VBP/VBC Domain – Financial Health & Planning

# Description

The Financial Health and Planning domain addresses the health center’s ability to leverage enough revenue to support its current and evolving value-based care model to improve patient/population health. The primary goal should be to align payment reform to support better care and improve health equity. Capabilities in the Financial Health and Planning domain include:

* Making sure the health center’s Medicaid PPS rate reasonably resembles costs.
* Developing a business case for the health center that links cost, quality and access outcomes to goals for VBP models.
* Identifying the up-front costs of participating in a proposed VBP model in order to assess whether the VBP model at least covers the added costs of participating in the payment reform model.
* Establishing processes to maximize fee-for-service and VBP revenue that supports better patient care.

The health center’s ability to negotiate contracts with health plans is covered in another domain entitled *Contract Negotiation* (i.e., develop/accept and/or adopt future Alternative Payment Methodologies (APM) and payer VBC/VBP incentive/risk contracts that serve the financial health of the HC).

# Rating Your HC Low, Medium, or High for this Domain

Attributes of HCs that are rated low, medium, or high for capabilities in this domain.

1. HC PPS rates reasonably reflect costs
   1. Low – The HC’s PPS rate is substantially under its allowable costs and has only been increased by the Medicare Economic Index since it was originally established.
   2. Medium – The HC’s PPS rate has been increased by at least 1 successful PPS change in scope application, but its rate is still less than 90% of its allowable costs.
   3. High – The HC’s PPS rate reasonably resembles its allowable costs and it has been successful increasing its rate though PPS change in scope applications.
2. The health center has developed a business case for linking reimbursement to utilization and social complexity of health center patients and health center cost structure (from Delta Center MAHP 2.0 Assessment)
   1. Low - The health center is able to identify data on its cost, patient utilization rates, and enabling service needs for its overall patient population.
   2. Medium - The health center is able to identify data on its cost, patient utilization rates, and enabling service needs of specific group(s) of patients to be involved in payment reform.
   3. High - The health center has data comparing its patients to the patient population in its market area, statewide, and/or nationally, and is able to demonstrate how its robust services lead to better outcomes/costs. The health center can clearly articulate how enabling services will contribute to achievement of clinical and cost goals of specific payment reform efforts to ensure they are maximizing the ROI of their value-based care approach.
3. HC identifies the upfront costs of participating in a proposed VBP model (from Delta Center MAHP 2.0 Assessment)
   1. Low - The health center has used historical costs to identify up-front costs associated with the payment reform initiative including staffing, space and HIT costs. Cost estimates for service delivery are based on historical health center per-visit costs.
   2. Medium - Cost estimates have been adjusted to account for patient population to be served (vis-à-vis average health center patient) and specific health needs and/ or utilization patterns they experience.
   3. High – The health center has developed a per-member-per-month cost for the full scope of services to be offered. The health center has analyzed this cost in comparison to expected reimbursement.
4. HC has financial and care model processes in place to maximize FFS and VBP revenue that supports better care.
   1. Low – The HC primarily relies on FFS revenue and hasn’t integrated VBP revenue into its budget or financial indicators reported to the board. Provider incentives are focused on producing more billable visits.
   2. Medium – The HC has integrated VBP revenue projections into its budget and financial indicators reported to the board. Providers receive incentives based on cost, quality, and/or access metrics in HC VBP contracts.
   3. High – The HC strategically enters into contracts that maximize FFS and VBP revenue that supports better care for patients/populations it serves. Provider teams receive incentives based on HC agreed upon care model goals and aligned with VBP contracts.

If you are interested in your HC taking a more comprehensive VBP assessment, below are some options:

* Delta Center’s MAHP 2.0 Assessment Tool <https://deltacenter.jsi.com/resources/road-ahead-model-advancing-high-performance-primary-care-and-behavioral-health-under>
* NACHC Payment Reform Readiness Assessment Tool <https://www.nachc.org/resource/payment-reform-readiness-assessment-tool/>

# Resources for CHCs to Improve this Capability

LPCA, HCCN and/or LPCACO programs/support:

* LPCA’s current efforts with LDH to increase HC rates in Louisiana and revise policies/administrative rules to be compliant with federal law, policy, and guidance for FQHC payment.
* LPCA’s support for HCs to develop cost reports that will be used to increase PPS rates.
* LPCACO’s VBP education and other financial health and planning support
* LPCA continues to provide capitated APM education.
* LPCA will continue to expand statewide study opportunities of FQHC services and costs.
* LPCA provides education on CMS VBP initiatives
* LPCA is tracking and influencing telehealth payment opportunities post pandemic.
* LPCA will advocate for payment for nonbillable members of the VBC provider team (e.g., peer support specialists).
* LPCA will advance post COVID VBP priorities in its policy platform.
* LPCA will support HCs in completing VBP/VBC self-assessments through these domain resources and by informing HCs of other tools and resources.
* LPCA Workforce efforts on training and certification in coding/billing that achieves sustainability.

Other partners that can help CHCs improve this capability:

* Hostetler Group
* PCA Value-Based Care Collaborative and Online Resources (Noddlepod)
* NACHC Financial Health and Planning Online Resources, Conferences (FOM/IT, CHI, Peer Learning, etc.)
* JSI/Delta Center For A Thriving Safety Net
* Capital Link
* CohnReznick
* Curt Degenfelder
* FORVIS (formerly BKD)
* LDH – Southeast AHEC, Central Louisiana AHEC

Links to resources for this capability:

* Louisiana’s Medicaid Managed Care Quality Strategy, March 2023 <https://ldh.la.gov/assets/docs/MQI/MQIStrategy.pdf>
* CMS Innovations Center <https://innovation.cms.gov>
* NACHC payment reform primer <https://www.nachc.org/resource/health-centers-and-payment-reform-a-primer/>
* NACHC fundamentals for developing a capitated APM <https://www.nachc.org/resource/the-fundamentals-of-developing-a-fqhc-apm/>
* CHCS Using prospective payment to support advanced primary care <https://www.chcs.org/using-prospective-payment-to-support-advanced-primary-care-opportunities-for-states/>
* HCP-LAN Framework for VBP models: <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>
* HCP-LAN paper on pivoting VBP models to improve health equity: <http://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf>
* Commonwealth Fund publication of FQHCs and VBP: <https://www.commonwealthfund.org/publications/2022/jan/perils-and-payoffs-alternate-payment-models-community-health-centers>