Overview

- Transitioning to Tomorrow
  - Keys to Success in VBP Arrangements
  - Preparing Financial Management Systems for VBP
    - Cost Efficiency of Current Operations
    - Financial Analysis of Patient-Centered Care
    - Analysis of Financial Health
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

Health Center Success in VBP Arrangements

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<tr>
<th>Fee-For-Service</th>
<th>Partial Capitation</th>
<th>Global Budgets</th>
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<td>Managing the Visit</td>
<td>Managing the Patient In-House</td>
<td>Managing the Patient Total Cost</td>
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<td>Effective Coding</td>
<td>Overall Patient Utilization</td>
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<td>Cost Efficiencies</td>
<td>High Value Providers</td>
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<td>Quality Metrics</td>
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Health Center Success in VBP Arrangements

- Systems Required for Success
  - Coding and clinical documentation
  - Managing patient centered care
  - Data analytics
  - Care management/delivery
  - 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
  - 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

FQHC Rate Protection

- Potential changes in base compensation payments under VBP/ACOs –
  - Global capitation arrangements
  - Opportunities to move toward “advanced payment models”
- Federal statute provides rate protections for FQHCs who contract with “Medicaid managed care organizations”
  - Do ACOs satisfy the definition of a “Medicaid managed care organization”
- FQHCs should ensure that its FQHC reimbursement rates are protected
- Out-of-network services
Preparing Financial Management Systems for VBP

Cost Efficiency of Current Operations

- In preparation for VBP, centers need to ensure that services currently provided in-house are provided efficiently as well as with high quality
- Efficiency is attained through the management of –
  - Actual cost of providing services
  - Clinician productivity (coupled with quality)
- Historically, centers have monitored the cost per visit of providing services; this measurement needs to move down to a per procedure basis
- Coding is also critical to improving efficiency and quality

What should a health center do today?

- Monitor/manage provider productivity levels
  - Move from a “per visit” basis to a “per procedure” basis
  - Regularly review provider productivity reports with clinical leadership
- Monitor/manage productivity/capacity levels of non-provider staff
- Improve cost efficiencies and reduce the current cost of care per unit
  - Concentrate efforts on reducing the current cost of care (move from a “per visit” to a “per procedure” basis)
  - Aside from productivity, identify other areas for improvement (e.g. support staff ratios, panel sizes)
- Refine and utilize your “cost-based charge structure” as a unit costing system
  - Begin to capture services for non-CPT codable services (e.g. social determinants of health)
Preparing Financial Management Systems for VBP

Financial Analysis of Patient Centered Care

- Success under VBP requires a financial system that provides financial and operational data to understand the underlying cost of a patient and linked to their clinical conditions
- For services provided in-house –
  - Coding of services is imperative as costs need to be captured and measured at the per procedure basis
  - Managing the utilization of services provided per patient is the second variable in understanding the cost per patient
  - Understand and quantify the impact social determinants of health has on patient health status and outcomes
- VBP will also require centers to take on the management of care outside of its 4 walls
- These analysis will require new capabilities and systems

Preparing Financial Management Systems for VBP

Financial Analysis of Patient Centered Care

- What should a health center do today?
  - Further enhance coding accuracy of providers
    • Coding training during orientation with annual updates
    • Monitor coding practices and address anomalies
    • Consider hiring of HIM professionals certified coders
  - Move to managing the total cost per patient for in-house services
    • Manage/monitor utilization of services
    • Move from a “per visit” to a “per procedure” analysis
    • Consider non-CPT codable services
  - Manage quality metrics that drive incentive payments
    • Document/catalog metrics which drive quality incentive payments
    • Design reports to manage/monitor metrics; understand data elements
    • Review quality incentive payment programs and metrics with clinical leadership on a regular basis and implement clinical interventions to improve outcomes
Preparing Financial Management Systems for VBP

Financial Analysis of Patient Centered Care (continued)

- What should a health center do today?
  - Design systems to measure and capture the social determinants of health
  - Actively engage with the management of the total cost of care of assigned patients/members
  - Consider participation in shared-savings arrangements
  - Demand claims data from third party payers!
    - Monthly Data Reports
      - Member Enrollment Roster
      - Member Emergency Room Utilization and Cost
      - Member Inpatient Utilization and Cost
      - High Risk Identification List (Top 10% High Risk Members)
    - Recent Claims Data
      - Outpatient Medical Claims
      - Outpatient Behavioral Health Claims
      - Pharmacy Claims
      - Inpatient Claims

Using Third-Party Claims Data

- Risk stratify patients
- Analyze “gaps in care”
  - Determine the Total Cost of Care by patient and PMPM
  - Identify high cost/high utilizing patients and develop clinical interventions
  - Outreach efforts/patient engagement
- Analyze “systemic” anomalies
  - Physician practice patterns – cost and outcomes
  - Specialty referral practices and high cost/low quality specialists
  - Care locations
Overview of Risk Stratification

- Not all patients are the same – even if they have the same condition or co-morbidities
- Patients have different levels and stages of illness, and co-morbidities which require different treatments, care services, resulting in different cost
- Managing patient populations requires patients to be proactively assessed and assign to a risk group to determine:
  - What care services they will require – within and across clinical pathways
  - What the cost of care will be – per member per year
- Risk stratification is the process of identifying the relative risk of patients in a served population. It involves: Diagnostic coding, linear regression modeling, patient risk assignment, and effect modeling

Actuarial Analysis: Current and Projected Performance Versus Targets
Bending the Curve: Value Selected Opportunities and Projected Financial Impact

Preparing Financial Management Systems for VBP

Financial Health

- VBP brings with it many unknowns to the financial well-being of health centers
  - Upfront costs required for infrastructure and new skills/expertise of workforce
  - Revenue cycle projections/forecasts and timing of payment
- Prior to participation in VBP, centers need to ensure that their financial house is in order –
  - Financial condition and reserves
  - Operational financial performance under today’s financing mechanisms
Financial & Operational Key Considerations

- Key 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 Value Based Payment (VBP) arrangements
    - Develop sound assumptions based on data
    - Utilize financial model to inform VBP negotiations

- 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!

Transitioning To Tomorrow

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<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>TOMORROW</th>
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<tbody>
<tr>
<td>Proper coding for services provided</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Monitor/improve provider productivity</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Provision of services in a cost-efficient manner</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Manage and improve quality metrics</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Manage/monitor patient utilization – in-house</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Manage/monitor the total cost of care</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>New skill requirements, communication &amp; technology</td>
<td>★</td>
<td>★</td>
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Need For Business Intelligence

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

![Diagram showing Keys to Success: High Quality, Low Cost, and integrating various systems like Electronic Health Record, Practice Management System, General Ledger, Third Party Claims Data, Payroll System.]

Changing Role of the CFO & Finance Function

- Additional roles/functionality of the future
  - Connecting with clinical leadership:
    - Understand metrics/outcome measures that drive incentive payments
    - Managing patient utilization both in-house as well as out-house
  - Better understanding of the health center’s patient base to impact attribution
    - Patient satisfaction
    - Primary care and preventive services coding
  - Create dashboards that monitor performance that drives revenue
Changing Role of the CFO & Finance Function

- Additional roles/functionality of the future
  - Emphasis on cost accounting and unit-costing
    - Analyze/drive cost efficiencies
    - Need to develop a new internal budget model centered around patients
      - in-house versus out-house
  - Heightened involvement with collaborations and strategic planning
    - Documenting value
    - Understanding funds flow
  - Risk management – managing risk-sharing arrangements
  - New required skill sets/functionality
    - Care management/coordination
    - Clinical informatics
    - Business intelligence solutions

Transitioning to Tomorrow

CMO + CFO = BFF
QUESTIONS

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