NATIONAL ASSOCIATION OF Community Health Centers®

PATHWAYS FOR PROGRESSION ALONG THE VALUE-BASED PAYMENT CONTINUUM

elevate

Session 2 in a 4-Part Series
June 13, 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.

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NACHC Speakers

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

Vacheria Keys, Esq.
Associate Vice President, Policy & Regulatory Affairs

During today's session:

- **Engage with us!** Throughout the webinar, type questions and comments in the chat feature. Be sure to send them to "Everyone"! There will be Q&A and discussion at the end.
- **Access resources!** Select to access related NACHC resources, tools, **and the slides for this webinar**!

Pathways for Progressing to VBP

Learning Objectives:

- ✓ Outline how a population health approach is critical to value-based care and value-based payment success.
- ✓ Overview of attribution fundamentals and how it relates to VBP.
- ✓ Outline what it takes to succeed in shared savings, upside risk (LAN 3A) and how to prepare for shared savings with downside risk (LAN 3B).
- ✓ Leverage payment opportunities to support SDOH and health equity goals

Q&A

NACHC's Value-Based Payment Learning Series

[Link to recorded module (10 mins)]

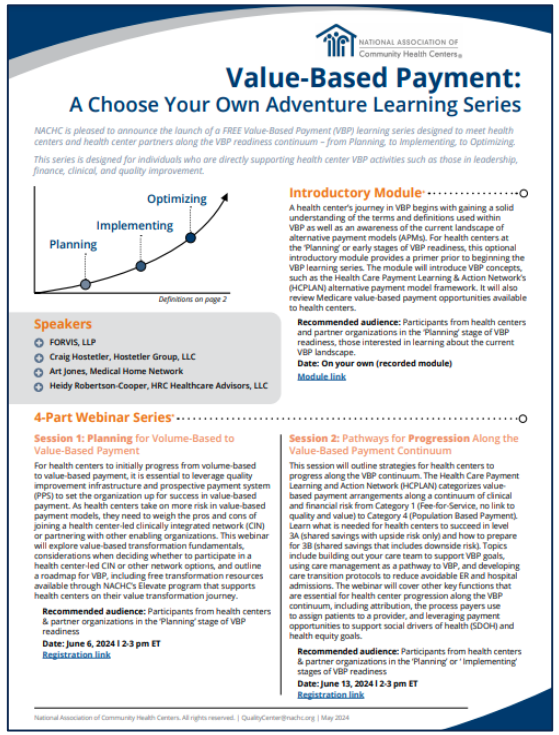
Session 1: Planning for Volume-Based to Value-Based Payment

Session 2: Pathways for Progressing Along the VBP Continuum

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

Session 4: Optimizing VBP Strategies while Mitigating Financial Risk

[Registration Link: 4-Part Series]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Value-Based Payment:
A Choose Your Own Adventure Learning Series

NACHC is pleased to announce the launch of a FREE Value-Based Payment (VBP) learning series designed to meet health centers and health center partners along the VBP readiness continuum – from Planning, to Implementing, to Optimizing.

This series is designed for individuals who are directly supporting health center VBP activities such as those in leadership, finance, clinical, and quality improvement.

Optimizing
Implementing
Planning
Definitions on page 2

Introductory Module

A health center's journey in VBP begins with gaining a solid understanding of the terms and definitions used within VBP as well as an awareness of the current landscape of alternative payment models (APMs). For health centers at the 'Planning' or early stages of VBP readiness, this optional introductory module provides a primer prior to beginning the VBP learning series. The module will introduce VBP concepts, such as the Health Care Payment Learning & Action Network's (HCPLAN) alternative payment model framework. It will also review Medicare value-based payment opportunities available to health centers.

Recommended audience: Participants from health centers and partner organizations in the 'Planning' stage of VBP readiness, those interested in learning about the current VBP landscape.
Date: On your own (recorded module)
Module link

Speakers
- FORVIS, LLP
- Craig Hostetler, Hostetler Group, LLC
- Art Jones, Medical Home Network
- Heidy Robertson-Cooper, HRC Healthcare Advisors, LLC

4-Part Webinar Series

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

For health centers to initially progress from volume-based to value-based payment, it is essential to leverage quality improvement infrastructure and prospective payment system (PPS) to set the organization up for success in value-based payment. As health centers take on more risk in value-based payment models, they need to weigh the pros and cons of joining a health center-led clinically integrated network (CIN) or partnering with other enabling organizations. This webinar will explore value-based transformation fundamentals, considerations when deciding whether to participate in a health center-led CIN or other network options, and outline a roadmap for VBP, including free transformation resources available through NACHC's Elevate program that supports health centers on their value transformation journey.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' stage of VBP readiness
Date: June 6, 2024 | 2-3 pm ET
Registration link

Session 2: Pathways for Progression Along the Value-Based Payment Continuum

This session will outline strategies for health centers to progress along the VBP continuum. The Health Care Payment Learning and Action Network (HCPLAN) categorizes value-based payment arrangements along a continuum of clinical and financial risk from Category 1 (Fee-for-Service, no link to quality and value) to Category 4 (Population Based Payment). Learn what is needed for health centers to succeed in level 3A (shared savings with upside risk only) and how to prepare for 3B (shared savings that includes downside risk). Topics include building out your care team to support VBP goals, using care management as a pathway to VBP, and developing care transition protocols to reduce avoidable ER and hospital admissions. The webinar will cover other key functions that are essential for health center progression along the VBP continuum, including attribution, the process payers use to assign patients to a provider, and leveraging payment opportunities to support social drivers of health (SDOH) and health equity goals.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' or 'Implementing' stages of VBP readiness
Date: June 13, 2024 | 2-3 pm ET
Registration link

Supplemental Sessions!

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

[Registration Link: Supplemental Sessions]

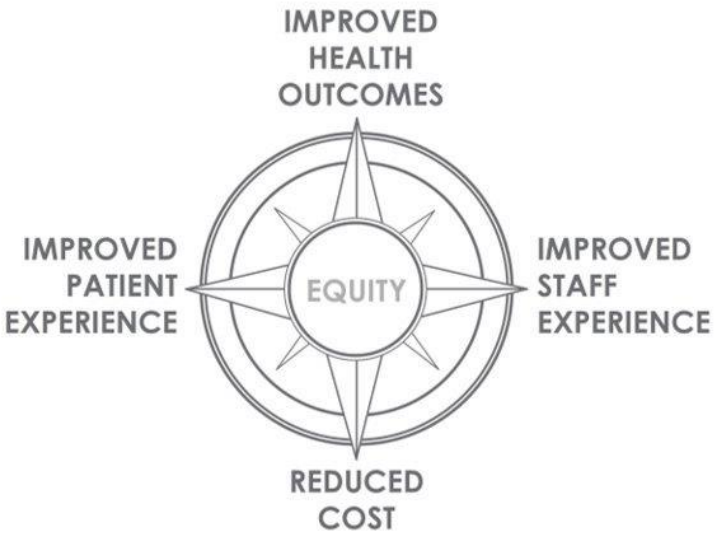
Learning Objective: Population Health

Outline how a population health approach is critical to value-based care and value-based payment success.

Population Health Approach Critical to VBP

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

Quintuple Aim:



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

WHAT is population health management?

Using data on patient populations to target interventions that result in improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity (Quintuple Aim)

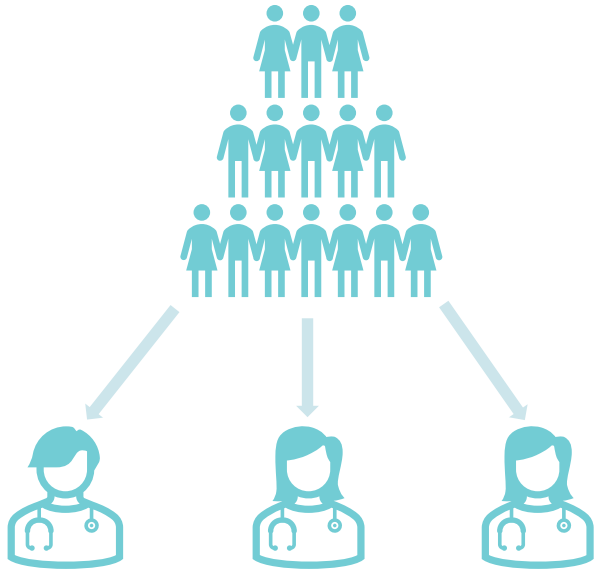
Population health management strategies include:

- ✓ Empanelment & Attribution
- ✓ Risk Stratification
- ✓ Models of Care

WHAT is population health management?

Empanelment → Risk Stratification → Models of Care

The process of matching every patient to a primary care provider and care team.



Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.

- Low Risk → *Focus is keeping patients engaged in the health care system without use of unnecessary services.*
- Rising Risk → *Focus is on managing risk factors more than disease conditions.*
- High Risk → *Requires structured care management and one-on-one support.*
- Highly Complex → *Requires intensive, pro-active care management.*

Designing care models based on risk allows patients to be paired with more appropriate care team members and services.

WHAT is population health management?

Health Center Processes:

Include all health center patients.

Empanelment → **Risk Stratification** → **Models of Care**

Attribution lists may be shared with health centers; used to inform empanelment.

Member risk scores may be shared with health centers; used to inform models of care.

Payor Processes:

Include members of that payor.

Attribution → **Risk Stratification**

A payor's process of assigning members to a provider.

A payor may have their own algorithm for risk stratifying members, for example, based on diagnosis codes or total cost of care.

Learning Objective: Attribution

Overview of attribution fundamentals and how it relates to value-based payment success.

Featured Speaker

Heidy Robertson-Cooper, MPA
President
Health Care Advisors

Heidy Robertson-Cooper, MPA served over ten years in health care, focusing on primary care policy, value-based payment, and delivery system redesign impacting primary care and the safety net community. Before starting HRC Health Care Advisors, she served in leadership roles for the Missouri Primary Care Association, MissourHealth+, the American Academy of Family Physicians, and a health center in Northeast Missouri. In these roles, she oversaw efforts to influence primary care delivery and payment systems reform, develop resources assisting primary care physicians in achieving professional success in all practice settings, and provide effective value-based practice transformation and performance improvement support for primary care and community health centers.

WHAT is attribution?

- A method used by payers to determine which provider or provider group is responsible for a patient's care and costs in value-based payment contracts.
- 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.
- It is foundational to every value-based payment model across all payers.

HCPLAN, Accelerating and Aligning Population-Based Payment Models: Patient Attribution

WHY does attribution matter?

- Provider Accountability
- Performance Measurement
- Financial Incentives
- Resource Targeting and Allocation

Attribution opportunities & challenges

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Opportunities

- Engage new patients with a favorable payer
- Increase access to care for a medically underserved population
- Expand population health capacity and expertise
- Increase opportunity to earn financial incentives to support all health center patients

Challenges

- Inaccurate demographic and contact information
- "These are not my patients" perspective
- Limited provider capacity
- Lack of consistency with payer reports & rosters
- Patient churn

HOW are patients attributed?

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Varies by Payor Type

- Medicare
- Medicaid
- Commercial

Methods

- Prospective
- Retrospective
- Hybrid

Process Flow

- Patient self-selected PCP (gold standard)
- Plurality of primary care services
- Historical claims
- Enrollment address
- Family members

Level

- Primary Care Provider
- ACO/CIN

HOW to optimize attribution?

HEALTH CARE ADVISORS

STEP 1 Develop an accurate up-to-date list of all providers eligible for attribution

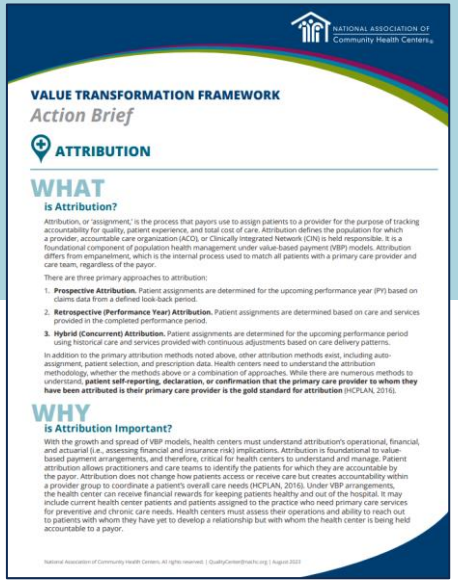
STEP 2 Understand the attribution methodology of payors

STEP 3 Develop processes for the intake of attribution lists

STEP 4 Leverage attribution lists to inform empanelment

STEP 5 Identify a process for patients not attributed but who receive care from your health center

STEP 6 Use attribution information to drive patient engagement and care needs



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VALUE TRANSFORMATION FRAMEWORK

Action Brief

ATTRIBUTION

WHAT

is Attribution?

Attribution, or 'assignment,' is the process that payors use to assign patients to a provider for the purpose 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 responsible. 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 to match all patients with a primary care provider and care team, regardless of the 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 historical 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 prescription data. Health centers need to understand the attribution methodology, whether 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 attribution's operational, financial, and actuarial (i.e., assessing financial and insurance risk) implications. 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. It may include current health center patients and patients assigned to the practice who need primary care services for preventive and chronic care needs. Health centers must assess their operations and ability to reach out to patients with whom they have yet to develop a relationship but with whom the health center is being held accountable to a payor.

Action Brief

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Learning Objective: Succeed in Shared Savings, Risk

Outline what it takes to succeed in shared savings, upside-risk (LAN 3A) and how to prepare for shared savings with down-side risk (LAN 3B).

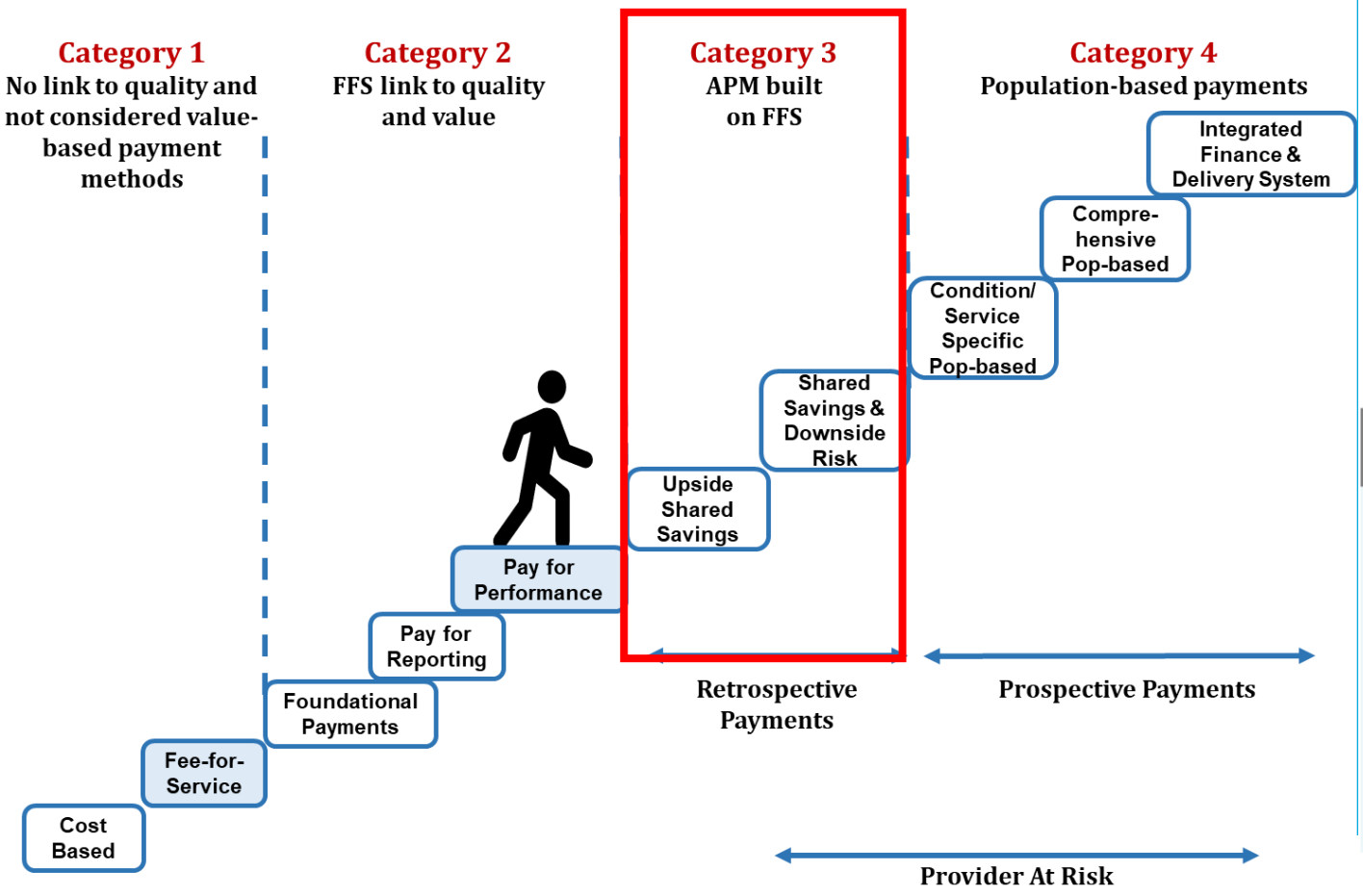
Featured Speaker

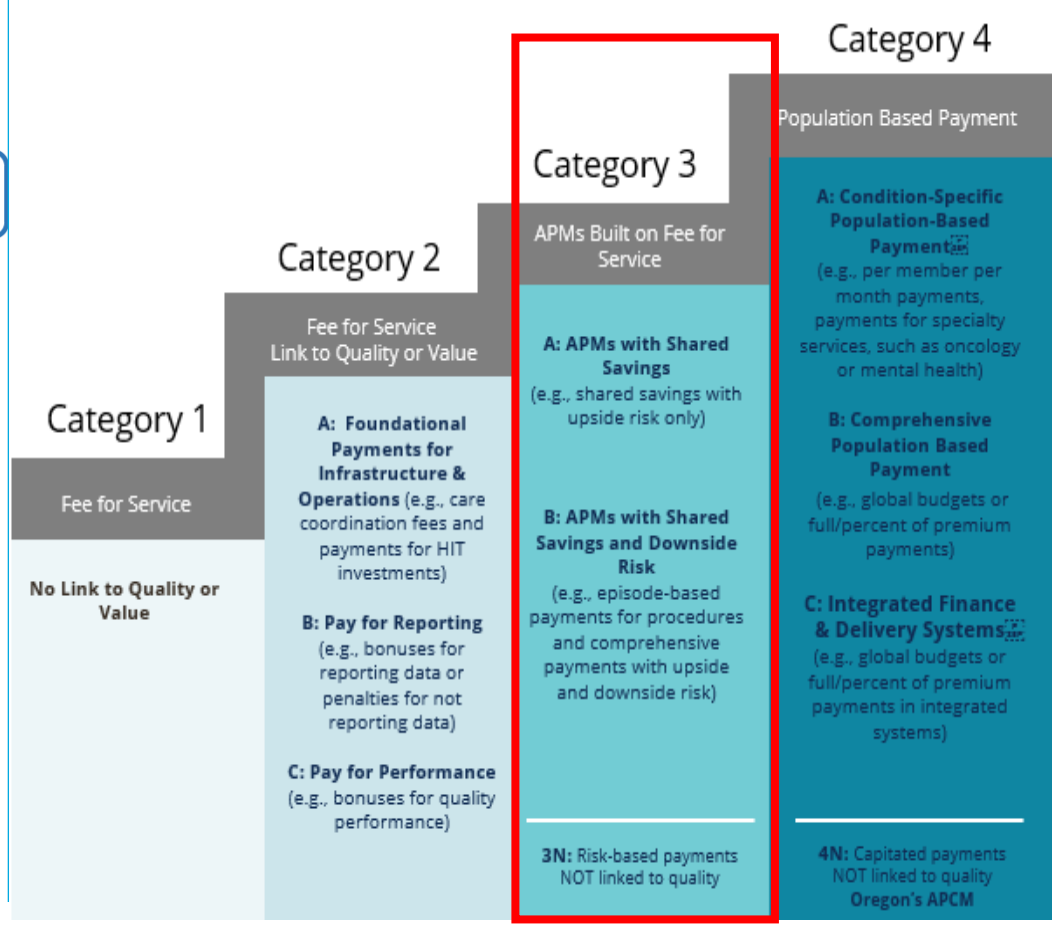
Art Jones, MD
Chief Clinical Officer, Medical Home Network
Principal, Health Management Associates

Art Jones, M.D. has 27 years of experience as a primary care physician and CEO at a Chicago area community health center that has adopted advanced alternative payment models since 1987. He was one of the founders and continues to serve as the Chief Clinical Officer for Medical Home Network (MHN) and MHN Accountable Care Organization (ACO) comprised of thirteen FQHCs and three health systems serving 180,000 Chicago area Medicaid recipients. MHN is completely delegated for care management and successfully operates under a global risk arrangement on total cost of care. MHN supports 64 FQHCs in ACO REACH or MSSP.

Dr. Jones is also a principal at Health Management Associates where he focuses on helping FQHCs and their clinically integrated networks succeed in advanced alternative payment models.

Alternative Payment Models: LAN Categories

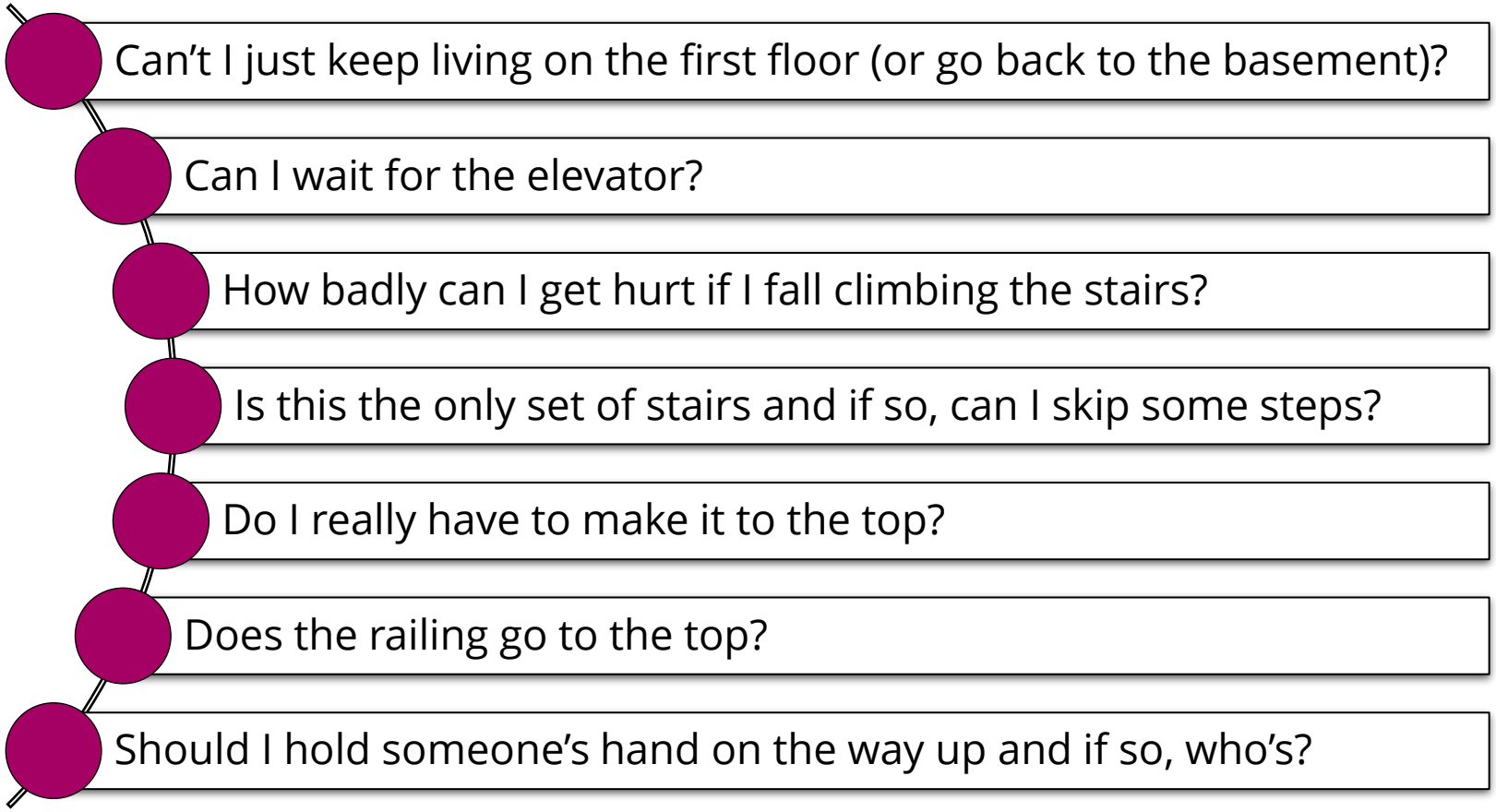




[Health Care Learning Action Network (HCPLAN) Alternative Payment Model (APM) Framework]

Is Value-Based Payment an Important Strategy?

MEDICAL HOME NETWORK



Keys to succeeding in LAN 3 or 4 APMs

MEDICAL HOME NETWORK

Assess VBP Readiness • Leadership • Information technology • Clinical & care management • Financial	**Project Performance Based on Historical Data** • Attributed membership • Quality metrics • Health service utilization and cost	**Identify and Prioritize Opportunities to Improve Outcomes**
Focus Care Management Resources for Maximum Impact	**Develop and Implement New Clinical Models of Care That Are Financially Sustainable**	**Distribute VBP Funds to Reward Value Performance and Prepare for LAN 3B or 4**

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

Assessing the Opportunity with Data

MEDICAL HOME NETWORK

Attribution

- Methodology for linking patients to a provider for accountability purposes.

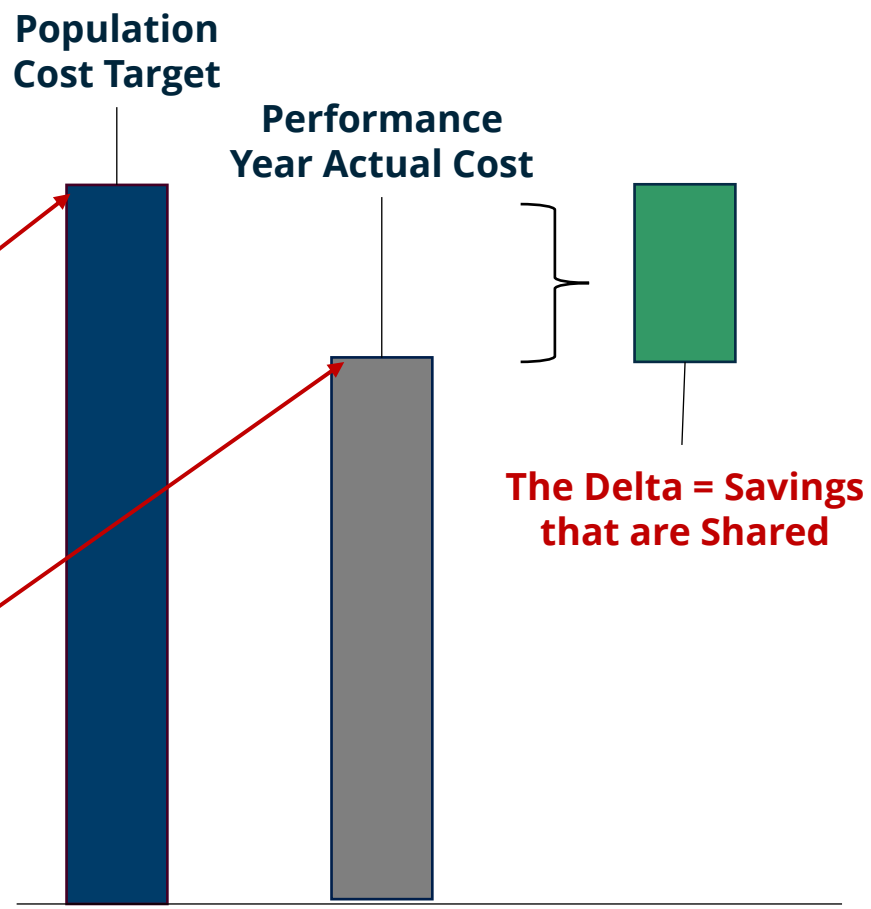
Benchmarking or Target Methodology

- A cost of care for the provider's attributed population, under which the provider needs to come in order to generate savings.

Medical Cost Experience

- Provider's actual cost of care during the performance year.

Savings on Total Cost of Care Model (3A/B, 4A)



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APM Contracts Offer Opportunities; Effective Care Models Produce the Savings

MEDICAL HOME NETWORK

Payment Reform
Without **Practice Transformation**
doesn't **change outcomes.**

Better Clinical Models

Care Management

Practice Transformation
without a **financial model**
is not **sustainable.**

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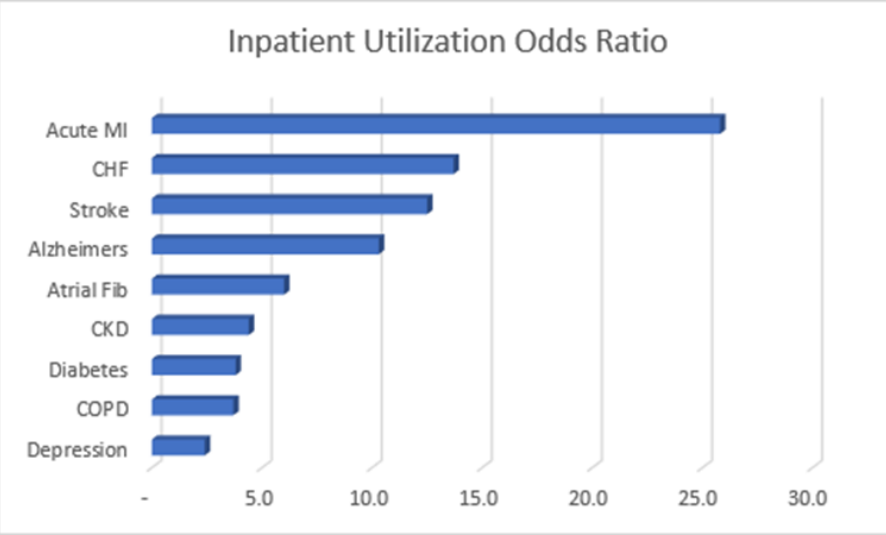
Analyze Utilization Data: Heart Failure

(for illustration purposes)

MEDICAL HOME NETWORK

Chronic Condition	# of Members	% of Members with Condition	# of Pts with Condition with Admission	% of Pts with Condition with Admission	# of Admissions	% of Admissions for All Population	Avg # of Admits for Pts with Condition	Odds Ratio
Acute Myocardial Infarction	29	0.1%	16	55.2%	39	2.2%	1.34	25.8
Atrial Fibrillation	92	0.3%	30	32.6%	60	3.4%	0.65	6.0
Alzheimer's	45	0.2%	10	22.2%	17	1.0%	0.38	10.3
Chronic Kidney Disease	2478	9.3%	352	14.2%	604	33.9%	0.24	4.4
COPD	580	2.2%	84	14.5%	133	7.5%	0.23	3.7
Heart Failure	**214**	**0.8%**	**82**	**38.3%**	**213**	**12.0%**	**1.00**	**13.7**
Depression	2707	10.2%	249	9.2%	383	21.5%	0.14	2.4
Diabetes	2993	11.3%	370	12.4%	603	33.9%	0.20	3.8
Stroke	114	0.4%	42	36.8%	55	3.1%	0.48	12.5



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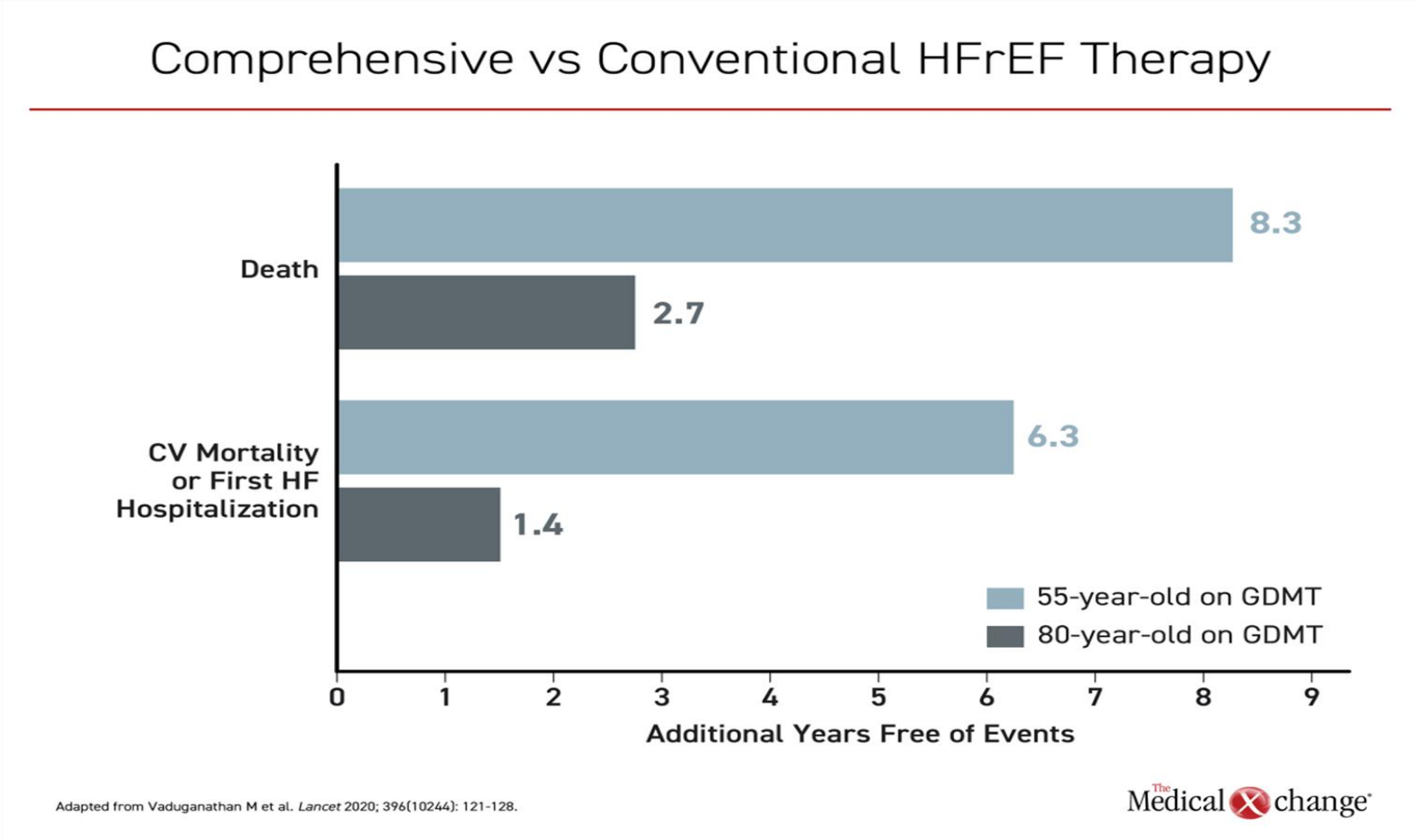
Analyze utilization data on your attributed membership to identify opportunities to improve outcomes and reduce total cost of care.

Impact of Guideline Directed Medical Therapy

(Example: Stage C Heart Failure)

MEDICAL HOME NETWORK



Implement an evidence-based model of care to generate improvements.

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Allocation of Care Management Resources to Maximize Impact

MEDICAL HOME NETWORK

PRIMARY CARE SERVICES

All patients receive this level of service, including PCP appointments, referral management, population health activities

Outreach to the assigned-but-not-yet-seen

CARE COORDINATION

Patients who are rising risk, have multiple care gaps, open referrals, complex social needs

COMPLEX CARE MANAGEMENT

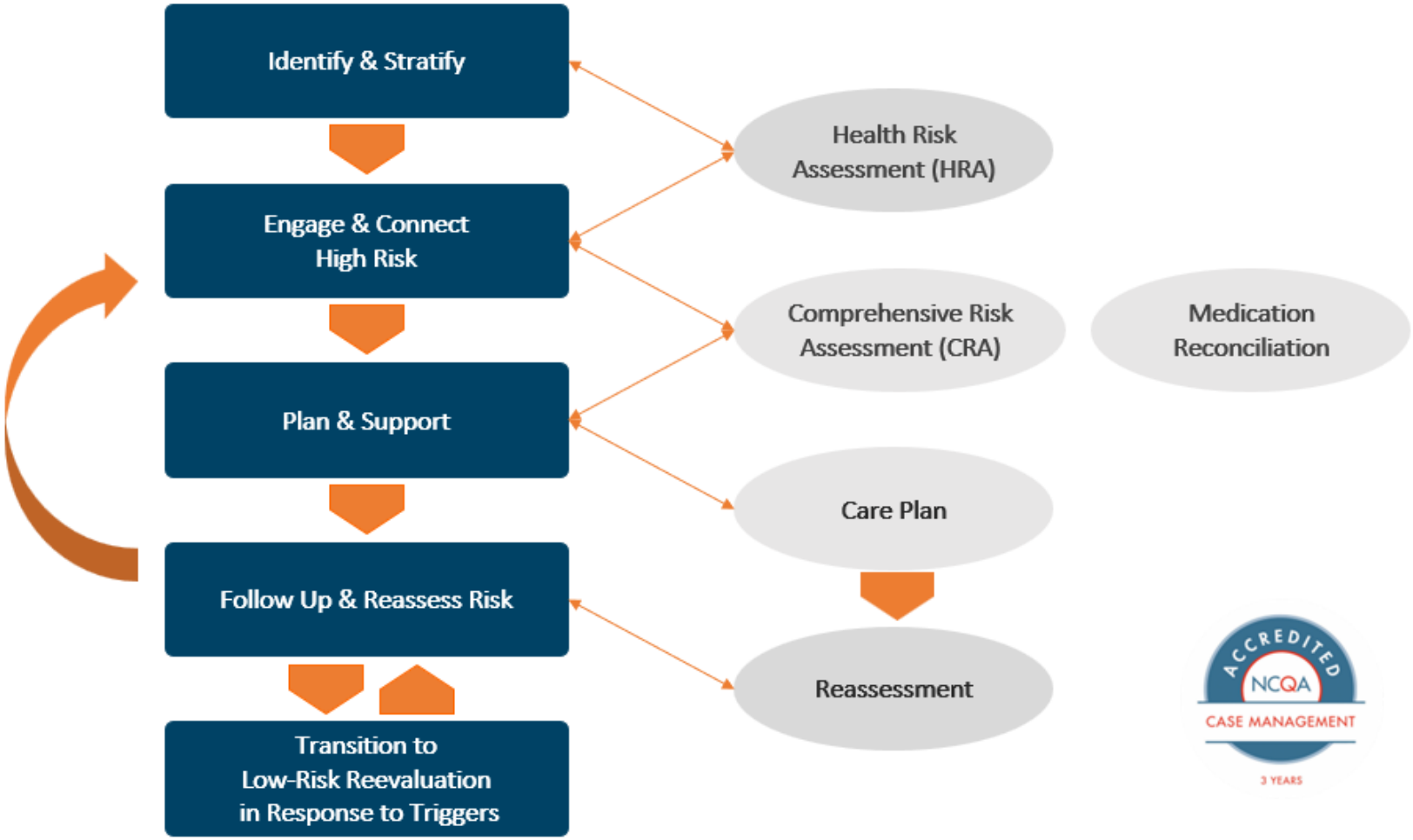
High-risk, multiple chronic conditions with many social determinants

ENHANCED CARE MANAGEMENT

The highest of the high-risk, Behavioral Health, Substance Use Disorder, unstable housing and high utilizers

Regulatory Compliant Approach to Care Management

MEDICAL HOME NETWORK



ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Evidence-Based Elements of Complex Care Management

MEDICAL HOME NETWORK

- Risk Stratification
- Integration within Primary Care Team
- Face to face interactions with care managers and their patients on a regular basis
- HIT to support
- Strong linkages between behavioral health and physical health
- Strong emphasis on medication management
- Transitions of care support
- Addressing SDOH
- Efficient use of the “right staff” - to the top of their license and having a team approach to getting the work done

Care Management Staff Should be Physically Integrated within the Care Team

MEDICAL HOME NETWORK

- Builds on established trust between the patient and the rest of the care team
- Gives direct access to the electronic health record and scheduling software
- Offers direct access to the rest of the care team allowing warm handoffs
- Permits participation in pre-visit planning and huddles
- Establishes relationships with community-based organizations
- Allows integration into new clinical models of care
- Facilitates multi-disciplinary case reviews

Transitions of Care Post-Hospitalization

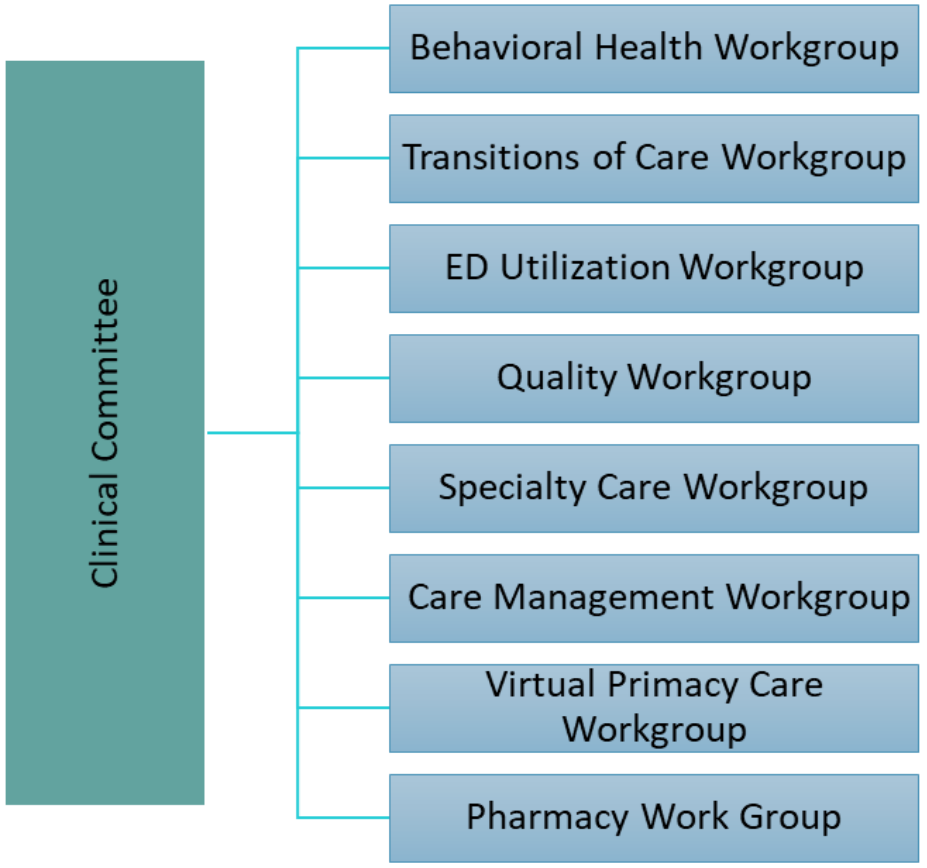
MEDICAL HOME NETWORK

- Establish initial contact during hospitalization
- Follow-up within 48 hours of discharge
  - Review discharge instructions with the patient
  - Review their medication changes
  - Verify the follow-up appointment with their PCP
  - Identify and address any barriers to adherence to the treatment plan
- Retrieve hospital records and scan them into the electronic health record
- Prioritize ambulatory follow-up within seven days of discharge with assigned PCP and/or appropriate specialist

Opportunity to Improve Outcomes: New/Modified Clinical Models of Care

MEDICAL HOME NETWORK

- **The importance of analytics and reporting**
- Importing, integrating and analyzing disparate data sources
- Risk stratifying to guide development and application of the model of care
- Reporting to guide operations and improvement activities
- Reporting outcomes to demonstrate compliance and effectiveness to payers and other regulatory agencies



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Test Models of Care for Financial Sustainability

MEDICAL HOME NETWORK

Payer Class

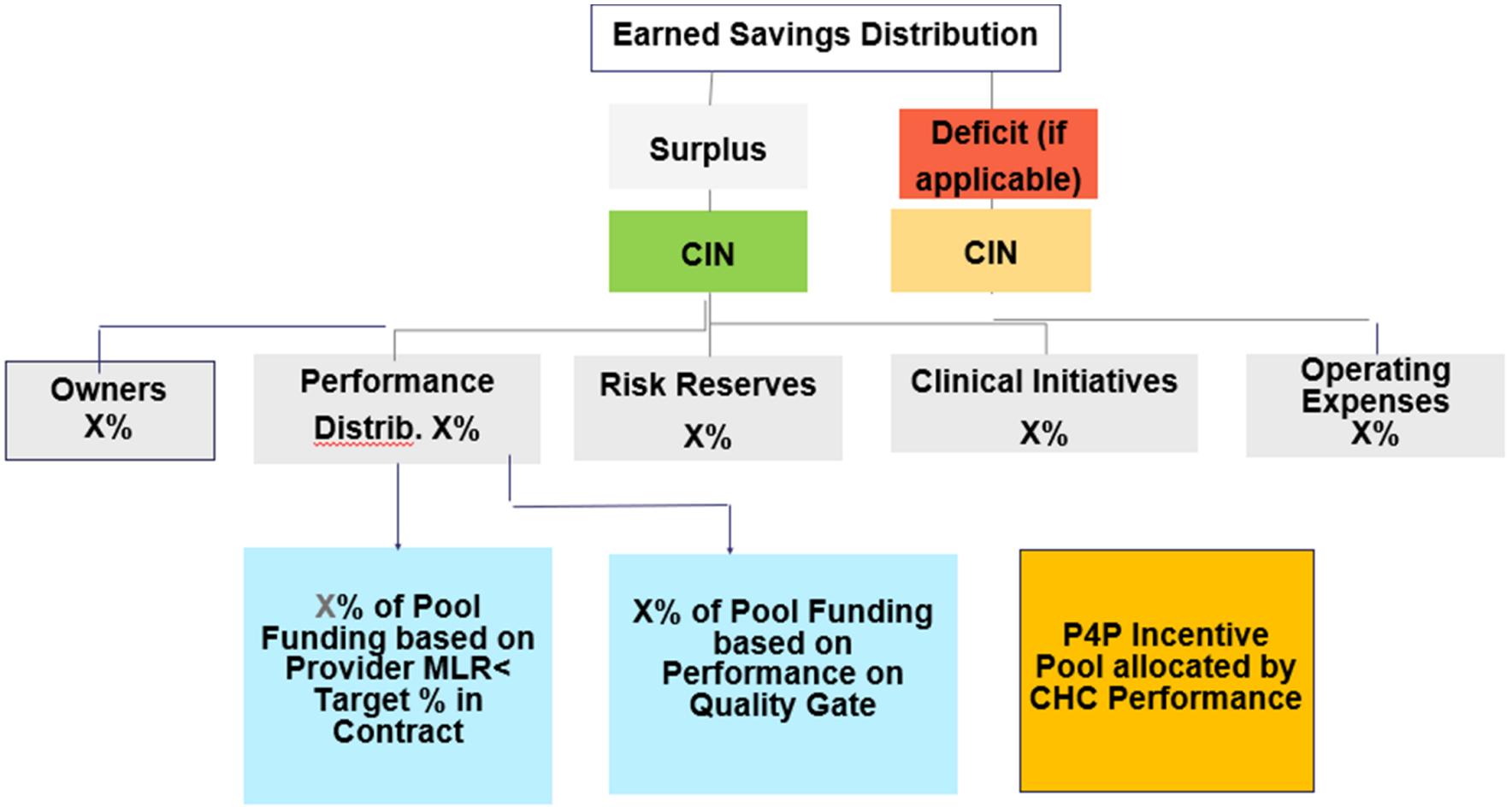
1. Managed care members
2. Insured, non-managed care patients
3. Medically uninsured

Financial Model

1.
   - Billable visits
   - Reduced in-person no-show rates
   - Improved “billable” provider efficiency
   - Increased market share
   - Value-based payment opportunity
   - Impact on a rebased encounter rate
2.
   - Billable visits
   - Reduced in-person no-show rates
   - Increased market share
   - Improved “billable” provider efficiency
3.
   - Reduction in uncompensated care costs
   - Reduced in-person no-show rates

Allocate a Portion of Savings to Build Reserves to Assume Risk

MEDICAL HOME NETWORK



Learning Objective: SDOH

Leverage Payment Opportunities to Support Social Drivers of Health (SDOH) and Health Equity Goals.

WHY consider Social Drivers of Health?

The conditions in which people are born, grow, work, live, and age, have an important influence on health outcomes.

These non-medical factors are referred to as social drivers of health (SDOH) and can influence health equity in positive and negative ways.

Examples of SDOH include:

- Income
- Education
- Unemployment and job insecurity
- Food insecurity
- Housing, basic amenities and the environment
- Social inclusion and non-discrimination

Research shows that the social drivers can be more important than health care or lifestyle choices in influencing health.

SDOH account for between 30-55% of health outcomes!*

* "Social determinants of health." World Health Organization. 2023. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

WHY consider Social Drivers of Health?

Health centers can play a pivotal role in addressing SDOH:

Social Impact	Care delivery models that account for and seek to address SDOH can reduce health disparities and inequities.
Quality Impact	Considering the relationship between SDOH and health outcomes, addressing SDOH can help to improve quality measures.
Financial Impact	Movement toward value-based care can provide financial incentive to address SDOH.

Featured Speaker

HOSTETLER GROUP

Craig Hostetler
Owner and Principal
Hostetler Group

Craig Hostetler is a consultant focused on aligning payment reform with practice transformation, particularly for vulnerable populations. He is nationally recognized as a pioneer in evolving FQHC payment to support holistic, team-based care. In his previous job, he was the executive director of the Oregon Primary Care Association (OPCA) for 15 years. Under his leadership, OPCA designed a Medicaid capitated Alternative Payment Methodology (APM) for FQHCs, removing the incentive to produce billable visits. Craig has been a consultant for over 6 years, working with FQHCs, PCAs, NACHC, and other organizations supporting health centers on understanding VBC and capabilities FQHCs need to be successful, developing VBC strategies that takes the current environment into account, developing and implementing FQHC capitated APMs for Medicaid, understanding and addressing SDoH barriers, and facilitating staff/board member strategic planning retreats.

Before coming to Oregon, Craig has worked in Washington, DC and overseas in London, England and Sydney, Australia as a health care manager.

Grant Opportunities to Address SDoH & Improve Health Equity

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- With the increased focus on improving health equity there are more grant opportunities at the local, state and national levels, e.g.:
  - HRSA's 2024 strategic plan includes incorporating health equity into grants.
  - The Robert Wood Johnson Foundation's vision is achieving health equity – faster and together.
  - One of four focus areas for The Commonwealth Fund is advancing health equity.
  - Direct Relief has a fund for health equity.
  - One of three priority areas for the W.K. Kellogg Foundation is equitable communities.
  - Corporate sponsors and local foundations are also increasing their focus on supporting health equity through grants.
- This is a good way to build capabilities to address SDoH priorities in your community and improve health equity.
- However, grants can have a limited timeframe and health centers would have to figure out how to continue these services when the funding runs out.

Medicaid/CHIP Opportunities

CMS Guidance to States on SDoH, Health Related Social Needs (HRSNs)

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- Services and supports that can be covered under Medicaid/CHIP to address SDoH:
  - Housing related services and supports
  - Non-medical transportation
  - Home-delivered meals
  - Educational services
  - Employment
  - Community Integration and social supports
  - Case management
- Opportunities to address SDoH, HRSNs under Medicaid and CHIP authorities, includes 1905(a) state plan authority (including reimbursements for FQHCs), section 1115 demonstrations, section 1945 health homes, managed care programs, and ACOs.

CMS letters to state health officials – January 2021 and November 2023

Medicare Opportunities CMS Innovation Center Strategy to Support Primary Care

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- CMS Portfolio of payment reform can support SDoH and health equity by:
  - Creating more opportunities for primary care to move from fee-for-service (FFS) to VBP to support whole-person care, including social needs.
  - Advancing health equity by:
    - ✓ Increasing safety net provider participation,
    - ✓Increasing payments to underserved areas, and
    - ✓Requiring health equity plans.

Medicare FFS Payment for Health Equity Services (2024)

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- **Health Equity Services in the 2024 Physician Fee Schedule Rule**
- Effective January 1, 2024, HCs can bill for Community Health Integration (CHI) services in addition to their Medicare PPS rate.
- CHI services include supportive services provided to patients with unmet SDOH needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.
- NACHC provides a guide for **CHI reimbursement tips**

FQHC Medicaid PPS & SDoH

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Many of the capabilities needed to address SDoH can be an allowable cost in developing PPS rates (e.g., care coordination, CHW services, connecting with CBOs, SDoH data collection, risk stratification).

However, you would need to have a good PPS Change in Scope process to get these services or infrastructure expenses included in the PPS rate.

SDoH services could be paid for outside of the PPS rate by the State or MCOs, but you should work with your PCA to determine the best strategy for utilizing PPS vs. payment outside of PPS to support SDOH capabilities in your state.

VBP & SDoH

HOSTETLER GROUP

- Fee-for service (FFS) is too inflexible for cross sector collaboration important to supporting SDoH interventions.
- VBP models can provide financial flexibility and accountability to allow providers to more easily address SDoH.
- There is relatively strong evidence that when health care organizations and CBOs work together on housing and nutrition interventions, they can reduce costs and generate an ROI.

Duke Margolis Institute for Health Policy, "How Are Payment Reforms Addressing Social Determinants of Health' February 4, 2021

Leveraging Infrastructure Payments & VBP to Support SDoH and Health Equity

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- Infrastructure payments (LAN 2A) pay for reporting (LAN 2B) can help health centers build SDoH and health equity capabilities (e.g., SDoH data collection, risk stratification, care coordination, HIT investments).
- VBP revenue (e.g., shared savings), that is greater than health center expenses to participate in the VBP model, can be used to build SDoH and health equity capabilities.
- Moving from FFS to primary care capitation can provide flexibility for health centers to provide holistic care to their patients, including addressing the SDoH needs of their patients.

A Closer Look at a CMS VBP Model:
Making Care Primary

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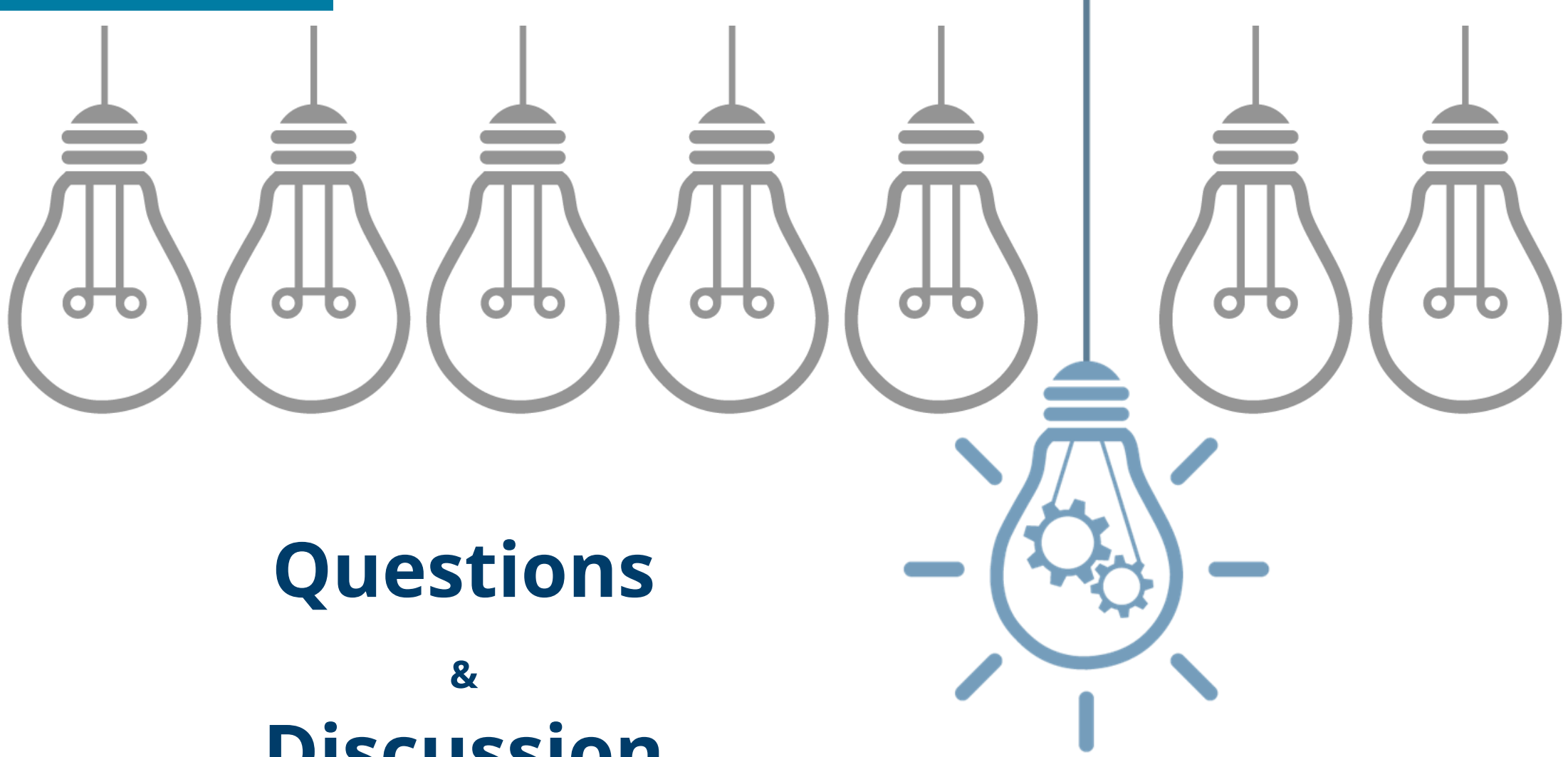
- Making Care Primary (MCP) is a CMS primary care VBP model that includes FQHCs.
- Although MCP is currently limited to 8 states, it does show CMS' commitment to paying health centers significant revenue in addition to Medicare PPS to advance high-quality primary care and health equity.
- MCP will pay significant infrastructure payments and pay-for-performance (P4P) payments on top of Medicare PPS revenue.
    - Infrastructure payments can be used to support SDoH and health equity activities, such as SDoH screening and referral.
- It also transitions Medicare PPS payments to capitation that can provide flexibility for health centers to address the holistic needs of their patients.
- Health centers participating in MCP will have to develop a strategic plan to reduce health disparities.

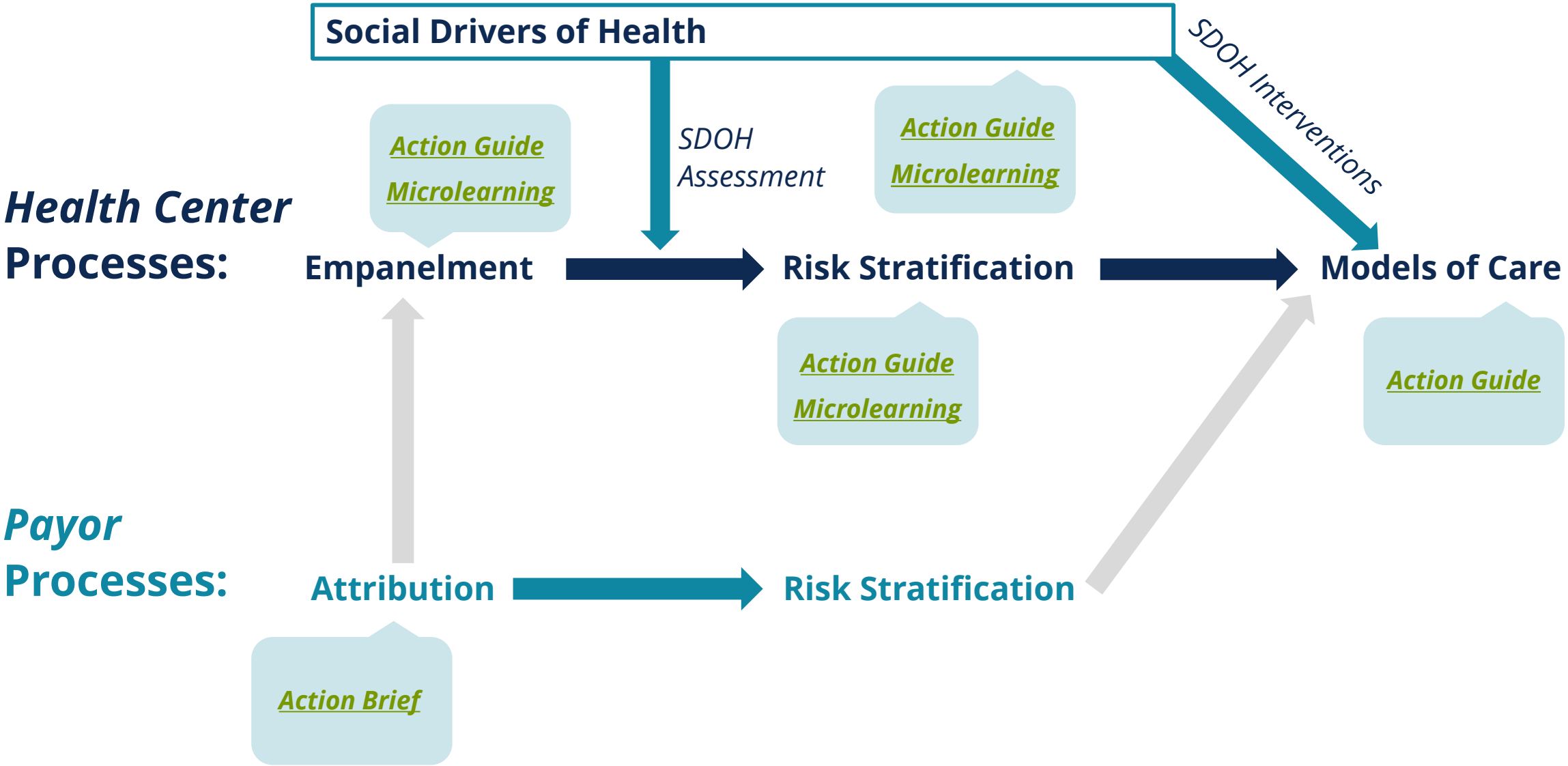


Questions

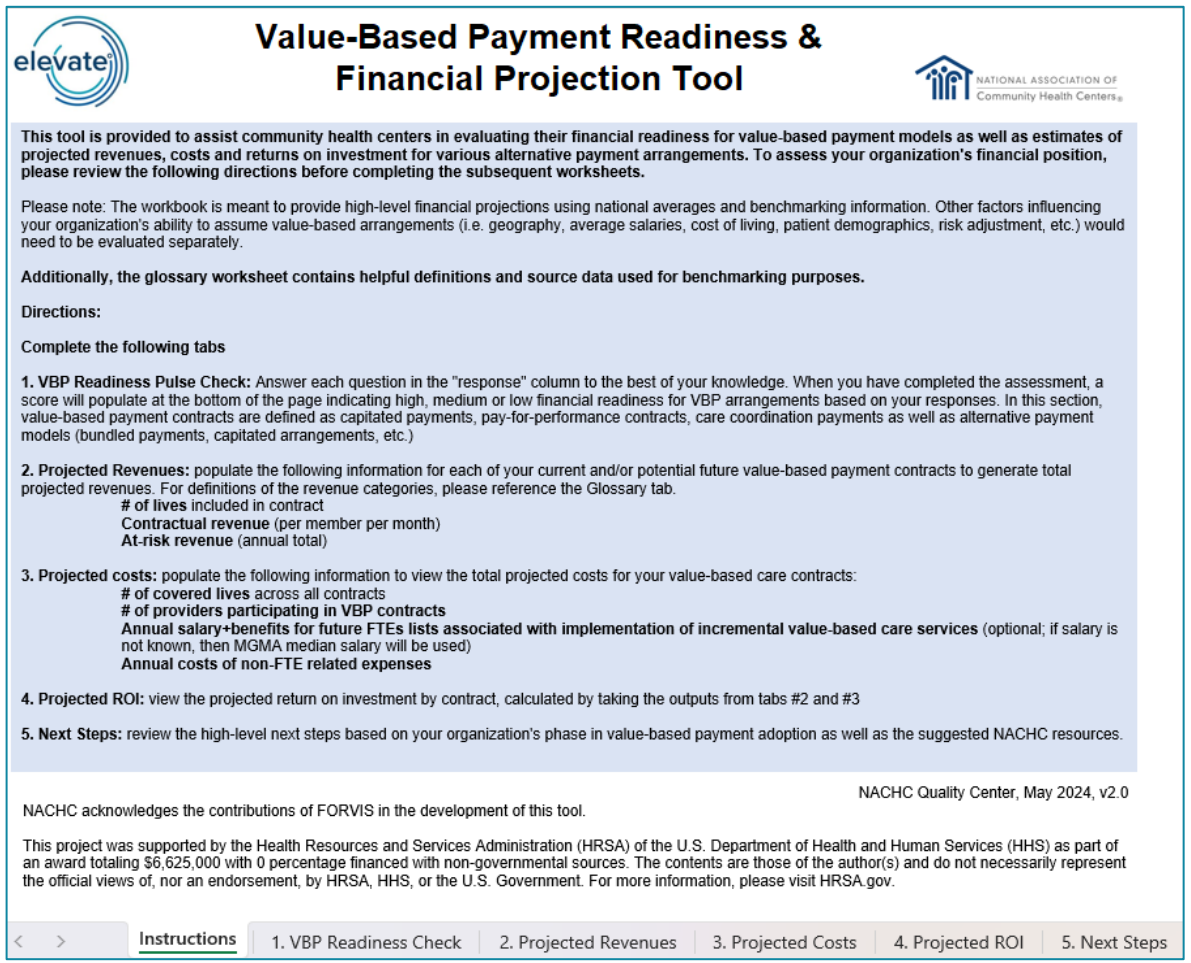
&

Discussion

Resources for every process



NACHC: Value-Based Payment Resources



elevate

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 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

NACHC acknowledges the contributions of FORVIS in the development of this tool.

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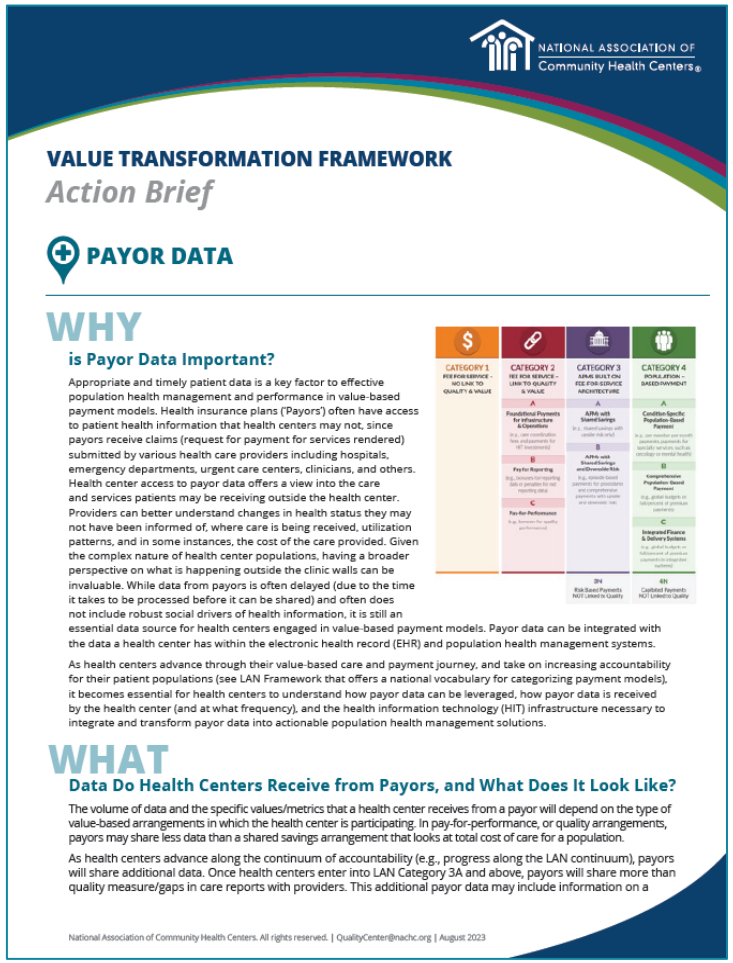
Instructions | 1. VBP Readiness Check | 2. Projected Revenues | 3. Projected Costs | 4. Projected ROI | 5. Next Steps

Value-Based Payment Readiness & Financial Project Tool (2024 update)
(Coming Soon!)



NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
Action Brief

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

COMING SOON...Business Case for Value-Based Payment

Welcome to NACHC's Value-Based Payment Learning Series

Link to recorded module (10 mins)

6/20

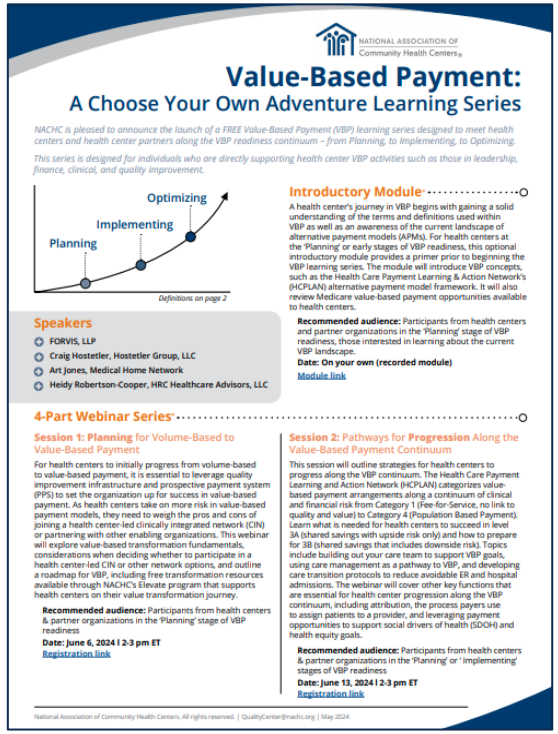
Session 1: Planning for Volume-Based to Value-Based Payment

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


NATIONAL ASSOCIATION OF Community Health Centers®

Value-Based Payment:
A Choose Your Own Adventure Learning Series

NACHC is pleased to announce the launch of a FREE Value-Based Payment (VBP) learning series designed to meet health centers and health center partners along the VBP readiness continuum – from Planning, to Implementing, to Optimizing.

This series is designed for individuals who are directly supporting health center VBP activities such as those in leadership, finance, clinical, and quality improvement.

Optimizing
Implementing
Planning

Definitions on page 2

Speakers
- FORVIS, LLP
- Craig Hostetler, Hostetler Group, LLC
- Art Jones, Medical Home Network
- Heidy Robertson-Cooper, HRC Healthcare Advisors, LLC

Introductory Module

A health center's journey in VBP begins with gaining a solid understanding of the terms and definitions used within VBP as well as an awareness of the current landscape of alternative payment models (APMs). For health centers at the 'Planning' or early stages of VBP readiness, this optional introductory module provides a primer prior to beginning the VBP learning series. The module will introduce VBP concepts, such as the Health Care Payment Learning & Action Network's (HCPLAN) alternative payment model framework. It will also review Medicare value-based payment opportunities available to health centers.

Recommended audience: Participants from health centers and partner organizations in the 'Planning' stage of VBP readiness, those interested in learning about the current VBP landscape.

Date: On your own (recorded module)

Module link

4-Part Webinar Series

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

For health centers to initially progress from volume-based to value-based payment, it is essential to leverage quality improvement infrastructure and prospective payment system (PPS) to set the organization up for success in value-based payment. As health centers take on more risk in value-based payment models, they need to weigh the pros and cons of joining a health center-led clinically integrated network (CIN) or partnering with other enabling organizations. This webinar will explore value-based transformation fundamentals, considerations when deciding whether to participate in a health center-led CIN or other network options, and outline a roadmap for VBP, including free transformation resources available through NACHC's Elevate program that supports health centers on their value transformation journey.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' stage of VBP readiness

Date: June 6, 2024 | 2-3 pm ET

Registration link

Session 2: Pathways for Progression Along the Value-Based Payment Continuum

This session will outline strategies for health centers to progress along the VBP continuum. The Health Care Payment Learning and Action Network (HCPLAN) categorizes value-based payment arrangements along a continuum of clinical and financial risk from Category 1 (Fee-for-Service, no link to quality and value) to Category 4 (Population Based Payment). Learn what is needed for health centers to succeed in level 3A (shared savings with upside risk only) and how to prepare for 3B (shared savings that includes downside risk). Topics include building out your care team to support VBP goals, using care management as a pathway to VBP, and developing care transition protocols to reduce avoidable ER and hospital admissions. The webinar will cover other key functions that are essential for health center progression along the VBP continuum, including attribution, the process payers use to assign patients to a provider, and leveraging payment opportunities to support social drivers of health (SDOH) and health equity goals.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' or 'Implementing' stages of VBP readiness

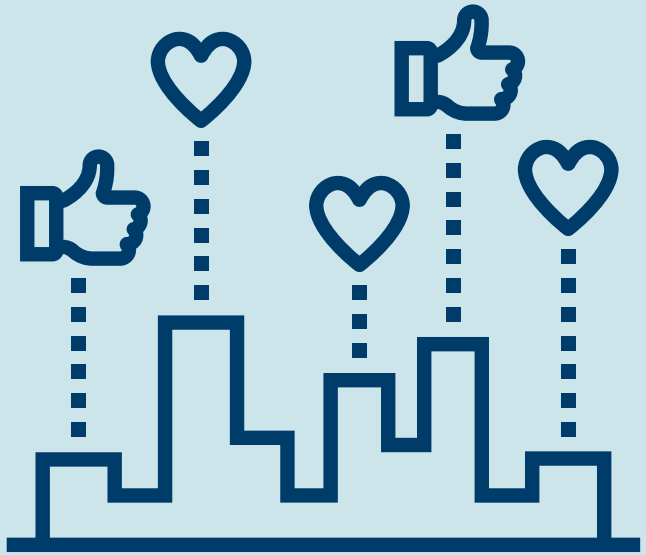
Date: June 13, 2024 | 2-3 pm ET

Registration link

Supplemental Sessions!

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

Registration Link: Supplemental Sessions



Provide Us Feedback

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