# Using American Rescue Plan Act (ARPA) Funds to Build Health Center Value Based Payment (VBP) Capacity

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## WHY VALUE-BASED PAY HAS BECOME MORE POPULAR

The shift to value-based payment (VBP) models has stemmed from the recognition that fee for service (FFS) is flawed. In fact, some would say that FFS has led to a fragmented health care system that does not deliver well on cost, quality, access and, most importantly, health equity. Issues that have been identified with FFS include that it:

- Rewards volume without accountability to quality, cost, or health equity
- Focuses on a short face-to-face visit with a billable provider instead of the work of the team
- Does not reward continuity between the patient and provider team
- Does not incentivize proactively managing patients
- Does not incentivize provider organizations, like hospitals, specialists, and primary care providers, to work together
- Does not incentivize efficiencies in the health care system
- Has not sufficiently supported primary care and behavioral health integration.

Some payors and providers define the value equation for value-based models as Value = Quality/ Cost. FQHCs tend to add more to the value equation to reflect the needs of vulnerable populations where access to billable and non-billable services, health equity, and adjustments for social determinants of health (SDoH) characteristics and behavioral health of the population are included. Health Centers have also included addressing the needs of rural populations in their value equation.

$$\text{Value} = \frac{\text{Quality, Access, Health Equity}}{\text{Total Cost}} \times \text{Adjustment for SDoH/ Behavioral/ Medical Complexity}$$

Payors are more interested in linking provider payments to improved performance (i.e., advancing VBP) than paying for volume of services. Even during the COVID-19 pandemic, Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Directors letter on September 15, 2020, encouraging states to advance value-based payment, with a particular focus on Medicaid populations. Payment reform by itself will not work unless it supports a care model that meets the needs of the patients and populations served, while lowering the total cost of care. Different populations have different needs, which adds complexity to how VBP models should develop. In particular, FQHCs serve vulnerable populations with complex medical, behavioral health, dental and SDoH needs. However, it does not look like the advancement towards VBP models will slow down anytime soon which means FQHC's will need to develop capabilities to be successful in a VBP world.

Examples of capabilities that FQHC's will need in VBP include:

- **Patient-centered team-based care** which addresses the holistic needs of vulnerable patients and families
- **Population** health approaches to care delivery
- **Care coordination** and care management, particularly for high-risk patients
- **Tracking and moving** cost, quality, and access metrics
- Providing **same day access** to primary care services for patients
- **Better data** and data analytics, including understanding SDOH characteristics of patients
- **Finance** departments will need to manage a sizeable proportion of their payment in FFS along with increasing revenue in VBP
- FQHCs should **know their costs** associated with value-based pay models and how much risk they are able to assume under these models
- There should be a **culture of quality improvement** throughout the organization

## OPPORTUNITY

FQHCs have the opportunity to make some short-term investments in developing VBP capabilities through flexible American Rescue Plan Act (ARPA) H8F funding for Health Centers. The funding can support Health Center priorities over the next two years. ARPA funds can be used in the following categories:

- Vaccine related activities
- Detect, diagnose, trace, and monitor COVID-19 infections and related activities to mitigate the spread of COVID-19
- Purchase equipment and supplies to conduct mobile testing or vaccinations for COVID-19
- Establish, expand, and sustain the health care workforce
- Modify, enhance, and expand health care services and infrastructure
- Conduct community outreach and education activities related to COVID-19

**OPPORTUNITY**

Within these ARPA funding categories there is a lot of flexibility to invest in preparing health centers for a value based-pay world. For example, HCs can invest in:

- Ensuring availability of comprehensive primary and behavioral health care by investing in personnel
- Aligning strategic priorities to reflect recovery and stabilization needs due to COVID
- Facilitating access by expanding or increasing enabling services, expanding home and/or virtual visits, and addressing social or other risk factors amplified or worsened by the public health emergency
- Developing and/or updating patient registries, patient engagement, care transitions and coordination, and population health capabilities to improve health equity, including the use of social service referral tracking software and/or personnel
- Expanding and enhancing Health Center telehealth capacity to perform triage, deliver care, support care transitions, and support follow up via telehealth including use of home monitoring devices
- Developing and/or enhancing software and digital applications to support patient access to and engagement in virtual care
- Enhancing telehealth and health information technology cybersecurity infrastructure, including mobile device management, patient portal, and digital applications
- Purchasing equipment and supplies to support the provision of comprehensive primary care,
- Purchasing or upgrading a certified EHR
- Enhancing or expanding mental health and substance use disorder services
- Establishing and strengthening community partnerships and referrals for SDoH interventions
- Other qualifying investments, such as addressing early childhood health priorities

# AREAS OF FOCUS FOR SHORT-TERM INVESTMENTS

We wanted a broader lens of where Health Centers are planning to invest individually or collaboratively in value-based capabilities, so we surveyed Health Centers, primary care associations, HCCNs, and Health Center networks to add to our current thinking.

The following areas of focus for these short-term investments fell into the following categories:

- Developing a strategy or a roadmap to prepare Health Centers for a value-based world
- Additional staffing to provide comprehensive, team-based care
- Leadership development and change management support
- Expanding the amount and breadth of services
- Integrating services
- Improving access and health equity
- Improving data and IT
- Facility improvement and transportation
- Building capabilities in the finance department
- Collaboration with other Health Centers, the broader health care system, and social service agencies

# EXAMPLES OF EACH AREA OF FOCUS

## Developing a Strategy or a Roadmap to Prepare Health Centers for a Value-Based World

Short-term Investments in this area include developing an overarching strategy and aligning strategic priorities to prepare for the new normal as the public health emergency winds down, developing a roadmap to build Health Center value-based capabilities, and assessing Health Center readiness for a value-based world.

Health Centers could use the ARPA funding on a consultant that can bring in outside expertise and regional or national experience developing overarching strategies and roadmaps to build Health Center value-based capabilities. Health Centers should also consider either utilizing existing staff or add staff that can oversee the implementation of the key priorities or strategies to build value-based capabilities across the Health Center.

## Additional Staffing to Provide Comprehensive, Team-Based Care

Additional staffing ideas to provide comprehensive team-based care included hiring:

- Population Health Directors/ additional staff with population health capabilities
- Nurse Practitioners with a focus on wellness visits and care coordination for Medicare patients
- Diabetes Educators
- Complementary Medicine positions (e.g., Chiropractors, Physical Therapists, Acupuncturists)
- Care Coordination/Case Managers
- Community Health Workers
- Chief Information Officers
- Data Analysts

Continued investment in these staff beyond two years would have to be supported by other revenue sources or by decreasing expenses in other parts of the Health Center.

## Leadership Development & Change Management Support

Ideas for investments in leadership development included:

- Diversity, equity, and inclusion training
- Addressing staff burnout
- Training staff to improve value-based care
- Developing a culture of quality improvement

## Expanding the Amount and Breadth of Services

- Expanding the breadth of services to address the holistic needs of patients
- Expanding behavioral health and SUD services
- Adding an in-house pharmacy
- Adding more types of virtual services (i.e., beyond telehealth) and adding capacity to meet the virtual needs of more patients
- Outreach and members engagement services
- Adding a wellness center

### Integrating Services

Integrating services included integration of medical, behavioral health (inclusive of SUD), dental, and SDoH services. It also included the integration of pharmacists onto the care team. Examples of investments in integration included:

- Behavioral Health Integration: Investing in consulting expertise to develop an evidence-based integration model, like the Collaborative Care Model that is led by a primary care provider.
- Dental Integration: Investing in staff to participate in an oral heath integration collaborative.
- SDoH Integration: Investing in the development of workflows to capture patient SDoH information and software that connects patient needs to available resources in the community through closed-loop referrals.

### Improving Access and Health Equity

Improving access included adding patient engagement services, expanding hours of operations, providing same day appointments, and growing the number of patients served.

Improving health equity included being able to measure and improve health disparities, diversifying staff to reflect the diversity of patients served, and developing cultural awareness for health center staff to better serve diverse populations.

### Improving Data and IT

Ideas for improving data and IT included:

- Collecting SDoH data and tracking closed loop referrals
- Expanding telehealth capacity, particularly for rural populations
- Improving electronic health record capabilities
- Advancing interoperability
- Improving data analytics
- Adding population health software
- Improving coding accuracy
- Adding remote patient monitoring capabilities
- Improving cybersecurity

### Facility Improvement and Transportation

Facility improvement ideas included adding capacity to serve more patients and renovating existing space to co-locate provider teams. Co-location of teams can facilitate care integration by increasing communication and collaboration.

Addressing patient transportation barriers included adding mobile units, expanding home care services, and adding transportation options for patients to be seen at the clinic.

### Building Capabilities in the Finance Department

Building capabilities in the finance department included providing training for staff to manage dueling fee-for-service and value-based pay models, analyzing costs for providing value-based services, and aligning provider team compensation with value-based goals. Other ideas included bringing in

consultants to assess the Health Center's added costs associated with value-based pay models and the health center's capacity to enter into VBP models with increasing levels of risk.

### Collaboration with other Health Centers, the Broader Health Care System, and Social Service Agencies

Collaboration ideas included collaborating with other Health Centers, the broader health care system, and social service agencies. Health Centers were planning on:

- Partnering to invest in expanding services (e.g., tele-psychiatry), developing a data warehouse, sharing data transparently and spreading best practices, adding IT capabilities, and bringing in consulting expertise to build their finance department capabilities.
- Partnering with the broader health care system to integrate behavioral health services, improving transitions in care by investing in care coordination capabilities, and reducing the total cost of care by investing in the ability to ingest claims data.
- Partnering with health neighborhoods to collect SDoH data and testing SDoH interventions to determine their impact on health outcomes.

## KEEPING THE EYE ON THE PRIZE

These short-term investments should improve the Health Center's value equation in the context of a value-based delivery system. Since the value equation of Health Centers is more expansive than just quality and cost, investments also need to:

- Address different forms of access that meets the needs of vulnerable populations
- Measure and address health disparities
- Meet the behavioral health and social needs of vulnerable populations that impact health outcomes.

Many of the short-term investments listed in this document will have ongoing expenses that last beyond the two-year ARPA funding opportunity. Health Centers will need to identify alternative revenue sources to continue services that enhance their value equation or identify and reduce expenses in other areas that are less important to supporting the Health Center value equation. For example, one strategy could be to develop an ROI for value-based capabilities that could be supported by future value-based pay models.

As Health Centers build their strategies to support value-based capabilities added through short-term investments, they will need to assess their state environments to determine how to best leverage VBP models to meet their needs. For example, the following are considerations using the HCP-LAN framework for payment categories (https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf):

- Category 2A – Foundational Payments for Infrastructure & Operations: Payors with more advanced VBP models would have moved beyond this payment category. However, some payors may be willing to support value-based capabilities, like care management and IT, without accountability to cost and quality metrics. Health Centers using ARPA funds can consider the federal stimulus a two-year foundational investment that could be continued through ongoing foundational payments from MCOs or other payors.

- Category 2B – Pay for Reporting: Payors may be willing to reimburse providers to report data that the provider is not currently reporting, like newly developed metrics or social determinants of health (SDoH) data on members. This SDoH data could be used to make a case for including SDoH risk adjustment for categories 2C through category 4B to account for the impact that social complexities have on cost and quality metrics.
- Category 2C – Pay for Performance: As Health Centers improve their quality and utilization metrics through short-term ARPA investments, they could consider entering into up and downside risk arrangements. Upside risk means that Health Centers would earn revenue if they met agreed upon benchmarks or improvements to quality and/or utilization metrics. Downside risk means that Health Centers would be at risk for financial penalties if they do not perform to agreed-upon standards. Payors are willing to pay more upside revenue if providers are willing to go at-risk for financial penalties, this could lead health centers to consider downside risk. Health Centers will need to consider the timing for these payments to see if the cash flow would be timely enough to maintain capabilities added through ARPA investments. For example, if Health Centers need to wait over 12 months to receive pay for performance revenue, are the payments timely enough to maintain added value-based capabilities?
- Category 3A – Shared Savings, Upside Risk: Health Centers that can individually or collectively participate in shared savings arrangements based on the total cost of care (e.g., hospital, specialty, pharmaceutical costs) could increase revenue to support value-based capabilities added through ARPA funds. Again, Health Centers will need to consider the timing of these payments to ensure that availability of additional revenue is in time to maintain added capabilities.
- Category 3B – Shared Savings, Downside Risk: Health Centers will need to collaborate (i.e., join a clinically integrated network (CIN) or accountable care organization (ACO)) to enter into shared savings with downside risk arrangements. Cash flow for this category of payment needs to be considered along with the ability of the Health Centers to collectively enter into downside risk arrangements.
- Category 4A – Condition Specific Population Health Payment: Health Centers could enter into a primary care sub-capitated arrangement to receive prospective payment that would provide flexibility to support value-based capabilities that Health Centers have added through ARPA funds. If the sub-capitation includes accountability to quality metrics, it is considered category 4A. If there is no accountability to quality metrics, the payment methodology is considered 4N. NACHC and Primary Care Associations have been supporting the development of Medicaid primary care capitated APMs for FQHCs in order to support the advancement of value-based care.
- Category 4B – Comprehensive Population-Based Payment: This category of payment provides the most risk and reward for Health Centers. Health Centers entering into these arrangements would receive prospective payment to cover most or all of a population's health care needs.

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