own specific updated expenditure benchmark.
  - Certain ACOs will be accountable for sharing losses by requiring ACOs to repay Medicare for a portion of losses.

Massachusetts Primary Care Payment Reform Initiative

- Comprehensive Primary Care Payment (CPCP):
  - A risk adjusted*, per Panel Enrollee, per month payment for a –
    - Defined set of primary care services,
    - Medical home services, and
    - Options for a defined set of behavioral health services
  - 3 tiers of CPCP rates will be developed -

<table>
<thead>
<tr>
<th>Tier</th>
<th>Type of Behavioral Health Integration</th>
<th>Level of Behavioral Health Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-Co-Located but Coordinated</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Co-Located</td>
<td>Minimum</td>
</tr>
<tr>
<td>3</td>
<td>Clinically Integrated</td>
<td>Maximum</td>
</tr>
</tbody>
</table>

* Risk-adjusted means a health center’s rate will be adjusted to reflect (1) the demographics of patients served and (2) adjusted for CPCP services provided by external providers.
Massachusetts Primary Care Payment Reform Initiative

- **Quality Incentive Payment**: Additional payments for achieving certain thresholds relative to selected quality measures
- **Shared Savings/Risk Payment**: Additional payment/payback, with an option of one of the following 3 risk tracks, with varying levels of risk and reward -

<table>
<thead>
<tr>
<th>Track</th>
<th>Risk Arrangement</th>
<th>Minimum Panel Size</th>
<th>Risk/Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>Upside/Downside</td>
<td>5,000</td>
<td>For all 3 years, receive/owe 60% of difference between actual and target spend levels, with a risk corridor</td>
</tr>
</tbody>
</table>
| 2*    | Transitioning to Downside | 5,000            | Year 1 - similar to Risk Track 3  
Year 2 – transitional downside risk  
Year 3, similar to Risk Track 1 |
| 3     | Upside Only           | 3,000              | For Year 1, receive an increasing amount of the savings, capped at 50%  
Year 2 – expected to move up to Track 2 or 3 |

* Selection of Risk Tracks 1 and 2 require certification as a risk-bearing provider

Medicaid and the DSRIP Program

- Delivery System Reform Incentive Payment (DSRIP) programs are part of the Section 1115 Waiver program to support providers in changing the way they provide services to Medicaid beneficiaries

DSAIRP waivers generally focus on 4 main areas with an increasing focus on clinical and population improvements over time.
Massachusetts Waiver Request

- Goals
  - Enact reforms that promote integrated, coordinated care and hold providers accountable for quality and total cost of care
  - Improve integration of physical health, behavioral health, LTSS and health related social services
  - Maintain near-universal coverage
  - Sustainably support safety net providers
  - Address the opioid crisis

- DSRIP Funding Levels (Statewide)
  - $1.8B over 5 years (eff. July 1, 2017)
  - Payments to Commonwealth contingent upon hitting pre-defined metrics and milestones
  - Statewide accountability:
    - ACO adoption – increase ACO enrollment from 30% in DY1 to 60% in DY5
    - Avoidable hospital utilization
    - Control statewide spending
    - Improvement in quality metrics

MassHealth restructuring: overview of accountable care models

1. ACOs are provider-led organizations that are held contractually responsible for the value - quality, coordination, integration and total cost of members’ care – rather than volume of care
2. 3 ACO model designs reflect a range of provider capabilities
3. All models include strong care delivery and integration standards, member protections including appeals to ensure access and quality, and expectations for linguistically and culturally appropriate care

Model A: Integrated ACO/MCO
- Fully integrated: ACO joins with MCO to provide full range of services
- Includes admin (e.g., claims payment) and care delivery & coordination
- ACO/MCO receives a prospective capitation payment and is at full risk

Model B: Direct to ACO
- ACO provider contracts directly with MassHealth
- Full MassHealth/MHBP provider network, but ACO may have preferred provider relationships
- ACO accountable for total cost/quality and integration of care
- MassHealth/MHBP pay claims up-front, retrospective reconciliation with ACO for total cost of care

Model C: MCO-administered ACO
- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- MCO pays claims, contracts provider network
- ACO accountable for total cost/quality and integration of care, with varying levels of risk (all levels include two-sided performance risk)

Source: MassHealth 1115 Waiver Hearing – June 24, 2016
New York’s DSRIP Program

- The overarching goal of the DSRIP plan is to:
  - Transform the health care delivery system in New York
  - Reduce avoidable hospital use by 25% statewide and achieve significant improvements in other health and public health measures at both the provider systems and state levels
  - Reduce Medicaid spending trend rates statewide
- DSRIP requires the creation of “Performing Provider Systems” that are expected to be collaborative networks of care that are responsible for most or all Medicaid beneficiaries in the given geography or medical market area
  - Should include all of the major providers of Medicaid services in the region
  - Must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings
- The State’s expectation is that at the end of 5 years,
  - Performing Provider Systems will contract directly with managed care plans to meet all the health care needs of Medicaid beneficiaries, and
  - 80-90% of managed care payments to providers will be based on value instead of volume
New York State - DSRIP and Value Based Payment Roadmap

- DSRIP is a 5-year incentive payment program to be paid “in addition to” the Medicaid program to assist providers with transforming to a high-performing healthcare delivery system.
- During the DSRIP project period (April 1, 2015 – March 31, 2020), the Medicaid program will be transitioning to value-based payment.

- When we wake up on April 1, 2020, the Medicaid program will be reformed to include integrated Performing Provider Systems with:
  - 100% Medicaid managed care AND
  - 80-90% Value Based Payment

Overview – NYS VBP Roadmap

How should an integrated delivery system function – DSRIP Vision

Source: "Value Based Payment in NYS Medicaid; The FQHC/Primary Care perspective", DOH – August 10, 2015
The Path towards Payment Reform

- There will not be one path towards 90% Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.
- PPSs/providers and MCOs will be stimulated to discuss opportunities for shared savings arrangements (often building on already existing MCO/provider initiatives):
  - For the total care for the total attributed population of the PPS (or a hub or other entity)
  - Per integrated service for specific condition (bundle): maternity care; diabetes care
  - For integrated PCMH/APC
  - For the total care for a subpopulation: HIV/AIDS care; care for HARP population

MCOs and providers may choose to make VBP arrangements between MCOs and groups of providers within the PPS rather than between MCO and PPS

Source: "Value Based Payment in NYS Medicaid; The FQHC/Primary Care perspective", DOH – August 10, 2015

Overview – NYS VBP Roadmap

Examples of potential VBP Arrangements

<table>
<thead>
<tr>
<th>Outcome Targets % Met</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 2 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upside only</td>
<td>Up- and downside</td>
<td>When actual costs &lt; budgeted costs</td>
</tr>
<tr>
<td>≥ 50% of Outcome Targets met</td>
<td>50-60% of savings returned to PPS/Providers</td>
<td>90% of savings returned to PPS/Providers</td>
<td>PPS/Providers responsible for 50% of losses.</td>
</tr>
<tr>
<td>&lt; 50% of Outcome Targets met</td>
<td>Between 10 – 50/60% of savings returned to PPS/Providers (sliding scale in proportion with % of Outcome Targets met)</td>
<td>Between 10 – 90% of savings returned to PPS/Providers (sliding scale in proportion with % of Outcome Targets met)</td>
<td>PPS/Providers responsible for 50%-90% of losses (sliding scale in proportion with % of Outcome Targets met).</td>
</tr>
<tr>
<td>Overall outcomes Worse</td>
<td>No savings returned to PPS/Providers</td>
<td>No savings returned to PPS/Providers</td>
<td>PPS/Providers responsible for 90% of losses. (For Stop Loss see text.</td>
</tr>
</tbody>
</table>

By the end of DY 5, the State intends to move:
- 80-90% of MCO payments to VBP Levels 1 and higher, and
- 50-70% of MCO payments to VBP Levels 2 and higher
- The more dollars captured in higher level VBP arrangements, the higher the PMPM payment the MCOs will received from DOH

Source: "A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform", DOH
**VBP Contracting Entities**

Tomorrow

- Medicaid Payments
- ACOs
- VBP Contracting Entity
- IPAs
- Hospitals
- Physicians
- FQHCs
- LTC Providers

**Oregon Medicaid Health System Transformation**

- Coordinated Care Organizations (CCOs)
  - Governed by partnership of providers, community members and other stakeholders
  - Tasked with the development of new models of integrated care: patient-centered and team-focused; integrated physical, behavioral and dental health
  - A global budget that grows at a sustainable, fixed rate with payment alternatives that incentivize positive health outcomes
- Safety-net FQHCs may elect to be paid under an Alternative Payment Method (APM) rather than the “encounter method” for FQHC “wraparound” protection
### Oregon Medicaid Health System Transformation

- APM is aligned with Health System Transformation objectives
  - Move away from billing for each office visit
  - De-links the treadmill of churning office visits for payment by paying a Per Member Per Month (PMPM) payment
  - Maintain same level of revenue in to the FQHCs
  - Oregon to pay a PMPM (“wraparound”) payment to supplement payments received from the MCOs up to the total PMPM payment target for each FQHC based on historical payment experience
  - Quality and access measures developed to make sure they do not deteriorate
  - Payment based on attributed members to the FQHC given an 18-month lookback on claims data
  - Pilot contract stipulates if the APM results in less payment than PPS, OHA will pay the difference

---

### Oregon Medicaid Health System Transformation - Example

<table>
<thead>
<tr>
<th>Base Wrap Calculation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Members</td>
<td>13,000</td>
</tr>
<tr>
<td># of Months</td>
<td>12</td>
</tr>
<tr>
<td># of Member Months</td>
<td>156,000</td>
</tr>
<tr>
<td>Average Visits per Member</td>
<td>3.0</td>
</tr>
<tr>
<td># of Visits</td>
<td>39,000</td>
</tr>
<tr>
<td>FQHC Medicaid Rate Calc:</td>
<td></td>
</tr>
<tr>
<td>FQHC PPS Medicaid Rate</td>
<td>$ 150.00</td>
</tr>
<tr>
<td># of Visits</td>
<td>39,000</td>
</tr>
<tr>
<td>MCO Capitation Revenue</td>
<td>$ 5,850,000</td>
</tr>
<tr>
<td>MCO Revenue:</td>
<td></td>
</tr>
<tr>
<td>Capitation Revenue PMPM</td>
<td>$ 20.00</td>
</tr>
<tr>
<td># of Member Months</td>
<td>156,000</td>
</tr>
<tr>
<td>MCO Capitation Revenue</td>
<td>$ 3,120,000</td>
</tr>
<tr>
<td>Wraparound Payment Due</td>
<td>$ 2,730,000</td>
</tr>
<tr>
<td>Wraparound Payment PMPM</td>
<td>$ 17.50</td>
</tr>
</tbody>
</table>

- In the base period, the FQHC’s average member utilization is 3.0 visits per member
- Based on the baseline utilization, 13,000 members would generate 39,000 visits
- Under FQHC PPS, the FQHC is entitled to $5,850,000
- Since the MCO payments totaled only $3,120,000, the FQHC is entitled to wraparound payments of $2,730,000
- Under the APM, the FQHC’s wraparound payment rate is set at $17.50 PMPM
Oregon Medicaid Health System Transformation - Example

<table>
<thead>
<tr>
<th></th>
<th>Scenario One</th>
<th>Scenario Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Members</td>
<td>14,000</td>
<td>13,000</td>
</tr>
<tr>
<td># of Months</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td># of Member Months</td>
<td>168,000</td>
<td>156,000</td>
</tr>
<tr>
<td>Average Visits per Member</td>
<td>2.8</td>
<td>3.2</td>
</tr>
<tr>
<td># of Visits</td>
<td>39,200</td>
<td>41,600</td>
</tr>
<tr>
<td>Wraparound Payments per APM:</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Member Months</td>
<td>168,000</td>
<td>156,000</td>
</tr>
<tr>
<td>Wraparound Payment PMPM</td>
<td>$17.50</td>
<td>$17.50</td>
</tr>
<tr>
<td>Wraparound Payments Made</td>
<td>$2,940,000</td>
<td>$2,730,000</td>
</tr>
<tr>
<td>FQHC PPS Medicaid Rate</td>
<td>$150.00</td>
<td>$150.00</td>
</tr>
<tr>
<td># of Visits</td>
<td>39,200</td>
<td>41,600</td>
</tr>
<tr>
<td>MCO Capitation Revenue</td>
<td>$5,880,000</td>
<td>$6,240,000</td>
</tr>
<tr>
<td>Capitation Revenue PMPM</td>
<td>$20.00</td>
<td>$20.00</td>
</tr>
<tr>
<td># of Member Months</td>
<td>168,000</td>
<td>156,000</td>
</tr>
<tr>
<td>MCO Capitation Revenue</td>
<td>3,360,000</td>
<td>3,120,000</td>
</tr>
<tr>
<td>Wraparound Payment Due</td>
<td>$2,520,000</td>
<td>$3,120,000</td>
</tr>
<tr>
<td>Difference</td>
<td>$470,000</td>
<td>($390,000)</td>
</tr>
</tbody>
</table>

Scenario One:
- Members increase while utilization decreases
- Results in APM payments greater than historical “per encounter” model

Scenario Two:
- Members remain constant while utilization increases
- Results in APM payments less than historical “per encounter” model

California’s Alternative Payment Model Demonstration

- PPS rate converted to a monthly capitation payment similar to Oregon’s APM
  - Move away from the billable visit payment model to per patient basis
  - Future goals
    - Incorporate alternative touches into rate-setting
    - Social determinants of health utilized to risk-adjust rates
    - Access to surplus-sharing if achieve outcomes
- PMPM capitation amount to be paid to the MCOs directly
- MCOs to pay a monthly capitation payment to FQHCs for all services included in the FQHC PPS rate
California’s Alternative Payment Model Demonstration

Today - PPS

- DHCS sets rates for health plans
- Plans pay market-based primary care capitation to health centers
- Health centers bill state a wrap-around payment
- Annual reconciliation

Source: “Payment Reform for FQHCs in California”: California PCA, Sept. 2015

California’s Alternative Payment Model Demonstration

Future – APM Demonstration

- DHCS sets rates for health plans
- Monthly, plan would tell State how many Medi-cal members are assigned to FQHC site in demonstration.
- State would pay the plan an additional “Wrap Cap” for all pilot sites’ assigned members
  - Wrap around payment becomes a PMPM payment that is AID Category specific
  - Health center would receive 4 PMPM payments (Child, Adult, SPD, Expansion)
  - More members = more $ 
- Rate Adjustment between FQHC and plan.
- Health center receives PMPM amount for all services in their PPS rates for the four aid categories for assigned members

Source: “Payment Reform for FQHCs in California”: California PCA, Sept. 2015
CMS State Health Official Letter (SHO# 16-006)

- Provides clarification to FQHC Medicaid “wraparound” protections as states begin the implementation of VBP arrangements
- FQHC and RHC supplemental payment requirements under Medicaid managed care
  - FQHCs and RHCs entitled to receive payment for covered services to Medicaid eligible patients under the PPS methodology (including APMs)
  - Payment from the managed care organizations (MCOs) must be at amounts not less than payment made to non-FQHC providers for similar services
  - A state could amend its state plan to implement an APM requiring MCOs to pay FQHCs and RHCs their full PPS rate, with 2 conditions:
    • The state and FQHC/RHC must agree to use an APM, and
    • The APM results in FQHCs and RHCs receiving at least their full PPS rate

CMS State Health Official Letter (SHO# 16-006)

- FQHC and RHC network sufficiency under Medicaid managed care
  - MCOs are required to make FQHC and RHC services available to beneficiaries, within the areas served by the MCO
  - Consistent with CMS’ long-standing position, CMS has determined that, in order for a Medicaid MCO’s provider network to be sufficient, the MCO must include access to FQHC and RHC services, if available
  - MCOs must include at least one FQHC and one RHC in their provider networks, effective July 1, 2017
    • States have flexibility to require MCOs to contract beyond this minimum standard
  - When FQHC and RHC services are not included under a state’s managed care contracts, the services must be provided or arranged by the state directly
Common Themes in VBP Arrangements

- Integration of physical and behavioral health care services
- Payment for care coordination services
  - PCMH/Health home services
- Additional payments for improving outcomes and managing the “total cost of care” of patients
- Movement away from “per visit” payment models to “per patient”
- Development of FQHC integrated care networks
  - As competition for health center patients increases, FQHCs need to join forces to maintain market share
  - With the expansion of global payment/budget models, FQHCs need to pool patients to increase members, minimize risk and share best practices
  - Creation of shared service-type arrangements to obtain high-quality services at reasonable cost
- Transition of wraparound payments from “per visit” to “per patient”

CONTACT INFORMATION

Peter R. Epp, CPA, Partner
Practice Leader – Community Health Centers
CohnReznick LLP
646.254.7411
Peter.Epp@CohnReznick.com