Increasing your Organization’s Financial Health Through Value-Based Care **Community Health Centers**

David Fields, CPA, CMA, CFM, June 6, 2024

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Meet the Presenter

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Partner

Agenda

1. Basics of Value based care and evolution
2. Health Care Payment Learning & Action Network Framework
3. What it takes to deliver value-based care:
    1. Operational
    2. Clinical
    3. Financial

Helpful Acronyms

- APM – Alternative Payment Models
- VBC - Value Based Care
- VBR – Value Based Reimbursement
- VBP – Value Based Payment
- ACOs – Accountable Care Organizations

Value-Based Care
What is it?

“Value-Based Health Care is a framework for restructuring health care systems around the globe with the overarching goal of value for patients.”

-Professor Michael Porter,
Harvard Business School

Evolution of Value Based Care

2011-2015

- Let's Dabble in APMs
- Mandatory Program Losses are Part of Business Model
- Financial Results are Irrelevant

2016-2021

- Be on the APM List
- Invest only for Now
- Top-line In-Model Financial Results Must be Positive

2022-????

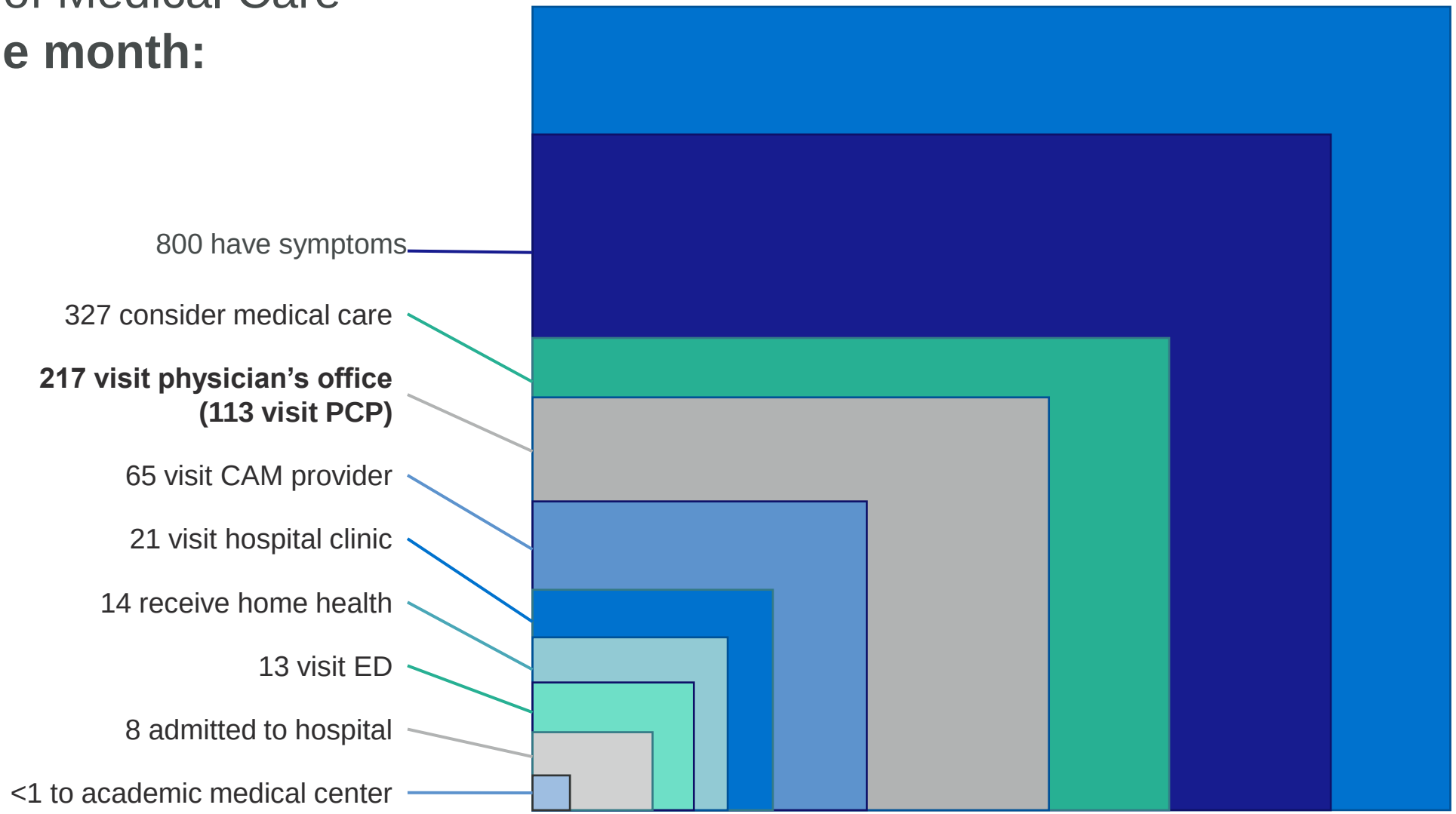
- VBC is Permanent & Growing
- Build Capabilities for Long-Term Population Health Success

Passive Management & Learning Opportunities → Active Management & ROI Imperative

The Ecology of Medical Care

In an average month:

Of 1,000 people:



Source: Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. N Engl J Med 2001;344:2021–2025.

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Remarks at the 2019 CMS Quality Conference

“Seventeen percent of Medicare beneficiaries have six or more chronic conditions, and spending on that group alone is more than half of fee-for-service Medicare spending…Much of what ails our system can be attributed to the under-lying flaws in reimbursement. The current financing structure treats episodes of sickness rather than promoting a lifetime of health, and it doesn’t reward providers who deliver high quality care, and positive results.”

- Seema Verma,
CMS Administrator

Alternative Payment Models:
Path to Adoption

Health Care Payment Learning & Action Network

GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of **two-sided risk APMs.**

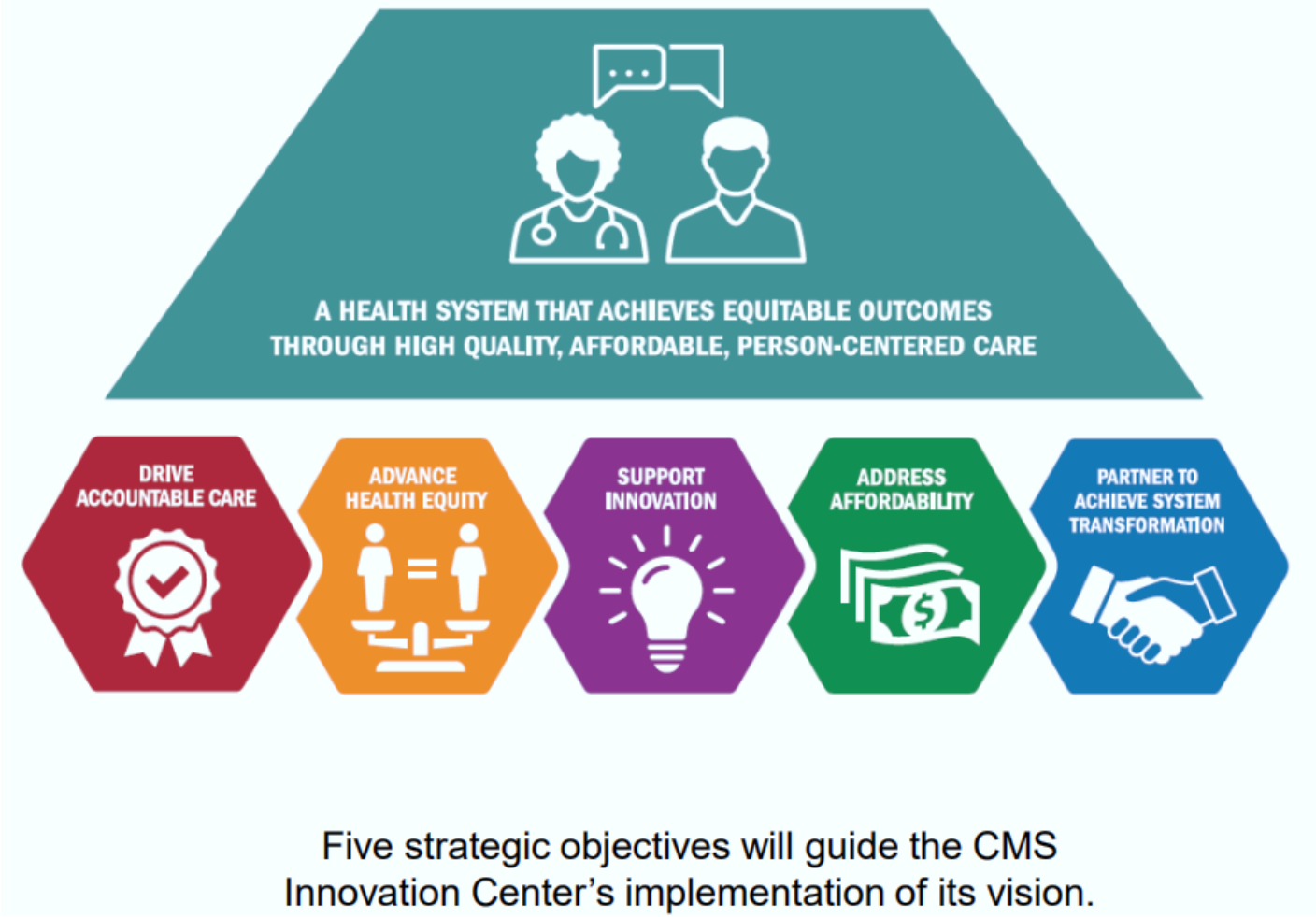
Strategic Consideration: Aligning Care Delivery Models with Advancing Alternative Payment Models

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

https://hcp-lan.org/

The Five Strategic Objectives
Strategic Direction

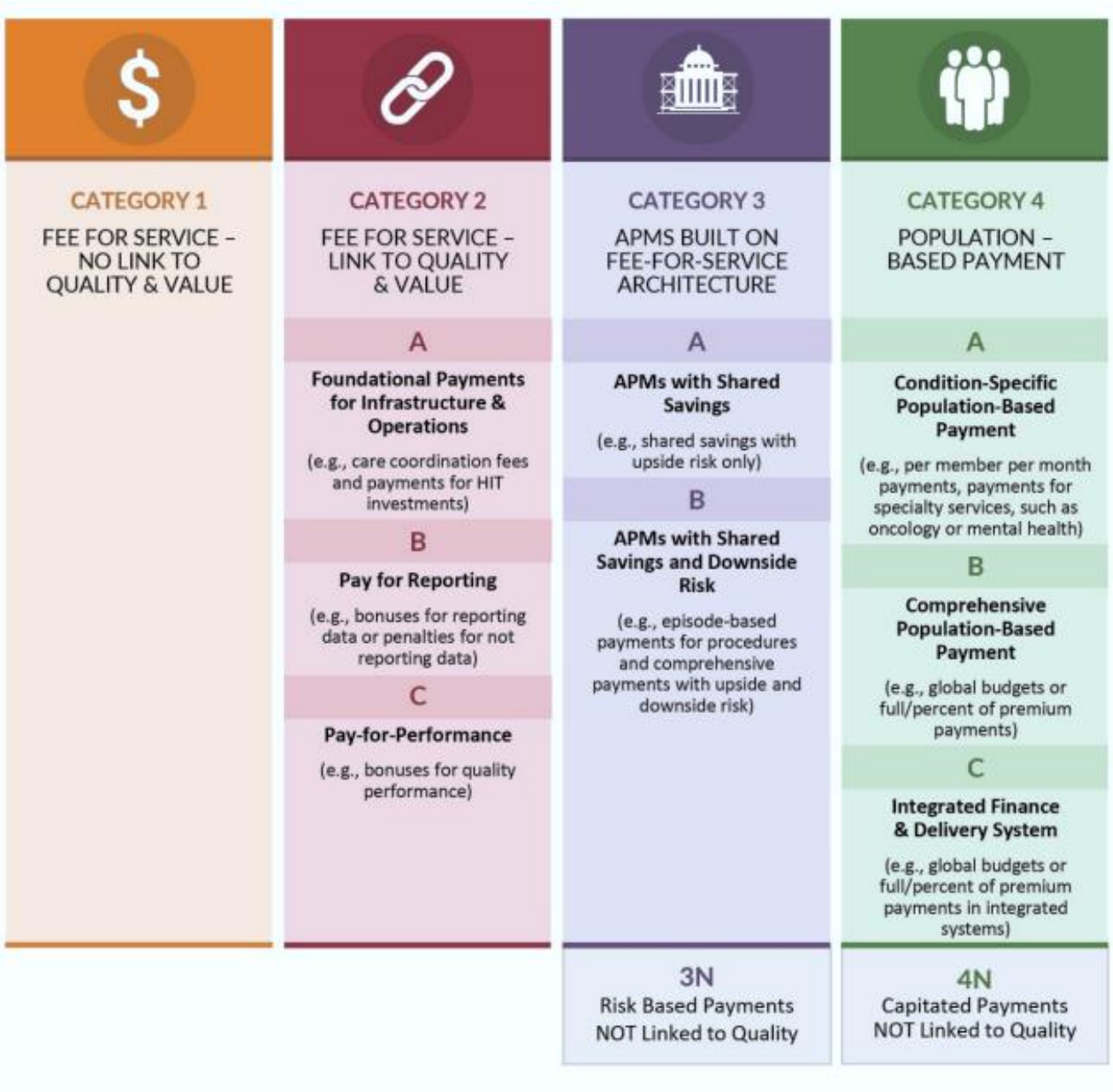
- Types of models may include:
- Total cost of care, national and state
- Advanced primary care
- Specialty that support integrated, whole-person care



Five strategic objectives will guide the CMS Innovation Center's implementation of its vision.

HCP-LAN APM Framework

- https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf



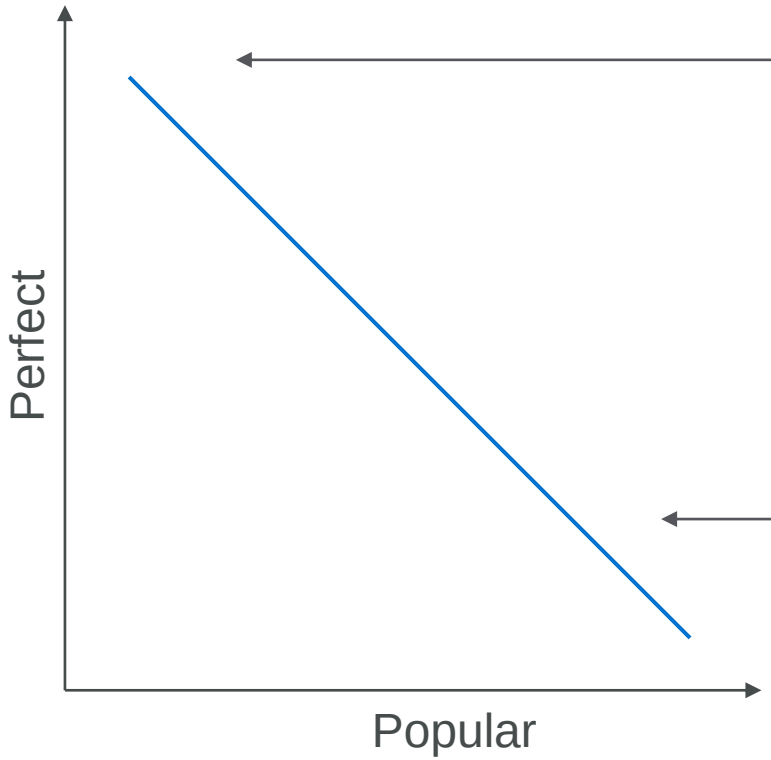
2020 Value-Based Care Landscape

	No Link to Quality & Value	Some Link to Quality & Value	APMs Built on FFS Architecture	Population-Based Payments
Commercial	55%	13%	32%	3%
Traditional Medicare	15%	42%	38%	5%
Medicare Advantage	38%	4%	36%	22%
Medicaid	59%	6%	29%	6%

Source: HCPLAN 2020 Measurement Effort

Arbitrage and Inefficiencies

VBC Model Design Theory



> “Perfect” models require active management participation to capture gains and avoid losses. These are generally less popular.

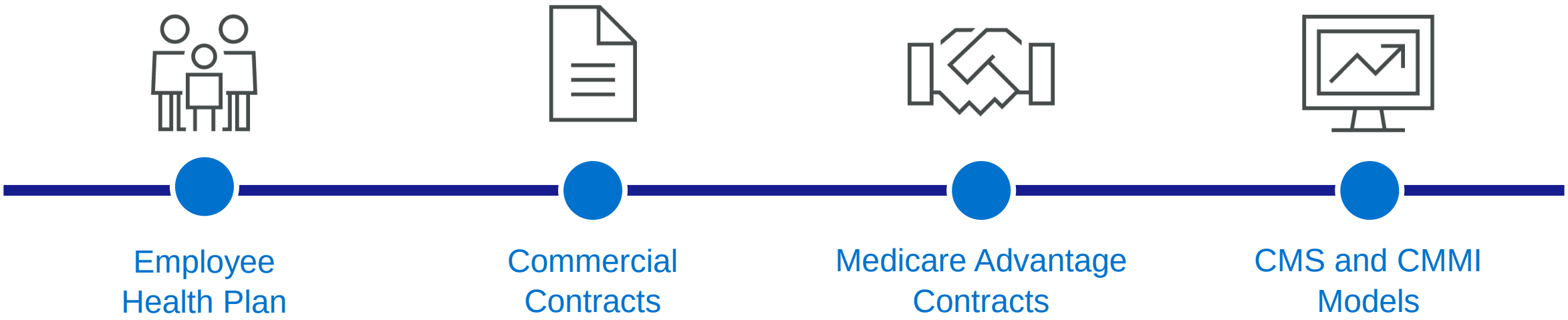
> “Imperfect” models allow passive participation with less risk of negative financial results. These are generally more popular.

APM and Value-Based Care Background

Strategic Considerations

- Timing
- Volume
- Governance & Oversight
- Build Vs. Buy
- Clinically Integrated Network
- Physician Alignment
- Change Management & Culture
- Data Analytics Capabilities

Movement Toward Value



What Does it Take To Deliver Value-Based Care

The core components and requirements to deliver value-based care are similar across contracts and models

Financial Considerations

Provider Incentive Alignment & Funds Flow

- Ensuring our provider compensation model is rewarding the activities associated with VBC delivery (e.g. Annual Wellness Visits, Chronic Disease Gap coding gap closure, screening compliance, etc.)

Scenario Modeling & Reconciliation

- Understanding the financial implications associated with participation in value-based arrangements, as well as being able to pinpoint drivers of success or failure

Contract/Model Implementation & Administration

- Developing a deep understanding of the contract/model specifics around performance measurement, population attribution, criteria for payment

Operational Considerations

Structure and Governance

- Engaging the right set of stakeholders to drive the deployment and oversight of VBC participation, to ensure the “Voice of the Provider” and the “Voice of the Patient” are heard

Care Continuum Network Strategies

- Creating and curating a network of high performing, engaged providers across the care spectrum, including post-acute providers, home care providers, hospice provider, etc.

KPI Development & Performance Monitoring

- Establishing a set of timely, measurable metrics that have direct/indirect implications for performance against VBCs

Clinical Considerations

Care Management & Coordination

- Building the right team of care navigators and social workers, supported with the right technology, enabling appropriate interventions to take place

Patient & Clinician Engagement

- Engaging key stakeholders in the delivery of VBC through regular communication on program development progress and updates, as well as engagement of patients via a portal or other feedback mechanism

SDOH & Quality Initiatives

- Understanding what other needs the patient population is managing with respect to access to transportation, housing, healthy food options, etc. and how that translates into healthcare utilization

Let’s Look at the Data
What is the Medicare Shared Savings Program (MSSP)?

- Contractual relationship between an Accountable Care Organization (ACO) and CMS
- Covers all traditional Medicare patients (ESRD, Disabled, Aged-Dual, and Aged-Non-Dual) not aligned to Medicare Advantage or other models
- Total Cost of Care model with multiple levels of risk available for participants

Medicare Shared Savings Program (MSSP)		
475 Participating ACOs in 2021 Performance Year	3,407 FQHC Participants in 112 ACOs	1,549 RHC Participants in 157 ACOs

2021 Participation Breakdown

ACOs with FQHCS

- ACOs = 112
- Percent of ACOs with CMS Savings = 57%
- Average Gross Savings Amount = $8,483,408

ACOs with RHCs

- ACOs = 157
- Percent of ACOs with CMS Savings = 57%
- Average Gross Savings Amount = $9,135,817

ACOs w/o FQHCs or RHCs

- ACOs = 252
- Percent of ACOs with CMS Savings = 58%
- Average Gross Savings Amount = $6,668,167

Success is just as likely in the ACO program for ACOs that include FQHC/RHC providers as it is for all other groups!

Note: FQHC/RHC groups are not mutually exclusive

Other Financial Considerations

- Staffing can be model adjusted to reflect the lack of need of a billable encounter (e.g. – more nursing, potentially less providers)
- Face to face becomes less important – more frequent check-ins but many virtual will help decrease cost
- Shared savings have been received by several CHCs which incentivizes the health center to monitor key metrics
- Data analysis will be very key and that should not be added to an already stressed-out CFO

What's Next in the APM World?

- Further Push Toward Providers Accepting/Managing Risk
- Mandatory Governmental Programs
  - CMS Stated Strategic Direction
    - All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
    - The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
  - Mandatory Bundle Programs
  - Cross-Model Capability Development
- Voluntary Governmental Program
  - Medicare Shared Savings Program (MSSP) – Advance Investment Payment (AIP) Model
- Blurring Lines in Medicare Advantage Relationships

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In Summary

- The shift to Value-Based Care (VBC) is not slowing
- Participation by FQHCs / RHCs has shown to produce similar results to other participants in Value-Based models
- Opportunities to leverage voluntary programs to build appropriate value-based infrastructure are likely coming soon

Contact

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