NATIONAL ASSOCIATION OF
Community Health Centers®

PLANNING FOR VALUE-BASED PAYMENT

elevate

Session 1 in a 4-Part Series

June 6, 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 and Innovation

Rita Lewis, MPH, CPHQ
Director, Value-Based Care

Planning for Value-Based Payment

Learning Objectives:

- ✓ Overview of NACHC's Value-Based Payment Series
- ✓ Understand the current healthcare landscape driving value-based care and value-based payment.
- ✓ Outline how Medicaid PPS provides a successful foundation for VBP.
- ✓ Highlight the role of clinically integrated networks and other partners in advancing health center VBP.
- ✓ Develop a VBC Roadmap.
- ✓ Leverage NACHC's Elevate Program.

Q&A

Welcome to NACHC's Value-Based Payment Learning Series

NATIONAL ASSOCIATION OF Community Health Centers

INTRODUCTION TO VALUE-BASED PAYMENT

elevate

Recorded Module (10 Minutes)

June 2024

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

Supplemental Sessions!

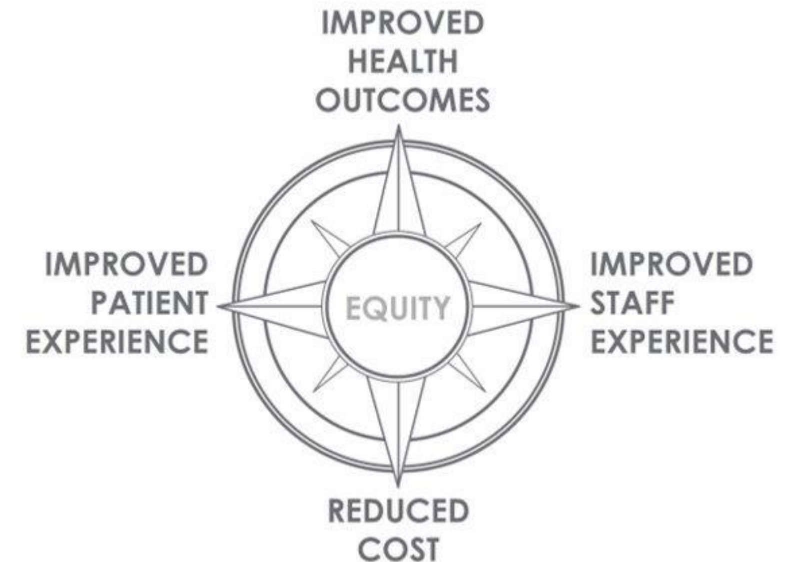
1. **FQHC VBP Financial Projection Tool**
2. **Total Cost of Care**

Registration Link: Supplemental Sessions

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

WHAT is your Health Center's Level of VBC Progress? VBP Readiness?

FQHC Assessment

Transformation Progress

Learning

Basic

Applied

Skilled

Expert

Planning

Implementing

Optimizing

Value-Based Payment Readiness

Learning Objective: Healthcare Landscape

Understand the current healthcare landscape driving value-based care and value-based payment.

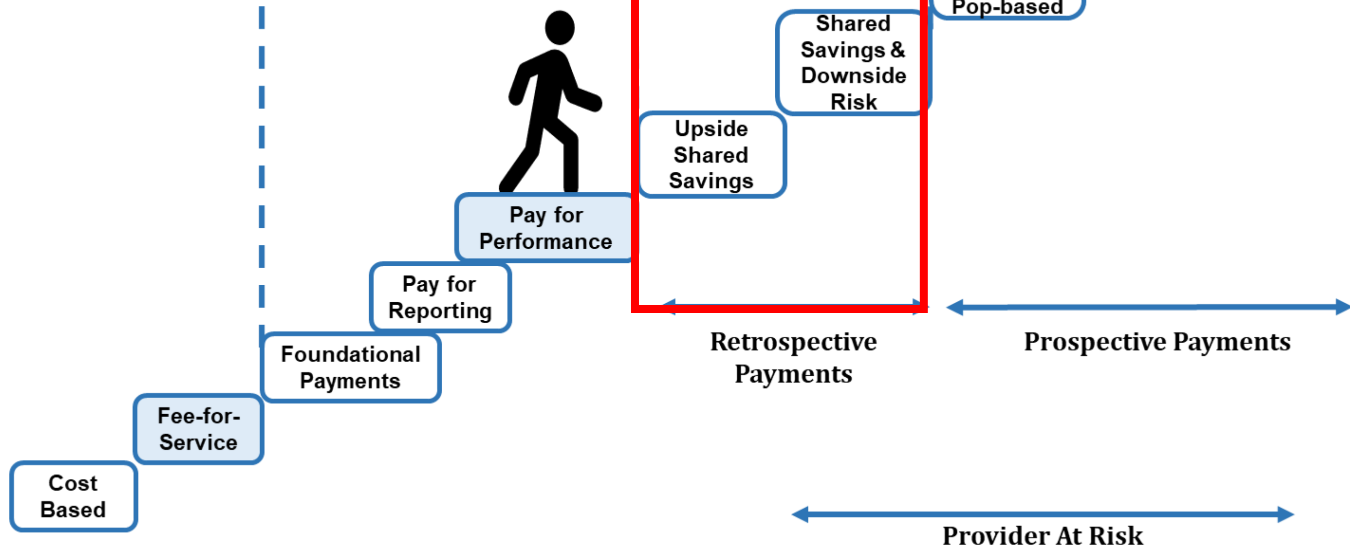
Featured Speaker

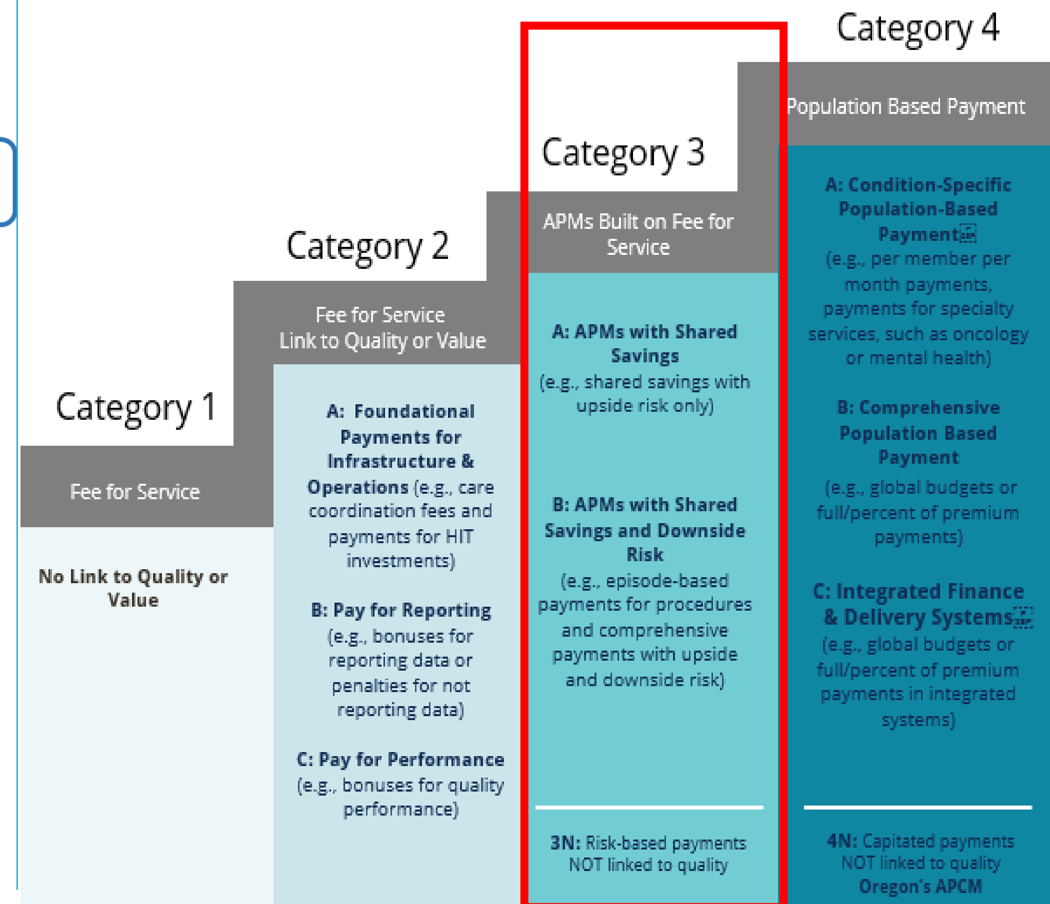
Art Jones, MD
Chief Clinical Officer, Medical Home Network
Principal, Health Management Associates

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: Health Care Learning Action Network Categories





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

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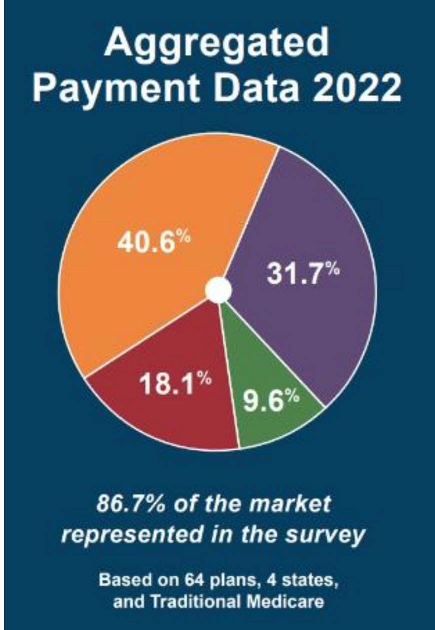
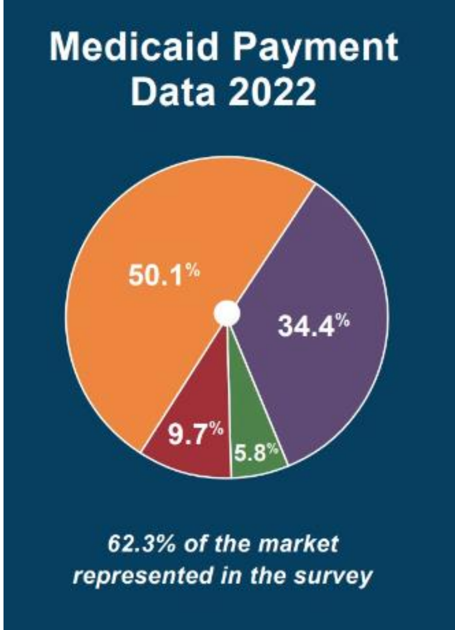
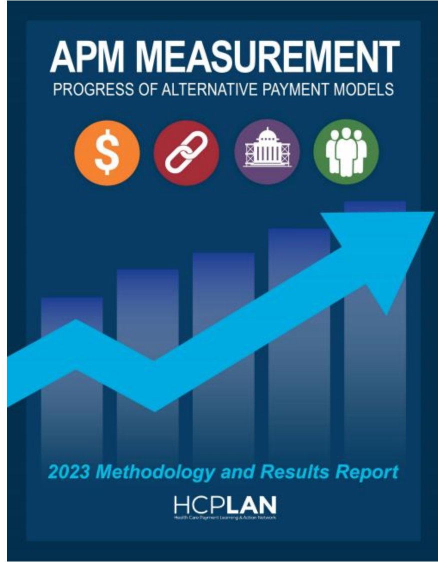
Value-Based Payment Model Adoption by LAN Category

MEDICAL HOME NETWORK





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



- Across lines of business, >50% of payments are pay-for-performance or more advanced valued-based models.
- The Medicaid line of business lags the overall trends still having a higher level of payments tied to providers in FFS arrangements.
- However, in the past four years, the Medicaid line of business has been increasing its presence of LAN category 3 and 4 value-based models.

HCPLAN APM Measurement: 2021 Survey

WHY Value-Based Payment? Why Now?

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- **CMS:** 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.
- **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.*

Implementing High Quality Primary Care

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National Academy of Medicine
PDF is available at http://nap.edu/25983

Contents

- A new vision for primary care
- Defining high-quality primary care
- Integrated primary care delivery
- Interprofessional teams
- Future primary care workforce
- Digital health and primary care
- Primary care measures
- Research in primary care
- **Payment to Support high-quality primary care**
- Implementation strategy
- ...and more!!!

Learning Objective: Medicaid PPS

Outline how Medicaid PPS provides a successful foundation for VBP

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.

Medicaid PPS: A Successful Foundation for VBP

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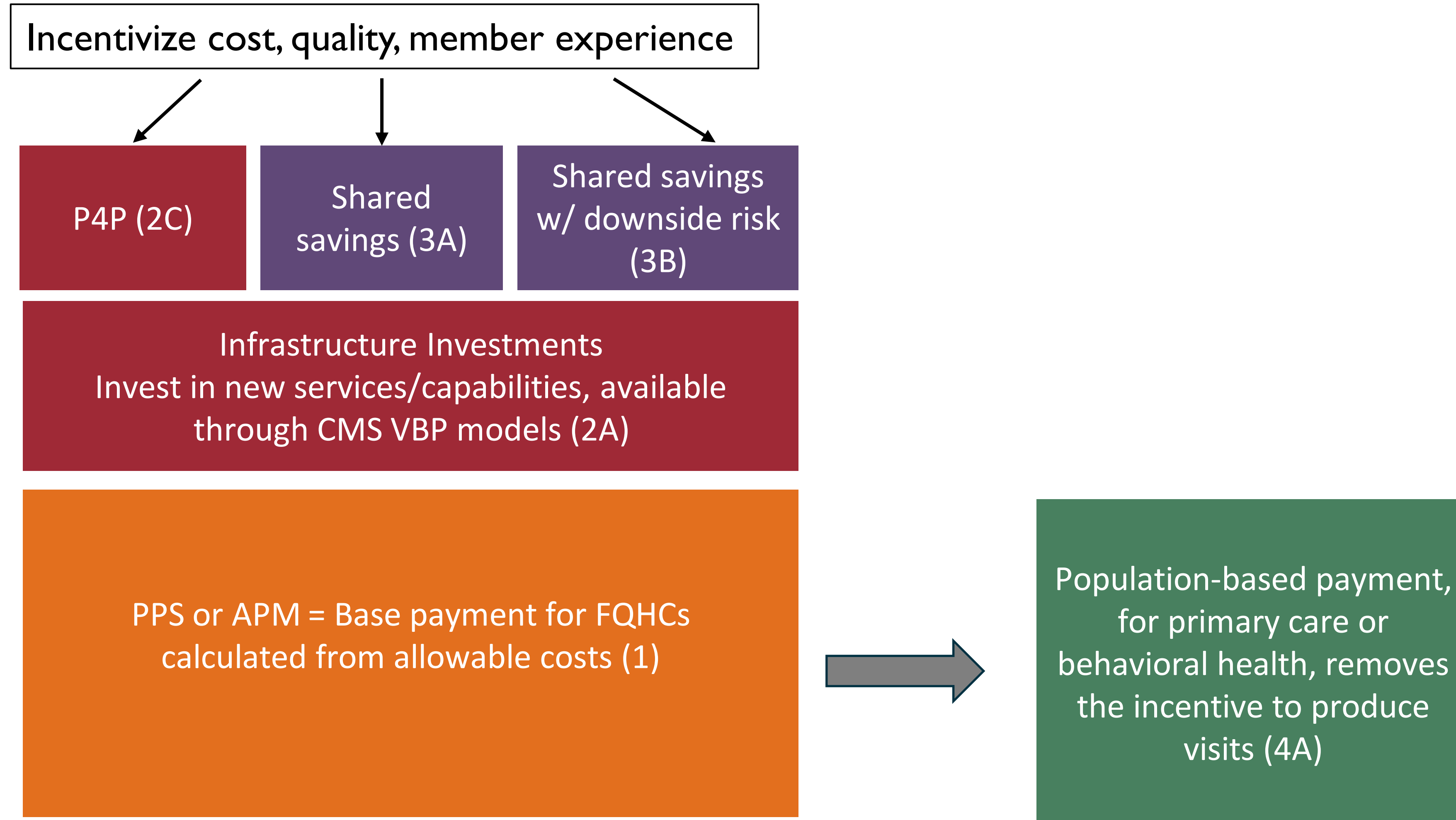

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Based on slides presented by NACHC and JSI

Build Your Base:
Prospective Payment System (PPS)

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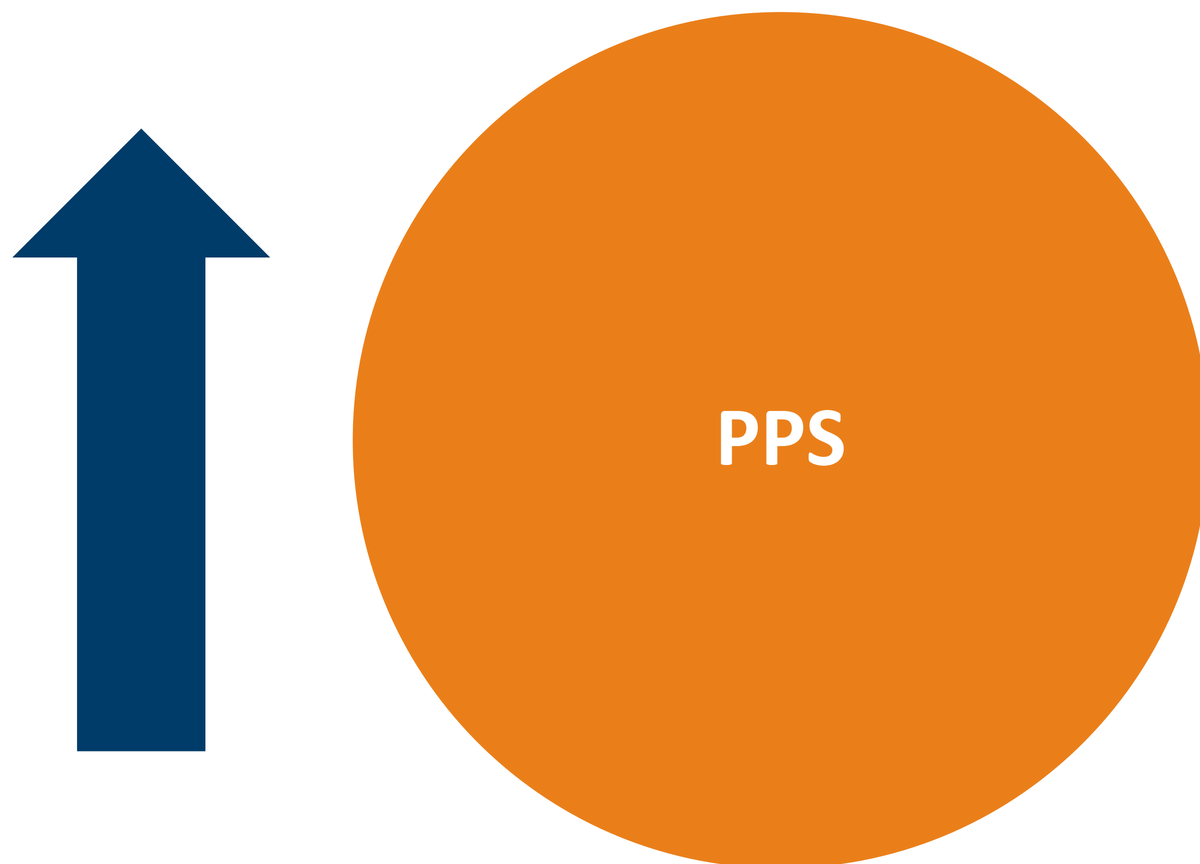

Rates can be increased through:

- Change in Medicare Economic Index
- **Change in Scope**

+Medicaid Prospective Payment System (PPS) rates are a fixed, per-visit rate. States must determine and assure that the payments are based upon, and cover, the reasonable costs related to the cost of furnishing FQHC services and other ambulatory services defined in §1905(a)(2)(C) of the Social Security Act of providing services to Medicaid beneficiaries

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Evaluate: Change in Scope of Services

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A **Change in Scope (CiS)** of services is a change in the type, intensity, duration, and/or amount of services

Recalculates the PPS Rate

- Each state defines its CiS rules and they do vary significantly from state to state, including some that don't comply with federal law, policy or guidance (e.g., the only qualifying event that the state will allow is a change in type of service).
- States have to implement a CiS process to assure payments cover reasonable costs.
- CiSs can include services that are not a face-to-face visit with a provider.
- Since CiSs can either increase or decrease the FQHC PPS rate, HCs should calculate the impact on its encounter rate before requesting a CiS.

Consider: Alternative Payment Methodologies

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- Voluntary for states and FQHCs.
- Approved through a State Plan Amendment (SPA)
- Because it must be at least as much as PPS, it requires a reconciliation process and that FQHCs continue to implement a PPS methodology.

Examples: FQHC APMs

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- Cost-based / Rebasing
- Paying between cost-based and PPS
- Enhanced rate above PPS for some services
- Capitated or population-based
- Using an inflation index other than Medicare Economic Index (MEI)
- Converting a baseline greater than PPS to an APM and weaving in VBP (payments above PPS can be connected to performance metrics)

PPS and VBP: Medicaid

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- PPS is baseline payment
- PPS + VBP added on top
- VBP isn't counted against PPS payments

PPS – payment for direct services

VBP – incentive payments tied to value-related outcomes

Examples: FQHC Medicaid Rates + VBP

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Payment Method	Example
PPS + VBP (e.g., PCMH, Pay-for-Performance, shared savings). VBP models implemented by MCOs, ACOs, or directly with the state	Several states
APM for billable services + VBP	Maine
Cost-Based APM that includes VBP (payments above PPS can be put at risk)	Colorado
Converting PPS to a capitated APM + VBP	Oregon
Converting a baseline > PPS to a capitated APM (payments above PPS can be connected to value)	Washington Colorado

Not a comprehensive list of states implementing these models

Medicaid PPS: A Successful Foundation for VBP

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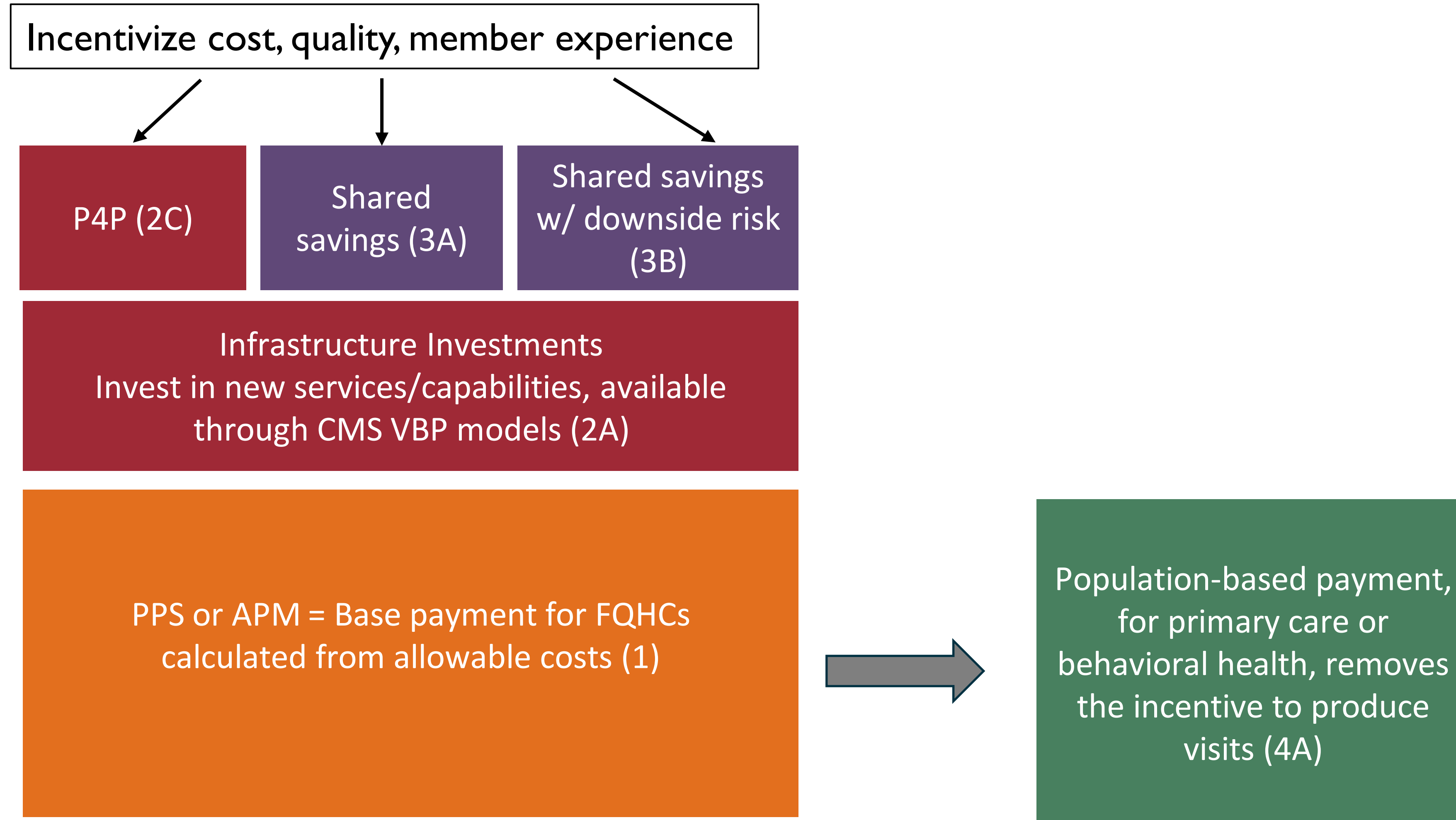

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Based on slides presented by NACHC and JSI

Opportunities in New Healthcare Landscape

- **Base Payment**: States are more supportive of increasing rates through Medicaid PPS Change in Scope or cost-based APMs to improve outcomes for vulnerable populations/health equity.
- **Infrastructure Payments**: Opportunities to add infrastructure payments to advance SDOH and health equity efforts, aligned with new CMS VBP models.
- **VBP**: Opportunities to increase revenue for primary care through VBP.
- **Primary Care Capitated Models**: Population-based payments for primary care provide flexibility to implement comprehensive, team-based care.

Patient service revenue funding streams have to work together to support health center care models in the current environment (workforce shortages, escalating salaries, the importance of primary care to VBP models, FQHC's evolving care model).

Part of the Equation: FQHC Wrap Payment

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FQHC Wrap Payment is the difference between a FQHC's encounter rate and what it would have received if paid at the Medicaid market rate

- PPS rate recognizes the additional services HRSA requires of FQHCs, including enabling services, and their associated costs.
- Value-based payments do not count when determining if a FQHC is paid at its encounter rate.

FQHC Wrap Strategy in VBP

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If not carefully managed, the wrap can eliminate the icing and even shrink your piece of the cake.

Payment for Direct Services

Fee-for-service PPS or Capitated APM

Value-Based Payment Opportunities

- Care Management Fee
- PCMH
- P4P
- **Shared Savings/Risk**
- Partial Capitation for non-PCP Services

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Learning Objective: Partnerships

Highlight the role of clinically integrated networks and other partners in advancing health center value-based payment.

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 are different types of Networks and Why Join?

Clinically Integrated Network (CIN) is a group of independent healthcare provider organizations that collectively collaborate to improve patient outcomes, reduce costs, and enhance patient experience through value-based payment agreements they cannot access independently on their own.

Messenger Model Independent Practice Association (IPA) is a network of independent healthcare providers. The network negotiates separate agreements for each provider with payors for efficiency purposes.

Accountable Care Organization (ACO) is a is a group of healthcare providers who work together to provide coordinated, high-quality care to Medicare patients. ACOs are contracting entities for the Medicare Shared Savings Program.

What is a Health Center-Led CIN?

A ***Health Center-led CIN*** is a group of independent ***Health Centers*** that work together to improve patient outcomes, reduce total cost of care, and improve patient experience, care team experience, and equity.

A Health Center-Led CIN may offer:

- Collective contracting for value-based incentives or base payments
- Protection from anti-trust claims at the Federal and State level
- Patient data aggregation to inform the development of better care models.
- Expanded or improved care and/or services to health center patients
- Expanded shared services and infrastructure to inform value-based care delivery

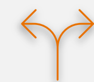
What can a Health Center-Led CIN Offer?

Harnesses collective power to negotiate better value-based payment

Aligns with the Health Center mission

Creates synergies with Health Center programs

Leverages shared infrastructure already in use


Directs CIN efforts through Health Center-led Governance

Other Potential VBP Partners – 'Enablers'

Enables primary care providers to engage in down-side value-based payment models

Provides scale and capital reserves to take on downside risk

Provides tools and resources to facilitate and expedite the transition toward value

Largely focused on Medicare & Medicare Advantage with an increased interest in Medicaid

Increased growth of companies

Funded by private equity or venture

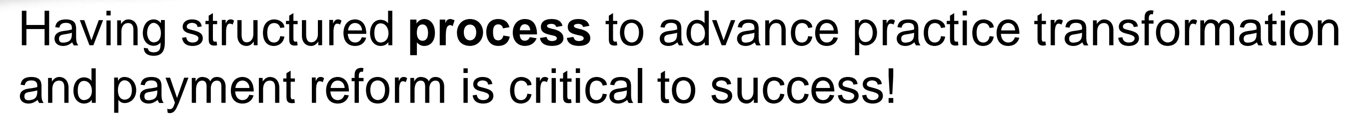
Considerations for Joining a Network

- Do it alone or do it with a partner?
- Identify mission and value-aligned partners
- Do your homework on partners and participants
- Seek program and initiative synergy
- Know your power and value

Objective: Roadmap

Develop a VBP Roadmap.

Why Develop a VBP Roadmap?



Having structured **process** to advance practice transformation and payment reform is critical to success!

Actions to Developing a VBP Roadmap?

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This process takes time; it doesn’t happen overnight

- Educate staff on VBC and VBP
- Establish a group to guide the work
- Gather external information
- Gather internal information
- Develop VBC goals/ priorities
- Rank order goals/ priorities
- Implement goals/ priorities
- Evaluate & communicate

Actions to Developing a VBP Roadmap?

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- Educate board and staff on VBC and VBP
- Discuss staff roles – where does everyone fit in?

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INTRODUCTION TO VALUE-BASED PAYMENT

elevate

Recorded Module (10 Minutes)

June 2024

DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE

ATTRIBUTION

PAYOR DATA

VALUE TRANSFORMATION FRAMEWORK

Action Brief

PAYOR DATA

WHY

WHAT

Suite of Value-Based Payment Action Briefs

Developing VBP Goals, Attribution, Attribution Thresholds, Payor Data

Establish a Group to Guide VBP Work

Convene a **VBP Work Group** to oversee the work

- Determine composition
- Select participants
- Decide meeting frequency
- Establish a Charter, including high-level VBP Goals

Work can be rolled into an existing committee once it gains momentum and has commitment from leadership

Gather External Information

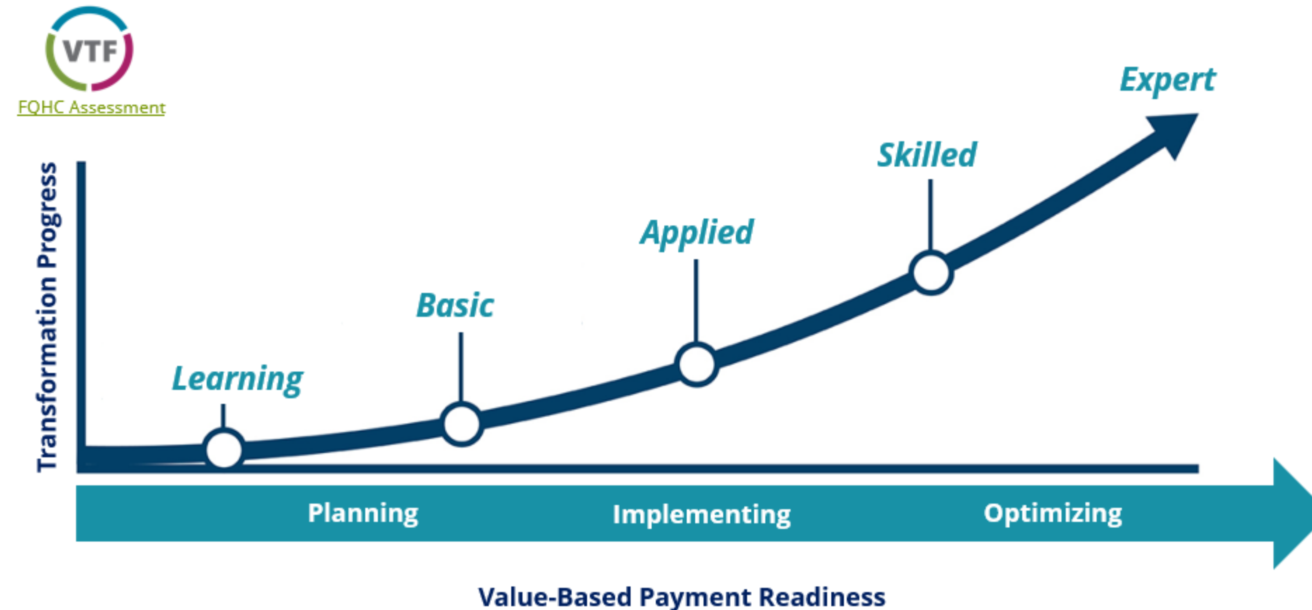
Essential part of developing a VBC Roadmap

Elements of gathering information

- Monitor the local, state, and national VBP environment
- Meet with key stakeholders; determine their VBP goals

Gather Internal Information

- Self assess your health center's VBC/VBP capabilities
- Consider NACHC's Value Transformation Framework assessment
- It's a good way to self assess your VBC capabilities, while engaging staff in the conversation.



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Develop VBP Goals and Priorities

Establish VBC & VBP Goals

Develop a comprehensive list of goals

Suggested Process

- Work with your Board and VBP Work Group to develop goal; update at least annually
- Use the results of the VTF Assessment tool to help identify priorities
- Determine how often to repeat VTF Assessment

Prioritize the Work

Rank	Rank order the comprehensive list of VBC/VBP work
Group	Group into short-term, long-term, and ongoing projects
Determine	Determine resources needed, which projects to focus on first, and timing for the prioritized projects

Implement VBC/VBP Work

Develop	Develop SMART goals and objectives (Specific, Measurable, Achievable, Relevant, and Time-based) https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/objectives.html
Select	Select project leads, develop a comprehensive workplan, and implement the work.
Think about	Think about starting with an easy win to gain momentum before implementing more difficult projects.

Evaluate & Communicate

- Develop an Evaluation Plan
- Track results against SMART goals and objectives
- Communicate VBC/VBP progress and accomplishments to staff and board
    - Include VBP updates on Work Group and Board agendas
    - Provide regular updates to health center staff

Learning Objective: Elevate

Leverage NACHC's Elevate Program.

NACHC Tool: FQHC VBC Glidepath

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.			

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

VTF Assessment Helps Guide Improvement

FQHC Assessment

Transformation Progress

Learning

Basic

Applied

Skilled

Expert

Planning

Implementing

Optimizing

Value-Based Payment Readiness

A Systems Approach to Transformation

Value Transformation Framework

Step-by-Step

Guided Application

Trainings & Resources

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

National Learning Forum

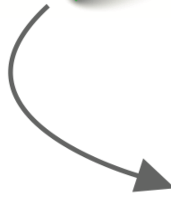
836 CHCs | 90 PCAs/HCCNs/NTTAPS | >15 Million Patients

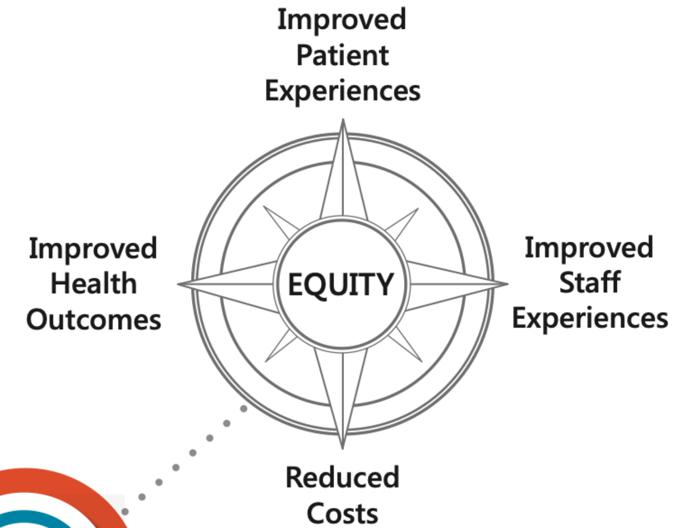
- ✓ *Monthly Webinars*
- ✓ *Supplemental Sessions*
- ✓ *Evidence-Based Action Guides*
- ✓ *Action Briefs*
- ✓ *eLearning Modules*
- ✓ *Tools & Resources*
- ✓ *Professional Development Courses*
- ✓ *Online Learning Platform*

Register for free HERE

Elevate Journey

Your transformation journey begins here!





STEP 1 - ENGAGE
Register for Elevate and participate in the **FREE** health center learning community. Invite others

STEP 2 – ASSESS
Measure transformation progress using the Value Transformation Framework (VTF) Assessment

STEP 3 – PLAN
Incorporate transformation efforts into your Improvement Strategy

STEP 4 – TRANSFORM
Apply the VTF and suite of transformation tools and resources

STEP 5 – REASSESS
Measure transformation progress over time using the VTF Assessment; monitor, adjust, and improve

NACHC: Value-Based Payment Resources

Value-Based Payment Readiness & Financial Projection Tool

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!)

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

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Suite of Value-Based Payment Action Briefs:

Developing VBP Goals

Attribution

Attribution Thresholds

Payor Data

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

FOR MORE INFORMATION CONTACT

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Faculty Contact Information:

Craig Hostetler, Principal
Hostetler Group, LLC
503-913-6916
craig@hostetler-group.com

Art Jones
Medical Home Network
773.891.6812
ajones@healthmanagement.com

Heidy Robertson-Cooper
HRC Healthcare Advisors, LLC
816.419.9577
Heidy@hrc-advisors.com