NATIONAL ASSOCIATION OF Community Health Centers®

IMPLEMENTING HIGH-QUALITY PRIMARY CARE WITHIN VALUE-BASED PAYMENT MODELS

elevate

Session 3 in a 4-Part Series
June 20, 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

Jen Nolty
Director, PCA & HCCN Relations

Implementing High-Quality Primary Care

Learning Objectives:

- ✓ Discuss landmark report on the current state of primary care.
- ✓ Outline fee-for-service model shortcomings and value-based payment model advantages.
- ✓ Highlight new models of care using interprofessional teams and integrated delivery of care.
- ✓ Outline health center considerations for new Centers for Medicare and Medicaid (CMS) Innovation Center value-based payment models.

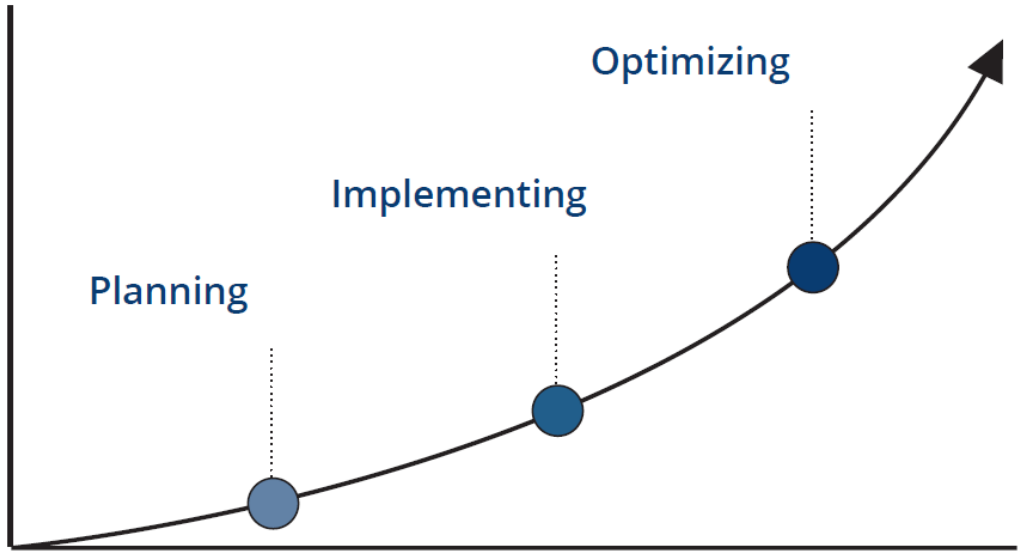
Q&A

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.



Learning Objective: High-Quality Primary

Discuss current state of primary care and health center opportunities for new models of care to advance high-quality care and value-based payment success.

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.

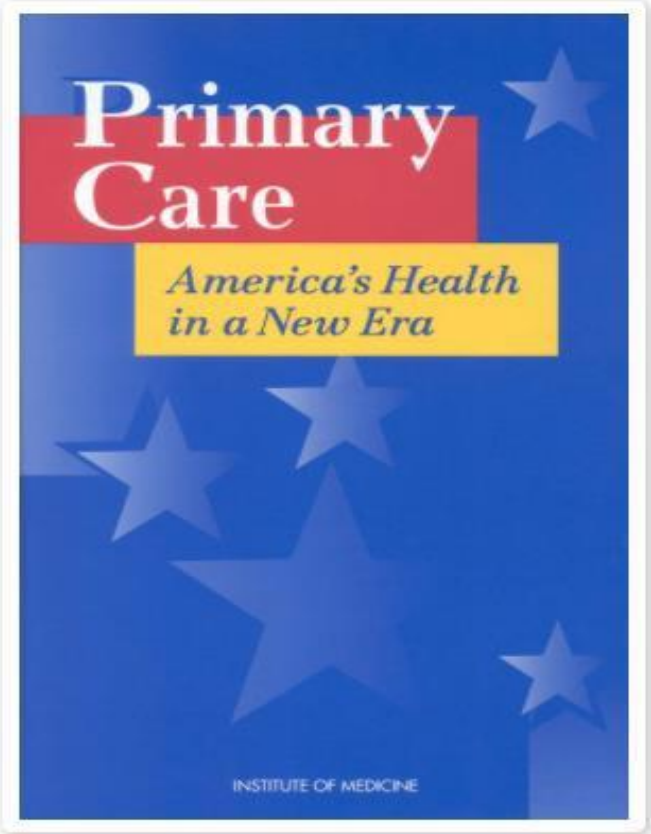
Dr. Jones is also a principal at Health Management Associates where he focuses on helping FQHCs and their clinically integrated networks succeed in advanced alternative payment models.

Has Primary Care Lived Up to Expectations?

MEDICAL HOME NETWORK

- Primary care is ideally conceptualized as accessible, timely, first-contact, coordinated, long-term, and holistic ambulatory care for most common conditions and most people.

- Accessible: Minimal obstacles to obtaining primary care.



Institute of Medicine (1996), Primary Care: America's Health in a New Era

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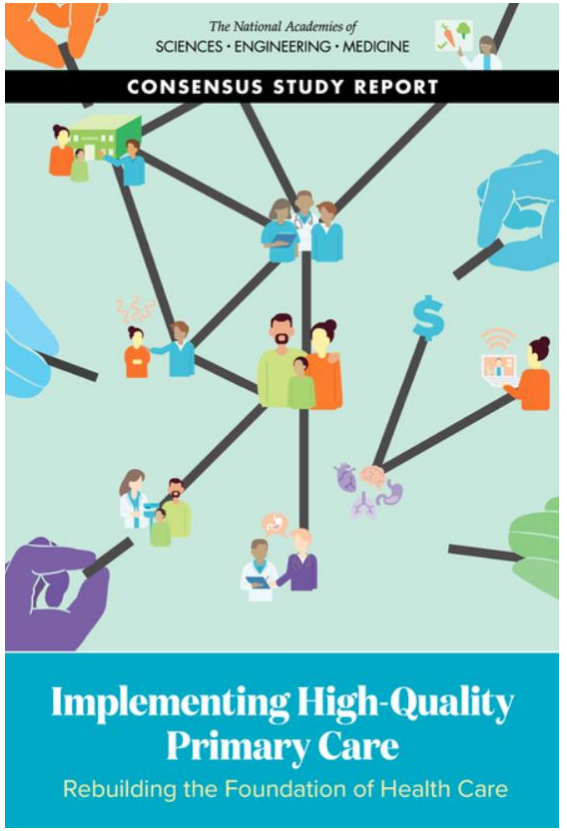
High Quality Primary Care (Revised)

MEDICAL HOME NETWORK

"Provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings, and through sustained relationships with patients, families and communities."



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

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Has Primary Care Not Learned from these Service Industries

MEDICAL HOME NETWORK

- Timely access to services.
- In the most convenient yet appropriate setting.
- Facilitated by the latest technology.
- Delivered by a repurposed work force.
- At an affordable price.

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Is Value-Based Payment Worth It?

MEDICAL HOME NETWORK

If I must give up some of my fee-for-service revenue to possibly earn shared savings in 18 months?

If I must change to partial fee-for-service reimbursement and partial capitated payment for my medical and behavioral health services to possibly earn shared savings in 18 months?

If I must change completely from fee-for-service reimbursement to capitated payment for my medical and behavioral health services to possibly earn shared savings in 18 months?

If I must change completely from fee-for-service reimbursement to capitated payment for my medical and behavioral health services to hold onto or increase my market share?

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Using New Technology: The Digital Front Door

MEDICAL HOME NETWORK

Before the Visit

Digital self schedule
- Fill medical history
- Get reminders
- Get pre-visit tasks
- E-sign consent forms
- Pay balance / co-pay

During the Visit

- Self-check-in
- As clinically appropriate practitioner responds via secure message, telehealth or in-person

Post Visit

- Remote monitoring with peripheral devices and commercially available wearables
- Post-procedure tasks
- HIPAA compliant secure messaging
- eConsult specialty care
- Telehealth follow-up care
- Notifications and health tips

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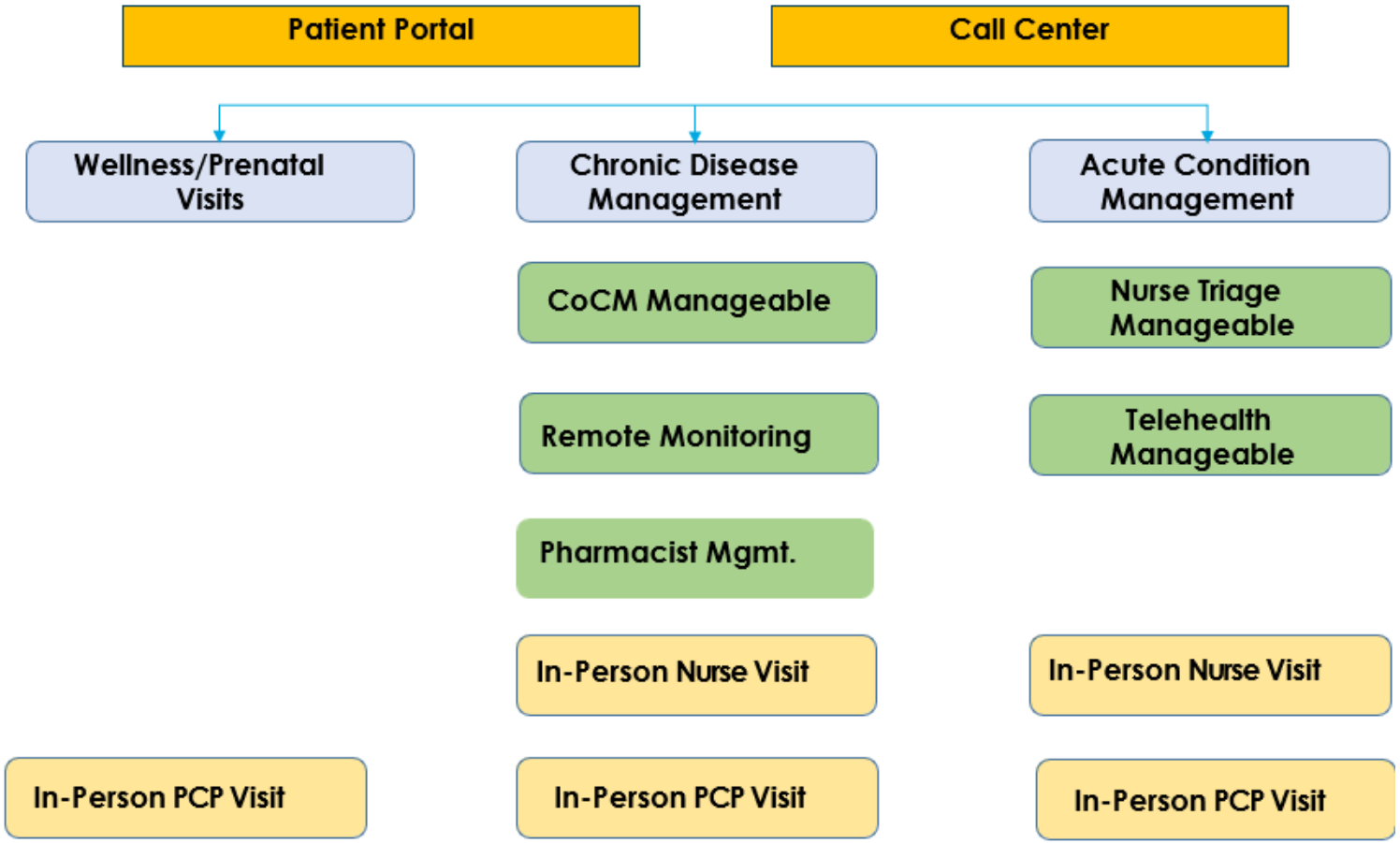
Service in the Most Convenient Setting Even If It is Not Billable

MEDICAL HOME NETWORK



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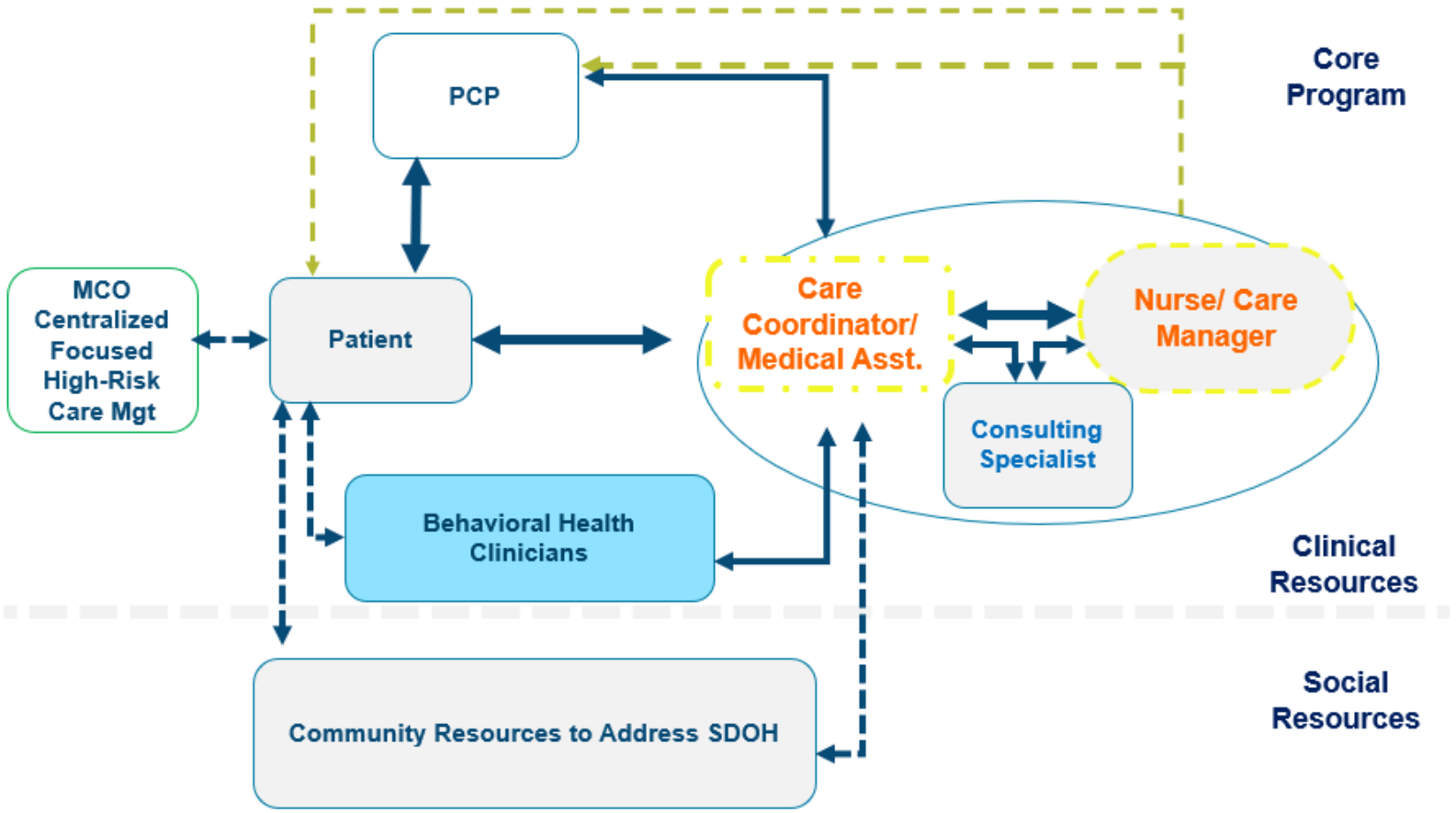
Making Better Use of Available Workforce

MEDICAL HOME NETWORK

- Care team members are looking for better work/life balance offered by working at least part of the time from home.
- They want more fulfilling work in which they assume greater responsibility for improving the health of their patients.
- The current fee-for-service payment system is a barrier to using the full care team to help patients self-manage and optimize their health.
- It hampers provision of the most timely and convenient access to care.

PCMH as it was intended: a Care Team Approach

MEDICAL HOME NETWORK



- **Use the Full Care Team**
- Capitalize on established patient-provider trust
- Use the most culturally competent and cost effective yet clinically appropriate care team member for the task
- Create and train a new health care workforce
- Improve work experience for the full care team to retain that workforce
- Manage a larger panel of patients

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Collaborative Model for Hypertension

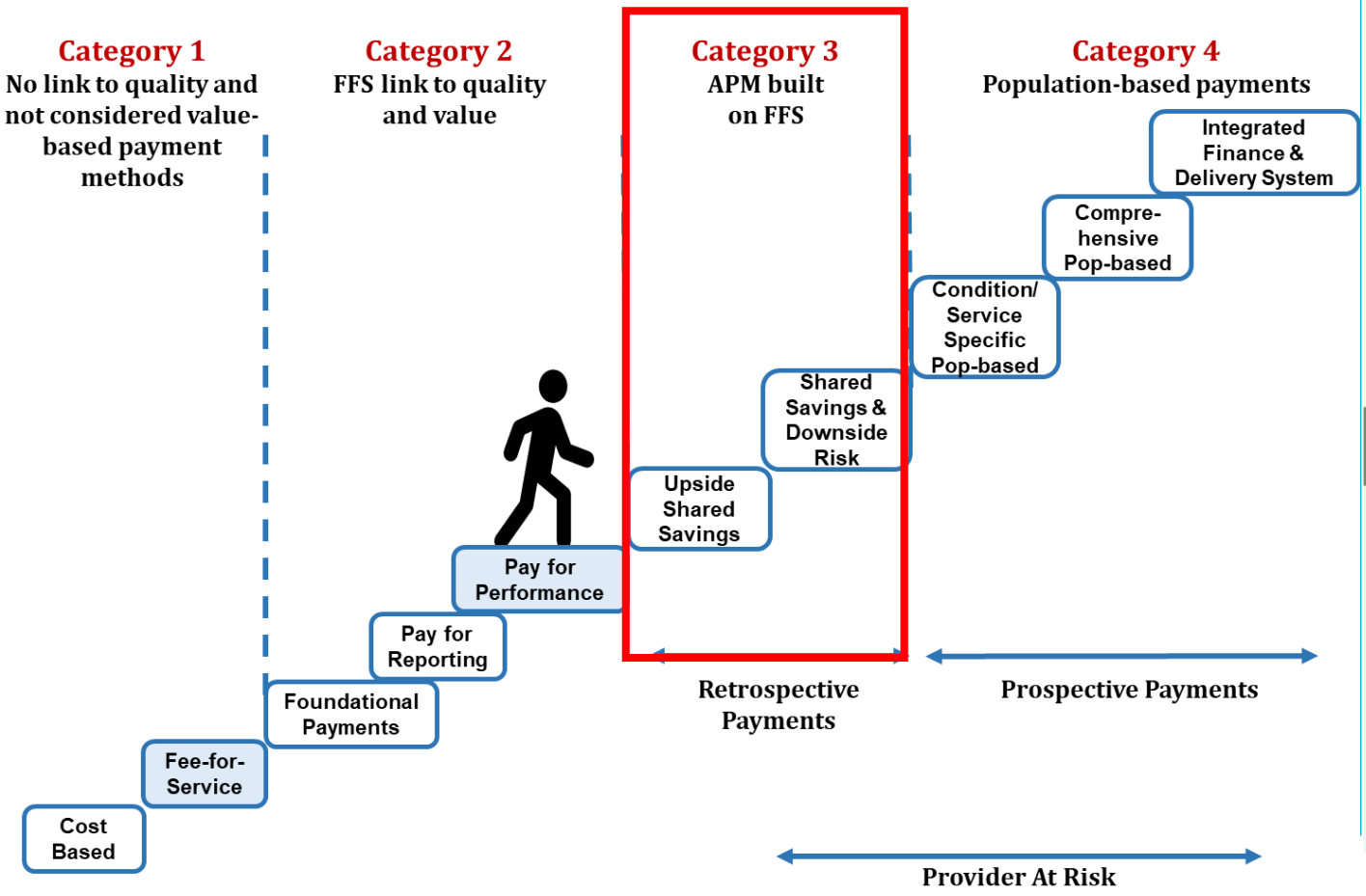
MEDICAL HOME NETWORK

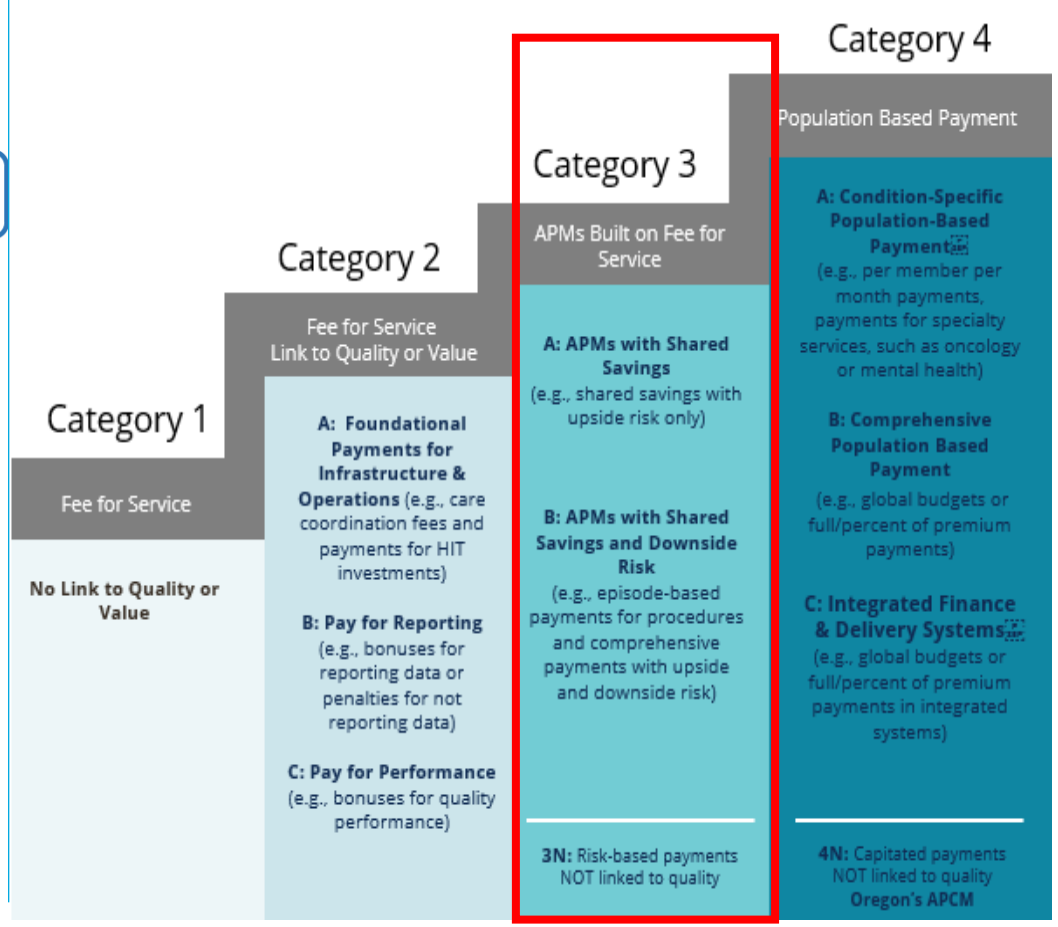
Under Fee-for-Service Reimbursement

- Identify which PCPs have enough patients with the condition to keep their MA busy at least 1/2 day per week with virtual care.
- Medical assistant for each participating PCP is allocated 4 hours per week to provide virtual care for his/her assigned PCP.
- PCP is scheduled for hypertension management clinic in which patients are scheduled by telehealth or in-person visits at 10-minute intervals to only address the patient's hypertension.
- Medical assistant will "room" patients (virtually or in-person) and determine if there are additional conditions that need to be addressed and either arrange follow-up appt. to address those issues at another time or by a same-day nurse visit immediately after the PCP hypertension visit as clinically indicated.

Increase Spending on Primary Care by Managing Total Cost of Care

MEDICAL HOME NETWORK





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

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Using a Capitated FQHC APM to Pay for Expanded Care Team

MEDICAL HOME NETWORK

Assumptions		
PCP productivity: billable visits per year		3500
PPS rate		$160.00
Payer mix Medicaid		55.0%

	Baseline Year	Year One	Year Two
PCP visits PMPY	2.8	2.6	2.4
PCP panel size	1250	1346	1458
% Medicaid	55%	55%	55%
PCP Medicaid panel size	688	740	802
PCP Medicaid panel revenue PPS	$308,000	$308,000	$308,000
PCP Medicaid panel revenue APM		$331,692	$359,333
PCP Medicaid panel revenue PMPM PPS	$37.33	$34.67	$32.00
PCP Medicaid panel revenue PMPM APM	$37.33	$37.33	$37.33
Increase in Medicaid revenue **per provider FTE**		**$23,692**	**$51,333**

all cells in red should be individualized by each FQHC

Expand use of non-billable members of the care team to reduce 'billable' encounters and expand care team panel size generating revenue to pay for that care team.

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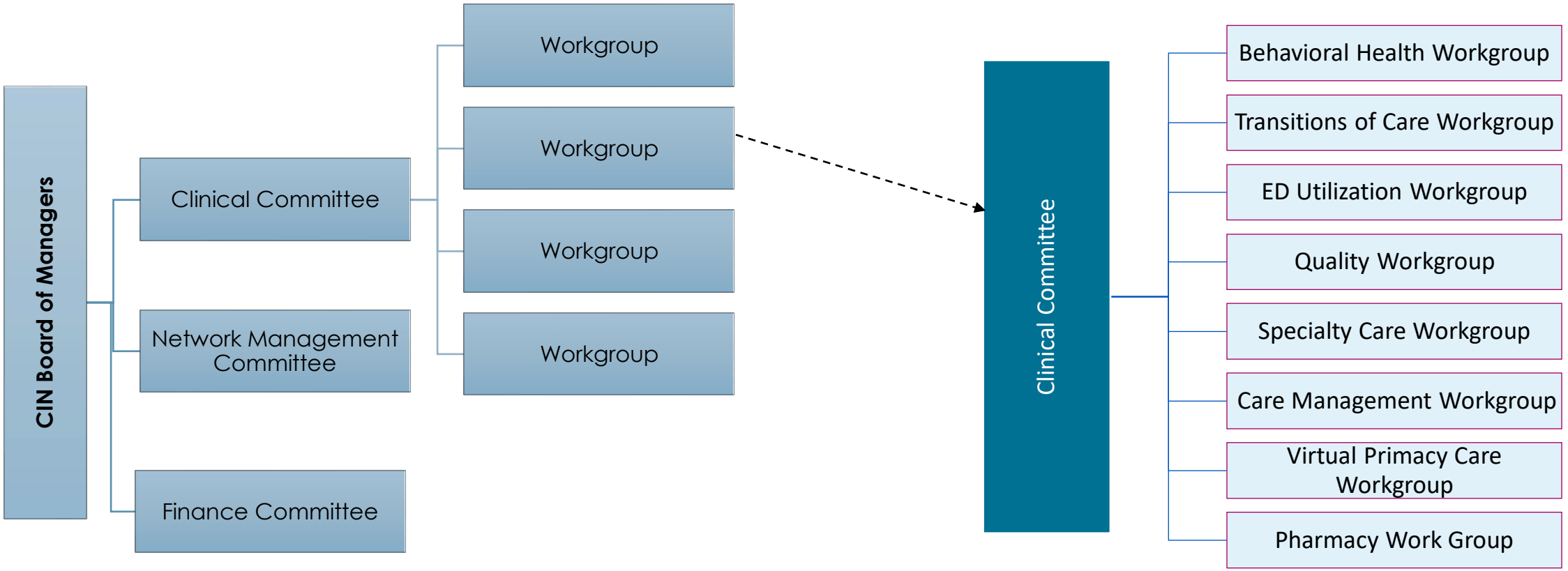
Unleash Provider Creativity to Design New Models of Care in the New Payment Paradigm



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Learning Objective: New CMMI Models

Outline health center considerations for new Centers for Medicare and Medicaid Innovation Center (CMMI) value-based payment models.

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.

CMS Innovation Center:
Health Center Inclusive Models

Model	ACO Primary Care Flex	Marking Care Primary	ACO REACH
Description	MSSP FQHC-inclusive option with prospective payments and increased primary care funding	FQHC inclusive pilot program in 8 states with three progressive transformation tracks	Pilot ACO focused on health equity for primary care practices experienced in value-based care
LAN APM Category	3A-4A	2A-4A	4

Participation

Eligibility:

- Understand if you are eligible to participate at the health center level or if you need to work with an Accountable Care Organization to do so.
- Determine if you are prohibited from participating in other CMS models and assess which one is most advantageous to your health center from a financial and care model perspective.

Model Duration:

- Evaluate whether your health center is willing to participate in the model for the duration and understand the consequences of leaving it early.

Cross-sector Collaboration:

- Understand if the model requires collaboration with your state Medicaid agency, specialists, or other partners such as hospitals to participate.
- Evaluate if the cross-sector collaboration supports your health center's value-based care goals or potentially be a barrier.

Infrastructure: Payment

Prospective Payment System (PPS):

- Consider how the model involves PPS and if your PPS rate accurately reflects your health center's costs.

Value-Based Payment Model Design:

- Ensure that the alternative payment model guarantees that payment for delivering primary care services is not less than it would have been under PPS reimbursement.

Payment Distribution:

- Understand how payments reach your health center, whether directly or through an ACO distribution model.
- If payments go directly to the ACO, assess if your health center is comfortable with the oversight and decision-making of how VBP funds are distributed.

Infrastructure: Finance & IT

HEALTH CARE ADVISORS

Infrastructure Support:

- Assess how the model supports building infrastructure to enable value-based care delivery, including FFS payments and prospective primary care payment structures.
- Consider the need for upfront infrastructure investment to support the care transformation, such as staff and technology for managing population health.

Financial Planning:

- Evaluate the potential impact on your health center's financial environment when shifting to an alternative payment methodology, such as a population-based payment.

Technology:

- Assess whether your current data and analytics systems can leverage new data to understand potential financial impacts, inform value-based care delivery, and conduct required annual reporting.

Care Delivery

Care Management:

- Understand how your health center is effectively integrating care management, coordination, and transitions to prepare for patient-centered care delivery and a payment model based on outcomes.

Care Coordination:

- Determine how your health center coordinates and integrates behavioral health, specialty care, and services from community-based organizations.

Quality Performance:

- Evaluate how your health center is doing on performance metrics compared to expectations in the model.

Flexibility:

- Consider the model's ability to provide financial flexibility to invest in additional staff or technology to support the care model.

Care Delivery: Social Drivers of Health

Health Equity:

- Explore how the value-based payment model can provide financial flexibility to address health-related social risk factors.

Social Drivers of Health Data Collection:

- Understand your health center's experience in assessing social risk factors, stratifying patients based on health disparities, or developing health equity plans.

Adjustment for Health-related Social Needs:

- Understand how payment and performance will be adjusted to reflect your health center population's social needs.

People

Culture:

- Evaluate the staff's willingness to embrace change, the presence of collaborative and patient-centered practices, and the alignment of organizational goals with value-based care principles.

Care Teams:

- Consider how your health center is leveraging and optimizing care teams to collaborate and deliver value-based care.

Operational and Financial Expertise:

- Do we have properly trained staff to manage the administration and financial acumen to operate in a value-based payment model?

Technical Assistance:

- Many health centers will require technical assistance to transition to value-based payment models, including culture change and better collaboration with other providers and health plans.

Craig Hostetler
Owner and Principal
Hostetler Group

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

Heidy Robertson-Cooper, MPA
President
Health Care Advisors

Questions & Discussion

NACHC's Value-Based Payment Learning Series

Link to recorded module (10 mins)

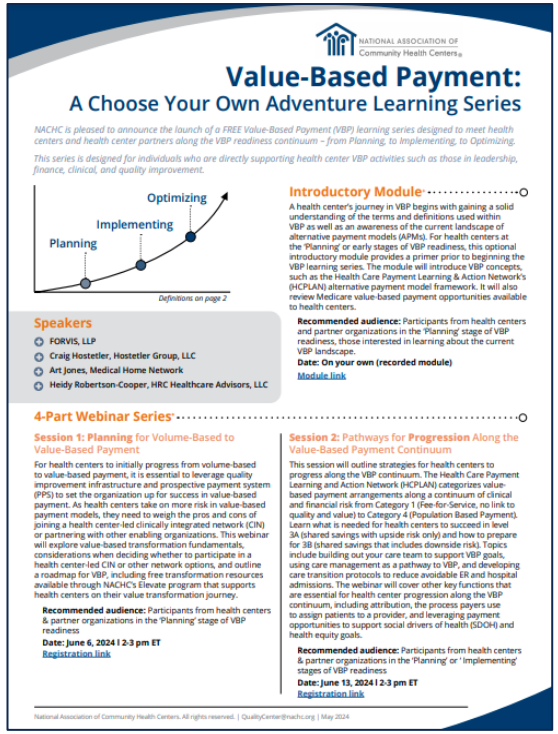
Session 1: Planning for Volume-Based to Value-Based Payment

Session 2: Pathways for Progressing Along the VBP Continuum

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

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

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

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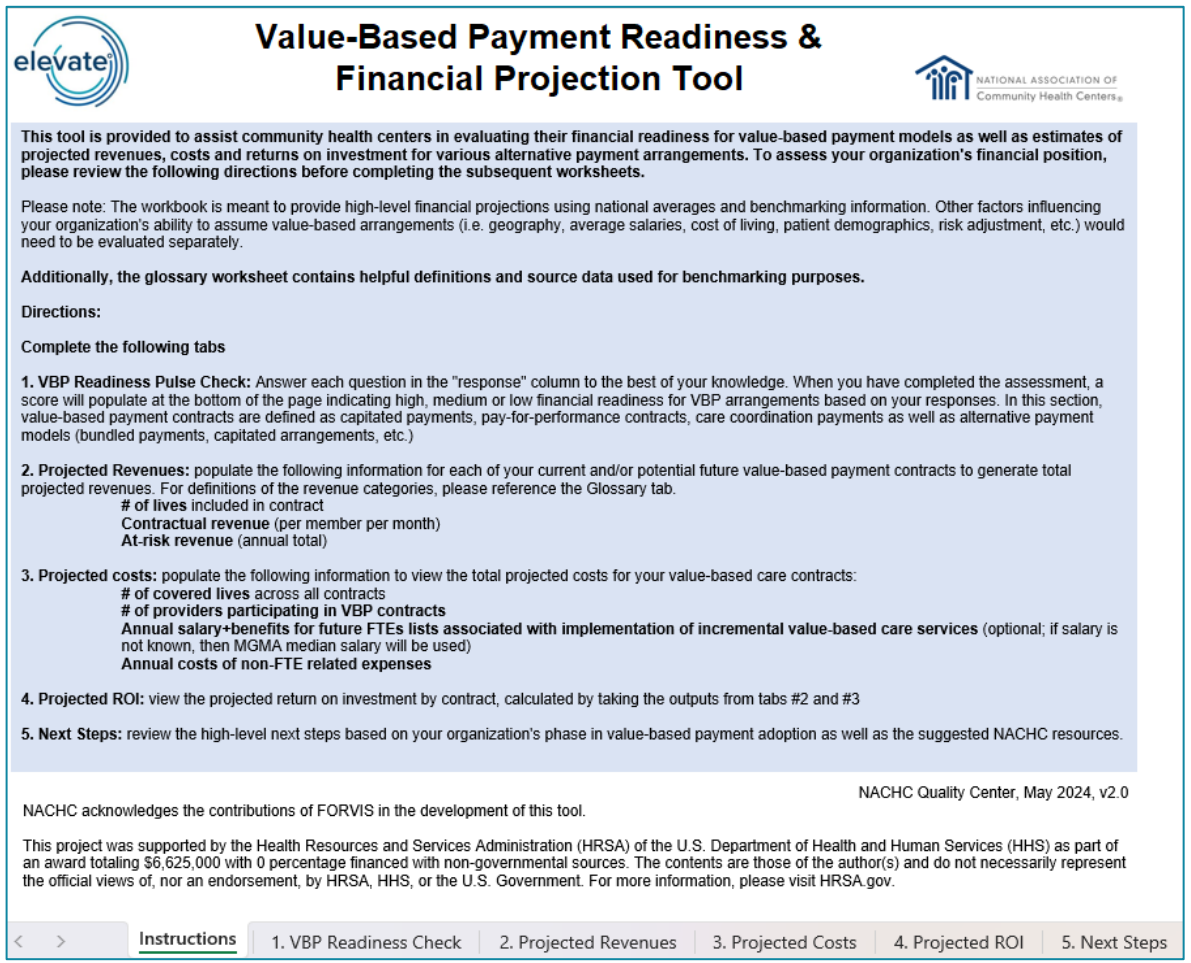
Supplemental Sessions!

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

Registration Link: Supplemental Sessions

NACHC: Value-Based Payment Resources



Value-Based Payment Readiness & Financial Projection Tool

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

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

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

Directions:

Complete the following tabs

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

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

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

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

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

NACHC Quality Center, May 2024, v2.0

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

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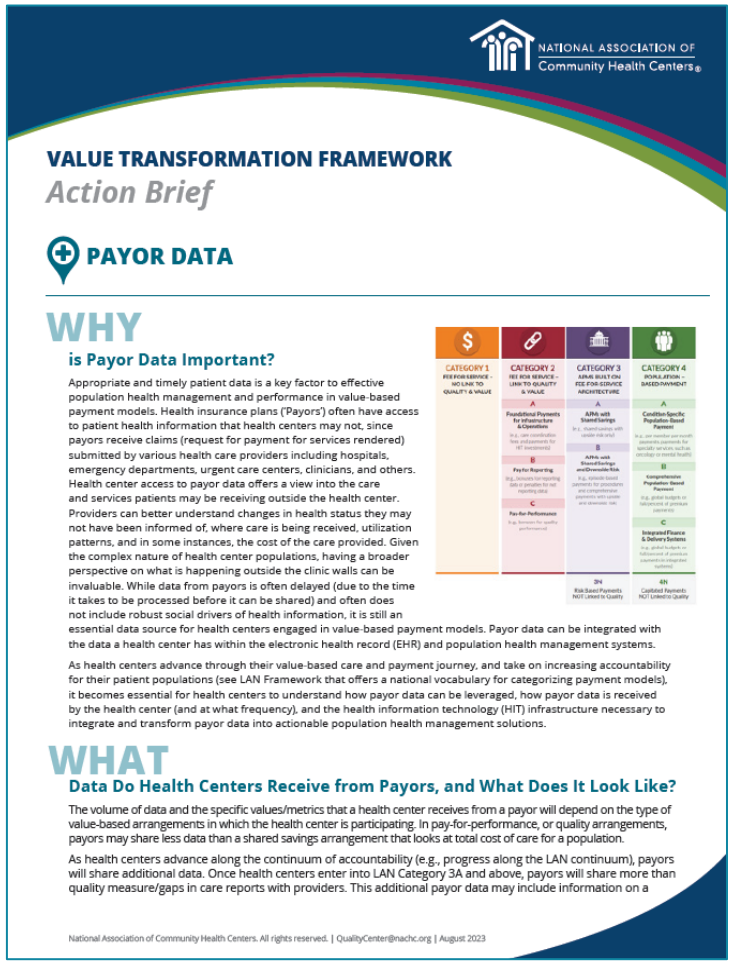
Instructions | 1. VBP Readiness Check | 2. Projected Revenues | 3. Projected Costs | 4. Projected ROI | 5. Next Steps

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

(June 25th Supplemental Session, 2-3 pm ET)



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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

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*

Register for free HERE

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