Building Bridges to Value: Infrastructure Essentials for Community Health Centers

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ABSTRACT

Primary care providers, especially those working within community health centers (CHCs), are pivotal in the shift from fee-for-service to value-based payment (VBP) for health care. VBP models, in turn, offer financial incentives like up-front care management payments or shared savings opportunities. However, successfully adopting VBP models demands new competencies and investments, a challenge made more acute for many CHCs, which face financial pressures as they strive to provide high-quality, accessible care to all. This report offers CHCs, their partners, policymakers, and others a place to start in addressing these challenges, particularly as the safety net faces potential cuts in federal funding for Medicaid. Drawing on interviews with experts and available literature, the authors organize the services and supports critical for VBP success into a practical framework consisting of four infrastructure domains: (1) leadership, governance, and legal; (2) operations; (3) data, analytics, and technology; and (4) financial. Each domain is explored in depth, with real-world examples and actionable recommendations to help CHCs prioritize investments tailored to their specific VBP opportunities. The report also offers considerations to help CHCs make informed, context-specific choices as they implement VBP models that optimize their resources and impact.

INTRODUCTION

The health care sector has seen a proliferation of value-based payment (VBP) models,[1] or models that hold health care providers accountable for cost and quality outcomes.[2] Many VBP models aim to drive down potentially preventable hospitalizations,[3] given the significant costs of hospital encounters relative to other health care costs.[4] Primary care providers, which deliver community-based services that identify, prevent, or halt the progression of disease, can help ensure the success of VBP models.

Traditionally, primary care and other providers in the health care sector receive payments on a fee-for-service (FFS) basis, through which reimbursement is offered in exchange for services that the payers have previously defined and priced.[5] VBP models can depart from or add to this FFS structure, offering flexible payment structures for a defined population rather than for a specific service, enabling up-front payments, and/or providing opportunities to access bonus payments. These flexibilities then offer providers the opportunity to use resources to transform and optimize service delivery. For example, providers may invest in social care services not traditionally billable through a FFS schedule,[6] fund infrastructure investments like analytics platforms that support more efficient workflows, or offer financial rewards to high-performing providers.

VBP models can also offer vital financial infusions to participating providers. Despite its potential to improve health and lower costs, the US health care system has chronically underinvested in primary care, leading to growing clinician shortages and access barriers.[7] VBP models can at least partially address this underinvestment by channeling additional resources to providers in the form of structures like up-front payments and shared savings disbursements.

Value-Based Payment in Primary Care

While many provider types participate in VBP, primary care practices in particular have demonstrated positive outcomes when offered this type of financial latitude. Specifically, evaluations of Medicare accountable care organizations (ACOs), entities that receive VBP and hold providers accountable for total cost of patient care, have found that ACOs led by independent physician practices tend to generate greater savings[8] than entities helmed by health systems that encompass hospitals. Reasons for this improved performance may include the fact that independent primary care organizations are more financially incentivized to drive down avoidable hospital utilization,[9] compared with organizations integrated with hospitals, and are accustomed to focusing on preventative and care coordination services rather than urgent or acute care.

Despite the potential benefits of VBP participation and meaningful results within Medicare, independent primary care providers have still not adopted VBP models as rapidly as hospital-affiliated counterparts. Surveys of doctors participating in ACOs have shown that those that are part of hospital-owned practices are far more likely to actually participate in a Medicare or Medicaid ACO.[10]

In particular, federally qualified health centers and other community health centers (CHCs), subsequently referred to collectively as CHCs, have faced challenges when transitioning to VBP models. These safety-net providers of primary care serve 1 in 10 people nationally.[11] Key barriers for CHCs include limited access to capital to invest in new infrastructure, such as information technology and staffing; concerns that new payment models will compromise the

unique CHC cost-based Prospective Payment System (PPS);[12] state policies that prevent CHCs from being lead contractors in downside risk arrangements;[13] and organizational resistance to change. (A previous Milbank report[14] provides additional background on barriers.)

Despite these barriers, several practical developments have accelerated a desire among CHCs to move toward VBP models. Most notably, the need for virtual care delivery during the COVID-19 pandemic exposed a need for more flexible payment systems untethered to in-person, encounter-based PPS payments. Policymakers have also sought to help support CHC payment innovations,[15] recognizing that CHCs are crucial to facilitating access within communities that might otherwise face geographic or financial limitations; 90% of health center patients have incomes at or below 200% of the federal poverty line and nearly 30% are rural residents.[16]

The need for virtual care delivery during the COVID-19 pandemic exposed a need for more flexible payment systems untethered to in-person, encounter-based PPS payments.

Why Move to Value-Based Payment?

One key underlying premise of this publication is that health centers should move into VBP arrangements; however, this premise merits an examination. General literature on the impacts of VBP models on cost and quality outcomes is mixed. One meta-analysis of VBP arrangements found that these payment structures do reduce costs and improve quality.[17] Additionally, there is still a general acceleration toward VBP models fueled in part by intractable cost pressures in the health care sector. The overall percentage of health care payments paid through a VBP arrangement increased from 30% to 40% between 2016 and 2021.[18] While less than half report participating in some type of VBP payment arrangement,[19] anecdotally, many health centers report that they have only begun entering into such arrangements. In addition to keeping pace with the industry and the benefits previously outlined, health centers have several reasons to move to VPB:

- Flexibility to invest in care delivery outside of in-person, threshold visits traditionally reimbursed through the PPS (e.g., virtual care, community health worker supports)
- Improvements in staff retention and satisfaction, resulting from investment in additional staff whose presence enables primary care clinicians to focus on the work that only they are licensed to perform
- The ability to reinvest financial rewards available through VBP (if health centers perform well) into the primary care safety net, which is facing significant financial challenges[20]
- Greater alignment of financial and clinical incentives under VBP models than under FFS

Further resources available from the National Association of Community Health Centers[21] and the Commonwealth Fund[22] explore the reasons for health centers to consider VBP.

As CHCs consider *how* to enter into VBP, they must navigate a crowded and potentially confusing array of vendors and organizations that offer partnerships, VBP services, and technical assistance. Organizations that are offering to assist CHCs with VBP performance include:

- Primary care associations (PCAs)[23] that provide training and technical assistance to CHCs
- Independent practice associations (IPAs) or ACOs that aggregate CHCs and contract with health plans
- Health center-controlled networks (HCCNs)[24] that provide training and technical assistance focused on purchasing, training, and data analytics

- Privately backed VBP enablement companies such as Aledade, Yuvo, and others that contract with health plans on behalf of CHCs as well as provide supporting services (e.g., data analysis, risk coding, technology, population health strategy, etc.)

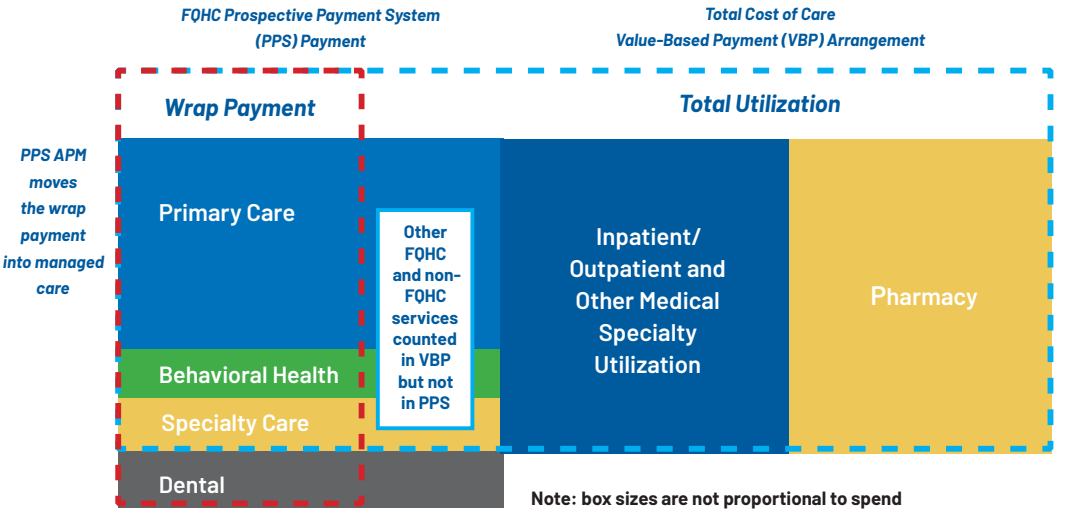
Individual CHCs, particularly those with limited or no VBP model experience, frequently rely on external entities and vendors to help identify the infrastructure supports essential for VBP success. Before entering VBP arrangements, CHCs need to objectively define what VBP-enabling services they most need to perform well under such arrangements and how existing options meet those needs. **This report seeks to offer CHCs and other organizations that work with CHCs a neutral accounting of the VBP infrastructure necessary for success under specific VBP arrangements.**

A Note on CHC Alternative Payment Methodologies

The underlying Prospective Payment System (PPS) rate, which guides payments for services directly rendered by CHCs that hold the specific Federally Qualified Health Center (FQHC) designation, has important implications for VBP design. The PPS was created in 2000 through the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act[25] to ensure that CHCs received adequate reimbursement to reflect the obligation to serve everyone and deliver comprehensive, preventative care. This publication draws a distinction between FQHC Alternative Payment Methodologies (APMs), which modify how FQHCs are paid for services they directly provide, and VBP arrangements, which offer supplementary payments beyond the PPS and/or consider utilization of services inside and outside of the FQHC (see Figure 1). Further, FQHC APMs from Medicaid require approval from the Center for Medicaid and CHIP Services, while VBP arrangements may be negotiated directly with payers.

Additionally, FQHC APMs do not have a clear, directional impact on VBP design, complicating related policy recommendations. The interaction of PPS reforms on VBP can vary from no impact to significant impact, positive or negative, depending on the type of VBP arrangement.[a] For these reasons, this publication does not discuss FQHC APMs and PPS reforms in depth; however, several resources are available on these topics.[26,27,28]

Figure 1: CHC Alternative Payment Methodologies vs. Value-Based Payment Structures



[a] For example, if PPS rates increase, such increased rates could create challenges managing total costs of care under VBP arrangements. Alternatively, if PPS rates decrease, FQHCs would face additional challenges in supporting infrastructure costs associated with VBP.

FRAMEWORK OVERVIEW

The framework in this report describes infrastructure elements (services and supports) necessary for CHC success under VBP arrangements. Services and supports are divided into four key domains: (1) leadership, governance, and legal; (2) operations; (3) data, analytics, and technology; and (4) financial. The purpose is to help readers understand what types of services and supports are most essential for specific payment opportunities, recognizing that payment models with increasing financial risk require different competencies. The framework does not indicate what entity should deliver the infrastructure, as the size, financial position, and market context of individual health centers will greatly influence whether it is appropriate to build these capacities in house, pay another entity to provide them, or partner with another organization to fulfill these needs.

Services and supports in the framework are meant to reflect new infrastructure elements or those that require upgrading/optimization for a health center to function under specific VBP arrangements. The framework distinguishes these new elements specifically required for a VPB arrangement from the types of services and supports already in place for day-to-day health center operations (e.g., a payroll service).[b] The following labels are used to indicate the necessity of services/supports relative to specific VBP opportunities:

- Foundational: elements that should be in place for **all** types of VBP payment structures
- Helpful: the service or support contributes to better performance
- Recommended: the service or support facilitates optimal performance or may accelerate the move toward VBP payment structures with greater financial opportunity (and associated financial risk)
- Essential: the service or support is critical for the specific payment structure
- No designation: the service or support is not needed for the payment structure

Important Caveats

The framework does not indicate what organization should provide the infrastructure services. Services denoted with an asterisk (*) are generally done in partnership with other entities versus at the individual health center level. it is important for health centers to consider the sequencing of activities before building foundational VBP infrastructure or making specific investments to meet the needs of particular VBP arrangements.

Payment Structures

The framework encompasses VBP payment structures with increasing financial risk; these payment arrangements are layered on top of, or in addition to, the PPS rates that health centers receive for threshold patient visits. Experts interviewed noted that each of the included structures can vary in attribution, quality metric, and benchmark design. High-level descriptions of each payment structure type and CHC examples are included below (Table 1).

[b] One illustrative example is actuarial support: A CHC would not typically need actuarial support in order to provide high-quality health care to patients but would need this support when determining whether a VBP arrangement that offers an up-front capitated payment with upside and downside risk appropriately accounts for the predictable risk of attributed patients.

Table 1. Value-Based Payment Structure Types and Community Health Center Examples

Payment Structure	Overview
Performance bonus (Health Care Payment Learning and Action Network [LAN] category 2)[c]	These payments are available if certain process or outcome metrics are met. *Example:* In Michigan, most health plans offer a performance bonus based on HEDIS (Healthcare Effectiveness Data and Information Set) measures that is automatically incorporated into FQHC contracts.[29]
Care management fee (LAN category 2)	These payments are made to support assessment, care plan development, and ongoing care coordination for a specified group of health center patients. *Example:* The Community Health Integrated Practice Association (CHIPA), a network of FQHCs in New York state, negotiated a contract with a health plan to pay a per-member, per-month fee for its attribution population. This fee was meant to enable CHIPA to invest in care management or other population health infrastructure to help drive down the total cost of care. The payer deferred to participating providers to determine specific types of interventions supported by the fee.[30]
Health-plan-delegated care management fee (LAN category 2)	When health plans "delegate" care management responsibility to a health center, the health center has additional contractual obligations to provide care management on behalf of the health plan to the specifications of the health plan. *Example:* The Missouri Primary Care Association (MO PCA) manages a clinically integrated network (CIN) for health centers in the state. The MO PCA has negotiated a delegated care management fee with managed care organizations in the state, under which the CIN or individual health centers are responsible for delivering care management in accordance with the managed care organizations' requirements, including credentialing providers to deliver such services.
Shared savings — upside (LAN category 3)	Shared savings arrangements typically are structures in which the total cost of care for a population is calculated to generate a baseline. If participating providers can manage care such that costs fall below the baseline in a performance year while meeting or exceeding quality expectations, they can share in savings associated with the reduced costs. In upside-only arrangements, provider participants only stand to gain; if costs exceed the baseline, there is no expectation to pay any monies back. *Example:* In New York, two health centers partnered to form the Family Health Accountable Care Organization. This ACO participates in the Medicare Shared Savings Program (MSSP) and initially joined in a track with upside-only opportunity.[31]
Shared savings — downside risk (LAN category 3)	This type of arrangement introduces new financial risk: if costs exceed a baseline, providers are expected pay back a portion of those costs (shared losses). In upside-downside shared savings arrangements, the portion of savings that can be retained if earned is usually higher than in upside-only arrangements. *Example:* Community Care Cooperative (C3), an ACO based in Massachusetts, is participating in the MSSP "enhanced track," which entails downside risk.[32]

[c] Interviewees frequently cited the LAN's Alternative Payment Model (APM) framework as a conceptual touchstone for thinking about VBP models. The LAN framework includes four categories and eight subcategories of payment. The authors of this publication discussed using the LAN framework as the default classification scheme, but several experts felt that because many CHCs tend to focus primarily on LAN category 2, a classification scheme that more finely parsed the lower-risk entry points into VBP would be more appropriate. Where relevant, the corresponding LAN APM framework classification is indicated.

Payment Structure	Overview
Partial risk (LAN category 4)	This type of arrangement involves payers delegating responsibility for a subset of covered services (e.g., primary care services and specialty care services) to a participating entity. This means that the participating entity needs to take on several functions normally held by the health plan and pay claims for those services. In the health center context, this would mean paying claims for services rendered both inside and outside of a health center. *Example:* Integrated Health Partners of Southern California is a CIN that takes on professional risk on behalf of two health centers. Through this arrangement, it is accountable for services rendered directly by the health centers as well as specialty care provided outside of the health center and any professional components of an office visit. This responsibility involves paying claims for those services and taking on related functions for those services including utilization management and utilization review.[33]
Full risk (LAN category 4)	This type of arrangement involves payers delegating responsibility for all covered services to a participating entity. This means that the participating entity needs to take on most health plan functions and pay claims for these services. In the health center context, this would mean paying claims for all or nearly all services rendered inside and outside of a health center. *Example:* North East Medical Services (NEMS), a nonprofit CHC serving San Francisco, runs an IPA that is designated as a "risk-bearing entity" by the state and takes on full risk from the San Francisco Health Plan. The IPA encompasses its CHC as well as hospitals, private practices, and other CHCs and community clinics. Under this arrangement, the IPA receives a global per-member, per-month payment that covers all professional services defined within attributed beneficiaries' medical benefit. NEMS runs a management services organization that performs a variety of services for the network, including provider credentialing, medical claims processing, utilization management, member activation, and more.[34]

The VBP Destination

As health centers enter VBP arrangements, it is important to consider the ultimate destination or goal. Should health centers, individually or collectively, seek to move into arrangements with increasing clinical and financial risk? Some studies of upside-only models show relatively limited impacts on cost and quality,[35] though these models can be a helpful entry point into VBP. By contrast, VBP arrangements found that models that entailed downside risk had the most significant improvements in outcomes.[36]

The LAN framework notes that payment mechanism reform is a necessary but not sufficient condition for success and that underlying delivery system capabilities and innovations are also key. This framework also cautions that while financial reforms should be significant enough to be impactful, it is also important that providers not take on undue financial risk.[37]

These considerations arguably take on additional urgency in the health center context, given the federal obligation of health centers to serve everyone regardless of ability to pay. In other words, if a health center participates in a VBP arrangement that entails downside risk that, if incurred, could shutter the health center, should this type of arrangement even be permissible? Additionally, CHC services are meant to be available to medically underserved regions/populations. Do VBP arrangements that introduce additional financial pressures and incentives push CHCs to respond to profit motives at odds with this mission-driven foundation?

Some experts interviewed for this publication indicated that for this and other reasons their ideal would be health-plan-delegated care management, with primary care rates adjusted to sufficiently account for current inflation-adjusted costs of delivering comprehensive primary care. Other interviewees suggested that concerns can be mitigated by health centers working collectively, thereby minimizing individual organizational risk, and/or working with national or privately funded vendors that can absorb some risk. In other cases, some health centers or networks of health centers take on full risk by paying claims for services and managing other health plan functions.

This framework offers an impartial accounting of the infrastructure needs associated with different types of VBP. The reality is that different goals for ideal VPB arrangements must be determined based on the local market context, provider capacity, and other features.

INFRASTRUCTURE FRAMEWORK

High-Level Takeaways:

- Regardless of the VBP arrangement, it is critical to have staff champions at all levels of leadership and operations to support implementation.
- The most significant infrastructure increase is required when moving from upside-only shared savings to upside and downside risk arrangements.
- Most of the infrastructure required for partial risk is applicable for full risk.

Table 2. Value-Based Payment Infrastucture Needs by Domain and Arrangement

			Increasing Financial Risk Accountability						
	Domain	Related Services & Supports	Performance Bonus	Care Management Fee	Health-Plan-Delegated Care Management	Shared Savings (Upside Only)	Shared Savings (Upside and Downside)	Partial Risk	Full Risk
	Leadership, governance, and legal	Senior leader champion for VBP work (ideally executive and clinical lead)	Foundational						
		Board champion for VBP work and buy-in among board members that precedes VBP implementation and investment	Foundational						
		Identification of policy, legal, or regulatory parameters that would impact VBP participation[d]	Foundational						
		Committee or governance body specific to the VBP arrangement				Helpful or Essential[e]	Essential	Essential	Essential
		Determination of whether an organizational entity can bear risk or whether it should join or create a risk-bearing entity*				Helpful	Recommended	Essential	Essential

[d] For example, state laws may define when and how health centers can take on certain levels of financial risk, or there may be state-level ACO designations.
[e] Some federal programs, such as ACO programs, may require establishment of specific governance committees to oversee the VBP arrangement.

			Increasing Financial Risk Accountability						
	Domain	Related Services & Supports	Performance Bonus	Care Management Fee	Health-Plan-Delegated Care Management	Shared Savings (Upside Only)	Shared Savings (Upside and Downside)	Partial Risk	Full Risk
	Operations	Designated staff responsible for educating health center staff about VBP and its impacts on patient care[f]	Foundational						
		Designated staff responsible for negotiating VBP contracts/terms with payers (vs. contracts related to services directly rendered by CHCs)	Foundational						
		Designated staff to identify vendors or partners to support the VBP work and assess terms and benefits/downsides	Foundational						
		Provider management: contracting with or organizing non-CHC providers participating in a VBP arrangement[g]				Essential[h]	Essential[i]	Essential	Essential
		Administering a help desk on behalf of a payer, or offering a help desk specific to members/providers within the VBP arrangement*				Helpful	Recommended	Essential	Essential
		Credentialing of providers outside the health center on behalf of a payer*						Essential	Essential
		Staff to oversee an appeals and grievance process on behalf of a payer*						Essential	Essential
		Utilization management and utilization review functions on behalf of a payer*						Essential	Essential

[f] Education should also highlight differences between typical patient engagement as individual health center (focused on access) and considerations under VBP (focused on reducing avoidable utilization)
[g] May be in the context of an ACO network or involve identifying high-quality specialty care providers within partial-risk or full-risk arrangements.
[h] Federal ACO programs, for example, require taxpayer identification numbers for all providers who drive attribution under an ACO model; participation in these models therefore requires staff designated to assemble the network, which could include
[i] Ibid.

			Increasing Financial Risk Accountability						
	Domain	Related Services & Supports	Performance Bonus	Care Management Fee	Health-Plan-Delegated Care Management	Shared Savings (Upside Only)	Shared Savings (Upside and Downside)	Partial Risk	Full Risk
	Data, analytics, and technology	Ability to validate the accuracy of members attributed to or assigned to health center under VBP contract	Foundational						
		Connections to local, regional, or state health information exchanges to obtain holistic data on patients (e.g., hospital discharges/admissions)	Foundational						
		Ability to obtain and analyze claims data				Recommended	Essential	Essential	Essential
		Development of dashboarding reports to monitor performance		Helpful	Recommended	Recommended	Essential	Essential	Essential
		Tracking of hospital, specialty care, and pharmacy utilization				Recommended	Essential	Essential	Essential
		Ability to review and validate a list of attributed members or a managed care roster against a list of patients who use care at the health center and make adjustments	Helpful	Helpful	Essential	Recommended	Essential	Essential	Essential
		Database of contact information enabling outreach to attributed patients			Essential	Recommended	Essential	Essential	Essential
		Ability to track rising risk index of patients and subpopulations				Recommended	Essential	Essential	Essential

			Increasing Financial Risk Accountability						
	Domain	Related Services & Supports	Performance Bonus	Care Management Fee	Health-Plan-Delegated Care Management	Shared Savings (Upside Only)	Shared Savings (Upside and Downside)	Partial Risk	Full Risk
	Financial	Ability to assess potential revenue associated with the VBP opportunity, taking into account infrastructure costs and incentive payments	Foundational						
		Determination of methodology for allocating and apportioning any gains or losses among participating providers or health center partners	Foundational						
		Funding of capital reserves*				Recommended	Essential	Essential	Essential
		Ability to pay claims on a fee schedule*						Essential	Essential
		Reinsurance				Recommended	Essential	Essential	Essential

BUILD OR BUY CONSIDERATIONS

As the examples above illustrate, there is no one-size-fits all approach for CHCs to participate in VBP. CHCs may choose to build some capacities in-house and outsource others or to vary their approach by population or payer contract. Regardless of which path CHCs choose, intentionally assessing whether to build or buy VBP infrastructure increases the likelihood of successful performance and effective expectation management among staff and patients. Below are questions for CHC leaders to consider when determining whether to build or buy supports within each infrastructure domain.

Key Questions for CHCs to Consider Related to Building Infrastructure

General

- What internal resources (e.g., staff expertise, IT infrastructure, financial reserves) are required to build the infrastructure, and do we have these resources on hand?
- If we use these resources to enable VBP, does that delay or prolong other planned projects?
- How scalable is this approach as our patient population grows or payer mix evolves?
- How will building this capacity ourselves be perceived by staff, our board, and external partners?
- If there is a desire to move to partial or full risk, will we be able to bring other organizations such as specialists and hospitals into the network as partners?

Leadership, Governance, and Legal

- If we build our own infrastructure, will we still need to outsource aspects of the operations to external vendors (e.g., software platforms)?
- Will building this new infrastructure ourselves and/or taking on increased financial risk under VBP introduce new liabilities?
- Do new legal entities, board committees, or advisory bodies need to be established to perform this work?

Operations

- How will this decision affect daily operations, including staff workflows and patient care?
- What training and support will staff need to adapt to new systems or processes?
- Will new divisions or internal meetings need to be developed to support the efforts to build capacity to enable VBP?

Data, Analytics, and Technology

- If outsourcing is required, what criteria should we use to evaluate external vendors, particularly for software platforms and analytics tools?
- What systems will we need to integrate with new tools (e.g., electronic health record, population health tools), and how will they align with existing workflows?

Financial

- How much initial and ongoing investment is required for building infrastructure in-house versus outsourcing specific functions?
- How will we evaluate the return on investment for different infrastructure options, ensuring financial sustainability in VBP models?

Key Questions for CHCs to Ask Potential Partners

General Considerations

- How long has the partner been operational, and what experience do they have with CHCs?
- What is the partner's ownership model, and does it reflect a commitment to the health sector or community-based care?
- How does the partner incorporate CHC perspectives into service offerings and implementation?
- How will buying this capacity be perceived by staff, our board, and external partners?
- If there is a desire to move to partial or full risk, will the partner be able to bring other organizations such as specialists and hospitals into the network as partners?

Leadership, Governance, and Legal

- What legal structure does the partner use, and does it vary by state?
- Will the collaboration create new governance structures, and how will CHC leadership be included in decision-making?
- How does the partner align with the CHC's mission and promote community health?

Operations

- How do the partner's staff integrate with CHC teams, and can they extend services to uninsured populations?
- Do they offer enhanced referral systems, and how do these integrate with existing CHC workflows?
- What training resources are available to prepare CHC staff for VBP?

Data, Analytics, and Technology

- How does the partner's software integrate with CHC systems such as electronic medical records?
- What methodologies are used to assess population risk, and do they consider social determinants of health?
- What type of data will they collect, and how will the data be used?

Financial

- Does the partner offer up-front financial resources or risk-mitigation strategies?
- How are financial gains shared, and what portions are retained by the partner?
- What expertise does the partner have with different payer types (Medicaid, Medicare, commercial)?

CONCLUSION

The transition of CHCs into VBP arrangements represents a pivotal opportunity to enhance care quality, reduce costs, and improve primary care capacity. The adoption of VBP by CHCs is not, however, without its challenges. CHCs face unique barriers, including limited capital for infrastructure investments, state policy restrictions, and the complexity of integrating VBP with existing PPS models. However, shifting payer priorities, growing cost pressures in the health care sector, and the evolving demands for on-demand care underscore the urgent need for change in how CHCs are paid. For CHCs to remain sustainable, they must proactively embrace these transformations while safeguarding their core commitment to accessible, community-focused care.

As this report highlights, the success of CHCs in navigating these innovative payment models depends on robust infrastructure across leadership, operational, technological, and financial domains. By intentionally planning to build, buy, or partner to develop such infrastructure, CHCs can position themselves to thrive in an increasingly value-driven health care landscape.

This report's framework provides a practical roadmap for CHCs and their partners to assess, prioritize, and implement the infrastructure necessary for VBP success. It emphasizes that the path forward requires a balance between ambition and prudence, as CHCs must carefully weigh the financial risks associated with advanced VBP models.

Looking ahead, the journey toward value-based care offers an opportunity to reimagine how health care is delivered and funded in underserved communities. By investing in targeted infrastructure, fostering innovation, and building strategic collaborations, CHCs can lead the charge in improving outcomes for the populations they serve and become exemplars of how value-based care can drive lasting change in the US health care system.

APPENDICES

A. Issue Brief Methodology

To inform this issue brief, the authors reviewed existing literature available on the adoption of VBP models in the primary care sector, particularly among CHCs (see Appendix B for detail). This literature review informed the development of a comprehensive interview guide to gather key insights from stakeholders across a diverse array of organizations. Authors interviewed over 50 individuals including policymakers, representatives from CHCs, PCAs, HCCNs, primary care IPAs, private companies, and other health care sector experts. Interview questions were tailored to each stakeholder type and included, broadly, an understanding of the stakeholder's experiences with VBP, input on the types of VBP models that CHCs are suited to participate in, infrastructure required for CHCs to be successful in VBP arrangements, and input on the policy landscape.

In addition to individual interviews, authors held several virtual convenings to solicit additional reactions and feedback on the content herein. The authors would like to thank the many individuals who shared their time and valuable insights to help develop this publication.

B. Literature Review: Enabling Services Most Closely Linked with VBP Success

Reference	Source	Intervention/ Design (Abstract)	Results
California Federally Qualified Health Center Alternative Payment Model Implementation Guide	Howe G, Silverman K, Houston R. Center for Health Care Strategies, March 21, 2023.	This implementation guide for the California Federally Qualified Health Center Alternative Payment Model discusses the importance under APMs of expanding where, how, and to whom the center delivers care.	a. Health center staff who have already transitioned to an APM underscore the importance of fully embracing a team-based approach to care. This includes expanding roles of current team members, establishing new roles, recruiting additional staff, and assessing training needs. It is valuable to think about career ladders and opportunities for staff such as nurses, medical assistants, and community health workers, as well as any supervising changes. b. Providers should take advantage of the opportunity under APM to expand how care is delivered, including via portal, via telehealth, at home, and in group visits. c. The transition to the FQHC APM requires a strategy for change management that outlines how to communicate with staff, colleagues, leadership, and the board. d. Data are critical to success in the FQHC APM. Data must be collected about quality, alternative touches (e.g., communication, education, case management, community supports, and care team supports), patient care and engagement, risk stratification, utilization and financial monitoring, patient and provider experience and satisfaction, and health equity. Staff will likely need additional training on coding, and internal processes will need to emphasize the importance of coding. Larger FQHCs may want to hire dedicated staff for coding and documentation. Capturing accurate data in all areas will need to be bolstered. External consulting firms may provide support for accurate coding and billing infrastructure. e. Changes that must be made to the current data infrastructure include creating a data governance plan, training of staff by internal data staff or external experts, reassigning roles and responsibilities among staff, in some cases hiring additional staff to meet data and infrastructure needs, and identifying electronic health record (EHR) changes and optimization. f. Community Care Cooperative (C3), a nonprofit ACO governed by 18 FQHCs in Massachusetts, offers risk adjustment and billing infrastructure support for FQHCs, and "C3 has found this level of support to be critical to each health center's success in the ACO model." It offers access to experts in ICD-10, HCPCS, and CPT coding; post-encounter coding; retrospective record review; individual or group provider education; and prospective chart review. It also assigns a cross-functional Health Center Performance Management Team (HCPM) that partners with each health center's leadership team to provide expertise in care management, risk adjustment, quality, practice transformation, telehealth, EHR optimization, and population health platform technology optimization. HCPMs meet with health centers to review performance metrics, offer help, and receive updates. g. FQHCs participating in APMs attribute success to strong collaboration with partners, including other health centers implementing similar initiatives, health plans, specialists, hospitals, and state agencies. h. A center participating in the FQHC APM will need to modify its contract with managed care plans, and should consider modifying these items: • Contract revision implementation timeline; • APM per-member, per-month payments to FQHCs for each assigned member; • Medicaid populations covered and not covered by the APM payment methodology; • Scope of services included in the APM; • Timing of notification to the plans of the capitation rate and the clinic-specific APM per-member, per-month payments; • Member assignment; • FQHC payment requirements; • Detailed reporting and data sharing requirements; • Reconciliation process; • Procedures for collecting and reporting accurate encounter data; • Alignment of the new payment methodology with existing health plan incentive programs for providers; and • Process for resolving disputes between health plans and health centers, including when the health plan does not have a relationship with the health center. i. Recommendations for requesting financial support for APM investments from managed care plans include: • Meet face-to-face with health plan leaders to align priorities before creating finalized plans or asks. • Align with the plan's major areas of focus. • Recognize that health plan financial performance is cyclical, with plans being more likely to invest in initiatives that have longer-term returns during up cycles and in those with quicker return during down cycles. • Create a well-thought-out financial business case showing how a proposal contributes to the health plan's mission, goals, and quality improvement efforts. • Ask for what is needed, since one-time investments may more easily gain approval than requests for ongoing support.

How Health Centers Can Improve Patient Care Through Value-Based Payment Models	Howe G, Houston R, McGinnis T. California Health Care Foundation Issue Brief, June 2020.	This brief describes VBP models that aim to provide patients with coordinated, team-based health care that is convenient to access and best meets their needs. The examples highlighted in this brief show that this transition has the potential to substantially benefit patients.	Cases where investment in data analytics helped: • Health centers in Minnesota used their resources to develop a data analytics infrastructure that includes a data warehouse that receives real-time clinical data from the FQHCs' electronic medical records, payer claims data, and admission and transfer data from hospital partners. This allowed FQHC Urban Health Network (FUHN) to gain deeper insights into their patients' conditions and utilization patterns, in order to improve care. Additionally, FUHN was able to support on-site care coordinators and other health care staff to use these data to coordinate care and manage costs. • To advance its care coordination efforts, the Medical Home Network (MHN) ACO in Illinois used its up-front funding to create MHNConnect, a data-sharing portal that integrates data from the ACO providers, area hospitals from within and outside of the ACO, and claims and pharmacy data. This gives providers access to real-time, actionable data to support care coordination activities and transitions of care. • Community Health Association of Spokane (CHAS) had positive outcomes for its health center from creating a utilization and care management team dedicated to improving the health of patients who often seek primary care in urgent/emergency settings. This new mix of providers enabled access to comprehensive, on-site behavioral health services in an environment equipped to also counsel patients experiencing co-occurring physical chronic disease and behavioral health disorders.
The Perils and Payoffs of Alternative Payment Models for Community Health Centers	Hostetter M, Klein S. The Commonwealth Fund, January 19, 2022.	This article profiles FQHCs that are participating in APMs, including some cases in which health centers that have banded together to build the data analytics and other tools needed to manage population health.	a. An FQHC in Oregon (Mosaic Medical) found that VBP success required "lots of culture work," with care team members learning about care beyond traditional, in-person visits. Clinical pharmacists work with patients with chronic conditions and community health workers use a standardized tool to screen patients for unmet social needs and help them find supports. Mosaic Medical works closely with other members of the Central Oregon Health Council, a coordinated care organization. The health council promotes transparency around contracting, encouraging hospitals and medical and behavior health providers to reach agreement on how Medicaid payments will be divided to achieve community health goals. To align incentives, the hospital shares the savings that are achieved by reducing hospitalizations with outpatient providers, including Mosaic Medical. b. In some regions, FQHCs have banded together to build a critical mass of patients and leverage shared resources to participate in APMs. Community Care Cooperative consists of 18 Massachusetts FQHCs (large and small) that used government funding to pay for population health staff and software. This system tracks where patients receive care by combining health centers' patient records with medical and behavioral health claims and data feeds on hospital admissions and emergency department visits, and incorporates information on patients' social circumstances. Community Care Cooperative then deploys field staff including community health workers to help patients make appointments and get other supports. c. A FQHC network formed in Iowa (Iowa Primary Care Association) spun off a company (IowaHealth+) to contract with payers on behalf of 11 health centers to advance VBP. The network is held accountable for quality and utilization measures, since its members are small and need to band together to spread risk. IowaHealth+ staff help the health centers build capacity to manage population health, including providing hands-on support from process improvement coaches, and having routine meetings to share best practices. This model has proven successful in terms of financial upside from VBP. d. Without external supports (e.g., funds from government, health plans, or health center networks), FQHCs may struggle to develop the data analytics and financial forecasting tools needed to predict the cost of caring for populations with complex medical and social needs (including resources to acquire software systems and hire dedicated staff to perform these functions).

Relationship Between Organizational Factors and Performance Among Pay-for-Performance Hospitals	Vina ER, Rhew DC, Weingarten SR, Weingarten JB, Chang JT. J Gen Intern Med. 2009;24(7):833-840.	This study identifies the key organizational factors associated with higher performance among hospitals participating in the CMS/Premier Hospital Quality Incentive Demonstration (HQID) pay-for-performance program.	a. The following factors distinguish top-performing hospitals in a pay-for-performance program, and all require resources to create and maintain: • Aspects of organizational culture and organizational support • A multidisciplinary team with the goal of improving care • Adequate human resources for projects to increase quality indicator adherence • Quality improvement interventions, including clinical pathways • Physician leadership, such as taking an active role in recruiting condition-specific physician champions • Using computerized physician order entry b. Factors that did not distinguish top from bottom performers include: • Offering condition-specific educational sessions for physicians and nurses • Data feedback through generation of quality performance reports
Designing Accountable Care: Lessons from CMS Accountable Care Organizations	Horstman C, Lewis C, Abrams MK. The Commonwealth Fund, November 10, 2022.	This article synthesizes evidence on CMS ACOs to identify factors that have facilitated or hindered success.	a. ACOs that include advanced primary care models in their design — emphasizing managing complex patients, addressing behavioral and social needs, and coordinating care — tend to perform better on cost savings, quality, and population health outcomes than ACOs without it. b. Experts have found that successful ACOs develop a strong culture that emphasizes collaboration, engagement with providers in decision-making, and feedback to providers on performance. Strong ACO management and administration is also imperative to success. Third-party technical assistance and learning collaboratives could promote both delivery and culture transformation.
How America's Largest Safety-Net Health System Built a High-Performing Medicare ACO	Stine N, Chokshi DA, Knudsen J, Cunningham M, Wilson R. Health Affairs Forefront, November 7, 2017.	This article describes lessons learned by NYC Health + Hospitals, which formed an ACO in 2012 to participate in the Medicare Shared Savings Program. In its first four performance years, the ACO was successful at reducing costs and improving quality.	a. The center used its initial analyses of ACO claims data to set strategic priorities and drive performance. Compared with the claims data provided by Medicare under FFS, the ACO claims data enabled more unfiltered analysis of how the center's patients interact with health care providers across settings and how its population's use compares with local and national benchmarks. One insight from this data was recognizing the need to focus on identifying high-risk patients instead of just high utilizers, and this led to the center developing an in-house risk scoring system. b. The group focused on optimizing and empowering its existing workforce to address population needs elicited from claims data analysis. This included building an infrastructure with site-specific physician champions and administrative leads to encourage local creativity and engagement. Local medical directors appointed an ACO clinical lead at each primary care center, and an ACO clinical leadership committee regularly brings teams together from across the city to share best practices. c. An ACO population dashboard that synthesizes clinical, financial and administrative data to highlight actionable opportunities was vital for organizing proactive care delivery. It helped with providing a set of standard high-value workflows (e.g., specific steps to connect specific patients to care). Having a single platform for organizing a diverse set of interventions created opportunities for better leveraging existing resources and matching them to patients most likely to benefit.

Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design	McGinnis T, Small DM. Center for Health Care Strategies, February 2012.	CHCS interviewed state Medicaid leaders, ACO stakeholders, and health plan officials who are pursuing ACO models. This paper shares emerging best practices from state ACO activities across the US.	a. Medicaid-focused ACOs must establish the following core capabilities centered on team-based primary care to manage patients across a continuum of medical, behavioral and social services: • Patient-centered care management and coordination, including using predictive modeling to identify high-risk subsets • Targeted and intensive complex care management, which requires developing cross-functional care teams • Data infrastructure and analytics, including EHRs that feed analytic software and a health information exchange across delivery system partners • Motivated and mission-driven leadership and providers b. Colorado contracts with an external statewide data and analytic contractor for help with data aggregation and analytics as a part of its Accountable Care Collaborative model. The contractor develops a repository of Medicaid claims data, cleans and aggregates data, and shares it with stakeholders. This data is critical in identifying best practices and opportunities for quality improvement. The contractor does cost evaluation and calculates incentive payments for providers. c. It is essential for Medicaid-focused ACOs to empower cross-functional teams of providers to transform care delivery. For example, an ACO is using quality improvement advisors to help practice teams reconfigure care delivery to serve patients more efficiently. d. Providers serving low-income populations may require assistance in securing up-front financing to build their ACO capacity and hire the necessary staff before they can achieve cost savings.
Lessons Learned from an ACO's Successes, Struggles	Small L. Fierce Healthcare, February 26, 2015.	The CEO of Primary Partners, LLC, which participated in the first cohort of ACOs in April 2012 under the advanced payment model, as well as the chief operating officer of medication therapy management firm Curant Health, share their insights.	a. For Primary Partners, a key cost-saving strategy was to identify the high utilizers in its patient population and use social workers to coordinate care for these individuals. Primary Partners is improving the model of data analytics it uses to identify these high utilizers. b. Organizations must develop standard operating procedures for how to use electronic medical record information throughout the continuum of care.
Four Years into a Commercial ACO for CalPERS: Substantial Savings and Lessons Learned	Melnick G, Green L. Health Affairs Forefront, April 17, 2014.	This article presents interviews with senior executives from organizations who discuss key operational aspects of their ACO and its implementation. Note that this ACO was for commercial patients.	a. A key to success is to provide all possible facility care within the ACO provider network (repatriation, as well as directing patients to ACO hospitals in the first place). One center dedicated a registered nurse for rounds involving CalPERS members receiving care outside of the ACO network, which enabled better patient management and earlier repatriation when patients became stable. b. Another key to success was focus on reducing readmissions. One group used a multi-entity readmission review process and rolled out a patient interview tool systemwide to understand drivers of readmission from the patient's perspective. A study found that a top reason patients returned within 30 days of discharge was the provider not recognizing other medical conditions. This center worked with its pre-surgery group to make calls and identify pre-admission issues that could keep people in the hospital or increase the likelihood for readmission, and has an internal medicine physician co-manage patients in for surgery. Medication reconciliation was another big issue, and the center saw major impact with patient education about what to do when the patient goes home, how meds are reconciled, and how a patient can connect to their primary care provider if questions arise. c. A center used predictive modeling to identify "frequent flier" patients and launched an initiative to facilitate transfer from the emergency department to more appropriate care (including a primary care provider home visit, intensive medical home management, home health care, and a skilled nursing facility).

2017 Value-Based Payment Study	American Academy of Family Physicians and Humana Inc. Data Brief. 2017.	This study by the American Academy of Family Physicians and Humana Inc. surveyed 386 family physicians in September 2017 to gauge family physicians' perceptions and attitudes about VBP and to determine if there were any changes in attitudes in comparison to their 2015 VBP study.	Family physicians reported these barriers to successfully implementing VBP: • Lack of staff time (90% of family physicians indicated this is a barrier to implementing VBP); • Health information technology investment (86%); • Lack of resources to report, validate and use data (74%); • Ability to understand the complexity of financial risk (75%); • Insufficient training on advance care delivery functions (64%); • Lack of interoperability between types of health care providers (73%); and • Lack of timely data to improve care and reduce costs (70%).
Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions	Damberg CL, Sorbero ME, Lovejoy SL, Martsolf GR, Raaen L, Mandel D. Rand Health Q. 2014;4(3):9.	This article reviews published literature, documentation from VBP programs, and discussions with a technical expert panel to summarize the current state of VBP. The report reviewed 14 studies that commented on characteristics associated with high-performing providers in VBP programs.	a. Higher-performing providers had more health information technology infrastructure; engaged in more external quality improvement initiatives; engaged in more care management processes; used order sets and clinical pathways for measured areas; used computerized physician order entry systems; had nursing staff support for quality indicators; and had adequate human resources for initiatives to improve performance. However, the authors rated the strength of evidence on these points as "low to insufficient" and noted that few studies have addressed this issue. b. Physician leadership with a clear strategy and vision is necessary to change practice culture to one that is comfortable with sharing the risk of a predetermined patient population. c. The panel discussed the importance of support to help providers improve, particularly through use of health information technology and data registries, and best practices for sharing, consultative support, health coaching, and other infrastructure building. d. Providers often lack clearly defined goals for their VBP. The authors suggest that the larger goal of VBP is to transform the way care is delivered to enhance performance. Panel members outlined the following additional goals that they believed would be important to establish and potentially measure to assess VBP program success: stimulate organizational nimbleness to rapidly learn and improve in order to achieve a new performance target, and promote innovation. Also, a program sponsor might define VBP success in terms of whether specific targets are met, but it is worthwhile to consider success in terms of whether performance is improving over time.
Implementing Value-Based Payment Reform: A Conceptual Framework and Case Examples	Conrad DA, Vaughn M, Grembowski D, Marcus-Smith M. Med Care Res Rev. 2016;73(4):437-457.	This article examines six case examples of implementation of VBP initiatives in the US.	The article describes how barriers and facilitators to translating strategy into implementation affect VBP implementation.

Search terms:

- FQHC VBP success
- FQHC VBP best practices
- Community health center VBP success
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- Medicaid VBP success
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- Center for Health Care Strategies
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- Patient-Centered Primary Care Collaborative (PCPCC)
- Primary Care Innovations and PCMH Outcomes
- Medicaid Accountable Care Organization Programs: State Profiles
- ACO lessons learned
- ACO best practices

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