

# VALUE TRANSFORMATION FRAMEWORK

## Action Brief

### DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

Preparing for value-based payment is an essential step in a health center's efforts to enhance the quality of care, improve patient outcomes and equity, contain costs, and adapt to evolving healthcare trends. Defining a value-based care strategy at your health center involves a thoughtful and strategic approach to align your organization's goals and resources with the principles of value-based care. Setting a clear 12-18 month plan is critical in today's changing payment environment. This Action Brief will support your health center in developing a clear set of value-based care goals.

#### STEP 1 UNDERSTAND VALUE-BASED CARE

Before setting value-based care goals, it is important to understand value-based care and related terms.

While there are multiple definitions and terms for value-based care, NACHC's suite of resources uses the following definitions:

- **Value-based care** is the model of care used to deliver services for payments that reward quality, cost, and outcomes.
- **Value-based payment** ties payment for care delivery to quality, cost, and outcomes rather than the volume of services delivered.
- **Accountable care** is a group of providers or organizations that assume responsibility for the quality, cost, and outcomes of a defined patient group.

Through financial incentives and other methods, value-based care programs aim to hold providers accountable for improving patient outcomes while giving them greater flexibility to deliver the right care at the right time.

- Understand the national vocabulary that aligns health care stakeholders in language around the value-based payment journey. This vocabulary, the [Alternative Payment Model \(APM\) Framework](#), was created by the Health Care Payment Learning and Action Network (HCP-LAN) to categorize payment models from payors to provider organizations along a transformation continuum.
- Consider using the [Value Transformation Framework](#) as your organizing framework for health center transformation, with NACHC's suite of free value-based care resources available through the national health center learning community called [Elevate](#). These resources will help you
- Learn about the various VBC models, including accountable care organizations (ACOs), bundled payments, or pay-for-performance models.
- Familiarize yourself with the key components of value-based care, including quality measures, cost reduction, care coordination, patient engagement, and outcomes improvement.

By understanding value-based care and payment, you can analyze your current contracts and set goals for your health center.



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

### STEP 2 ASSESS CURRENT STATE: ANALYSIS OF PATIENT POPULATION, EXISTING CONTRACTS & PERFORMANCE

To assess your organization's readiness for value-based care, evaluate organizational capabilities, infrastructure, and readiness to transition from fee-for-service models to value-based payment arrangements. This Action Brief offers guidance on how to analyze your patient population and current health plan contracts to develop health center specific value-based care goals for the next 12 to 18 months.

#### PATIENT POPULATION ANALYSIS

The aim of conducting a patient population assessment is to provide your health center with information about the major health plans your patients have or are attributed to. Consider this information in relation to your current contracts and potential new contract opportunities. This analysis will inform your health center's value-based care goals. Use your electronic health record, population health platform, or spreadsheet to complete the analysis. Include the following information:

- **Active, unique patients seen in your health center in the last 24 months.** Based on your health center's policies, the timeframe may vary. For value-based payment purposes, identify patients seen in the past 24 months. Ensure the data pulled includes each patient's active health plan type.
- **Health Plan attributed patients.** Patient attribution is how health plans determine the relationship between a patient and their healthcare provider. Attribution is a key aspect of value-based payment models. You will need access to the attribution reports, which should come regularly from your health plan value-based payment arrangements. If you are not receiving attribution reports, you can request this information from the health plan's provider representative.
- **Unique Patient Identifier.** Assign each patient a unique code to identify and manage patient information. Unique patient identifiers reduce the risk of inadvertent patient duplication.
- **Health Plan** (e.g., UnitedHealthcare). Consider working with the finance or billing team to pull this report, as you may need access to billing information.
- **Health Plan Product Identifier.** For each health plan, specify the product type (e.g., Preferred Provider Organization, Medicare Advantage, Medicaid Managed Care, etc.).

Once you have gathered the information outlined above, conduct an analysis to identify the largest and most significant health plans which patients are covered or attributed. Segment the population by product type and plan type, as it will help inform the contract analysis in the next step.

Below is an example of this analysis. As your health center is likely in-network with hundreds of plans, consider a "cut-off point" or threshold of 150 to 200 patients for any given plan to be included in the analysis. Due to variability and statistical reliability, many health plans will only engage in value-based payment arrangements if your patient population is over a certain threshold.

Table 1: Sample Patient Population Analysis – Major Health Plans

Health Plan	Product Type	Active and Attributed Patients
Aetna	Medicaid	5,000
Centene	Medicaid	8,000
Molina	Medicaid	1,100
Medicare	Medicaid	850
Anthem	Commercial	200
Humana	Medicare Advantage	150
UnitedHealthcare	Commercial	75
UnitedHealthcare	Medicare Advantage	30
BlueCross Blue Shield	Commercial	25



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

### CONDUCT A CONTRACT ANALYSIS

Reviewing contracts and available incentives can help a health center prioritize areas of focus and contract opportunities with the greatest financial rewards. The contract analysis aims to understand which fee-for-service and value-based payment contracts bring a large number of patients to your health center and provide the most favorable revenues. It will also help quantify the revenue the health center has not been earning or collecting from value-based care contracts. The analysis will help identify the performance measures that may be good choices to include in your health center's measure set of focus. It also informs decision-making on which health plans would best increase or decrease patient membership. The Contract Analysis helps you:

- **Identify your health center's health plan contracts.** Use the *Patient Population Analysis* to identify the contracts with over 150 patients with that coverage.
- **Categorize health plans.** Group payers into distinct categories based on their types: private insurance, Medicaid, Medicare, self-pay, or other specific programs. This categorization allows for a clearer understanding of the different payer segments within your patient population.
- **Identify health plan contracts with value-based payment models or opportunities.** Consider the contract's value-based payment arrangements. Not all contracts have value-based payment provisions and could be considered an opportunity.

### Create a Health Plan Contract Summary Table

Once you have all contract information available, the next step is to create a Health Plan Contract Summary table. Include the following information:

- **Health Plan Name.** The name of the health plans identified in the *Patient Population Analysis*. Include contracts with only 150 or more patients (or other threshold set by your health center).
- **Product Type or Line of Business.** Examples include Medicaid, Medicare, Medicare Advantage, and Commercial.
- **Active and Attributed patients.** Number of patients covered under the contract using the data from the *Patient Population Analysis*.
- **Contract Type:** A general description of the value-based care terms such as fee for service, pay for performance, etc.
- **HCP-LAN Category.** Indicate where the payment model falls within the [APM Framework](#).
- **Specific Value-Based Payment Terms.** Include columns for specific payment terms in your contracts such as per member per month or care coordination payments, quality incentives such as pay for performance, and any Medical Loss Ratio (MLR) or total cost of care benchmarks.



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

Table 2: Sample Health Plan Contract Summary Table

Health Plan	Product Type	Active and Attributed Patients	Contract Type	HCP-LAN Category	Care Coordination	Quality Incentives	Medical Loan Ratio (MLR)	Other
Aetna	Medicaid	5,000	Pay for Performance	Category 2c	\$1.50 Per Member Per Month (PMPM)	N/A	N/A	\$50 per visit - adult and peds follow-up visits \$25 per visit - post partum visits
Centene	Medicaid	8,000	Pay for Performance and Shared Savings	Category 3a	\$1.00 PM/PM	Yr 1: \$3.00 PMPM Yr 2: \$4.00 PMPM (HEDIS)	85%>- \$1.00 PMPM	N/A
Molina	Medicaid	1,100	Pay for Performance and Shared Savings	Category 3a	\$1.15 PM/PM	\$0.25-\$4.00 PMPM (HEDIS)	82%>- \$2.00 PMPM	visits, ED util. red.
Medicare	Medicare	850	Fee for Service	Category 1				
Anthem	Commerical	200	Shared Savings	Category 3a	\$3.00 PM/PM	Shared Savings program includes variable pay-out based on 5 composite		
Humana	Medicare Advantage	150	Shared Services	Category 3a	None	Shared Savings program includes variable pay-out based on 5 composite		
United Healthcare	Commerical	75	Fee for Service	Category 1				
United Healthcare	Medicare Advantage	30	Fee for Service	Category 1				
Blue Cross Blue Shield	Commerical	25	Fee for Service	Category 1				

### CONDUCT A FINANCIAL AND PAYMENT EVALUATION FOR EACH CONTRACT:

This evaluation would include the following:

- **Potential Value of Contract.** The maximum possible incentives available by each contract's terms.
- **Actual Payout.** Actual Incentive Revenue received for the 12-month period which is the incentive and withhold amounts actually received.
- **Improvement Margin.** The additional revenue that your health center could have earned on the contract for the 12-month period.

Table 3 illustrates an example of a health center contract evaluation. This health center has nine total contracts. Four are LAN Category 1: fee-for-service (not shown), five have value-based payment terms, one is LAN Category 2c, and four are LAN Category 3a. They earned significant incentives at \$172,505, but \$239,650 is currently unearned.



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

Table 3: Sample Contract Financial and Payment Evaluation

Health Plan	Product Type	Active and Attributed Patients	Contract Type	LAN Category	Care Coordination	Quality Incentives	Medical Loan Ratio (MLR)	Other	Actual Payout	Improvement Value	Potential Value
Aetna	Medicaid	5,000	Pay for Performance	Category 2c	\$1.50 PM/PM	N/A	N/A	\$50 per visit - adult and peds follow-up visits \$25 per visit - postpartum visits	\$90,000 PM/PM \$3,000 ER Follow-up Adult Visits \$2,250 ER Follow-up Pediatric Visits \$2,500 ER Follow-up Postpartum Visits	\$17,000 Adult ER Follow-up Visits \$12,750 Pediatric ER Follow-up Visits \$10,000 Postpartum Visits	
									\$95,725	\$39,750	\$135,475
Centene	Medicaid	8,000	Pay for Performance and Shared Savings	Category 3a	\$1.00 PM/PM	Yr 1: \$3.00 PMPM Yr 2: \$4.00 PMPM (HEDIS)	85%>- \$1.00 PMPM	50% of PMPM returned if patient visit does not occur in performance period	\$48,000 PM/PM	\$48,000 PM/PM \$96,000 MLR	
									\$48,000	\$144,000	\$192,000
Molina	Medicaid	1,100	Pay for Performance and Shared Savings	Category 3a	\$1.15 PM/PM	\$0.25-\$4.00 PMPM (HEDIS)	83%>- \$1.00 PMPM 82%>- \$2.00 PMPM	\$50 - Hospital Admission follow-up \$25 postpartum visits	\$15,180 PM/PM \$10,000 HEIDES	\$2,200 MLR \$25,000 HEDIS	
									\$25,180	\$27,200	\$52,380
Anthem	Commerical	200	Shared Savings	Category 3a	\$1.00 PM/PM	Shared Savings program includes variable pay-out based on 5 composite comprising cost, quality and utilization metrics.				\$13,500 Shared Savings	
									\$3,600	\$13,500	\$17,100
Humana	Medicare Advantage	150	Shared Services	Category 3a	None	Shared Savings program includes 20% payout based on year 1 based on meeting total cost of care benchmark and performance on 10 measures comprising of quality and utilization metrics.			\$0	\$15,200 Shared Savings	
									\$0	\$15,200	\$15,200
									<b>Total Payment</b>	<b>Improvement Value</b>	<b>Potential Value</b>
									<b>\$172,505</b>	<b>\$239,650</b>	<b>\$412,155</b>

Conduct further analysis to uncover value-based payment opportunities. To uncover value-based payment opportunities, Table 4 illustrates an example of a health center with several LAN Category 1a fee-for-service contracts that bear a significant patient population that could warrant a value-based payment contract.

Table 4: Sample Contract Evaluation for Value-Based Payment Potential

Health Plan	Product Type	Active and Attributed Patients	Contract Type	LAN Category
Medicare	Medicaid	850	fee-for-service	Category 1
UnitedHealthcare	Commercial	375	fee-for-service	Category 1
UnitedHealthcare	Medicare Advantage	30	fee-for-service	Category 1
BlueCross Blue Shield	Commercial	25	fee-for-service	Category 1



### STEP 3 PLAN 12-18 MONTH VALUE-BASED CARE GOALS

#### IDENTIFY PRIORITIES AND SET CLEAR OBJECTIVES

The purpose of this step is to determine priorities and learn which health center areas require the most attention and resources to succeed with payment contracts.

Use the results of the *Contract Analysis* to take the following action steps:

- 1. Increase patient attribution.** Determine which contracts are most favorable for your goals related to growth. Not all contracts will be ideal for this, so consider carefully. For managed Medicaid, there is often an administrative attribution process where the health plan can reassign patients who do not have an established primary care provider. Your health center can request to have more patients assigned to your health center through your health plan provider representative.
- 2. Maintain terms at the same level.** Determine which current contracts have satisfactory terms. It is important not only for goal setting but for future conversations with health plans.
- 3. Improve contract terms or replace health plans when possible.** There may be some contract terms your health center wants to improve due to the limited financial upsides or to reduce the administrative burden that is required to implement. Also, you may have current fee-for-service agreements that you would like to move towards pay for performance or shared savings. Identify contracts where you would like to improve the current value-based payment terms and those where you would like to enter into a value-based agreement.

For the health plans you select to increase or maintain patients, identify individual contracts for practice improvement efforts, and prioritize them. Consider the following:

- The patient populations and their prevalence in your health center.
- Whether the target measure or value-based payment model is present in multiple contracts.
- Whether target improvement measure(s) should be in your internal measure set.
- The incentive amount and the difficulty of improvement with associated workflow updates.

Some common priorities for health centers include improving patient access and engagement, adopting care management, reducing hospital readmissions, and increasing preventive care. These objectives should align with your health center's overarching vision and mission and where you desire to go on your value-based care journey in the next 12 to 18 months.

#### ESTABLISH KEY PERFORMANCE METRICS AND GOALS

Defining a value-based care strategy requires outlining key performance metrics that align with your value-based care goals. Consider process measures (e.g., preventive screenings, care coordination) and outcome measures (e.g., patient outcomes, readmission rates). Ensure your objectives are specific, measurable, achievable, relevant, and time-bound (SMART).



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

Based on the sample *Contract Analysis* in this Action Brief, below are examples of goals a health center could implement to improve performance on current contracts and expand where opportunity exists. Sample goals can include:

### Value-based Contracting

- Increase the percentage of earned value-based care incentive contracts by 30% in 2025.
- Increase access to health plan data from one Medicaid-managed care organization to three by the end of the 2024 calendar year.
- Identify and join a Medicare Accountable Care Organization for the 2025 performance year.

### Patient Engagement

- Increase primary care visits for attributed patients from 50% to 70% in 18 months.
- Increase Medicare Annual Wellness visits from 20% to 35% in 8 months.

### Care Management

- Design and implement a care management program for high-risk patients in 12 months.
- Increase the percentage of high-risk patients from 50% to 65% with completed care plans.
- Increase adult and pediatric follow-up visits following an emergency room visit from 8% to 20% in 12 months.

## STEP 4 DEVELOP STRATEGY AND IMPLEMENT ACTION PLAN(S)

Developing your health center's value-based payment goals should be part of the organization's overall [Improvement Strategy](#). Create an Improvement Strategy with a clearly defined vision, goals, and action steps that drive transformation and improved performance.

Once you have set your SMART goals, the next step is to develop strategies and action plans to achieve them. It involves identifying the necessary resources and tools, assigning responsibilities, and setting timelines. For example, suppose your health center's goal is to design and implement a care management program. In this example, you will need to develop a care management team, determine how to identify high-risk patients who need care management services and track and monitor progress. Use evidence-based practices, research findings, and expert recommendations as you develop your strategy. [Register](#) for NACHC's Elevate learning forum to join a national community of peers engaged in transformation and access the free suite of care management and value-based care resources. To ensure diverse perspectives and expertise, involve multidisciplinary teams in strategic planning and transformation efforts.

Each goal will require an action plan. As you develop your strategy, make sure to consider the following steps:

- Create a detailed plan with specific action steps for each strategy.
- Assign responsibilities to individuals or teams to ensure accountability.
- Include staff from across the organization, including those most impacted by the change
- Develop a timeline and milestones for implementation.
- Allocate necessary resources, including personnel, technology, and training.



## DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

### STEP 5 CONTINUOUS MONITORING AND IMPROVEMENT

Continuously monitor and evaluate the performance of your value-based care goals. Use the [Value Transformation Framework's \(VTF\) Assessment Tool](#) to assess organizational progress in 15 Change Areas for transformation. Regularly assess the impact of your interventions, measure progress against established metrics, and solicit feedback from patients, care teams, and providers. Use this information to identify areas for improvement, make necessary adjustments to your strategy, and drive continuous learning and innovation.

#### Resources:

Below you'll find resources to help your health center understand the basics of value-based care, payment arrangements, and care delivery models:

- [HITEQ Value-based Care Basics Module 1](#): Reviews the spectrum of value-based payment arrangements, using the APM Framework as a guide, and outlines capacity needed to be successful in each of those payment categories.
- [HITEQ Center Managed Care Glossary for Health Centers](#): Provides key definitions of value-based care from a health center perspective.
- [The Commonwealth Fund: Value-based Care: What It Is, and Why It's Needed](#): Provides a general overview of value-based care and trends that support adoption.
- [Center for Healthcare Strategy: How Health Centers Can Improve Patient Care Through Value-based Payment Models](#): Reviews health center specific models, considerations, and approaches to value-based care.
- Modica, Cheryl. [The Value Transformation Framework: An Approach to Value-Based Care in Federally Qualified Health Centers](#). *Journal for Healthcare Quality* 42(2):p 106-112, March/April 2020. Reviews how the Value Transformation Framework can provide an organizing framework to guide health center systems change and value transformation.
- [What is Value-based Healthcare?](#) NEJM Catalyst. January 1, 2017. Explores the definition, benefits, and examples of value-based healthcare.

*NACHC would like to acknowledge the contributions of HRC Healthcare Advisors to the development of this document.*

*This Action Guide was developed with support from the Centers for Disease Control and Prevention (CDC) cooperative agreement #NU38OT000310. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, the CDC or the U.S. Government.*