PAYMENT REFORM: SHIFTING TOWARDS ALTERNATIVE PAYMENT METHODOLOGY
What is Alternative Payment Methodology?
Current System

- Prospective Payment System (PPS)

- Payments are made based on a predetermined, fixed amount.

- Whether a patient visits with his or her physician for 15 minutes or 45 minutes, the health center is reimbursed the same amount.

- PPS rate is set nationally for Medicare reimbursements and state-wide for Medicaid payments.
Alternative Payment Methodology

- Alternative Payment Methodologies (APM’s) provide a counter approach to reimbursement

- Payments are not dependent on “face-to-face” visits

- Under such models, reimbursements reflect value of care provided to patients
Why Should We Transition from PPS?
Why Rock the Boat?

- Responsibility to Stakeholders
  - Patients
  - Payers
  - Providers

- Increased Pressure from State
  - Payment moving from volume to value
  - Transparency and accountability increasing
Goals for Payment Reform

Align a payment structure with high standard of care to achieve Triple Aim for Maryland’s Health Centers.

- Better Patient Experience
- Increased Population Health Outcomes
- Lower per Capita Cost
What does APM Look Like?
## Common Models

<table>
<thead>
<tr>
<th>Payment Methodology</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled Payment</td>
<td>Providers are paid a set amount for all services rendered during a defined “episode” of care. For example, a pre-determined amount may be paid to multiple providers for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that “episode”.</td>
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<tr>
<td>Shared Savings</td>
<td>This model evaluates payments made over a period of time and sets cost-saving targets. If providers meet or exceed those targets, they can then share in a portion of the savings. The distribution of savings across multiple providers is typically tied to quality measures and outcomes.</td>
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<tr>
<td>Pay-For-Performance (P4P)</td>
<td>Incentive payments are built on a fee-for-service base to reward structure, process, or health outcome achievements. These payments can be calculated as a percentage of the underlying fee-for-service payment or a portion of claims paid can be withheld and then redistributed to providers based on quality indicators.</td>
</tr>
<tr>
<td>Patient Centered Medical Home Payment (PCMH)</td>
<td>Additional activities and functions related to care management, data/utilization management, and population health are reimbursed by an extra fee that may be capitation or FFS based.</td>
</tr>
</tbody>
</table>
Model APMs across the U.S.

Minnesota
Background

- Minnesota currently utilizes both PPS methodology and alternative payment methodology for the reimbursement of health centers.

- The PPS rate is based on the Medicare Economic Index (MEI).

- An APM must pay at least what the center or clinic would receive under the PPS.
APM Rate Calculation

- **APM 1** = 100% of cost**
  **(pre-PPS cost rate methodology used to settle the year’s claims)

- **APM 2** = PPS rate + 2% to cover MennisotaCare**
tax obligations
  **(publicly subsidized program for residents who do not have access to affordable health care coverage)

- **APM 3** = 200% of APM 1 or APM 2 if medical and mental health encounter occurred on the same day
Model APMs across the U.S.

Colorado
Effective July 1, 2013, reimbursement for alternative payment methodology averages PPS rate and 100% Reasonable Cost + 2%

APM may not exceed 100% Reasonable Cost or PPS rate
APM Rate Calculation (part 1)

1. **Calculate Current Year Inflated Rate.** Use the health center’s current annual costs from the most recent audited Medicaid cost report and inflate that figure by the Medicare Economic Index (MEI) inflation factor.

2. **Calculate the Inflated Base Rate from the prior year.** Take a weighted average of the FQHC's costs for the past three years.**
   
   **The Base Rate is recalculated every three years, but is inflated annually by the MEI to get the Inflated Base Rate.

3. **Calculate the lower of the rate determined in step 1 and step 2 (to establish 100% Reasonable Costs).** 100% Reasonable Costs are calculated as the lesser of the Current Year Inflated Rate and the Inflated Base Rate.
4. **Calculate the current inflated Prospective Payment System (PPS) Rate**

5. **Calculate the midpoint between step 3 and step 4 as long as the PPS rate is lower than 100% of reasonable costs.** If the PPS rate is higher than 100% of reasonable costs, then the PPS rate is used.

6. **Increase the rate determined in step 5 by 2%.** The increase shall not be higher than the 100% reasonable cost determined in step 3 or the PPS rate determined in step 4. This will be the FQHC's final Alternative Payment Methodology Rate and **it shall not be lower than the PPS Rate**.
Example

1. Current Year Costs: 44,058,903.00
   Current Year Visits: 266,915
   Current Year Inflation Factor: 0.8%
   Current Year Inflated Rate: 166.39

2. Prior Year Base Rate: 163.42
   Current Year Inflation Factor: 0.8%
   Inflated Base Rate: 164.73

3. 100% Reasonable Costs
   Current Year Calculated Inflated Rate: 166.39
   Inflated Base Rate: 164.73
   Lesser of current year inflated rate or the inflated base rate: 164.73

4. Prospective Payment System (PPS)
   Prospective Payment System (PPS) Rate: 151.73
   Current Year Inflation Factor: 0.8%
   Prospective Payment System (PPS) Rate: 152.94

5. Midpoint between 100% Reasonable Costs and PPS
   Prospective Payment System (PPS) Rate: 152.94
   100% Reasonable Costs: 164.73
   Midpoint: 158.84

6. Midpoint: 158.84
   2% Increase: 3.18
   Final Alternative Payment Method Rate: 162.01
   New rate does not exceed 100% Reasonable Costs of $164.73
Model APMs across the U.S.

Oregon
Background

- Introduced by the Oregon Primary Care Association (OPCA) in collaboration with the Oregon Health Authority (OHA)
  - Driven by declining physician satisfaction and retention

- Dismantles treadmill of churning office visits for payment by paying a per-member per-month (PMPM) payment

- Budget-neutral

- Acts as a bridge linking to value-based pay, utilizing a per-member-per-month rate based fee-for-service baseline
APM Rate Calculation

- Divide health centers’ previous year total PPS reimbursement by the number of patients served, then dividing the figure by 12 into monthly payments.

- For example, a health center with a $100 medical PPS rate and 5,000 patients who average 3 visits per year:

  \[
  \text{PPS: ($100 PPS per visit) x (3 visits) x (5,000 patients) = $1.5 million per year}
  \]

  \[
  \text{APM: PPS/patients served = ($1.5 million/5,000) = $300 per patient per year}
  \]

  \[
  \text{$300 per patient per year / 12 months = $25 per patient per month}
  \]
Oregon has 32 total grantees. In a pilot program, clusters of health centers began adopting the alternative payment model over the course of three years.

1st Round – March 1, 2013
- 3 CHCs

2nd Round – July 1, 2014
- 4 CHCs, 1 RHC

3rd Round – July 1, 2015
- 3 CHCs
How Can an Aggregate Data Warehouse Support APM?
CCIC

- Bolsters Triple Aim
  - Measures patient outcomes
  - Evaluates cost per service
  - Targets interventions to meet needs of vulnerable populations

- Determine overall value of health center
When shifting towards value-based pay, we must take behavioral and socioeconomic indicators into account.

Behavioral patterns and social circumstance contribute greatly to one’s health status.

What are the Takeaway Points?
Summary

- We are in the midst of payment reform, aligning reimbursement models with care that strengthens our communities.

- States across the U.S. have made great strides in establishing programs that utilize unique alternative payment methodologies.

- Aggregate data should guide rate calculation.
Questions?
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