The expression "behaviors often follow the money," is increasingly evident in today's health care reimbursement environment, driven primarily by units of services such as number of visits or admissions. How has this impacted behavior? Providers have developed complex business processes to maximize volume and manage costs in an effort to remain financially viable. However, a major component missing from this equation is the patient.

The main objective of current health reform initiatives is to improve the quality of care provided to patients, ideally making them healthier, in addition to managing and/or reducing the total health care spend. Third-party payers, such as Medicare, Medicaid, commercial insurance companies and government funding agencies, such as the Health Resources Services Administration (HRSA), have started to alter their reimbursement models, or funding methodologies, to incentivize behaviors that attain both these goals.

Value-Based Payment Arrangements

Many are watching the continual evolution of Value-Based Payment (VBP) arrangements where, third-party payers are developing a hybrid payment mechanism for health centers to incentivize these new behaviors:

- Care management payments paid on a per-member-per-month (PMPM) basis to cover the cost and incentivize care coordination activities focused on services provided to a patient, both within and outside the four walls of the health center (e.g. hospitals, specialists, emergency rooms)
- Quality incentive payments (QIP) paid to health centers that improve or maintain selected quality metrics with the objective of improving quality of care
- Shared surplus arrangements allowing health centers to share in any reductions in the total health care spend of its patients thereby incentivizing providers to reduce the total cost of care

In January 2015, Medicare issued a press release with their VBP objectives, including moving 50% of Medicare fee-for-service payments to alternative payment models and tying 80% of traditional Medicare payments to quality and value.

In addition, the Center for Medicare and Medicaid Services (CMS) announced that it will intensify its work with states and private payers to support adoption of alternative payment models, attempting to exceed the goals and timeline set by Medicare. This has become increasingly evident as state after state seeks Delivery System Reform Incentive Payment (DSRIP) program waivers to transform the delivery system, ideally establishing VBP programs. Many commercial payers are already offering VBP demonstrations.

New Grant Funding Methodologies

Government funding agencies have also followed suit. Most grants or contracts received from federal, state and local governments have historically been cost-based – reimbursing health centers for the cost of services provided with no linkage to performance or outcomes. However, funding methodologies are changing and with that, grant award levels could now be impacted by the measured performance of the grantee against certain agreed upon benchmarks. This evolution is already underway in the HRSA Health Center Program.

- Commencing in 2014, HRSA set aside a pool of grant funding for Quality Incentive Awards. It was allocated to health centers that 1) improved quality scores/outcomes, 2) increased access to services to more patients and 3) effectively managed the medical cost per visit. The pool started at $36.3 million in 2014 and was increased to $63.3 million in 2015.
- The Office of Management and Budget's (OMB's) Uniform Guidance (more commonly known as the Super Circular) contained new language concerning performance management. The Uniform Guidance specifically states that recipients of federal grant funds must be required to relate financial data to performance accomplishments.

In addition, federal awarding agencies are required to provide recipients with clear performance goals, indicators and milestones. HRSA has effectively responded to these new requirements in at least two ways:

- Implementation of a "patient target" level for each health center. If a health center does not maintain or hit its individual "patient target," the federal grant funding level could be reduced.
- Requiring grant applications to contain certain performance measures that health centers must address. Goals are established for each performance measure and progress towards meeting the goals must be discussed. The Uniform Data System is also used to track progress towards these goals. The financial performance targets are clearly aligned with cost component of the value equation and include:
  - Total cost per patient
  - Medicaid cost per medical visit
  - Health center grant cost per patient

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Planning for the New Value Proposition

It is clear that both third-party payers and HRSA are increasingly evolving the changing financing system for health center services. This is most noticeable with how they pay health centers to change behaviors to align with the new value proposition – improve quality, reduce cost and increase access.

Financial success in this new world will be increasingly driven by what happens in the exam room. Health centers need to take a multidisciplinary look at planning for success, taking into consideration the following:

- **Clinical staff must be educated on how future funding streams will be impacted by quality and clinical behaviors.**

  Gone are the days of more visits, more revenue. Future revenue streams will be driven by improving and maintaining quality metrics, creation of care teams to address patient-centeredness, having people work at their "top of license," and the development of integrated treatment plans to manage the full spectrum of services across the continuum of care among others.

  These new core drivers of success are best understood by the clinical workforce; as such they need to be well informed on how these and other behaviors will impact financial performance.

- **Health center management needs input from the clinical leadership on the resources required to succeed in these new funding models.**

  To realize the potential of new funding/reimbursement in the "New World," new core competencies, staffing and technology will be required. The health center's clinical staff is best equipped to decide on what these are, and at what levels. What quality measures make sense and are the benchmarks/targets attainable?

  Accordingly, as new payment models and/or contracts are negotiated, the clinical leadership needs to be involved so that a health center does not commit to something that it cannot deliver, or cannot successfully perform financially.

- **Chief Financial Officers (CFOs) must convert these new core requirements to cost and determine how the health center will get paid for these services.**

  Value Based Payment models are introducing new payment methodologies such as care management payments PMPM, quality incentive payments and shared savings. Funding agencies are looking to move funding levels to reward high quality/performing health centers and reduce the funding of low performers.

  The one-to-one correlation of visits to revenue is slowly dissipating. Accordingly, it is up to the CFO to:

  — Verify that new core requirements including services, staff and technology, are recommended by clinical leadership;

  — Develop a cost projection of these new core competencies both from an up-front, one-time as well as on-going, operational perspective; and

  — Given these service and cost projections, negotiate payment arrangements with third-party payers and understand new funding agency initiatives to make sure the health center can sustain positive financial operating performance.

- **Success in these new payment models requires input from a multidisciplinary team (C-suite/Senior Executives).** ◆

Peter R. Epp, CPA, is Partner, Healthcare Industry Practice, at CohnReznick LLP. This article has been prepared for information purposes and general guidance only and does not constitute professional advice. For more information and/or specific professional advice, contact peter.epp@cohnreznick.com or (646)254-7411.