

Value-Based Payment: Overview and Models

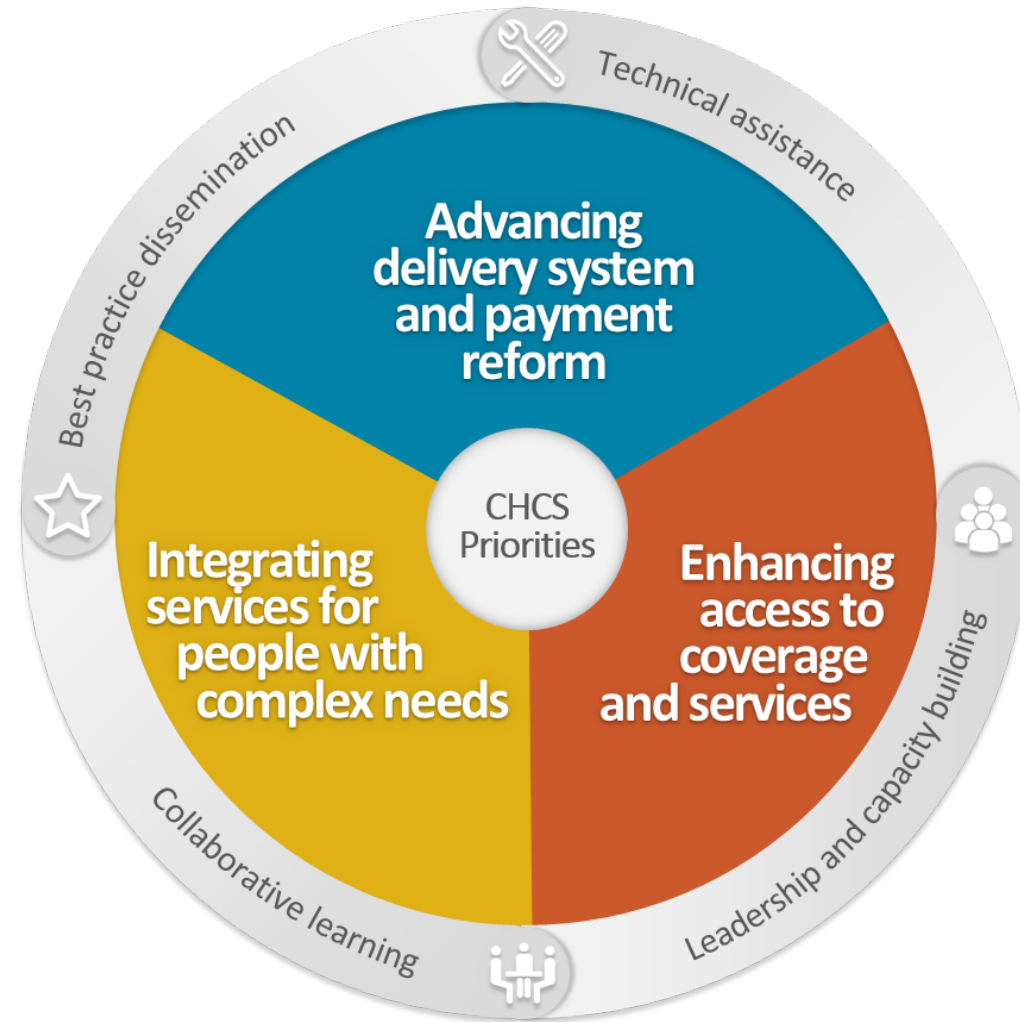
Population Health Learning Network

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12 PM – 1 PM PT

About the Center for Health Care Strategies

A non-profit
policy center
dedicated to
improving
the health of
low-income
Americans



Today's Presenters



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Agenda

By the end of this webinar you will have answers to the following questions:

- What is Value-Based Payment (VBP)?
- How can VBP help health centers in California?



What is Value-Based Payment?

Polling Question #1

- Which of the following would you associate with “Value-Based Payment?”
 - » Bundled payments and global budgets
 - » A way of linking payment to quality, not quantity
 - » A growing national initiative to control costs
 - » Shared savings/losses
 - » All of the above

We Pay For Transactions, Not Outcomes



- **Majority of reimbursement for health care services is fee-for-service (FFS)**

- » Encourages the provision of more services, so costs increase and more, not necessarily better, care is given
- » Limits services to those associated with a specific billing code
- » Continues fragmentation – no one is accountable for or paid to coordinate care, so no one does
- » Lack of integration – every provider is an island!

What is Value Based Payment and why do we need it?

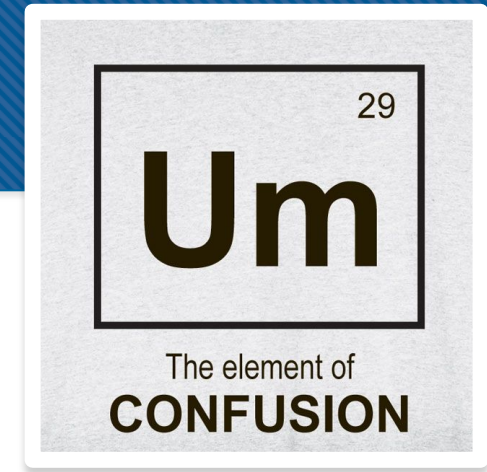
- **Value Based Payment (VBP)** - Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use

- **VBP Goals**

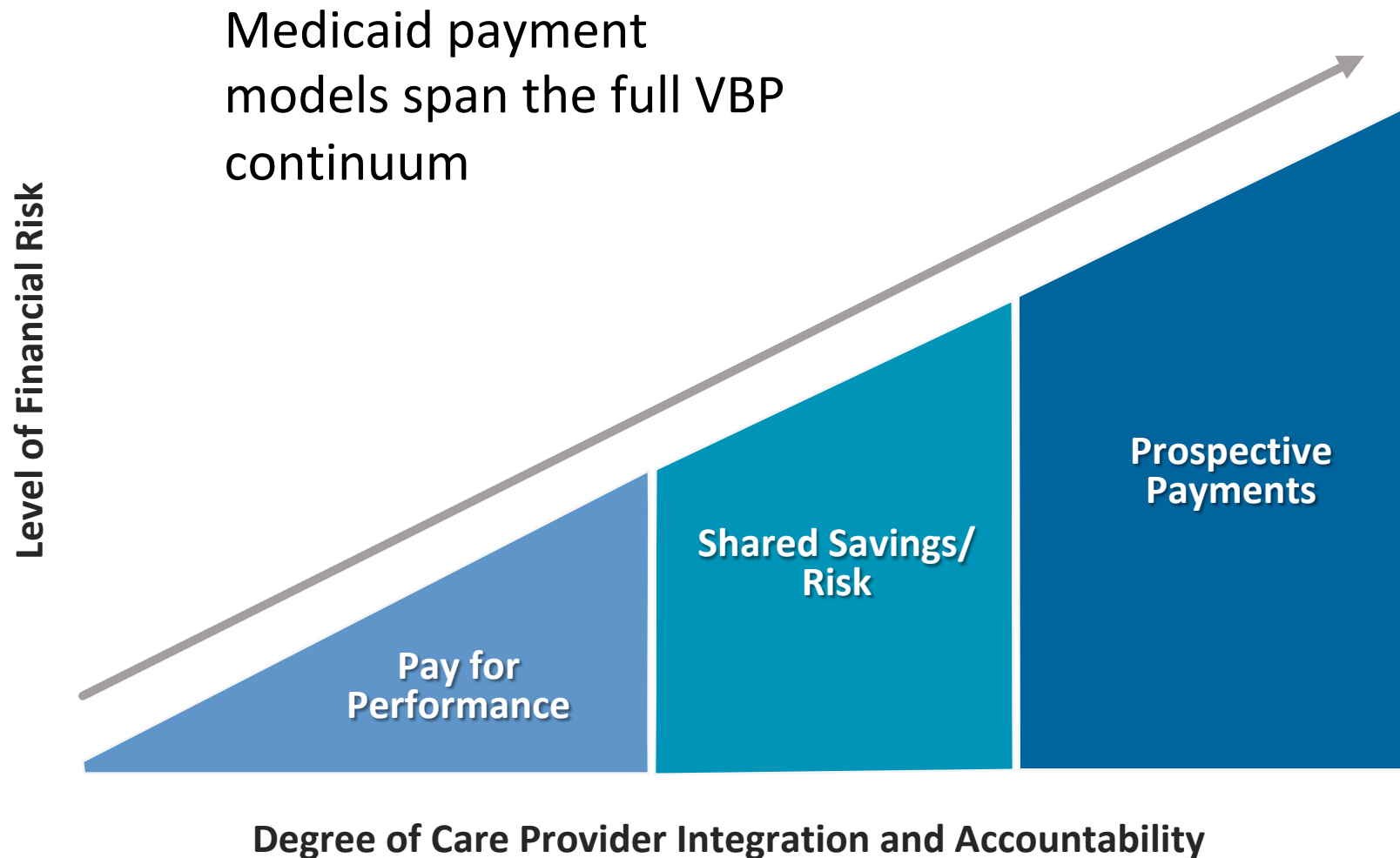


What VBP is not...

- Many delivery system reforms are confused as VBP models, but these are separate things
 - » A VBP model can be part of a delivery system reform effort
- Things often called “VBP models” that are not:
 - » Managed Care Organizations
 - » Accountable Care Organizations
 - » Patient Centered Medical Homes



Value-Based Payment Continuum







Alternative Payment Models



- Alternative Payment Models (APMs) are designed to move away from fee-for-service and toward VBP
 - » Aligns provider payment with patient outcomes, performance of evidence-based processes, and patient experience
 - » Incentivizes cost reduction
- APMs require health care providers to take on some form of financial risk
 - » “Upside Risk” – If savings are achieved, providers receive a percentage of savings
 - » “Downside Risk” – If savings are achieved, providers receive a percentage of savings, if costs increase, providers need to pay a portion of those “losses”
 - » “Full Risk” – Providers are accountable for cost and quality, and if savings or losses occur, they bear all financial risk for those outcomes

HCP LAN Alternative Payment Model Framework

			
CATEGORY 1 FEE-FOR-SERVICE - NO LINK TO QUALITY AND VALUE	CATEGORY 2 FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure and Operations (e.g., care coordination fees and payments for HIT investments)	APMs with Shared Savings (e.g., shared savings with upside risk only)	Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	B	B
	Pay-for-Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	APMs with Shared Savings and Downside Risk (e.g., episode-based payment for procedures and comprehensive payment with upside and downside risk)	Comprehensive Populations-Based Payment (e.g., global budgets or full/percent of premium payments)
	C		C
	Pay-for-Performance (e.g., bonuses for quality performance)		Integrated Finance and Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N	4N
		Risk-Based Payment NOT Linked to Quality	Capitated Payments NOT linked to Quality

Source: Alternative Payment Model (APM) Framework: Refresh for 2017. The MITRE Corporation. 2017. Available at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

The Four Most Common VBP Approaches



Pay-for-Performance (P4P)

- » Ties provider payment directly to specific indicators of quality or efficiency



Bundled Payments

- » A bundled payment for a set of services that occur over time and across settings



Shared Savings/Risk

- » Providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings



Capitation/ Global Payments

- » Providers receive an upfront per member per month (PMPM) payment to cover a wide range of services

Examples of VBP Approaches



Pay-for-Performance (P4P)

- » Various MCP and IPA P4P Programs
- » UDS Quality Improvement Awards



Bundled Payments

- » Bundled Payments for Care Improvement (BCPI)



Shared Savings/Risk

- » Proposed FQHC APM Pilot
- » PRIME – Attachment R
- » Merit-based Incentive Payment System (MIPS)
- » Medicare Shared Savings Program
- » CPC+



Capitation/ Global Payments

- » PRIME – Attachment R
- » Global Payment Program

Pay-for-Performance (P4P)



- Ties provider payment directly to specific indicators of quality or efficiency

- **Rewards**

- » Providers receive a bonus payment for measurable performance in quality, patient satisfaction, resource use, and/or cost (e.g., hospital readmissions from nursing homes)

- **Penalties**

- » Providers receive a withhold/clawback of payment based on performance
- » Providers receive lower payments, or no payments, for events and procedures that are harmful and avoidable

Bundled Payments



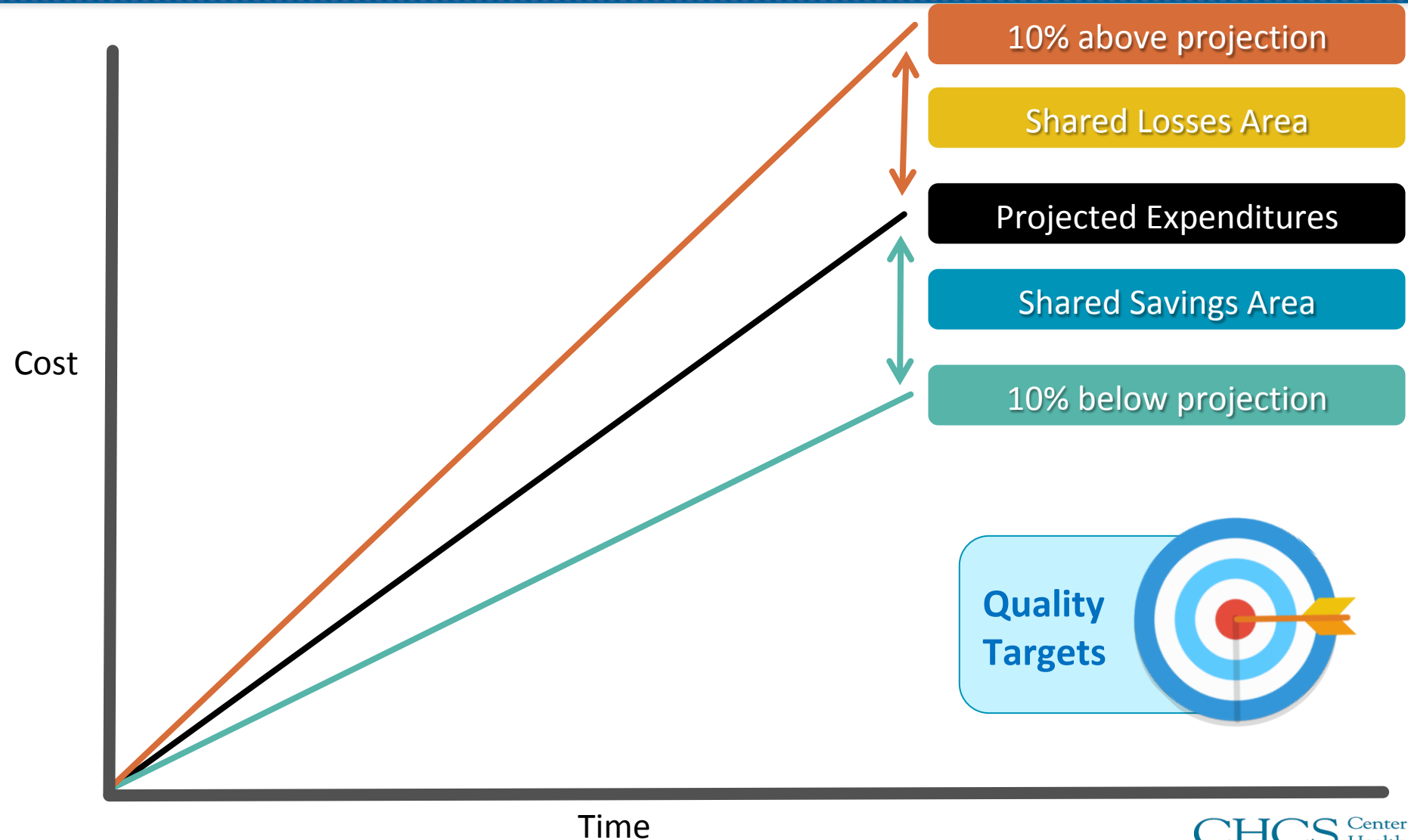
- **Clinical Episode Payment:** A bundled payment for a set of services that occur over time and across settings*
 - » This payment model can be focused on:
 - a setting (such as a hospital or hospital stay)
 - a procedure (such as knee/hip replacement)
 - a condition (such as diabetes)
 - » Incentivizes efficiency and coordination of care across providers to offer care at or below the payment level
 - Payment is contingent on quality performance
 - » Payment can be made retrospectively or prospectively

Shared Savings/Risk



- Providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings
 - » Incentivizes activities, such as coordination and effective care management across all services, to lower the total cost of care
 - » Payment received retrospectively, contingent upon amount of savings and quality performance
 - » Utilized primarily in accountable care organizations (ACOs)
 - But increasingly being explored in PCMH, health homes, and super-utilizer initiatives

Shared Savings/Risk Chart



Global or Capitated Payments



- Providers receive an upfront per member per month (PMPM) payment to cover a wide range of services
 - » Providers bear full financial risk for services
 - » Access to upfront funding to invest in care coordination, quality improvement, and efficiency across the full continuum of care
 - » Used with advanced ACOs, hospitals, and multi-specialty provider groups

Polling Question #2

- Which of the following payment models are you currently participating in?
 - » Pay-for-performance
 - » Bundled payments
 - » Shared savings/risk
 - » Global payments
 - » Not sure

Any Questions?



How can VBP Help Health Centers in California?

PPS Rates



- **Prospective Payment System (PPS)** – for “medically-necessary primary health services and qualified preventive health services furnished by an FQHC practitioner.”
 - » Paid by the encounter with state wraparound payment
- Straightforward and predictable way to be paid, but does not cover everything
 - » “Medically-necessary primary health services” and “qualified preventive health services”
 - » Furnished by an “FQHC Practitioner”
 - » Only delivered at certain locations
- Though certain exemptions have been made for telehealth and care management services, these services are limited and approval came slowly

Polling Question #3:

- What activities are your health center currently performing that are not being reimbursed? (please select all that apply)
 - » Group visits
 - » Multiple visits on one day
 - » Visits at other locations
 - » Services provided by individuals that are not considered "FQHC practitioners" under PPS (e.g., Community health workers)
 - » Innovative services or interventions that are not reimbursable under PPS or MCO contracts
 - » Innovative services or interventions that are currently grant funded

How can VBP Help FQHCs?



■ VBP can help FQHCs:

» Mitigate the limitations of PPS

- Fund services beyond “medically-necessary primary health services” and “qualified preventive health services”
- Pay for services furnished by someone other than an “FQHC Practitioner”
- Deliver care at any location

» Align payment with good care

» Fund innovative pilot programs

» Achieve sustainability for interventions currently funded by grants

“Slush Funds”

- Money saved under a VBP arrangement is usually flexible, and can be used for many purposes
 - » P4P bonuses
 - » Shared savings payments
 - » Savings under a bundled payment or capitated rate
- Health care organizations have used money to pay for:
 - » IT Infrastructure and data analysis improvement
 - » Supportive and permanent housing, air conditioners, and home asthma remediation for patients
 - » Community health workers and care management teams
 - » Innovative pilot programs and interventions



One Important Note



- While FQHCs can take on “upside risk” in P4P and shared savings arrangements, FQHCs cannot take “downside risk” on payments that include PPS (shared risk, capitation)
 - » (E.g., The California FQHC APM Pilot...)
- However, there are potential ways an FQHC could participate in downside risk if it wants to (usually have greater “upside” potential)
 - » Downside risk on non-PPS services
 - » Payments above PPS
 - » Entering into a VBP arrangement with a partner that can accept downside risk
 - » Entering into a payment arrangement with an MCO
 - Payment must be at amounts not less than payment made to non-FQHC providers for similar services

Shared Savings/Risk Example: Minnesota



■ Integrated Health Partnerships (IHPs)

- » Medicaid ACO model
- » Begun 2013 as part of state legislation
- » Performance assessed based on TCOC target & 32 quality measures, with possibility for shared savings/risk
 - Flexibility for smaller providers to participate in upside risk only

■ Results

- » \$213M savings to state, 2013-2016
- » 14% reduction in hospital stays, 7% reduction in ED visits
- » 460,000+ people served
- » Participation increased from 6 IHPs in 2013 to 24 IHPs in 2018

Shared Savings/Risk Example: Minnesota



■ IHP 2.0

- » Launched 2018 for three-year period
- » Changes based on feedback from providers, plans, community
- » Added quarterly population-based payment (PBP) to support care coordination & infrastructure needs; adjusts for social risk factors
- » Includes two tracks to accommodate diverse provider systems
 - **Track 1:** risk-adjusted quarterly PBP tied to health equity, performance and utilization metrics (no risk for small, independent providers)
 - **Track 2:** risk-adjusted quarterly PBP *and* TCOC two-way risk model for shared savings/losses tied to SDOH screening & health equity metrics
- » Standardized quality measures, to be finalized Dec. 2018
 - No more than 6 statewide measures for single specialty practices (10 for multispecialty)

Any Questions?





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FUHN's Journey: MN DHS's Integrated Health Partnership



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Dawn Plested, FACHE, MBA, FUHN COO



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Topics

- Overview of FUHN and the DHS Medicaid Program
- Why we did what we did
- The results we've achieved
- Where we are today
- Where we are heading



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What is FUHN?

Federally Qualified Health Center Urban Health Network

- Collaborative partnership of 10 Twin Cities Federally Qualified Health Centers (FQHC); including 40 unique primary care clinic sites.
- Nation's first FQHC-only Safety Net Medicaid Accountable Care Organization (ACO); right here in Minnesota!





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FUHN/DHS IHP

Project Overview

- FUHN's 10 member health centers are working together with MN Department of Human Services (DHS) on Medicaid health care reform to further enhance the health care provided to our Medicaid patients through Value Based Purchasing.
- The overall goal of the project is to demonstrate FUHN's ability accomplish the **Triple Aim Plus One**
 - Reduce enrollee Total Cost Of Care
 - Improving Clinical Quality
 - Improve the Patient Experience
 - Improve **PRIMARY CARE ACCESS** for vulnerable populations





FUHN/DHS IHP Project Overview (cont.)

- ***MNDHS IHP Program has achieved remarkable results over it's five years of operation. 25 IHP ACO's like FUHN achieved:***
 - ***Program savings of an estimated \$1B in Medicaid Program costs.***
 - ***Covered almost half a million Medicaid Enrollees; 50 percent of all MA Enrollees.***
 - ***Dramatic reductions in Hospital Service utilization.***



Background of the FUHN/DHS IHP

- MN Health Reform Legislation allowed for ACO Medicaid Demonstration
- FUHN viewed demonstration as
 - Opportunity - leverage resources, foster collaboration, learn together
 - Threat - survival in a quickly reforming health environment
- Question for each FQHC: Join larger systems to gain access to resources OR take a leap of faith to transform our clinical practice
- FQHC Mission
 - 10 independent FQHC Boards' support (51% patients) driving towards increased collaboration and efficacies

Why did the FQHC's choose to participate in this Medicaid ACO Project?

- Accelerating Health Payment Reform

Cost-based Reimbursement



Value-based Reimbursement (VBP)

- Holding primary care providers accountable for a patient's total cost of care, patient satisfaction and quality; both in and outside of a clinic's four walls.
- ACA/Expanded MA Coverage/ MNSure





Why did the FQHC's choose to participate in this Medicaid ACO Project? cont...

- Health Reform is taking shape: Our Clinics needed to complete a **significant operational transformation** in order to be relevant in this new environment.
- FQHC could **take charge for the first time ever**; FUHN decided we could shape changes or be shaped by them.
- FQHC's are the **model for this population**: Health reform trends place importance on primary care health care homes that focus on the health of patients and address social determinants.
- We were **ill-prepared to be successful** in this new environment. The private Health Systems started this activity 10 years ago.

Where are We Today?

*The overall goal of the contract is to demonstrate FUHN's ability to accomplish the **Triple Aim Plus One**:*

- 1. Reduce enrollee Total Cost Of Care (TCOC) (for all medical services- not just the services provided by the primary care provider)*
- 2. Improve Clinical Quality.*
- 3. Improve the Patient Experience.*
- 4. Improve Primary Care Access for these vulnerable populations.*

- We are better positioned now to operate in this new, value-based environment.

“Fierce competitors to extreme collaborators”





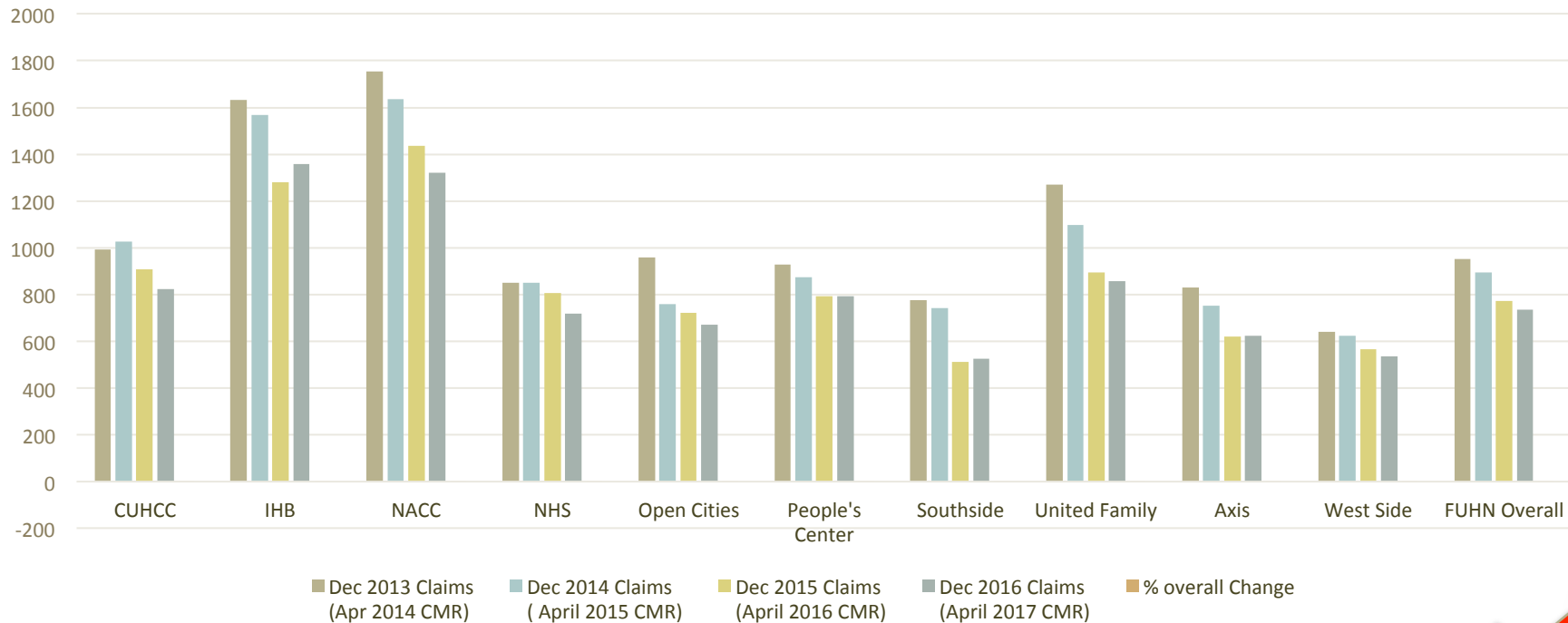
FUHN Results: Attribution

- 2013: 23,849
- 2017: 31,799 – 33% increase
 - Medicaid expansion
 - Move from 12 months to 24 months attribution period
- This represents roughly 55% of the MA patient population served by our 10 FUHN Member Clinics (remaining 45% did not meet eligibility at enrollment time)

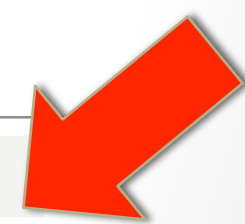


FUHN Results: ED utilization reduction graph 2013-2016

FUHN Trend
December 2103 Claims through December 2016 Claims
ED Visits / 1000 Members



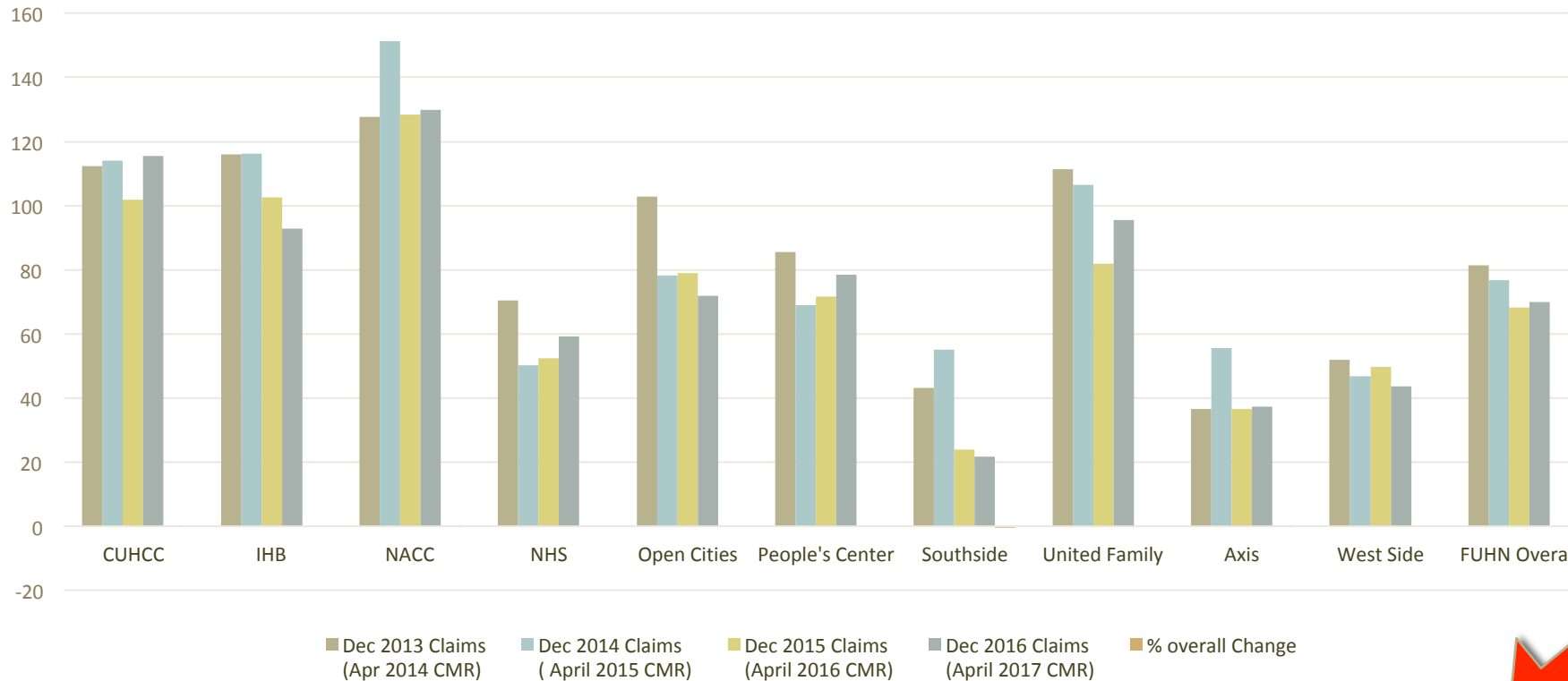
FQ	Dec 2013 Claims (Apr 2014 CMR)	Dec 2014 Claims (Apr 2015 CMR)	Dec 2015 Claims (April 2016 CMR)	Dec 2016 Claims (April 2017 CMR)	% overall Change
FUHN Overall	952	893	773	734	-23%





FUHN Results: Inpatient admissions reduction graph 2013-2016

FUHN Trend
December 2103 Claims through December 2016 Claims
IP Visits / 1000 Members



FQ	Dec 2013 Claims (Apr 2014 CMR)	Dec 2014 Claims (Apr 2015 CMR)	Dec 2015 Claims (April 2016 CMR)	Dec 2016 Claims (April 2017 CMR)	% overall Change
FUHN Overall	81	77	68	70	-14%





Health Information Technology Initiative

- FUHN, using almost **\$1.5M grants** received through MDH, DHS and the BPHC, is building the data analytics infrastructure and capability needed to manage VBP arrangements.
- A **data warehouse** that will receive real time data feeds from:
 - FQHC's EMR clinical data
 - Payer claims data
 - Available admit, discharge and transfer data provided by selected hospital care partners
- A **robust data reporting and analytics capabilities** for use by our Care Coordinators.
 - Future gain savings are expected to sustainably fund the ongoing operating costs with this new infrastructure.



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Sustainability Through Federal Grant

- In August 2016 FUHN was informed that it was one of 51 HRSA Grant Recipients for **Health Center Controlled Networks**.
- This three-year, \$1.5M Grant award provides FUHN and its members funding to continue our organizational transformation to value-based purchasing.
- Will help FUHN Clinics fund the automation of data reporting obligations from our annual Federal Uniform Data System, State MNCM Submissions and VBP Reporting obligations.



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Starting an ACO/IHP

In order to really dive into VBAs, certain structures are often developed: ACPs/ CINs. In order to create a functional integrated structure, clinics must:

- Develop a separate legal unit (usually a limited liability company)
- Gain cultural buy-in
- Strategic partners
- Firm business plan
- Effective CIN governance structure
- Robust IT infrastructure
- Capital and operational financing
- Understanding contracting (Pricing and negotiating bundled payments, capitation rates, and even health plan premiums will necessitate that CINs acquire actuarial, claims tracking, claims payment, cost accounting and care management and utilization review)
- Implementing marketing and business development



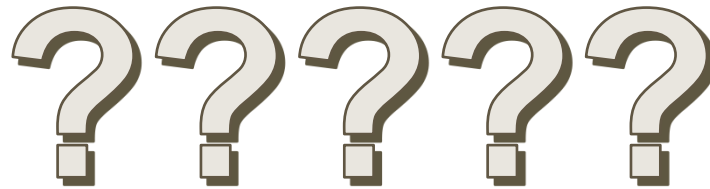
Current and Future Challenges

- Ability of clinics to continue to work together
- Clinical resources and capabilities
- Lack of infrastructure
- Lack of capital
- Lack of being clinically integrated
- Legal compliance challenges
- Lack of physician to physician collegiality
- Market demand



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Questions??



What's Next?

- What are practical next steps you can take to explore VBP Models?
 - » Create inventory of your health centers' existing VBP payment models
 - » Learning more about VBP models of interest and how they can be set up
 - » Speaking with MCOs about VBP payment arrangements
- Additional help available from CHCS
 - » Additional webinar (Fall 2018)
 - » Coaching help (Fall 2018)
 - » Presentation during next in-person meeting (January 2019)
 - » Technical assistance opportunities (Spring 2019)

