NATIONAL ASSOCIATION OF Community Health Centers®

INTRODUCTION TO VALUE-BASED PAYMENT

elevate

Recorded Module (10 Minutes)

June 2024

Value-Based Payment: Introduction Module

Learning Objectives:

- ***WHY* value-based care?** Demonstrate how value-based care builds upon the foundation of the health center history, mission, and models of care.
- ***WHAT* is the difference between value-based care and value-based payment?** Introduce terms, definitions, and the current landscape of alternative payment models
- ***HOW* to get started with value-based payment?** Outline FQHC Medicare value-based payment opportunities

Tools & Resources:
COMING SOON…Business Case for Value-Based Payment

Staying True to Our Roots and Advancing the Future of Healthcare

Healthcare System:
What's Broken

- **Sick care focus:**
  Not focused on prevention, social drivers of health, or primary care
- **Health disparities:**
  1 in 3 Americans <200% Federal Poverty Line
- **Workforce challenges:**
  Provider shortages, recruitment and retention challenges
- **Pace of change:**
  Innovation, technology, alternative payment models

Health Center Roots:
What's Working

- **Health & wellness focus:**
  Focused on prevention, social drivers of health, community, and primary care
- **Access for those in need:**
  Care for 1 in 5 uninsured; 1 in 3 people in poverty
- **Expanded workforce:**
  Expanded care teams, community health workers, integrated models
- **Innovative & resourceful:**
  Important and influential part of the healthcare system

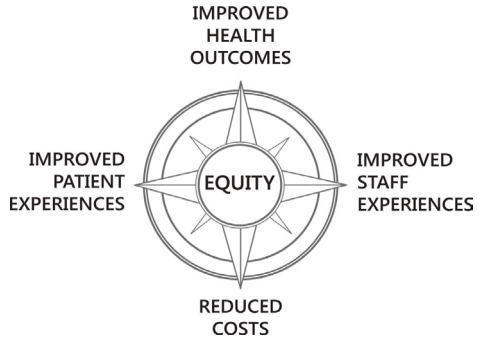
NACHC:
Advancing Change

Value Transformation Framework
VTF guides health center systems change and value transformation

Health Center Future:
Where We're Going

Building upon the foundation of our health center roots and leveraging the VTF to advance Quintuple Aim goals and become:

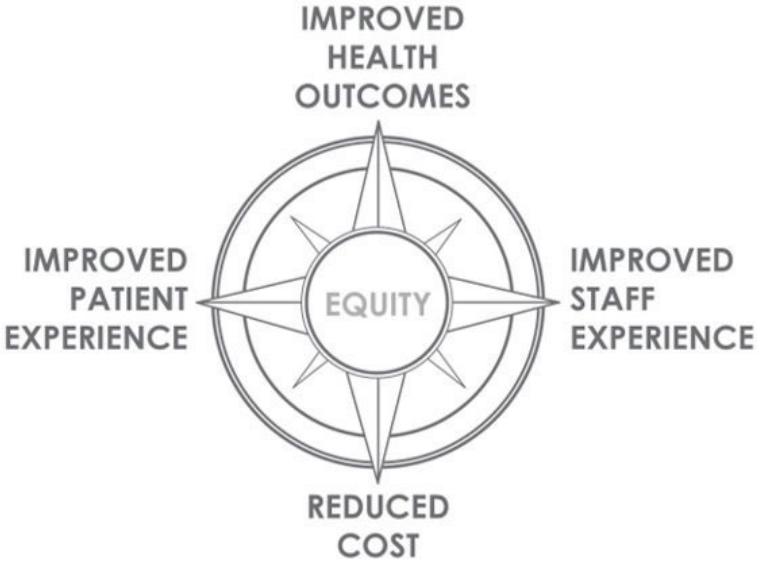
- **Provider of Choice**
- **Partner of Choice**
- **Employer of Choice**



WHAT is Value-Based Care? Value-Based Payment?

Value-Based Care (VBC) is the **model of care** used to deliver services that promote the Quintuple Aim goals.

Value-Based Payment (VBP) ties **payment for care delivery** to quality, cost, and outcomes rather than the volume of services.



Quintuple Aim

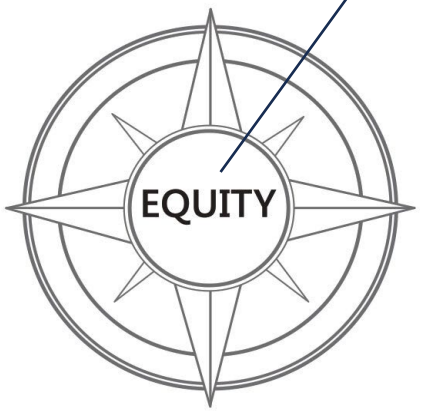
WHY is Value-Based *CARE* Important to Health Centers?

By way of health center history, mission, and model, health centers deliver value-based care:

Emphasizing preventive measures, chronic disease management, and overall health improvement.

Addressing social drivers of health, such as housing, nutrition, and education, which significantly impact health outcomes.

Identifying and following up on disparities in care.



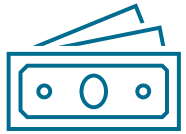
Prioritizing patient-centered approaches leading to better patient engagement, adherence, and overall trust in the healthcare system.

Engaging expanded care teams, community health workers, and integrated models.

Reducing unnecessary medical services and readmissions.

WHY is Value-Based *PAYMENT* Important to Health Centers?

Payers are moving towards rewarding and paying for "value" or patient outcomes.



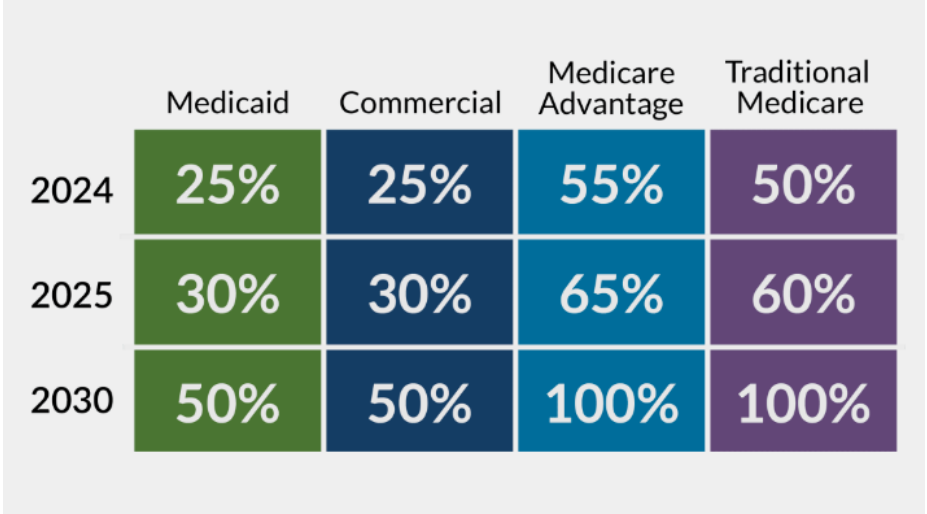
The landscape is changing with financial rewards tied to high-quality care rather than volume of services delivered.

Non-health center competitors entering the market and trying to imitate the health center model – getting patients and payments that would otherwise go to health centers.

Value-based payment models can provide flexibility and resources to empower health centers to implement innovative, team-based, person-centered, and proactive approaches to care.

WHY Value-Based Payment? Why Now?

- **Medicare:** The Centers for Medicare and Medicaid Services (CMS) aims to have all Medicare beneficiaries and most Medicaid beneficiaries enrolled in accountable care organizations (ACOs) by 2030. The agency is committed to promoting health equity through its value-based initiatives.
- **Medicaid:** CMS aims to have half of all Medicaid beneficiaries enrolled in ACOs by 2030. State Medicaid agencies are requiring providers to engage in value-based programs.
- **HCPLAN**: seeks to accelerate adoption of alternative payment models (APMs) and advancement of accountable care.



	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

HCPLAN APM Goals

Accountable care organization – group of providers or organizations that assume responsibility for quality, cost, and outcomes for a defined group of patients.

Alternative payment models – payer approach that links payment to quality, cost, and outcomes.

WHAT are VBC Payment Models?

HCPLAN
Health Care Payment Learning & Action Network

Developed the Alternative Payment Model (APM) Framework for classifying APMs establishing a common vocabulary for categorizing payment models.

Category 1

Fee for Service

No Link to Quality or Value

Category 2

Fee for Service
Link to Quality or Value

A: Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments; Making Care Primary Track 1)

B: Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting; Z code documentation)

C: Pay for Performance (e.g., bonuses for quality performance; HRSA QI Awards)

Category 3

APMs Built on Fee for Service

A: APMs with Shared Savings (e.g., shared savings with upside risk only; Medicare Shared Savings AIP)

B: APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk; MSSP BASIC C and Above)

3N: Risk-based payments NOT linked to quality

Category 4

Population Based Payment

A: Condition-Specific Population-Based Payment (PSEP) (e.g., per member per month payments, payments for specialty services, such as oncology or mental health; ACO REACH with primary care capitation)

B: Comprehensive Population Based Payment (e.g., global budgets or full/percent of premium payments)

C: Integrated Finance & Delivery Systems (PSEP) (e.g., global budgets or full/percent of premium payments in integrated systems)

4N: Capitated payments NOT linked to quality **Oregon's APCM**

WHAT are FQHC Medicare VBP Opportunities?

Summary Table:

	Medicare Shared Savings Programs (MSSP)			CMS Innovation Center Programs+	
Model	**MSSP**	**MSSP-AIP**	**ACO Primary Care Flex+**	**Making Care Primary+**	**ACO REACH+**
Description	Groups of providers coming together as an accountable care organization (ACO) to deliver care	MSSP ACOs in rural and underserved areas receive additional resources and savings	MSSP FQHC-inclusive option with prospective, population-based payments to increase flexibility in primary care delivery	FQHC inclusive pilot program in 8 states with three progressive transformation tracks	Pilot ACO (closed to new entrants) focused on health equity for primary care practices experienced in value-based care
LAN APM Category	3A-3B	3A-3B	3A-4A	2A-4A	4

See next slide for details on each program

Summary: FQHC Medicare VBP Opportunities

	Medicare Shared Savings Program (MSSP)	MSSP Advance Infrastructure Payment (MSSP-AIP)	ACO Primary Care Flex	Making Care Primary (MCP)	ACO REACH
Description	Groups of doctors, hospitals, and other health care providers come together as an accountable care organization (ACO) to deliver care. ACOs meeting specific quality standards and achieving savings by spending less than targets evenly split the amount of savings with Medicare.	MSSP ACOs in rural or underserved areas receive an upfront infrastructure payment, and eight quarterly risk-factor based per beneficiary payments. ACOs meeting specific quality standards and achieving savings by spending less than targets evenly split the amount of savings with Medicare.	MSSP FQHC-inclusive option with prospective, population-based payments to increase flexibility in primary care delivery.	Multi-state primary care initiative that introduces an innovative payment structure to financially support the role of primary care while improving patient outcomes and ensuring equitable healthcare delivery.	Realizing Equity, Access, and Community Health (ACO REACH) focuses on promoting health equity and addressing healthcare disparities for underserved communities.
Benefits	• Most established Medicare VBC program • Centers for Medicare & Medicaid Services (CMS) is using the program as a "chassis" to develop and test new ACO models • Options to remain in one-sided risk arrangements longer	• Provides upfront investment with no downside financial risk. • Entry point for health centers seeking to broaden value-based care experience with infrastructure support. • Funds can be used to impact health-related social needs	• FQHC inclusive • Flexible payment design will empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered and proactive approaches to care.	• FQHC inclusive • Three progressive tracks each focusing on different aspects of care transformation and payment arrangements • Payment supports pathway to value-based care adoption	• Heightened focus on health equity • Various payment arrangements to support value-based care • Option for primary care further along in VBC maturity to expand experience
Challenges	• Managing total cost of care including specialty and inpatient costs is key to generating shared savings • Expected to eventually take on downside risk • Requires retooling of workflow and care models for greatest impact	• Only available for new or low-revenue ACOs. • Five-year agreement period is required	• Single entry point: 2025-2029 • Limited to 130 ACOs • Payment methodology guidance is limited at this time • Switching to primary care capitation may be for more advanced ACOs	• Single entry point • Limited to 8 states: CO, MA, MN, NM, NC, NJ, NY, WA) • Unclear how it will impact state PPS policy	• Pilot program. FQHCs can still join but closed to other new ACO entrants • For primary care practices experienced in value-based care delivery
LAN APM Category	Category 3A – 3B	Category 3A-3B	Category 3A – 4A	Category 2A-4A	Category 4

Framework to Support FQHC's VBC Journey

Just as there is a national framework aligning health care stakeholders around ***value-based payment models:***

HCPLAN Alternative Payment Model (APM) Framework

There is a framework to organize health center performance improvement and ***value-based care progress***:

Value Transformation Framework (VTF)

Value Transformation Framework

Elevate: Supporting FQHC Performance & VBC

Value Transformation Framework

- ✓ Supports systems change
- ✓ Organizes and distills evidence-based interventions
- ✓ Incorporates evidence, knowledge, tools and resources
- ✓ Links health center performance to the Quintuple Aim

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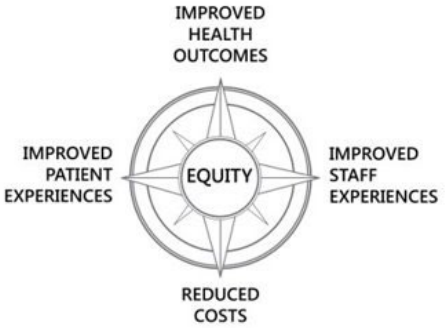
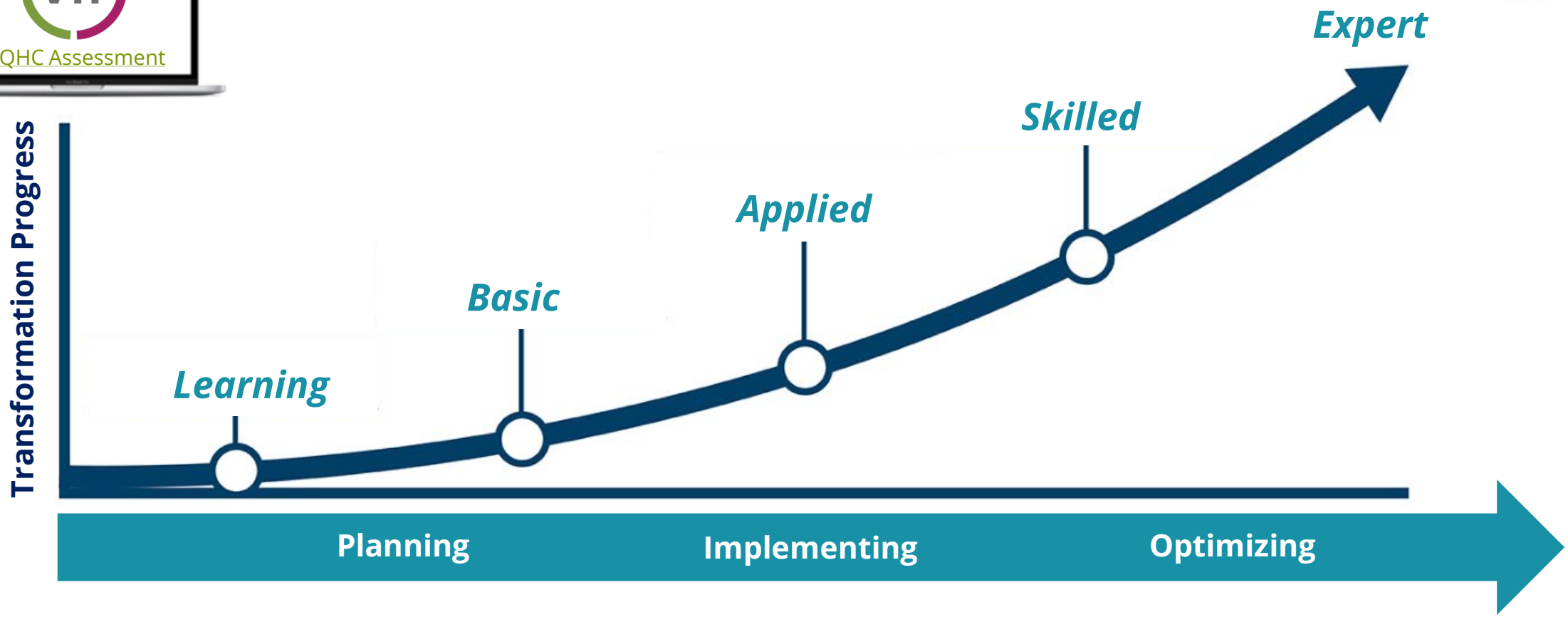
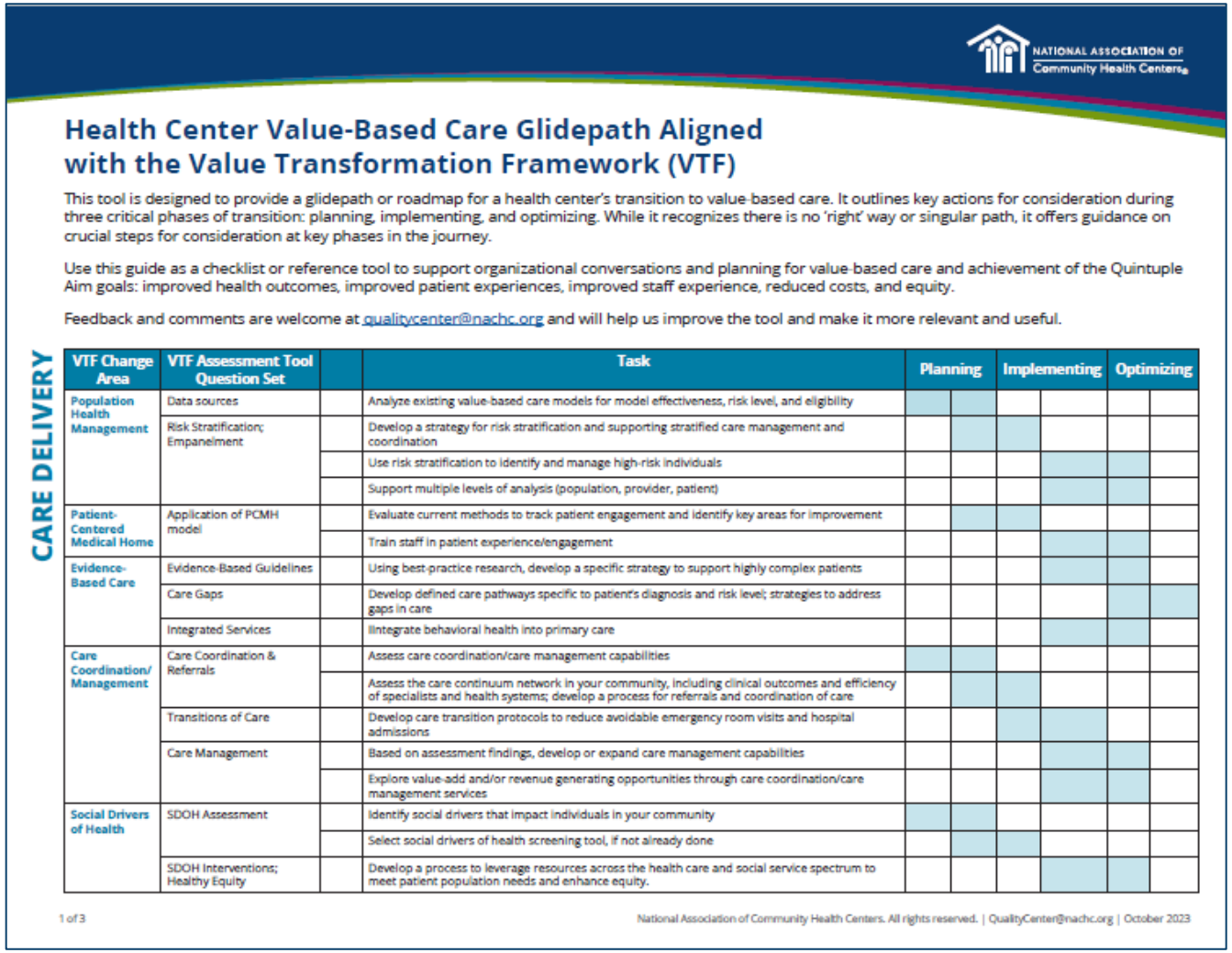
VTF Assessment Helps Focus Change Efforts





NACHC Tool: FQHC VBC Glidepath



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Health Center Value-Based Care Glidepath Aligned with the Value Transformation Framework (VTF)

This tool is designed to provide a glidepath or roadmap for a health center's transition to value-based care. It outlines key actions for consideration during three critical phases of transition: planning, implementing, and optimizing. While it recognizes there is no 'right' way or singular path, it offers guidance on crucial steps for consideration at key phases in the journey.

Use this guide as a checklist or reference tool to support organizational conversations and planning for value-based care and achievement of the Quintuple Aim goals: improved health outcomes, improved patient experiences, improved staff experience, reduced costs, and equity.

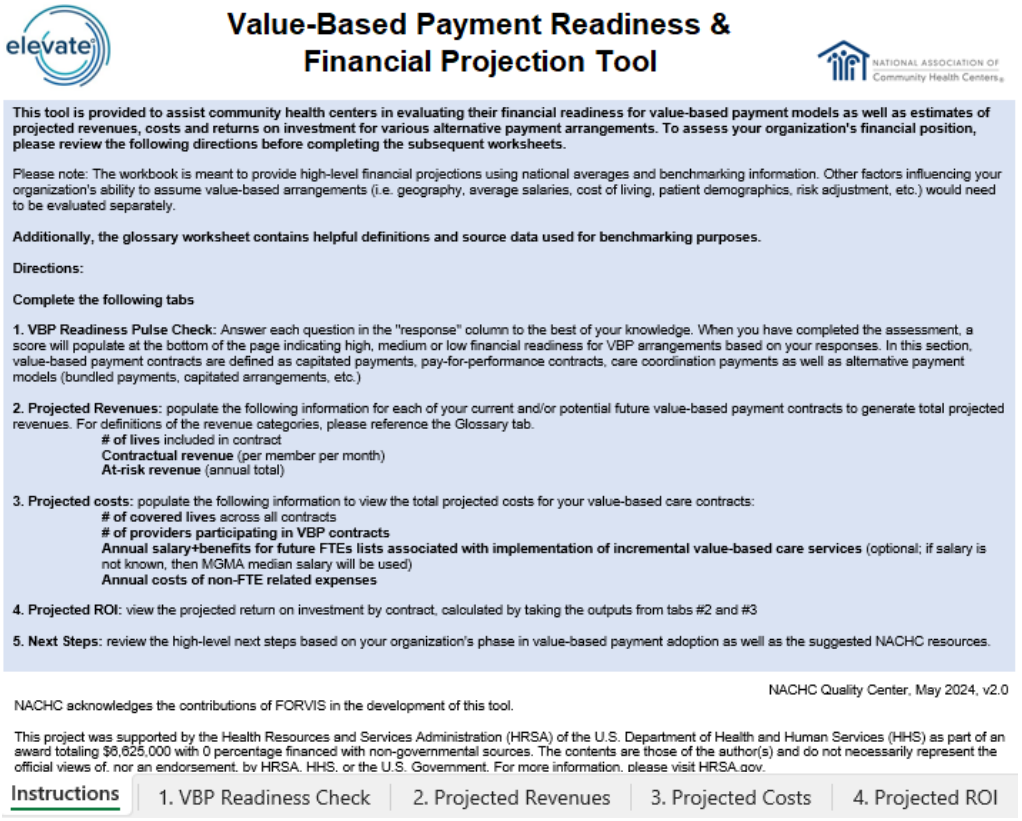
Feedback and comments are welcome at qualitycenter@nachc.org and will help us improve the tool and make it more relevant and useful.

CARE DELIVERY

VTF Change Area	VTF Assessment Tool Question Set		Task	Planning		Implementing		Optimizing	
Population Health Management	Data sources		Analyze existing value-based care models for model effectiveness, risk level, and eligibility						
	Risk Stratification; Empanelment		Develop a strategy for risk stratification and supporting stratified care management and coordination						
			Use risk stratification to identify and manage high-risk individuals						
			Support multiple levels of analysis (population, provider, patient)						
Patient-Centered Medical Home	Application of PCMH model		Evaluate current methods to track patient engagement and identify key areas for improvement						
			Train staff in patient experience/engagement						
Evidence-Based Care	Evidence-Based Guidelines		Using best-practice research, develop a specific strategy to support highly complex patients						
	Care Gaps		Develop defined care pathways specific to patient's diagnosis and risk level; strategies to address gaps in care						
	Integrated Services		Integrate behavioral health into primary care						
Care Coordination/ Management	Care Coordination & Referrals		Assess care coordination/care management capabilities						
			Assess the care continuum network in your community, including clinical outcomes and efficiency of specialists and health systems; develop a process for referrals and coordination of care						
	Transitions of Care		Develop care transition protocols to reduce avoidable emergency room visits and hospital admissions						
	Care Management		Based on assessment findings, develop or expand care management capabilities						
			Explore value-add and/or revenue generating opportunities through care coordination/care management services						
Social Drivers of Health	SDOH Assessment		Identify social drivers that impact individuals in your community						
			Select social drivers of health screening tool, if not already done						
	SDOH Interventions; Healthy Equity		Develop a process to leverage resources across the health care and social service spectrum to meet patient population needs and enhance equity.						

VBC Glidepath: A tool to help glide health center systems improvement and value-based care progression.

NACHC: Value-Based Payment Resources



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Value-Based Payment Readiness & Financial Projection Tool

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This tool is provided to assist community health centers in evaluating their financial readiness for value-based payment models as well as estimates of projected revenues, costs and returns on investment for various alternative payment arrangements. To assess your organization's financial position, please review the following directions before completing the subsequent worksheets.

Please note: The workbook is meant to provide high-level financial projections using national averages and benchmarking information. Other factors influencing your organization's ability to assume value-based arrangements (i.e. geography, average salaries, cost of living, patient demographics, risk adjustment, etc.) would need to be evaluated separately.

Additionally, the glossary worksheet contains helpful definitions and source data used for benchmarking purposes.

Directions:

Complete the following tabs

1. VBP Readiness Pulse Check: Answer each question in the "response" column to the best of your knowledge. When you have completed the assessment, a score will populate at the bottom of the page indicating high, medium or low financial readiness for VBP arrangements based on your responses. In this section, value-based payment contracts are defined as capitated payments, pay-for-performance contracts, care coordination payments as well as alternative payment models (bundled payments, capitated arrangements, etc.)

2. Projected Revenues: populate the following information for each of your current and/or potential future value-based payment contracts to generate total projected revenues. For definitions of the revenue categories, please reference the Glossary tab.
- **# of lives** included in contract
- **Contractual revenue** (per member per month)
- **At-risk revenue** (annual total)

3. Projected costs: populate the following information to view the total projected costs for your value-based care contracts:
- **# of covered lives** across all contracts
- **# of providers participating in VBP contracts**
- **Annual salary+benefits for future FTEs lists associated with implementation of incremental value-based care services** (optional; if salary is not known, then MGMA median salary will be used)
- **Annual costs of non-FTE related expenses**

4. Projected ROI: view the projected return on investment by contract, calculated by taking the outputs from tabs #2 and #3

5. Next Steps: review the high-level next steps based on your organization's phase in value-based payment adoption as well as the suggested NACHC resources.

NACHC Quality Center, May 2024, v2.0

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Instructions | 1. VBP Readiness Check | 2. Projected Revenues | 3. Projected Costs | 4. Projected ROI

Value-Based Payment Readiness & Financial Project Tool *(Coming Soon!)*

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VALUE TRANSFORMATION FRAMEWORK
Action Brief

DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE

ATTRIBUTION

WHAT
is Attribution?

Attribution or 'assignment' is the process that payors use to assign patients to a provider for purposes of tracking accountability for quality, patient experience, and total cost of care. Attribution defines the population for which a provider, accountable care organization (ACO), or Clinically Integrated Network (CIN) is held accountable. It is a foundational component of population health management under value-based payment (VBP) models. Attribution differs from empanelment, which is the internal process used by health centers to match all patients with a primary care provider and care team, regardless of payor.

There are three primary approaches to attribution:

1. **Prospective Attribution.** Patient assignments are determined for the upcoming performance year (PY) based on claims data from a defined look-back period.
2. **Retrospective (Performance Year) Attribution.** Patient assignments are determined based on care and services provided in the completed performance period.
3. **Hybrid (Concurrent) Attribution.** Patient assignments are determined for the upcoming performance period using historic care and services provided with continuous adjustments based on care delivery patterns.

In addition to the primary attribution methods noted above, other attribution methods exist, including auto-assignment, patient selection, and consideration of prescription data. It's important for health centers to understand the attribution methodology, whether it's the methods above or a combination of approaches. While there are numerous methods to understand, **patient self-reporting, declaration, or confirmation that the primary care provider to whom they have been attributed is their primary care provider is the gold standard for attribution** (HCPLAN, 2016).

WHY
is Attribution Important?

With the growth and spread of VBP models, health centers must understand the operational, financial, and actuarial (i.e., assessing financial and insurance risk) implications of attribution. Attribution is foundational to value-based payment arrangements and therefore critical for health centers to understand and manage. Patient attribution allows practitioners and care teams to identify the patients for which they are accountable by the payor. Attribution does not change how patients access or receive care but creates accountability within a provider group to coordinate a patient's overall care needs (HCPLAN, 2016). Under VBP arrangements, the health center can receive financial rewards for keeping patients healthy and out of the hospital. This may include current health center patients and patients assigned to the practice and in need of primary care services for preventive and chronic care needs. Health centers must assess their operations and ability to outreach to patients with whom they have yet to develop a relationship with but to which the health center is being held accountable to a payor.

PAYOR DATA

WHY
is Payor Data Important?

Appropriate and timely patient data is a key factor to effective population health management and performance in value-based payment models. Health insurance plans ('Payors') often have access to patient health information that health centers may not, since payors receive claims (request for payment for services rendered) submitted by various health care providers including hospitals, emergency departments, urgent care centers, clinicians, and others. Health center access to payor data offers a view into the care and services patients may be receiving outside the health center. Providers can better understand changes in health status they may not have been informed of, where care is being received, utilization patterns, and in some instances, the cost of the care provided. Given the complex nature of health center populations, having a broader perspective on what is happening outside the clinic walls can be invaluable. While data from payors is often delayed (due to the time it takes to be processed before it can be shared) and often does not include robust social drivers of health information, it is still an essential data source for health centers engaged in value-based payment models. Payor data can be integrated with the data a health center has within the electronic health record (EHR) and population health management systems.

As health centers advance through their value-based care and payment journey, and take on increasing accountability for their patient populations (see LAN Framework that offers a national vocabulary for categorizing payment models), it becomes essential for health centers to understand how payor data can be leveraged, how payor data is received by the health center (and at what frequency), and the health information technology (HIT) infrastructure necessary to integrate and transform payor data into actionable population health management solutions.

WHAT
Data Do Health Centers Receive from Payors, and What Does It Look Like?

The volume of data and the specific values/metrics that a health center receives from a payor will depend on the type of value-based arrangements in which the health center is participating. In pay-for-performance, or quality arrangements, payors may share less data than a shared savings arrangement that looks at total cost of care for a population.

As health centers advance along the continuum of accountability (e.g., progress along the LAN continuum), payors will share additional data. Once health centers enter into LAN Category 3A and above, payors will share more than quality measure/gaps in care reports with providers. This additional payor data may include information on a

Suite of Value-Based Payment Action Briefs

Developing VBP Goals, Attribution, Attribution Thresholds, Payor Data

If you have questions or comments about this module, please contact the NACHC Quality Center at qualitycenter@nachc.org.

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