NATIONAL ASSOCIATION OF Community Health Centers®

VALUE PROPOSITION: MEDICARE SHARED SAVINGS PROGRAM (MSSP)

elevate

Supplemental Session #2
July 25, 2024

THE NACHC MISSION

America's Voice for Community Health Care

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

NATIONAL ASSOCIATION OF Community Health Centers®

NACHC Speakers

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

Gervean Williams
Director, Finance Training & Technical Assistance

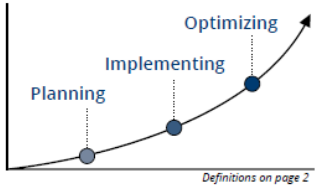
NACHC's Value-Based Payment Learning Series

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.



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

Session 3: Implementing High-Quality Primary Care within Value-Based Payment Models

The National Academies of Sciences, Engineering, and Medicine's (NASEM) landmark report entitled 'Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care' outlined an implementation plan for advancing high-quality primary care in the United States. The report outlined the shortcomings of fee-for-service payments and the need for an increased focus on supporting high quality primary care, including increased funding for primary care as a portion of overall healthcare spending. Health centers, as the nation's largest primary care safety net, play a key role in implementing the recommendations laid out in this report, including the need for interprofessional care teams, integrated delivery of care, primary care training, leveraging information technology, and implementing new models of care that will be required to advance high-quality care and that are crucial to health center success under value-based payment models. The Center for Medicare and Medicaid Innovation (CMMI), a component of the Centers for Medicare and Medicaid Services (CMS), recently developed several alternative payment models that include health centers and aim to support NASEM's recommendations to promote high quality primary care. This webinar will provide insights and key takeaways from the NASEM report and offer a framework for health center decision-making when considering whether to participate in CMS CMMI alternative payment models.

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

Date: June 20, 2024 | 2-3 pm ET

Registration link

Session 4: Optimizing Value-Based Payment Strategies while Mitigating Financial Risk

Recommended Pre-reading

Many health plans and some state Medicaid agencies are encouraging and even beginning to require providers, including health centers, to progress from LAN category 3A to LAN category 3B alternative payment models. HRSA discourages health centers from assuming such risk on their own so many health centers are contracting through clinically integrated networks (CINs) or other network models. This webinar will discuss contracting strategies to mitigate financial risk and enhance the prospect of success in these risk arrangements. It will also explore strategies for developing a health center primary care capitated alternative payment model for Medicaid to provide flexibility for implementing high quality primary care.

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

Date: June 27, 2024 | 2-3 pm ET

Registration link

Supplemental Sessions

Session 1: FQHC Value-Based Payment Financial Projection Tool*

This session will showcase a tool to assess current financial position relative to, or within, VBP contracts and assess a health center's risk tolerance.

Date: June 25, 2024 | 2-3 pm ET

Registration link

Session 2: Total Cost of Care*

This session will feature health center case examples to demonstrate the value proposition for health center participation in CMS' Medicare Shared Savings Program (MSSP), including a Total Per Capita Cost dashboard. Participants complete a value transformation assessment tool prior to session.

Date: July 25, 2024 | 2-3 pm ET

Registration link

PLANNING	Health centers in the **Planning** stage are aware of the importance of value-based care and working to increase knowledge in this area and prepare for value-based payment arrangements. Reliant on prospective payment system (PPS) with little to no participation in pay-for-performance models (LAN 2).
IMPLEMENTING	Health centers in the **Implementing** stage are primarily reliant on prospective payment system (PPS) payments though may participate in one or more alternative payment models, such as pay for performance (LAN 2) or an upside shared savings model (LAN 3a). Developing capability and legal structures to allow clinical and financial integration with external partners. Exploring or moving toward increased risk arrangements.
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.

FQHC MSSP Value Proposition

Learning Objective:

- Using health center case examples, demonstrate the value proposition for health center participation in the Medicare Shared Savings Program (MSSP), including a Total Per Capita Cost dashboard.
- MSSP benchmarking exercise:
  - Health center estimated performance (attribution, spend, Medicare Risk Adjustment Factor).
  - Estimated relative regional efficiency, compared to health center's beneficiary-based region.
  - Health center expenditure comparison to benchmarks.

Q&A

Health Center Case Examples: MSSP Value Proposition

Health Center	Total # Patients	% Medicare Patients	% at/below 200% Federal Poverty Line	% HTN Patients	% Diabetes Patients
1	50-60K	4%	94%	26%	13%
2	50-60k	7%	95%	25%	17%
3	25-30k	7%	92%	38%	20%
4	15-20k	7%	92%	38%	20%

Featured Speakers

Brandon Hill, Managing Director

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

Lauren Naumcheff, Senior Consultant

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

Forvis Mazars

Overview

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

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

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

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

We serve global industries including:

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

$5B
Combined Revenue (2023)

100+
Combined Countries, Territories & Markets

400+
Combined Offices & Locations

1,800+
Combined Partners

40,000+
Combined Team Members

Healthcare Consulting

Practice Overview

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

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

9th
Largest Healthcare Consulting Firm (2023)

92
*Net Promoter Score®

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

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

Healthcare Reimbursement

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

Performance Improvement

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

Payor Services

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

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Overview and Key Terms

Overview

- Forvis Mazars was engaged by NACHC to perform analysis of four health centers with insight into elements of the Medicare Shared Savings Program (MSSP)
- Using the CMS Innovator set for calendar years 2021-2023, Forvis Mazars has provided trended estimates for each health center around:
  - Estimated patient attribution
  - Renormalized Risk-Adjustment Factor (RAF) Scores
  - Per Member Per Year (PMPY) Expenditures
  - Utilization Statistics on Inpatient, Post-Acute, Emergency Department, and Imaging use per 1,000 Beneficiary Years

Key Terms

- **TPCC** – Total Per Capita Cost
- **PMPY** – Per Member Per Year
- **RA** – Risk Adjusted
- **Benchmark Groups**
  - End Stage Renal Disease
  - Disabled
  - Aged Dual
  - Aged Non-Dual

Key Considerations

Please Note

- This analysis utilizes Medicare claims data, which is representative of only a portion of the total population for most health centers, but is the best publicly available information for an analysis of performance in a shared savings program
- Data is oriented to show how CMS views a health center's performance and is driven by financial and utilization metrics
- This analysis is not a review of a health center's cash flows or financial position; instead, it shows the global expenditures of Medicare beneficiaries aligned to a health center
- Risk scores shown for beneficiaries use the CMS Risk Adjustment Factor (RAF) which is based on the beneficiary's age, dual eligibility and hierarchical condition categories (HCCs); these calculations do not include adjustments for social determinants of health
- Health centers and/or risk groups with fewer than 11 beneficiaries are not shown per CMS regulations

MSSP Value Proposition Development

MSSP Value Proposition Development

- Successful participants in the MSSP demonstrate the ability to perform favorably in the following areas:
  - Management of total cost of care
  - Accurate articulation of patient risk profile
  - Efficiency relative to national/regional benchmarks
- In our work with community health centers nationally, we have found that many health centers have the ability to demonstrate lower relative costs but have not accurately reflected the “riskiness” of their population
  - This leads to unfavorable performance with respect to risk-adjusted cost and utilization measurements
- The following slide shows an outlook of performance for a health center compared to its risk-adjusted county-level expenditures

Tableau Dashboards Demonstration

Health Center #2

Opportunity by Service Type

TPCC vs *All FQHC CCNs - National Level* Benchmark by Service Type - Risk Adjusted

Service Type (group)	Service Type	Avg PMPY RA Payment								Primary Benchmark Level - PMPY RA Payment (Non Trended)							
_Total	Total	$14,180	$6,798	$7,875	$10,156	$14,505	$14,935	$13,056	$12,624	$16,373	$16,373	$16,373	$16,373	$16,373	$16,373	$16,373	$16,373
Acute Admission	Inpatient - STAC admission	$3,852	$1,873	$2,215	$2,412	$5,549	$5,564	$3,773	$3,346	$2,976	$2,976	$2,976	$2,976	$2,976	$2,976	$2,976	$2,976
	Inpatient - STAC readmission	$1,454	$81	$0	$205	$1,246	$338	$240	$1,775	$521	$521	$521	$521	$521	$521	$521	$521
Imaging	CT	$160	$117	$109	$84	$162	$188	$171	$165	$181	$181	$181	$181	$181	$181	$181	$181
	MR	$30	$57	$49	$50	$53	$58	$78	$64	$86	$86	$86	$86	$86	$86	$86	$86
	Nuclear	$62	$21	$12	$24	$34	$78	$44	$35	$109	$109	$109	$109	$109	$109	$109	$109
	Standard X-ray	$193	$53	$51	$187	$90	$105	$131	$114	$218	$218	$218	$218	$218	$218	$218	$218
	Ultrasound	$95	$53	$102	$67	$77	$123	$92	$76	$156	$156	$156	$156	$156	$156	$156	$156
Post Acute Care	Home health	$236	$244	$355	$311	$344	$341	$498	$334	$568	$568	$568	$568	$568	$568	$568	$568
	Hospice	$603	$0	$0	$57	$382	$68	$31	$22	$418	$418	$418	$418	$418	$418	$418	$418
	Inpatient - IRF hospital	$0	$0	$0	$0	$0	$0	$0	$183	$373	$373	$373	$373	$373	$373	$373	$373
	Inpatient - LTCH hospital	$0	$0	$0	$0	$0	$223	$0	$0	$92	$92	$92	$92	$92	$92	$92	$92
	Inpatient - other hospital	$179	$248	$0	$899	$194	$32	$878	$130	$72	$72	$72	$72	$72	$72	$72	$72
	Skilled nursing facility	$278	$353	$0	$21	$383	$360	$400	$685	$1,135	$1,135	$1,135	$1,135	$1,135	$1,135	$1,135	$1,135
Tests	Anatomic pathology	$19	$35	$4	$29	$19	$50	$15	$47	$81	$81	$81	$81	$81	$81	$81	$81
	Cardiography	$14	$11	$19	$10	$24	$17	$40	$17	$48	$48	$48	$48	$48	$48	$48	$48
	Neurologic	$8	$5	$60	$28	$19	$33	$16	$9	$31	$31	$31	$31	$31	$31	$31	$31
	Pulmonary function	$5	$0	$18	$15	$14	$17	$5	$1	$13	$13	$13	$13	$13	$13	$13	$13
Treatments	Chemotherapy administration	$29	$0	$0	$11	$0	$3	$3	$0	$52	$52	$52	$52	$52	$52	$52	$52
	Chiropractic	$3	$7	$0	$2	$0	$2	$0	$4	$26	$26	$26	$26	$26	$26	$26	$26
	Dialysis	$1,430	$0	$1,357	$1,190	$1,060	$1,079	$1,461	$597	$301	$301	$301	$301	$301	$301	$301	$301
	Injections and Infusions - non-onco..	$58	$54	$233	$44	$79	$77	$76	$109	$84	$84	$84	$84	$84	$84	$84	$84
	Physical, occupational, and speech..	$72	$83	$126	$123	$37	$145	$81	$86	$433	$433	$433	$433	$433	$433	$433	$433
	Radiation oncology	$15	$0	$0	$0	$0	$59	$3	$38	$120	$120	$120	$120	$120	$120	$120	$120

Health Center Example

MSSP Snapshot (2022)

Average PMPY expenditures are $2,093 above the county-level risk adjusted expenditures, indicating unfavorable financial performance in a shared savings model

CCN Name	Benchmark Group	# Benes	Beneficiary Months	Beneficiary Risk Score	Normalized Bene Risk Score	PMPY Standardized Payment	PMPY Winsorized Actual Payment	County-Level Risk Adjusted Expenditures	Difference
CCN #1	Aged Dual	54	668	0.84	0.45	$8,686	$9,320	$6,618	$2,702
	Aged Non Dual	20	257	0.7	0.65	$7,246	$8,001	$6,569	$1,432
	Disabled	49	632	1.21	0.94	$9,666	$10,034	$10,280	-$246
CCN #2	Aged Dual	97	1,212	1.04	0.56	$9,454	$6,885	$8,235	-$1,350
	Aged Non Dual	13	154	0.64	0.6	$16,622	$13,061	$6,063	$6,998
	Disabled	63	800	0.99	0.77	$16,230	$16,310	$8,421	$7,889
Total		**296**	**3,723**	**0.98**	**0.66**	**$10,957**	**$10,203**	**$8,110**	**$2,093**

All Health Centers // Aged Dual
MSSP Snapshot (2022)

The four health centers evaluated have normalized beneficiary risk scores below 1.0, indicating potential opportunity to improve coding and documentation to appropriately capture patient acuity

Health Center 1 has the highest risk score and shows favorable PMPY spend compared to its county-level risk adjusted expenditures

CCN Name	# Benes	Beneficiary Months	Normalized Bene Risk Score	PMPY Winsorized Actual Payment	Risk-Adjusted PMPY	County-Level Risk Adjusted Expenditures	Difference
Health Center 1	134	2,493	0.87	$14,607	$16,764	$20,223	-$3,459
Health Center 2	242	4,383	0.60	$9,458	$15,802	$14,706	$1,096
Health Center 3	43	827	0.50	$11,005	$21,824	$17,174	$4,649
Health Center 4	35	606	0.55	$11,139	$20,106	$$17,483	$2,623

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All Health Centers // Aged Non-Dual
MSSP Snapshot (2022)

Two health centers have risk-adjusted expenditures below their county-level spend, indicating potentially favorable performance in a shared savings model on Aged Non-Dual beneficiaries

CCN Name	# Benes	Beneficiary Months	Normalized Bene Risk Score	PMPY Winsorized Actual Payment	Risk-Adjusted PMPY	County-Level Risk Adjusted Expenditures	Difference
Health Center 1	84	1,726	0.79	$10,102	$12,762	$10,390	$2,372
Health Center 2	108	1,650	0.72	$6,673	$9,231	$10,105	-$874
Health Center 3	125	2,220	0.67	$4,850	$7,240	$9,081	-$1,841
Health Center 4	259	3,620	0.80	$10,197	$12,676	$9,990	$2,686

Health Center Action Steps

Success in MSSP and Similar VBP Opportunities

Understand your health center's current PMPY expenditures, risk scores and volume by payer

Evaluate your expenditures compared to national and regional benchmarks

Identify areas of opportunity to reduce expenditures (i.e. acute admissions, post-acute care, procedures, etc.) and develop an action plan for improvement

Educate providers on HCC coding best practices to accurately represent risk scores

Questions?

Contact

Forvis Mazars

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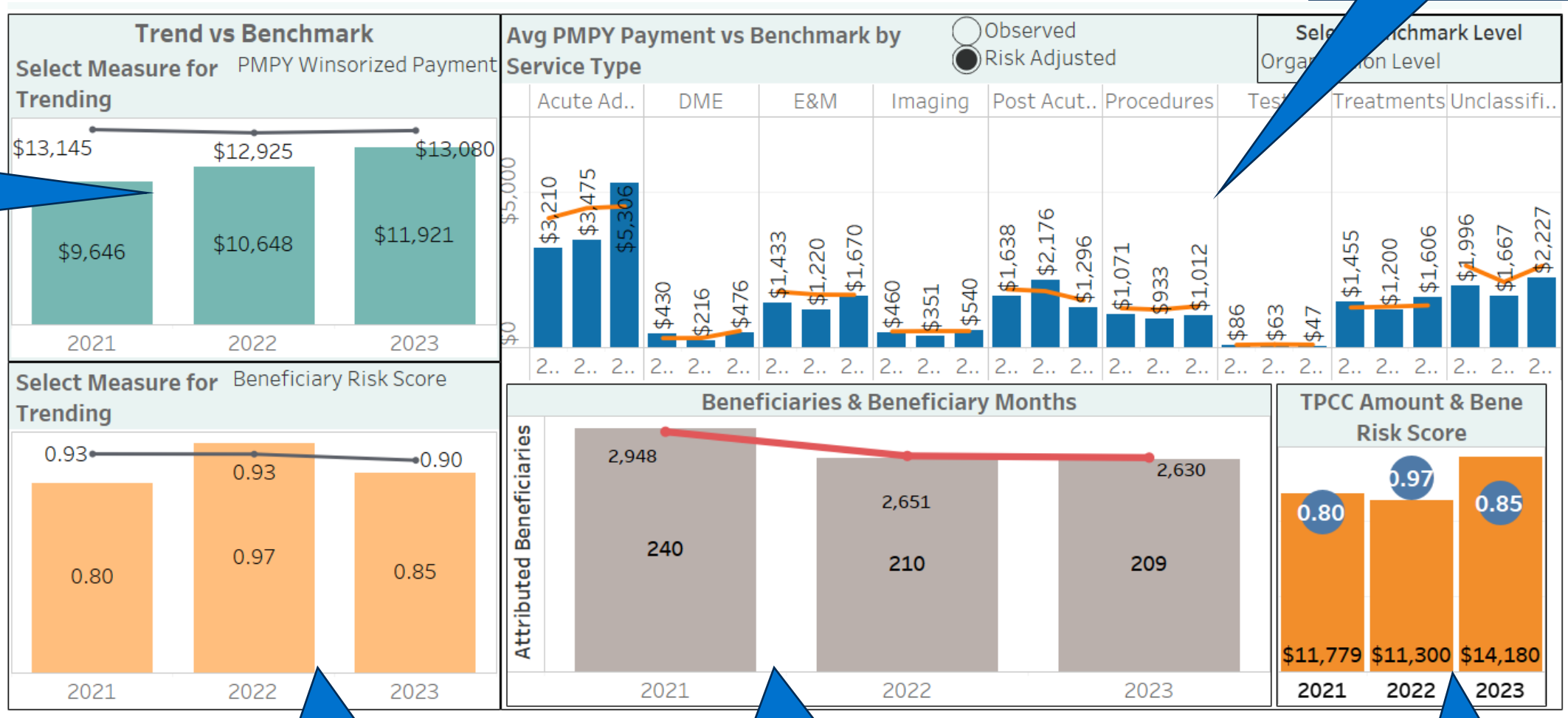
Appendix

Trended Year Over Year Performance Compared to Benchmarks **Sample**



Total spend below benchmark but rising year over year

Significant increases in spend for Acute Admissions and DME in 2023 while Post-Acute spend decreased

Beneficiary risk scores below benchmark in 2021 and 2023

Total Medicare attributed beneficiaries decreased significantly from 2021 to 2022

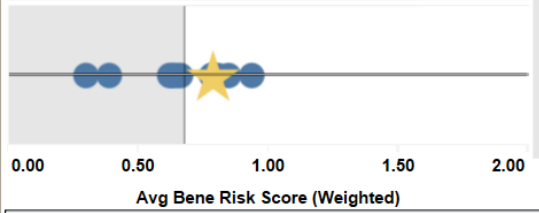
Total Per Capita Costs rose significantly in 2023

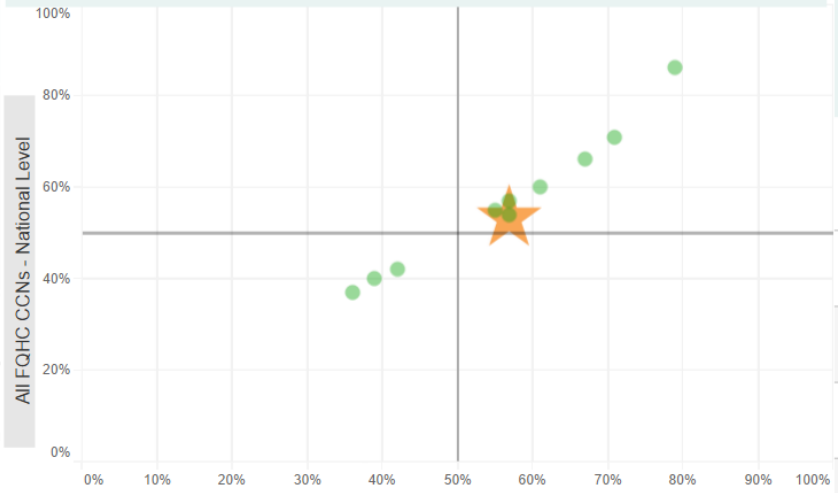
TPCC Overview
Sample

Overall spend for this health center is below Average TPCC but there are opportunities to reduce spend for Acute Admissions, DME & Imaging

TIN - Locati.. Select a Provider | Year

Benes	445
Bene Months	5,651
Avg Standard Payment	$10,799
Avg Bene Risk Score	0.79
Avg PMPY RA Payment	$14,537
TPCC Amount	$13,664
Benchmark Percentile	54%





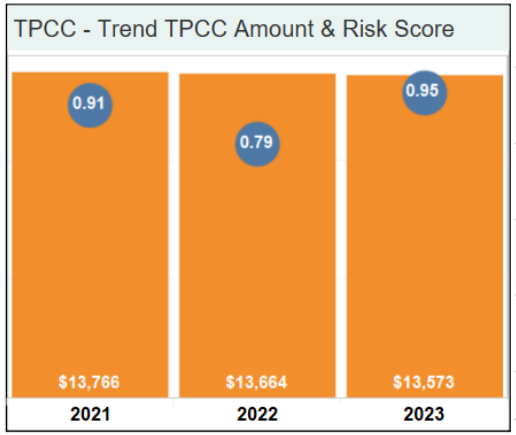
Provider Spend % Difference 5% | Provider Spend Min $5.00 | Observed / Risk Adjusted

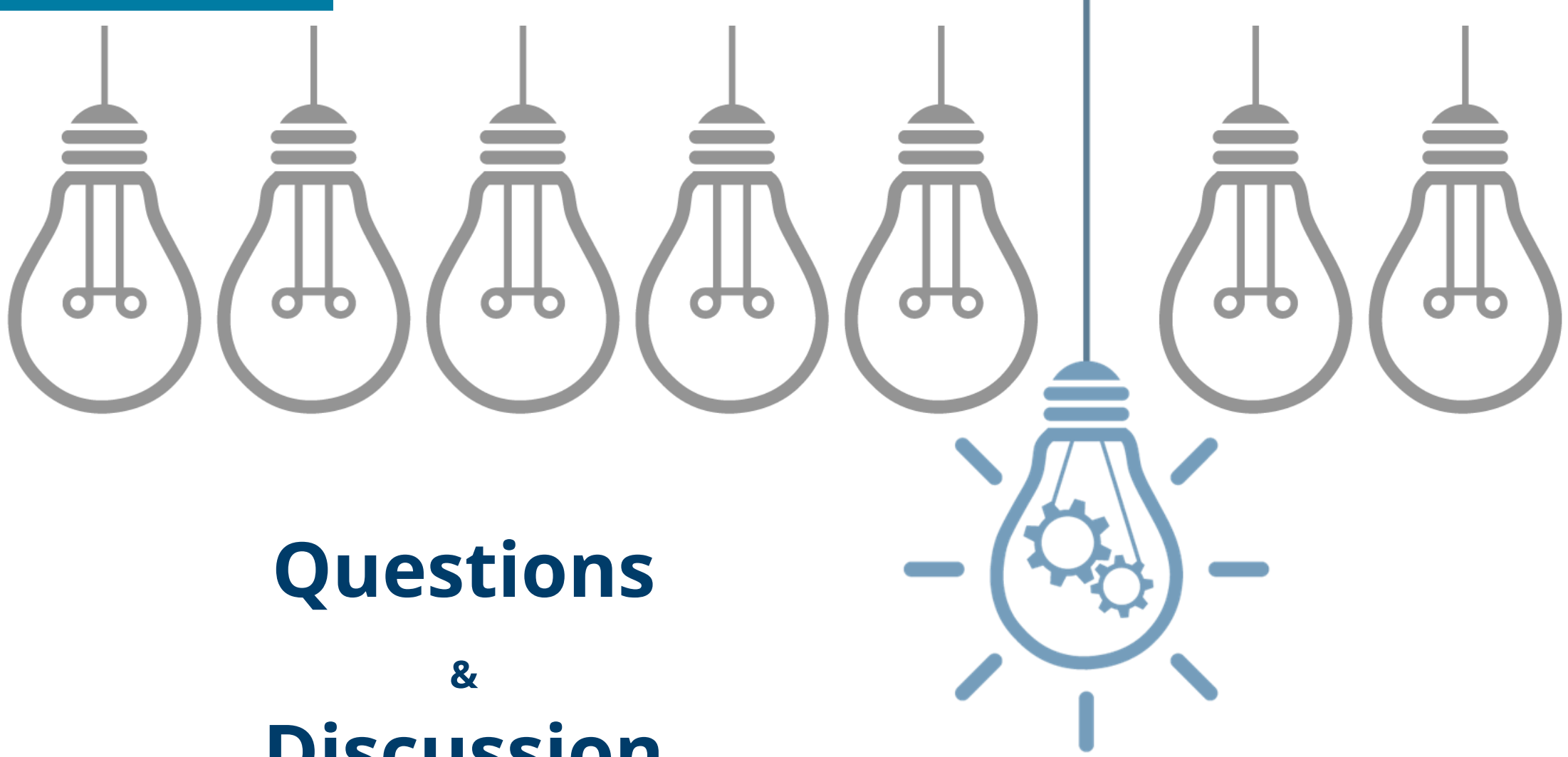
Avg PMPY Pmt by Service Type (Choose Observed or Risk Adjusted Above):
All FQHC CCNs - National Level - Risk Adjusted

Service Type (group)	Avg PMPY RA Payment	Primary Benchmark Level - PMPY RA Payment (Non Trended)	Avg TPCC vs Primary BM (Parameter Controlled) PCT
_Total	$13,664	$15,341	-11%
Acute Admission	$4,238	$3,415	24%
DME	$552	$415	33%
E&M	$1,518	$2,163	-30%
Imaging	$1,090	$721	51%
Post Acute Care	$991	$2,591	-62%
Procedures	$1,767	$1,940	-9%
Tests	$173	$164	6%
Treatments	$660	$996	-34%
Unclassified	$2,676	$2,936	-9%

Utilization by Service Type:
All FQHC CCNs - National Level - Risk Adjusted

Service Type (group)	Service Type	Claims per 1,000 bene years	Benchmark Claims per 1,000 b..	Days/ Visits per 1,000 bene yea..	Benchmark Days/visits per 1,..
Acute Admission	Inpatient - STAC admission	281	220	1,127.5	1,109
	Inpatient - STAC readmission	52	38	274.3	237
E&M	Emergency department services	1,033	469	0.0	0
	Observation care services	79	4	0.0	0
	Office/ outpatient services	4,337	9,322	0.0	0
Imaging	CT	868	877	0.0	0
	MR	283	302	0.0	0
	Nuclear	101	117	0.0	0
	Standard X-ray	2,837	2,921	0.0	0
	Ultrasound	786	1,039	0.0	0
Post Acute Care	Home health	197	295	1,580.3	2,367
	Hospice	11	94	140.6	2,025
	Inpatient - IRF hospital	3	14	33.4	171
	Inpatient - LTCH hospital	0	2	0.0	51
	Inpatient - other hospital	3	6	70.5	73
	Skilled nursing facility	43	122	527.7	1,774





Questions

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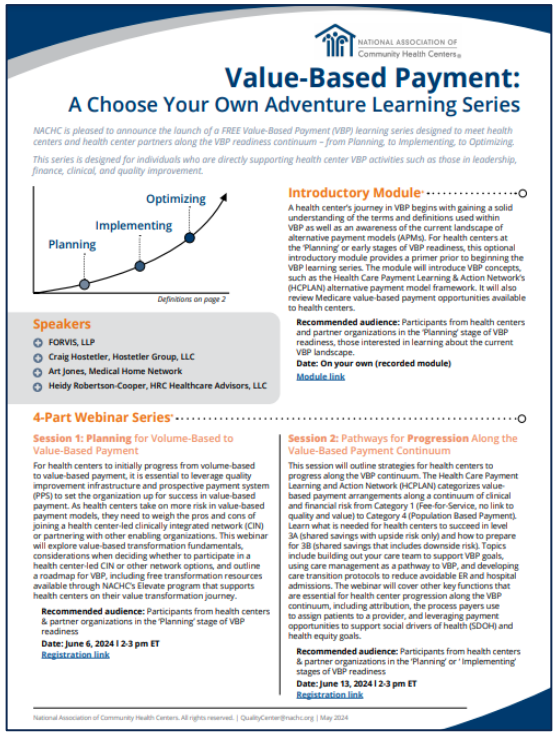
Discussion

NACHC's Value-Based Payment Learning Series

Link to recorded module (10 mins)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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.

Planning
Implementing
Optimizing
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

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

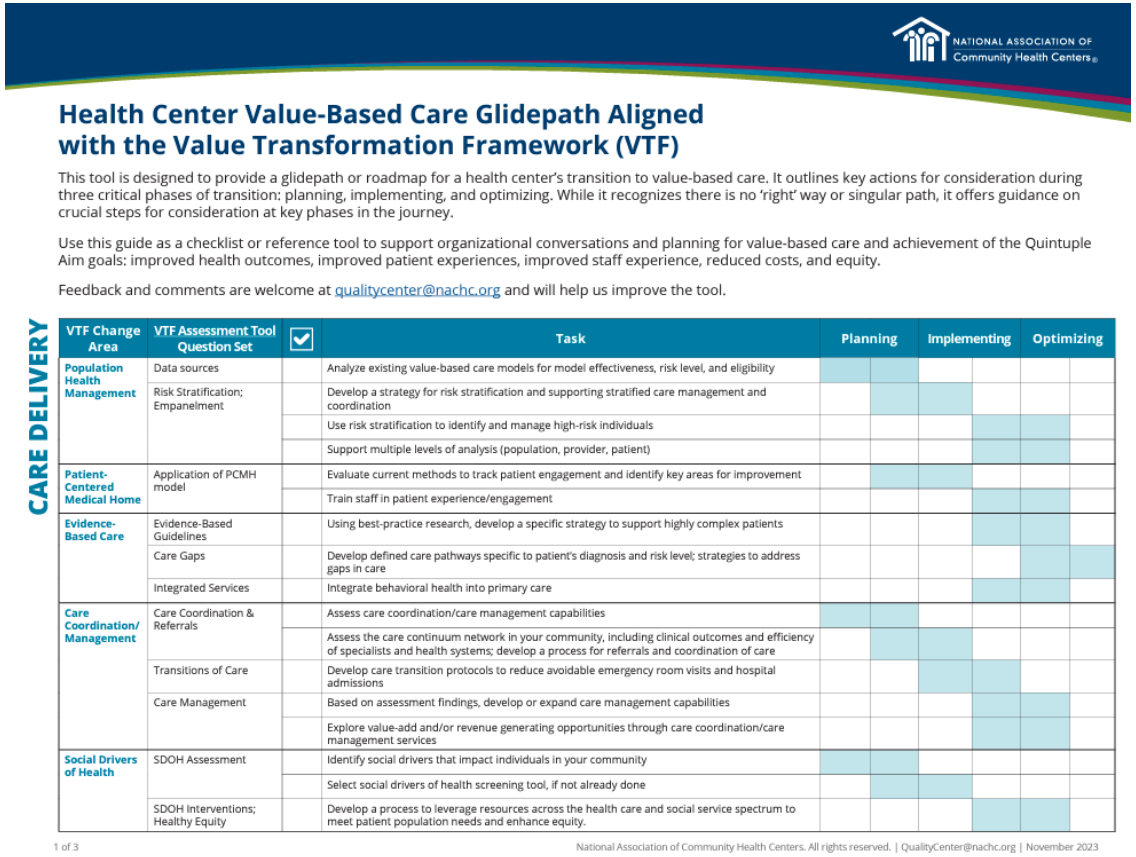
Session 4: Optimizing VBP Strategies while Mitigating Financial Risk

Supplemental Sessions!

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

Link to VBP Series Slides & Recordings

NACHC: Value-Based Payment Resources



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

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

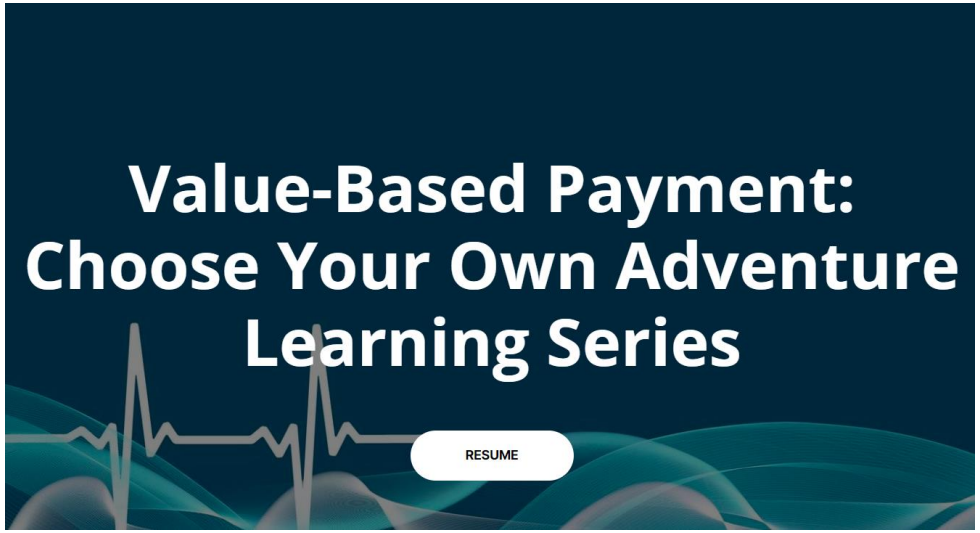
Use this guide as a checklist or reference tool to support organizational conversations and planning for value-based care and achievement of the Quintuple Aim goals: improved health outcomes, improved patient experiences, improved staff experience, reduced costs, and equity.

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

CARE DELIVERY

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

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



[Link to VBP Series Slides & Recordings]

Suite of Value-Based Payment Action Briefs:

[Developing VBP Goals]

[Attribution]

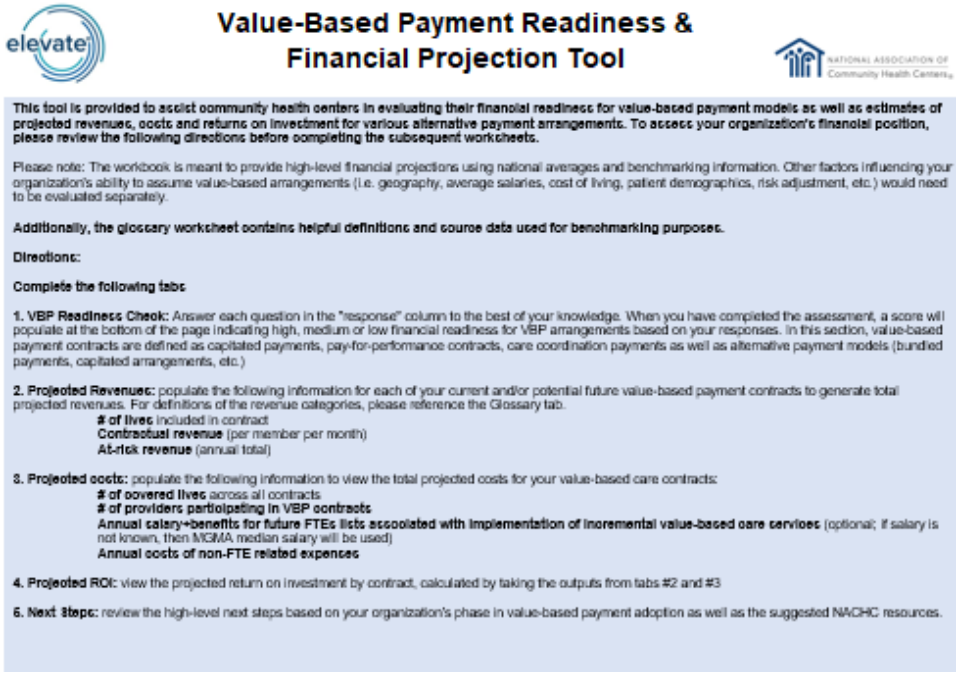
[Attribution Thresholds]

[Payor Data]

Value-Based Payment Financial Projection Tool

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

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



elevate

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 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.

VBP Readiness & Financial Projection Tool

HOW Elevate Supports Value 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*

Step-by-Step

Guided Application

Trainings & Resources

elevate 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

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FOR MORE INFORMATION CONTACT

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