NATIONAL ASSOCIATION OF Community Health Centers®

# HEALTH CENTER VALUE-BASED PAYMENT FINANCIAL PROJECTION TOOL

elevate

**Supplemental Session #1**
June 25, 2024

# THE NACHC MISSION

## America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.


NATIONAL ASSOCIATION OF Community Health Centers®

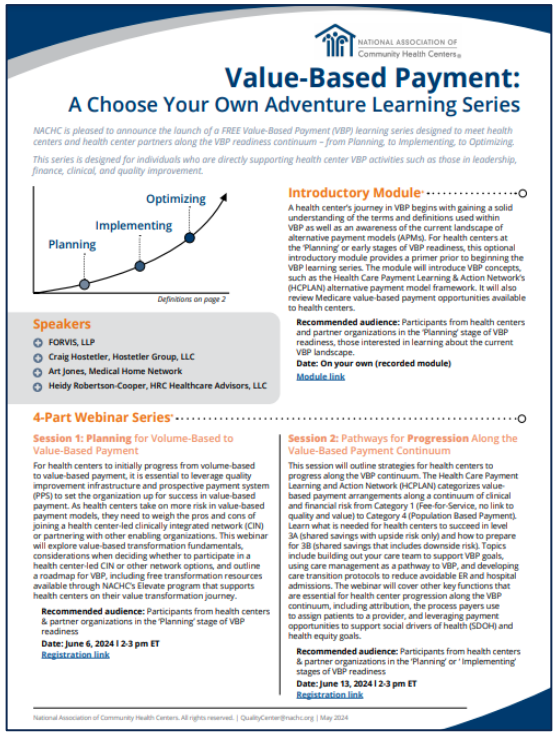
# NACHC Speakers

**Cheryl Modica, PhD, MPH, BSN**
Director, Transformation & Innovation

**Gervean Williams**
Director, Finance Training & Technical Assistance

# NACHC's Value-Based Payment Learning Series


Link to recorded module (10 mins)




6/27

**Session 1: Planning for Volume-Based to Value-Based Payment**

**Session 2: Pathways for Progressing Along the VBP Continuum**

**Session 3: Implementing High-Quality Primary Care within VBP Models**

**Session 4: Optimizing VBP Strategies while Mitigating Financial Risk**

Registration Link: 4-Part Series

## *Supplemental Sessions!*

7/25

1. **FQHC VBP Financial Projection Tool**
2. **Total Cost of Care**

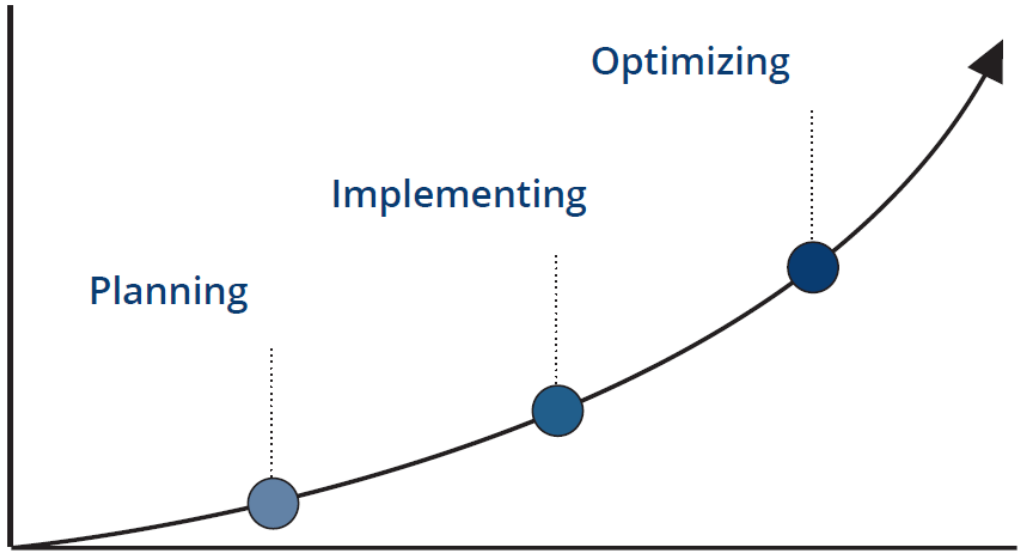
Registration Link: Supplemental Sessions

# Value-Based Payment Readiness

**Planning:** Health centers in the *Planning* stage are aware of the importance of value-based care and working to increase knowledge in this area and prepare for value-based payment arrangements. Reliant on prospective payment system (PPS) with little or no participation in pay-for-performance (LAN2).

**Implementing:** Health centers in the *Implementing* stage are reliant on PPS payments though may participate in one or more alternative payment models, such as pay for performance (LAN 2) or an upside shared savings model (LAN 3a). Developing capability and legal structures to allow clinical and financial integration with external partners. Exploring or moving toward risk arrangements.

**Optimizing**: Health centers in the *Optimizing* stage are in upside and downside risk arrangements (LAN 3a-4). Includes strategies to transform care and services and working to deliver on the Quintuple Aim and value-based care metrics important to payers.



# Value-Based Payment Financial Projection Tool

**Learning Objectives:**

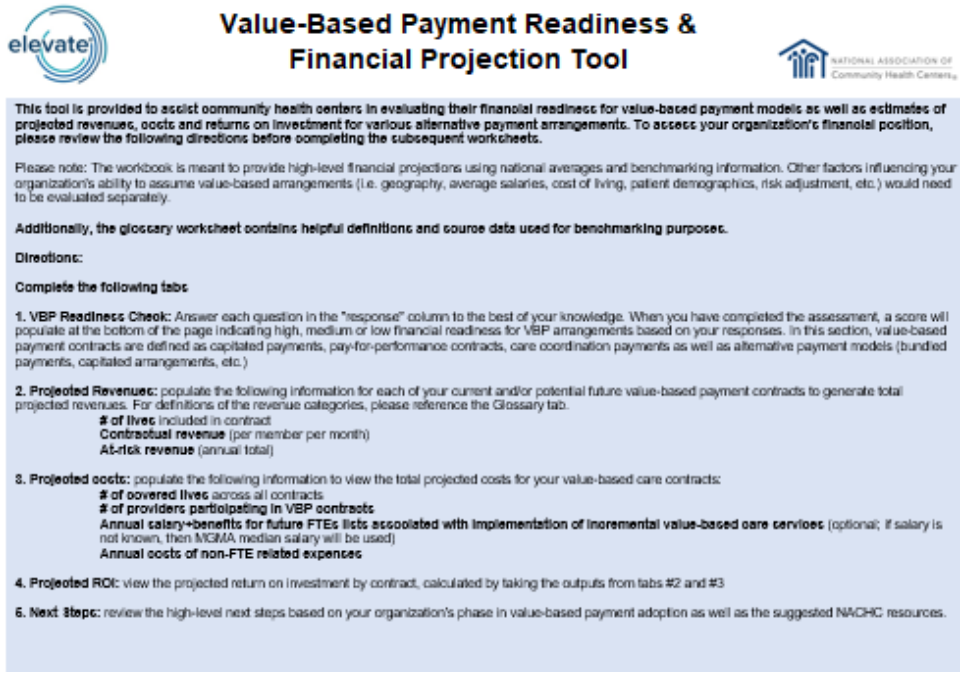
- ✓ Showcase a health center tool designed to assess current financial position relative to, or within, value-based payment contracts and assess a health center's risk tolerance.

**Q&A**

# Value-Based Payment Financial Projection Tool

Tool is created as an Excel spreadsheet with pre-populated formulas designed to generate projections.

- **Instructions**
- **VBP Readiness Check**
- **Projected Revenues**
- **Projected Costs**
- **Projected Return on Investment (ROI)**
- **Next Steps**
- **Glossary**



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**Value-Based Payment Readiness & Financial Projection Tool**

NATIONAL ASSOCIATION OF Community Health Centers

**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 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.

Access the VBP Financial Projection Tool within the VBP Series eModule

# Featured Speakers

**Brandon Hill, Managing Director**

*Brandon has over 10 years of healthcare industry experience, with expertise in Accountable Care Organization (ACO) development and population health/contract advisory. He has worked with numerous clients in helping to determine opportunity within value-based contracts, as well as many considering entry into population health-based models. Brandon also has extensive provider experience in strategic planning (for hospitals, as well as individual service lines and ambulatory planning), physician/provider alignment strategies and financial analytics.*

**Lauren Naumcheff, Senior Consultant**

*Lauren has served in the Forvis Mazars healthcare practice for over five years. During her tenure, she has focused on supporting clients in furthering their value-based care initiatives through participating in alternative payment models, improving care coordination and conducting strategic planning assessments. Lauren has experience working with a wide variety of clients including academic medical centers, community hospitals, community health centers, large health systems, physician practices and post-acute providers.*

# National Association of Community Health Centers
# Value-Based Payment Readiness & Financial Projection Tool

June 25, 2024

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# Forvis Mazars

## Overview

With a legacy spanning more than 100 years, Forvis Mazars is committed to providing a different perspective and an unmatched client experience that feels right, personal and natural. We respect and reflect the range of perspectives, knowledge and local understanding of our people and clients. We take the time to listen to deliver consistent audit and assurance, tax, advisory and consulting services worldwide.

We nurture a deep understanding of our clients' industries, delivering greater insight, deeper specialization and tailored solutions through people who listen to understand, are responsive and consult with purpose to deliver value.

## Global Industry & Services

Forvis Mazars' deep understanding of industry-specific environments, issues and trends helps us anticipate and address evolving needs to prepare you for strategic opportunities ahead.

Every industry is different, and we put a strong focus on specific industry experience and knowledge of your complex and evolving environment. We provide a range of audit and assurance, tax, advisory and consulting services to help your business by bringing together experienced professionals from all over the globe who understand local contexts and cultures.

### We serve global industries including:

- Financial Services
- Manufacturing & Distribution
- Technology, Media & Telecommunications
- Life Sciences
- Private Equity

**$5B**
Combined Revenue (2023)

**100+**
Combined Countries, Territories & Markets

**400+**
Combined Offices & Locations

**1,800+**
Combined Partners

**40,000+**
Combined Team Members

# Healthcare Consulting

## Practice Overview

### Leveraging Our Forward Vision to Help You Achieve Financial & Operational Excellence

Forvis Mazars has designed its healthcare consulting solutions portfolio specifically to address a healthcare organization's unique and complex challenges and opportunities. We combine informative analytics and deep technical resources and competencies to help you make informed decisions that drive value, quality, and results.

**9th**
Largest Healthcare Consulting Firm (2023)

**92**
*Net Promoter Score®

Modern Healthcare's Largest Management Consulting Firms 2023 ranking and UCX survey NPS®
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**Strategy & Finance**

Mergers, Acquisitions & Partnerships, Organizational Health, Physician Alignment, Strategic Planning, Value-Based Care, Dynamic Financial Modeling, Financial System Optimization, Prospective Reporting & Feasibility Studies, and Payor Strategies

**Healthcare Reimbursement**

Cost Reporting, DSH & Uncompensated Care Reporting, Medicare Bad Debt, Regulatory Compliance, Post-Acute Care Targeted Offerings, and Strategic Reimbursement Offerings

**Performance Improvement**

Clinical Documentation: Integrity, Improvement & Coding, Clinical & Operational Excellence, Cost Management, Pharmacy & 340B, Physician Services, and Revenue Cycle & Integrity

**Payor Services**

Growth & Strategy, Mergers & Acquisitions, Risk-Based Contracting & Reporting, Compliance, Accreditation & Credentialing, Survey Services, Risk Mitigation, Transformation, Business Intelligence, and Managed IT Services



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# Instructions

**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 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.

# Value-Based Payment Readiness Check

## Section 1: Yes/No Questions

**The following questions are intended to inform your organizational position as it relates to readiness for Value-Based Payment. The survey is intended to be completed by key organizational stakeholders, with aggregate results providing you a profile of your Risk Readiness.**

| Question | Response |
|---|---|
| 1. Does your organization participate in any alternative payment models (pay-for-performance contracts, shared savings programs, episode-based payments, per-member per-month payments for specific populations, etc.)? (Y/N) | Yes |
| 2. Do providers within your organization have value-based incentives tied to their compensation? (Y/N) | Yes |
| 3. Does the leadership team of your organization meet regularly (at least quarterly) review performance on financial and operational indicators with your providers? (Y/N) | No |
| 4. Does your organization utilize an electronic health record? (Y/N) | Yes |
| 5. Does your organization have an evidence-based methodology to risk stratify patients? (Y/N) | No |
| 6. Does your organization employ staff to offer chronic care management and/or transitional care management to Medicare insured individuals? (Y/N) | Yes |
| 7. Does your organization provide coding, documentation and risk adjustment training to staff and providers at least annually? (Y/N) | No |
| 8. Do you have means of informing the care team of gaps in coding as part of pre-visit planning? | Yes |
| 9. Do you have a process for providing feedback to providers on coding gaps before and after a patient visit? | No |
| 10. Does your organization participate in an Accountable Care Organization, Independent Practice Association (IPA), or other type of clinically integrated network (CIN)? (Y/N) | Yes |
| 11. Is your organization's employee health plan self-insured? (Y/N) | No |
| 12. Does your organization contract with any other self-insured employers in a non-fee-for-service type arrangement? (Y/N) | No |
| 13. To your knowledge, has your organization ever participated in a non-fee-for-service payment arrangement ? (Y/N) | Yes |
| 14.Do you have a dashboard of key performance indicators including financial indicators that is used to monitor and improve performance on value-based care arrangements? (Y/N) | No |
| 15. If using a dashboard, does it include performance targets, internal trending, and external benchmarks? (Y/N) | No |





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# Value-Based Payment Readiness Check

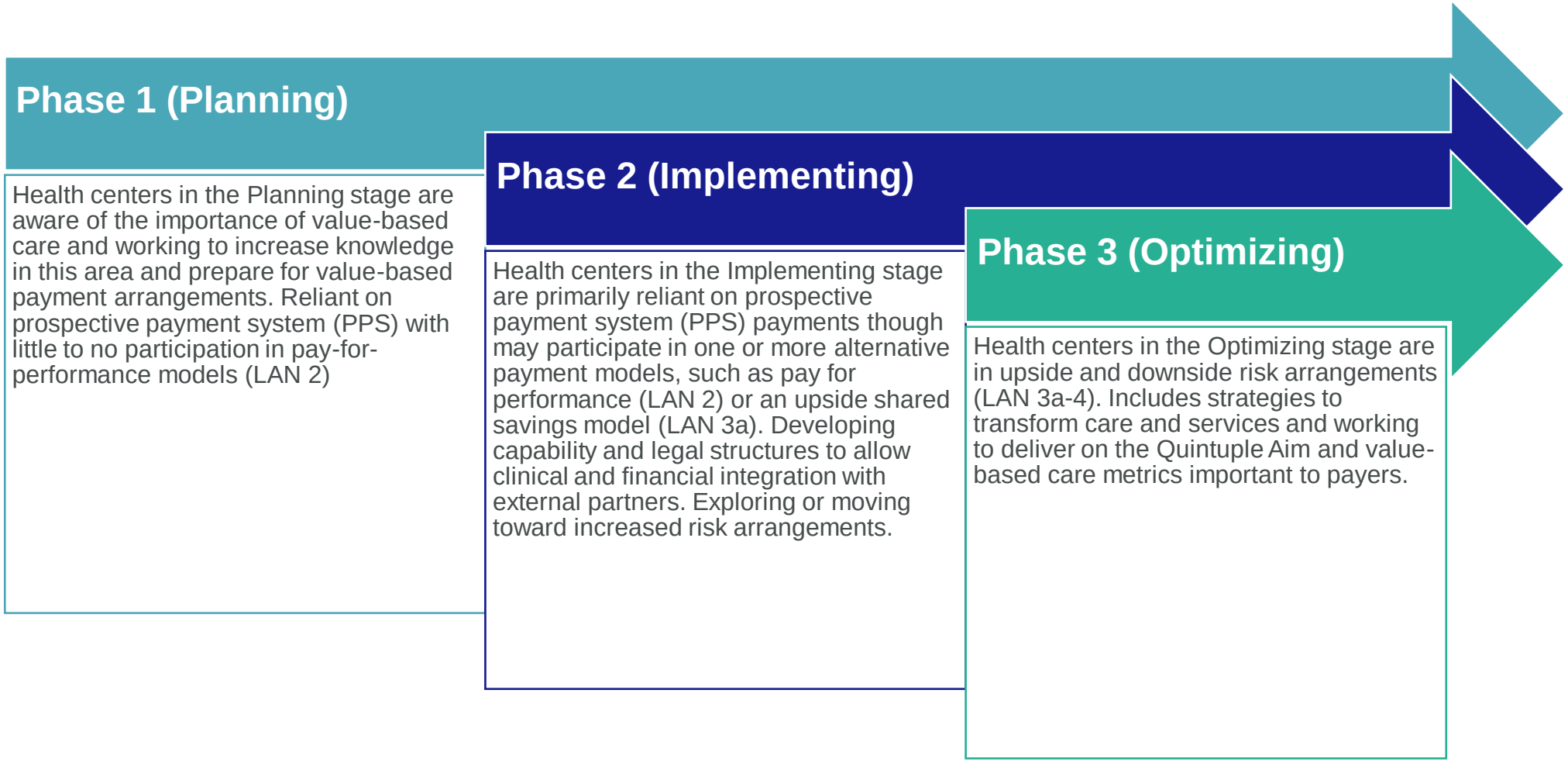
## Section 2: Ranking Questions and Score

| Ranking Questions | | Example of Organizational Positioning for Each Response | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 16. How would you rate your organization's urgency to pursue non-fee-for-service based contractual relationships? (1-5) | 5-Highest (Best) Rating | No organizational urgency to shift from FFS | | We know it is important, but haven't invested fully in building capabilities | | Fully risk capable in every element |
| 17. How well is your organization positioned to successfully take on value-based payment arrangements with downside risk over the next three years? (1-5) | 3 | Our team is focused solely on fee-for-service | | Our team has started to build the operational, financial, and clinical acumen associated with VBP | | Out team has the operational, financial, and clinical acumen to take on downside risk now |
| 18. How aggressive are payors in your market pushing providers to take on value-based payment agreements? (1-5) | 5-Highest (Best) Rating | We have not had any VBP related discussions | | We have had a few VBP discussions | | We have had 3+ VBP discussions |
| **Please rank your opinion on the following statements (Disagree, Neutral, Agree or Unsure)** | | | | | | |
| 19. My organization has a history of accurately forecasting profit and loss associated with individual payor contracts. | Agree | | | | | |
| 20. My organization has generated positive financial margins over the last three years and is projecting a positive margin for this year. | Neutral | | | | | |
| 21. My organization has sufficient capital to invest in resources to further our value-based care initiatives. | Neutral | | | | | |
| 22. My organization consistently meets to discuss monitored performance against VBP arrangements. | Agree | | | | | |
| 23. My organization has a history of successfully adapting to change. | Agree | | | | | |
| 24. My organization has a history of successfully negotiating contracts with payors. | Unsure | | | | | |
| 25. My organization tracks financial performance on at least a monthly basis. | Agree | | | | | |

| | |
|---|---|
| Score: | 14.6 |
| Phase 2 (Implementing): Based on your score, your organization has some capabilities associated with value-based or risk-based arrangements, and should use the subsequent worksheets to identify and quantify gaps that will improve your performance in value-based care strategies. | |
| **Please note:** this survey is meant to serve as a directional indication around an organization's ability to execute against value-based or risk-based arrangements, and is not meant to be a comprehensive assessment of an organization's capabilities. Users should use this output in conjunction with other elements to determine whether or not value-based arrangements are right for their organization. | |

Responses will generate an estimated VBP adoption phase of Planning, Implementing or Optimizing

# NACHC Value-Based Payment Adoption Phases



# Projected Revenues

| 1500 Insert Number of Covered Lives | | | At-Risk Revenue[1] | Contractual Revenue[2] | | |
|---|---|---|---|---|---|---|
| **Model** | **Contract** | **# of Lives** | **Projected Incremental Revenue** | **Care Management Revenue (total annual)** | **Pay-For-Performance / Quality Programs (total annual)** | **Other Revenue (total annual)** |
| **Applicable LAN Mapping[6]** | | | **3A, 3B** | **2A** | **2C** | **2A,2C** |
| Medicaid Value-Based Care Plans | Medicaid Contract #1 | 500 | $20,000 | | | |
| Medicare Shared Savings Program | | 750 | $65,000 | | | |
| Medicare ACO Reach | | | | | | |
| Commercial Value-Based Care Programs | Commercial Contract #1 | | | | | |
| Medicare Advantage Plans | Medicare Advantage Contract #1 | 250 | $30,000 | $15,000.00 | | |
| Grants, Additional Funding Sources, Other | | | | | | |
| **Total** | | **1500** | **$115,000** | **$15,000** | **$0** | **$0** |

1. At risk revenue - Additional revenue that is generated through positive performance in value-based payment contracts (i.e. shared savings, performance bonuses); revenue is "at risk" because it is tied to performance against value-based payment metrics (i.e. quality improvement, spend reduction)
2. Contractual revenue - PMPM revenue that is allocated by the payor for a value-based care contract to provide various services
3. If number of visits is not known, multiply total lives by 0.2064 to project number of recommended CCM visits to complete in a calendar year
4. National average taken from FQHC Prospective Payment System updated for Calendar Year 2024
5. If number of visits is not known, multiply total lives by 0.11 to project number of recommended TCM visits to complete in a calendar year
6. LAN Category Definitions
Category 1: Fee for service - no link to quality & value
Category 2A: Foundational Payments for Infrastructure & Operations
(e.g. care coordination fees and payments for HIT investments)
Category 2C: Pay-for-Performance
(e.g. bonuses for quality performance)
Category 3A: APMs with Shared Savings
(e.g. shared savings with upside risk only)
Category 3B: APMs with Shared Savings and Downside Risk
(e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)

**Instructions:**

1. Insert number of total covered lives in highlighted cell.

2. Insert number of covered lives by contract type in row D

3. Insert projected incremental revenue (if known) by contract type in column E. If projected incremental revenue is unknown, the leave cells in this column blank.

4. Insert total annual care management revenue by contract type for each contract that provides a pre-determined per member per month revenue amount for care management services in column F. If no such arrangement exists with your organization, then leave the cells in this column blank.

5. Insert the total annual pay-for-performance/quality-based revenue for each contract where this applies in column G. If no such arrangement exists with your organization, then leave the cells in this column blank.

6. Insert the total annual other contractual revenue by contract type in column H. If no such arrangement exists with your organization, then leave the cells in this column blank.

# Projected Revenues (continued)

**Instructions:**

7. If known, populate cells in column H and/or L with the total number of CCM/TCM visits completed by contract type. If not known, use the formula provided in the comment on these row to project volumes for these services

8. If known, populate the cells in column K and/or column O with the actual fee-for-service reimbursement per visit.

9. If known, populate the cells in row O with the total fee-for-service revenue net of the CCM and TCM incremental revenue

10. Review the projected total number of visits and fee-for-service revenue for chronic care management (CCM) and transitional care management (TCM) visits per year.

1500 Insert Number of Covered Lives

| | | | Fee for Service | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Model | Contract | # of Lives | Total Chronic Care Management (CCM) Visits[3] | CCM Revenue per Visit (standard, national average)[4] | CCM Revenue per Visit (Custom) | Total CCM Revenue | Total Transitional Care Management (CCM) Visits[5] | TCM Revenue per Visit (standard, national average)[4] | TCM Revenue per Visit (Custom) | Total TCM Revenue | Total FFS Revenue Net CCM and TCM | Total Projected Revenue |
| **Applicable LAN Mapping[6]** | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Medicaid Value-Based Care Plans | Medicaid Contract #1 | 500 | | | | $0 | | | | $0 | | $20,000 |
| Medicare Shared Savings Program | | 750 | 155 | $78 | | $12,065 | 83 | $196 | | $16,169 | | $93,234 |
| Medicare ACO Reach | | | | $78 | | | | $196 | | | | |
| Commercial Value-Based Care Programs | Commercial Contract #1 | | | $78 | | | | $196 | | | | |
| Medicare Advantage Plans | Medicare Advantage Contract #1 | 250 | 52 | $78 | | $4,022 | | $196 | | $0 | | $49,022 |
| Grants, Additional Funding Sources, Other | | | | $78 | | | | $196 | | | | |
| **Total** | | **1500** | **206** | | **$0** | **$16,087** | **83** | | **$0** | **$16,169** | **$0** | **$162,256** |

1. At risk revenue - Additional revenue that is generated through positive performance in value-based payment contracts (i.e. shared savings, performance bonuses); revenue is "at risk" because it is tied to performance against value-based payment metrics (i.e. quality improvement, spend reduction)
2. Contractual revenue - PMPM revenue that is allocated by the payor for a value-based care contract to provide various services
3. If number of visits is not known, multiply total lives by 0.2064 to project number of recommended CCM visits to complete in a calendar year
4. National average taken from FQHC Prospective Payment System updated for Calendar Year 2024
5. If number of visits is not known, multiply total lives by 0.11 to project number of recommended TCM visits to complete in a calendar year

# Projected Costs

| | |
|---|---|
| 1500 | Insert Number of Covered Lives |
| | Insert Number of Providers |
| 50 | Participating in VBC Contracts |

| Cost Category | Name | VBC Adoption Phase | Include FTE/Service in Cost Projection? Select Yes or No | FTE(s) Required | National Median Annual Salary + Benefits[4] | Actual Annual Salary + Benefits | Total Cost |
|---|---|---|---|---|---|---|---|
| Care Coordination & Quality Improvement | Social Worker | Planning/Implementing | Yes | 0.2 | $62,168 | | $12,434 |
| Care Coordination & Quality Improvement | Chronic Care Management Nurse | Planning/Implementing | Yes | 0.2 | $77,494 | | $15,499 |
| Care Coordination & Quality Improvement | Transitional Care Management Nurse | Optimizing | No | 0.0 | $77,494 | | $0 |
| Care Coordination & Quality Improvement | Quality Reporting Costs | Planning/Implementing | Yes | | | | |
| Care Coordination & Quality Improvement | Data Analyst | Planning/Implementing | Yes | 0.2 | $61,128 | | $12,226 |
| Care Coordination & Quality Improvement | Dietician | Optimizing | No | 0.0 | $69,350 | | $0 |
| Care Coordination & Quality Improvement | CDI Specialist | Optimizing | No | 0.0 | $37,732 | | $0 |
| Care Coordination & Quality Improvement | Clinic Pharmacist | Optimizing | No | 0.0 | $125,370 | | $0 |
| Care Coordination & Quality Improvement | Care Navigator (MA or LPN) | Planning/Implementing | Yes | 0.2 | $36,504 | | $7,301 |
| Care Coordination & Quality Improvement | Behavioral Health Consultant | Optimizing | No | 0.0 | $69,036 | | $0 |
| Care Coordination & Quality Improvement | Community Health Worker | Optimizing | No | 0.0 | $34,872 | | $0 |
| Network Development & Management | Revenue Cycle Specialist | Optimizing | No | 0.0 | $38,448 | | $0 |

**Instructions:**

- Insert number of total covered lives in highlighted cell.
- Insert number (or estimated number) of providers participating value-based care contracts
- In column D, select Yes or No for each cost category to include or exclude the item from calculation
- If known, insert the actual annual salary + benefits amount for each staff role in column E
- Note: Column C (VBC Adoption Phase) denotes the phase typically associated with the resource/cost

4. National Median Salary + Benefits taken from the MGMA 2021 Management and Staff Report (using 2020 data) for Federally Qualified Health Centers and the American Case Management Association 2021 Survey

# Projected Costs (continued)

| | |
|---|---|
| 1500 | Insert Number of Covered Lives |
| | Insert Number of Providers |
| 50 | Participating in VBC Contracts |

| Cost Category | Name | VBC Adoption Phase | Include FTE/Service in Cost Projection? Select Yes or No | FTE(s) Required | National Median Annual Salary + Benefits[4] | Actual Annual Salary + Benefits | Total Cost |
|---|---|---|---|---|---|---|---|
| Network Development & Management | Legal and Consulting Support[4] | Planning/Implementing | No | | | | |
| Network Development & Management | Appointment Scheduling Platform[5] | Optimizing | No | | | | |
| Network Development & Management | SDOH Screening Tool[6] | Optimizing | No | | | | |
| Network Development & Management | Health Information Exchange[7] | Optimizing | No | | | | |
| Network Development & Management | Electronic Medical Record (Annual Exp | Planning/Implementing | No | | | | |
| Network Development & Management | Population Health Management System | Optimizing | No | | | | |
| Network Development & Management | Continuing Education (Annual Expense) | Optimizing | No | | | | |
| Other | Other Costs | | | | | | |

**Instructions:**

- (Optional step) In column F, insert estimated total annual costs for services outlined in rows 19-27
- Note: Column C (VBC Adoption Phase) denotes the phase typically associated with the resource/cost

# Projected Costs (continued)

| | |
|---|---|
| 1500 | Insert Number of Covered Lives |
| | Insert Number of Providers |
| 50 | Participating in VBC Contracts |

| | | | Cost Allocation by Contract Type | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cost Category | Name | Total Cost | Medicaid Value-Based Care Contract #1 | Medicare Shared Savings Program | Medicare ACO Reach | Commercial Value-Based Contract #1 | Medicare Advantage Contract #1 | Notes |
| Care Coordination & Quality Improvement | Social Worker | $12,434 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 7,500 lives |
| Care Coordination & Quality Improvement | Chronic Care Management Nurse | $15,499 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Transitional Care Management Nurse | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Quality Reporting Costs | | 33% | 50% | 0% | 0% | 17% | |
| Care Coordination & Quality Improvement | Data Analyst | $12,226 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Dietician | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 10 primary care providers |
| Care Coordination & Quality Improvement | CDI Specialist | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Clinic Pharmacist | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 20 primary care providers |
| Care Coordination & Quality Improvement | Care Navigator (MA or LPN) | $7,301 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Behavioral Health Consultant | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 5,000 lives |
| Care Coordination & Quality Improvement | Community Health Worker | $0 | 33% | 50% | 0% | 0% | 17% | 1 FTE for every 7,500 lives |
| **Projected Total Cost** | | **$47,459** | **$15,820** | **$23,729** | **$0** | **$0** | **$7,910** | |

**Instructions:**

- (Optional step) In columns G-H, insert prorated cost for each row by contract type
- Note: Column C (VBC Adoption Phase) denotes the phase typically associated with the resource/cost

# Projected ROI

## Value-Based ROI Calculator

**Instructions:**

1. Review total lives, projected revenues, projected costs and projected operating income by contract type based on values pulled from previous tabs.

| Model | Contract | # of Lives | Total Projected Revenue | Total Projected Cost | Total Net Operating Income |
|---|---|---|---|---|---|
| Medicaid Value-Based Care Plans | Medicaid Contract #1 | 500 | $20,000 | $15,820 | $4,180 |
| Medicaid Value-Based Care Plans | Medicaid Contract #2 | 0 | | $0 | |
| Medicaid Value-Based Care Plans | Medicaid Contract #3 | 0 | | $0 | |
| Medicare Shared Savings Program | | 750 | $93,234 | $23,729 | $69,505 |
| Medicare ACO Reach | | 0 | | $0 | |
| Commercial Value-Based Care Programs | Commercial Contract #1 | 0 | | $0 | |
| Commercial Value-Based Care Programs | Commercial Contract #2 | 0 | | $0 | |
| Commercial Value-Based Care Programs | Commercial Contract #3 | 0 | | $0 | |
| Medicare Advantage Plans | Medicare Advantage Contract #1 | 250 | $49,022 | $7,910 | $41,112 |
| Medicare Advantage Plans | Medicare Advantage Contract #2 | 0 | | $0 | |
| Medicare Advantage Plans | Medicare Advantage Contract #3 | 0 | | $0 | |
| **Total** | | **1,500** | **$162,256** | **$47,459** | **$114,797** |

# Next Steps

**Instructions:**

1. Review the projected revenues, costs and return on investment with your team to validate assumptions. Refine projections based on actual revenues, salaries and other costs using your organization's information.

2. Using the results of the risk assessment (Tab 1: VBP Readiness Check) as well as your own understanding of your organization's tolerance for risk, review the following next steps for each phase of value-based payment adoption.

**Planning Phase:**

1. Ensure that your organization is following best practices in financial monitoring
2. Consider moving to utilization of Certified Electronic Health Record Technology if not already deployed
3. Work within your organization to gain a deeper understanding of its current financial position and appetite for accepting risk
4. Begin establishing a value-based care/value-based payment governance structure
5. Assess key patient needs and social determinants of health that will need to be addressed in a value-based payment arrangement

*Resources:*

*NACHC Action Brief: Developing Your Health Center's Value-Based Payment Goals*
*NACHC Value Transformation Framework Assessment Portal*
*NACHC Action Guide: Social Drivers of Health*

**Implementing Phase**

1. Develop and/or refine process for tracking your organization's financial performance in value-based payment contracts/models
2. Deploy the value-based care/value-based payment governing body and care teams
3. Implement care management programs for patients in value-based payment arrangements

*Resources*

*NACHC Action Guide: Care Management*
*NACHC Action Guide: Care Teams*
*NACHC Action Guide: Payment*

**Optimizing Phase**

1. Identify additional value-based payment opportunities
2. Consider two-sided risk models if not already participating in downside risk, as well as capitated/prospective payment models
3. Develop and/or refine collaborative relationships with post-acute providers
4. Cultivate disease-specific pathways for patients

*Resources*

*NACHC Action Guide: Models of Care*
*NACHC Action Guide: Improvement Strategy*
*CMS FAQ on New Codes Adopted to Address Health-Related Social Needs*

# Glossary

**NACHC Value-Based Payment Adoption Phases:**

**Phase 1 (Planning):** Health centers in the Planning stage are aware of the importance of value-based care and working to increase knowledge in this area and prepare for value-based payment arrangements. Reliant on prospective payment system (PPS) with little to no participation in pay-for-performance models (LAN 2)

**Phase 2 (Implementing):** Health centers in the Implementing stage are primarily reliant on prospective payment system (PPS) payments though may participate in one or more alternative payment models, such as pay for performance (LAN 2) or an upside shared savings model (LAN 3a). Developing capability and legal structures to allow clinical and financial integration with external partners. Exploring or moving toward increased risk arrangements.

**Phase 3 (Optimizing):** Health centers in the Optimizing stage are in upside and downside risk arrangements (LAN 3a-4). Includes strategies to transform care and services and working to deliver on the Quintuple Aim and value-based care metrics important to payers.

**HCP LAN VBC Categories**

| Category 1 | Category 2 | Category 3 | Category 4 |
|---|---|---|---|
| FEE FOR SERVICE – NO LINK TO QUALITY & VALUE | FEE FOR SERVICE – LINK TO QUALITY & VALUE | APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE | POPULATION-BASED PAYMENT |
| | A | A | A |
| | **Foundational Payments for Infrastructure & 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 payments for procedures and comprehensive payments with upside and downside risk) | **Comprehensive Population-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 & Delivery System** (e.g. global budgets or full/percent of premium payments in integrated systems) |
| | | 3N Risk Based Payments NOT Linked to Quality | 4N Capitated Payments NOT Linked to Quality |

**1. At Risk Revenue -** Additional revenue that generates positive performance in value-based payment contracts (i.e. shared savings, performance bonuses); revenue is "at risk" because it is tied to performance against value-based payment metrics (i.e. quality improvement, spend reduction)

**2. Contractual Revenue** - Per-member-per-month (PMPM) revenue that is allocated by the payor for a value-based payment contract to provide various services

**3. National Average TCM & CCM Revenue** taken from FQHC Prospective Payment System updated for Calendar Year 2024

**4. National Median Salary + Benefits** taken from the MGMA 2021 Management and Staff Report (using 2020 data) for Federally Qualified Health Centers and the American Case Management Association 2021 Survey

**5. Legal and Consulting Support -** Services to review and/or negotiate payor contracts, establish governance structures, develop funds flow methodologies, draft agreements, etc.

**6. Appointment Scheduling Platform -** Software solution that enables patients to self-schedule appointments or request appointments online

**7. Health Information Exchange -** Tool that allows healthcare to access and securely share a patient's vital medical information electronically to promote better care coordination and decision making

**8. Social Determinants of Health (SDOH) Screening Platform -** Software tool that identifies health equity gaps, including employment, housing, income, education and other factors that influence patients' health

**9. Population Health Management System -** Software solution that supports data aggregation, risk stratification of patients, care management, HCC coding, etc.

# Contact

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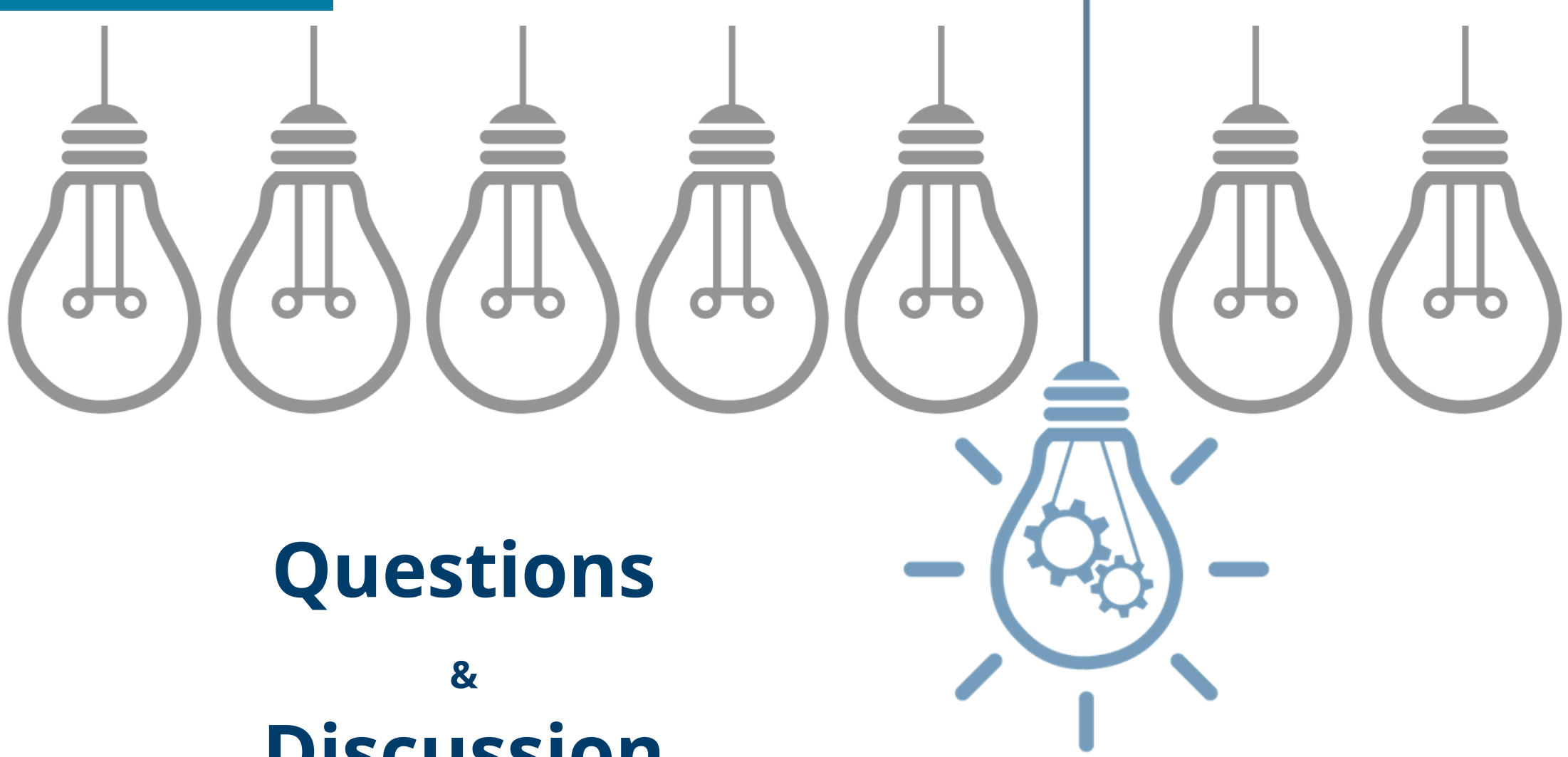


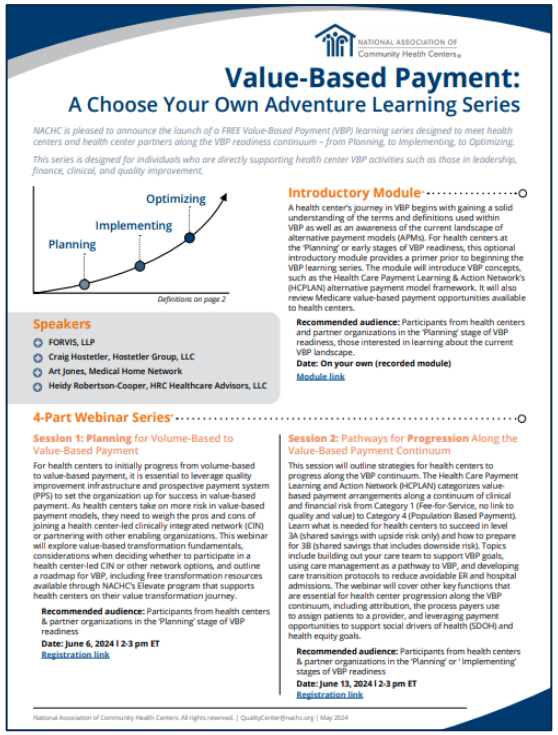
# Questions

# &

# Discussion

# NACHC's Value-Based Payment Learning Series


Link to recorded module (10 mins)




**Session 1: Planning for Volume-Based to Value-Based Payment**

**Session 2: Pathways for Progressing Along the VBP Continuum**

**Session 3: Implementing High-Quality Primary Care within VBP Models**

6/27

**Session 4: Optimizing VBP Strategies while Mitigating Financial Risk**

Registration Link: 4-Part Series

## *Supplemental Sessions!*

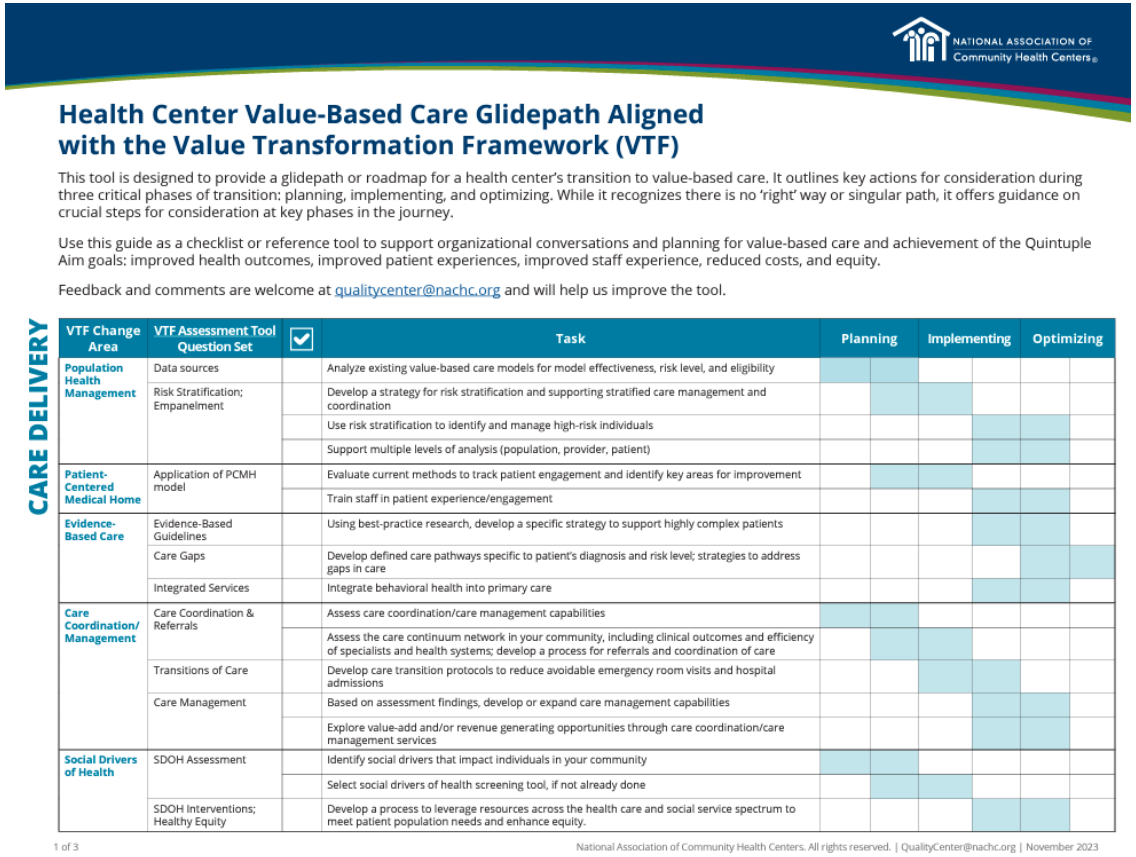
1. FQHC VBP Financial Projection Tool

7/25

2. Total Cost of Care

Registration Link: Supplemental Sessions

# NACHC: Value-Based Payment Resources



NATIONAL ASSOCIATION OF Community Health Centers®

## 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.

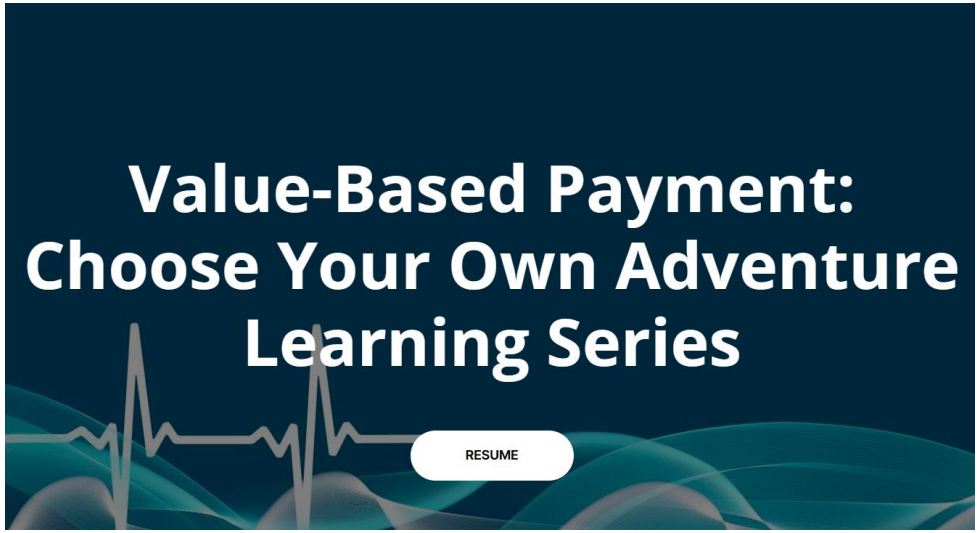
Feedback and comments are welcome at qualitycenter@nachc.org and will help us improve the tool.

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. | | | | | | |




[Health Center Value-Based Care Glidepath Aligned with the Value Transformation Framework]




[Link to VBP Series Slides & Recordings]

## Suite of Value-Based Payment Action Briefs:

[Developing VBP Goals]

[Attribution]

[Attribution Thresholds]

[Payor Data]

# A Systems Approach to Transformation

## 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*
- ✓ *Assess health center transformation progress*

*Step-by-Step*

*Guided Application*

*Trainings & Resources*

elevate

## National Learning Forum

**848 CHCs | 90 PCAs/HCCNs/NTTAPS | >15 Million Patients**

- ✓ *Monthly Webinars*
- ✓ *Supplemental Sessions*
- ✓ *Evidence-Based Action Guides*
- ✓ *Action Briefs*
- ✓ *eLearning Modules*
- ✓ *Tools & Resources*
- ✓ *Professional Development Courses*

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