

**Health Center Program
Governing Board Workbook**

PAYMENT REFORM SUPPLEMENT

**National Association of Community Health Centers
March 2017**

ABOUT NACHC

Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's health centers and as an advocate for health care access for the medically underserved and uninsured.

NACHC's mission is: "To promote the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community directed for all underserved populations."

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DISCLAIMER

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FOR MORE INFORMATION

For more information about this publication, contact NACHC Training and Technical Assistance at 301-347-0400.

INTRODUCTION

Health center board members need to understand Payment Reform so they can make *informed*, strategic decisions about how to improve health care and resources for care in the community. Understanding changes to payment and services will support board members in meeting their legal responsibilities to the health center: providing oversight and acting for the good of the organization, and protecting the health center's assets.

NACHC is happy to provide you with this **Payment Reform Supplement** as an addition to the **Health Center Program Governing Board Workbook**, a guidance developed in 2015 by the National Association of Community Health Centers (NACHC). The **Supplement** expands on the **Workbook's** Chapter 11 – “A Changing Health Care Environment” – and is a self-study guide that highlights Payment Reform basics. Its purpose is to help health center board members lead more effectively by addressing the following questions:

1. **Why do we need payment reform?**
2. **What does payment reform mean for health centers?**
3. **What is the board's role in supporting the health center in payment reform?**

Informed board members are better equipped to:

- Champion their health centers that are changing the way they provide care
- Maintain healthy financials such as having an operating margin and different sources of revenue.

→→→ To access the **Health Center Program Governing Board Workbook**, visit **MyNACHC** at <http://mylearning.nachc.com>. After signing in, search for “governance.”

See the Glossary at the end of the Supplement for the meaning of words related to Payment Reform used in this document.

NOTES:

In the **Supplement**, the term “health center” refers to public or private nonprofit entities that: (1) receive grants under Section 330 of the Public Health Service Act (Section 330), including Sections 330(e), 330(f), 330(g), and 330(h) (collectively “Health Center Program Grantees”); and (2) entities that have been determined by the Department of Health and Human Services (DHHS) to meet the requirements to receive funding without actually receiving a grant (“health center look-alikes”).

Because at least 51% of health center board members are patients, the Supplement highlights implications of changes as perceived by patients.

1. Why Do We Need Payment Reform?

Right now, most patients face a health care system that is fragmented. Patients often have to deal with many different types of providers such as hospitals, specialists, behavioral health, and primary care providers. For a variety of reasons, these different types of providers often do not work together for the common good of the patient. For example, a primary care doctor may not know if her patient spent the previous night at the emergency room. This lack of care coordination leads to higher costs to the health care system.



What do you think are the biggest problems in the way health care is delivered and paid for today?

In our fragmented, high-cost system, taxpayers and patients pay a lot for health care but are not necessarily healthier. The United States (U.S.) cannot afford to continue this trend. As health care costs increase, federal dollars for health care add to our national debt and take away our ability to invest in other important parts of the economy like education and transportation.ⁱ Similarly, at the state/territory level, Medicaid programs are an increasing part of state/territory budgets.ⁱⁱ To get control of these growing costs, health care payers such as Medicare, Medicaid, and health insurance companies are changing *how* they pay for care. They want to see more value for their money. *Payment Reform* refers to these efforts to change how care is paid for.



Did you know that . . . across the nation, Medicaid patients make up nearly half of all health center patients?ⁱⁱⁱ

Federally qualified health centers (FQHCs) are paid by Medicaid through the FQHC Medicaid **Prospective Payment System (PPS)**. Under PPS, FQHCs receive a set payment for all primary and preventive care services delivered during each patient visit. PPS was created to ensure predictability and stability for health centers while ensuring Federal 330 grant dollars can be dedicated to caring for patients without health insurance—as intended by Congress.

Remember, each state/territory has its own Medicaid program to help make health care more affordable to the patient.

To make sure the state/territory stays within its budget, many states/territories try to limit Medicaid payments. Each state/territory can do this differently. This is a big deal for health centers since Medicaid is one of their biggest sources of payment.

Medicaid is sometimes confused with Medicare. Medicaid is run by the state/territory government and is based on income guidelines. Medicare is run by the federal government and is for people who are 65 and older and some who are disabled.

→→→ To learn more about Health Centers and Medicaid, see NACHC's fact sheets "[The Facts about Medicaid's FQHC Prospective Payment System](#)" and "[Health Centers and Medicaid](#)."^{iv}

WHAT IS VALUE?

When you think about the word *value*, you already know that people define it differently. As the saying goes, *Beauty is in the eye of the beholder*; and so it goes that *value* is in the eye of the beholder. For a health center, the *beholders* are often referred to as *stakeholders*, and stakeholders usually define value. Health center stakeholders are people who have a specific interest in the health center. Stakeholders can include patients, other providers, payers/funders, and health center staff.

Think about who your stakeholders are. They hold the key to how your health center defines *value*. Your stakeholders include patients, communities, providers, and payers. The definition of *value* may change, depending on the stakeholders, or they all may value things similarly. Either way, it is important first to understand who your stakeholders are, what they value, and how your health center holds that value. Stakeholders have come up with very similar ideas about what is value, which include:

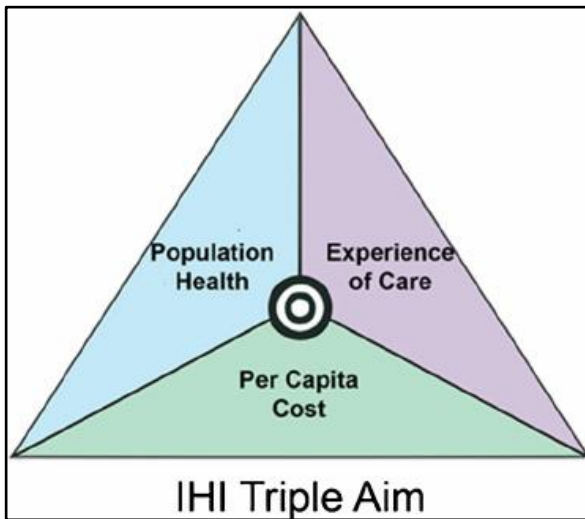
- Health of the patient
- Patient experience
- Health of a community
- Cost
- Equity
- Access

The Quality Improvement Awards of the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) note these elements of health center value:

Access Cost Quality Equity

To create a common understanding of how to improve *value* in health care, a national effort started at the Institute for Healthcare Improvement called the *Triple Aim* is driving Payment Reform efforts. The Triple Aim includes these three common goals:

- (1) Better health for a community
- (2) Lower costs of care
- (3) Improved patient experiences^v



To the Triple Aim, some people add a fourth goal of improving the work life of health care staff for the *Quadruple Aim*.^{vi}



One important way to move toward these goals, the Triple or Quadruple Aim, is to shift health care from being *volume-based*, rewarding *how many* services are provided, to *value-based*, rewarding *how well* a clinic keeps its entire patient population.



EXAMPLE

Instead of only paying a health center each time a provider sees a diabetes patient (for a patient visit), a health center is paid for keeping that diabetes patient's blood sugar at a healthy level all year long. Sometimes keeping this patient healthy can mean providing services outside the exam room such as a health coach going grocery shopping with the patient to help the patient understand how to read food labels.

» **In this example, the health center is rewarded based on “how well” the patient does (Value) rather than “how many” times that patient met with a health center provider (Volume).**



EXAMPLE

If you are paying for “value:” you pay a driver to take you safely and comfortably to Canada.

If you are paying for “volume:” you pay a driver for each mile she drove you (even if you did not make it all the way to Canada and the drive made you carsick).



DISCUSS

Think about what you spend money on each day. Can you think of other examples of paying for “value” rather than “volume?” In your example, does paying for value result in more satisfaction?

Under Payment Reform, the Triple and Quadruple Aims will drive changes toward how health centers deliver care. The community served by the health center and patients need to understand what the changes are and why they are happening. This understanding will support patients in engaging actively with health center staff and their overall health and wellness. Informed patients will be better equipped to champion their needs as the health center model evolves and everyone is working toward the Triple and Quadruple Aims.

2. What Does Payment Reform Mean for Health Centers?

As payers begin to change *how* they pay for what they value, health care providers need to change *how* well they deliver care so care is more valuable without costing more. Together, these changes are referred to as being “Value-Based.” From this basic concept of care *and* payment being “Value-Based,” some key terms emerge.

Value-Based Care

Delivering care with more value

When focusing on changing *how care is delivered*, many people refer to this as *Value-Based Care*.

Value-Based Payment/Value- Based Purchasing

Paying for care based on valued outcomes

When focusing on changes to *how care is paid for*, many people refer to this as *Value-Based Payment*.

Payment Reform

Changing payment models for the Triple and/or Quadruple Aims

Focusing on major changes to *how payers are changing the way they pay for care* and shifting it toward value, many people refer to this as *Payment Reform*. Even though most payers are moving toward the Triple and/or Quadruple Aims, Payment Reform efforts vary from payer to payer. In the case of Medicaid, which is specific to each state/territory, each state/territory may be doing Payment Reform differently.



EXAMPLE

Payment Reform at the Federal Level: **Alternative Payment Models (APM)** is Medicare's approach to value-based payment, which often involves payment to an entire network of providers, ranging from hospitals to primary care providers.



EXAMPLE

Payment Reform at the State/Territory Level: Instead of PPS, states may work with health centers to develop a Medicaid Alternative Payment Methodology (also called APM, but referred to as FQHC APMs in this document) as long as the payments are not less than they would have been under PPS. FQHC APMs allow for increased flexibility in how care a health center delivers care based on the specific needs of the patients and community they serve, including the use of integrated care teams and new visit types.

To keep it simple, this Supplement will refer to *Payment Reform* throughout. However, keep in mind that Payment Reform can only work well if the way health care is delivered (the care model) also changes. Although this supplement will cover some basic concepts needed by board members to understand *Payment Reform*, they will need to look at what is happening in their own state/territory to get a deeper understanding, since each state/territory's Medicaid program and other payers are different.

HOW MIGHT PAYMENT REFORM LOOK TO A HEALTH CENTER?

As health care leaders and policy makers alike have considered this question, Payment Reform (Figure 1) may address three “layers:”^{vii, viii, ix, x} Board members can use these three layers to understand the type of Payment Reform their health centers may use.

Base Payments

Payments for in-scope primary care services

Base Payments include PPS or FQHC APMs. *For both PPS and APM, some health centers are working with Medicaid to expand the services included in their PPS or APM.* These services include those provided by telehealth or new types of health care providers. Some health centers are working with Medicaid to reform the PPS/APM so it is no longer tied to a face-to-face visit with a certain type of provider. These changes will allow more flexibility for the health center to shape their patient-centered approaches.



How can your health center provide high-quality care at the lowest cost to make the most of your base payment?

An “Investment” payment is an incentive for a health center to change how care is delivered or improve the quality of care. These are payments in return for new or enhanced services but they are not dependent on how well the services are executed. However, these payments can make services less fragmented and improve the value of overall services, so they are considered part of Payment Reform.



EXAMPLE

In some states/territories, health centers that are certified [Patient Centered Medical Homes](#) can get enhanced payments. The National Committee for Quality Assurance (NCQA) defines the patient-centered medical home as “a way of organizing primary care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” Some health centers receive *payments for coordinating care* for patients with chronic disease or for those just discharged from the hospital. These payments are intended to make the system less fragmented and avoid expensive health care services such as a hospital stay.



DISCUSS

What would you do to improve your care model if you had investment payments? What resources can help you be ready to provide care in collaboration with other providers in your community?

Payments (or Losses) Depending on Cost and Quality

Health center payments (or losses) usually happen when the health center is paid based on their efforts to reduce the cost and improve the quality of care for patients within and sometimes beyond the clinic walls.

To participate in this type of payment, health centers need to be able to understand and demonstrate these successes through reporting data. As a starting point, one example of this data may include what nearly all health centers already report to the Bureau of Primary Health Care Uniform Data System (UDS), especially if the health center does not have access to any other data. Many health centers also report data to health insurance companies through other systems such as the Healthcare Effectiveness Data and Information Set (HEDIS). It is important for health centers to understand the similarities and differences in the data used to determine cost and quality and compare them to other providers.



EXAMPLE *The U.S. Health Resources and Services Administration (HRSA) Quality Improvement Awards* has paid health centers that performed well for their patient population on certain clinical and cost measures reported in their UDS data.



EXAMPLE *Payments to an Accountable Care Organization (ACO)*

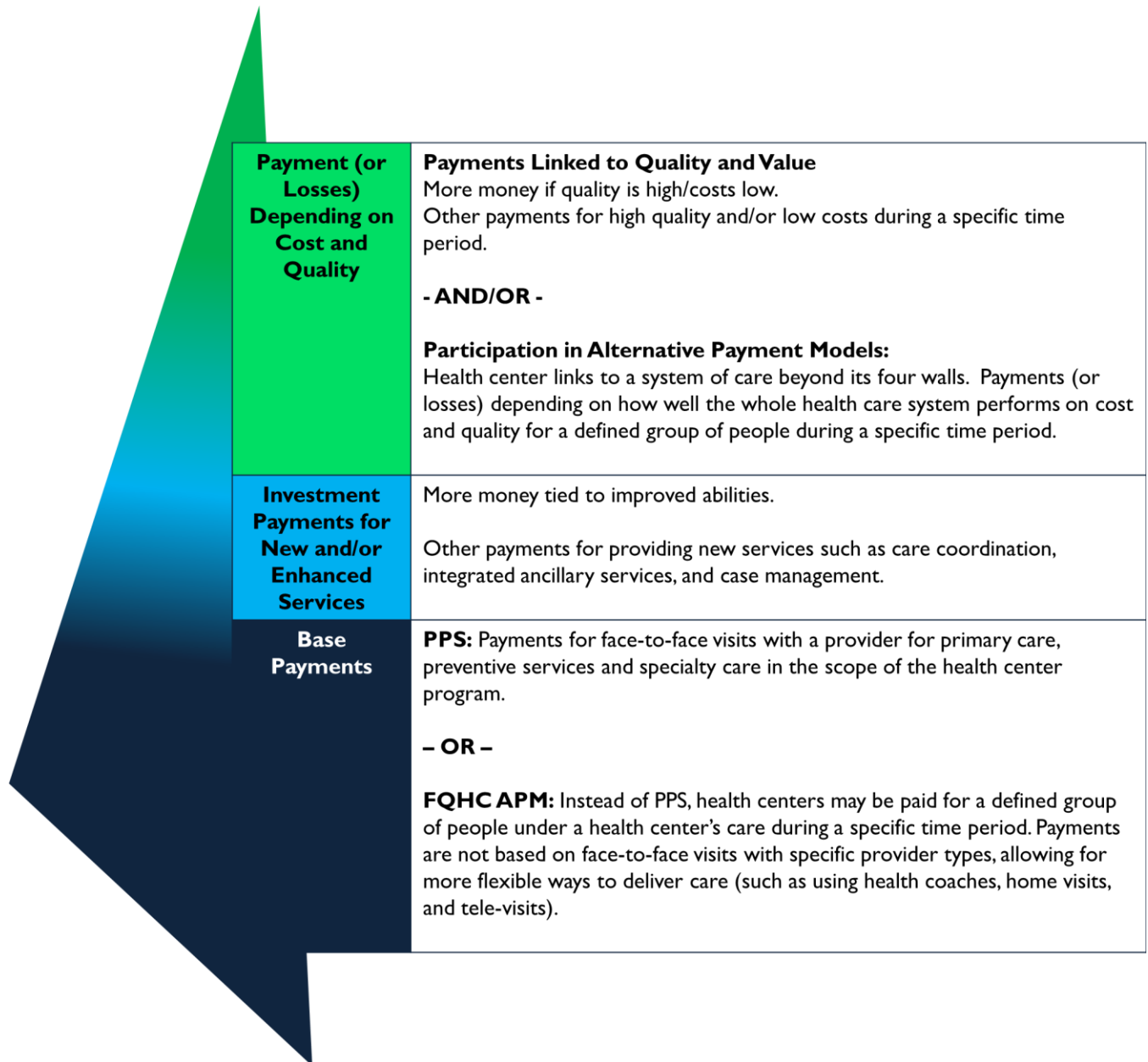
- An ACO is a network of health care providers that could include hospitals, social services, behavioral health and other providers, as well as the health department.
- An ACO usually focuses on preventing inappropriate expensive care needs such as emergency room visits, x-rays or other imaging services, and hospital readmissions within a month of being released.
- In an ACO, the health center may play a key role in coordinating care and services to avoid these costly situations. This care coordination will hopefully reduce costs to the overall system and improve the quality of care for patients. Reducing costs results in savings.
- Health centers then share in cost savings with other ACO members and are often paid extra for achieving high quality. On the other side, if the system is unable to reduce costs or meet quality standards, they would also stand to lose.



Can your patients benefit from these more advanced Payment Reforms? These payments depend on providing and demonstrating high-quality services at low cost. The health center would share in savings and high quality they create, but they could also share in losses if they do not create savings or high quality.

Figure 1 shows how Payment Reform might fit together for a health center. Start with what you already have, begin at the bottom with Base Payments and move up to the most advanced at the top

Figure 1. Payment Reform for Health Centers.



In which of these three layers of payment reform is my health center participating?

HOW MIGHT PAYMENT REFORM IMPROVE MY HEALTH CENTER?

Payment Reform provides an opportunity for health centers to re-think how they will keep patients and their communities healthy, rather than having to focus on their ability to generate traditional, face-to-face visits with patients. This section describes the potential health center benefits of Payment Reform.

<p>More Satisfied Patients</p>	<p>“Investment” payments can improve the way health centers deliver care, such as providing resources for a health center to move toward changing to a Patient Centered Medical Home and/or adding health coaches who can make home visits. <i>These improvements to care delivery result in happier patients.</i> Payment for these improvements can provide health centers with funds to help address their patients’ complex needs.</p> <p>Because health centers serve people with complex needs, to achieve these aims, health centers often need to consider other factors that affect health outcomes beyond what happens at the health center—problems such as violence, hunger, and housing. This approach to dealing with the “whole person” rather than just their primary health care needs can improve the overall wellbeing and health of individual patients as well as the community.</p>
<p>More Satisfied Staff</p>	<p>More flexibility for health center staff to provide care based on individual patient needs. Right now, payment for most health centers requires that a patient visit a provider at the health center. Being paid based on value supports “joy in practice” among staff since they have more control over how they provide care. <i>If they are happy in their work, they are more likely to stay and work at the health center, and other staff will want to work there as well.</i> This flexibility can also lead to happier patients, since patients are getting care tailored to their individual needs.</p>



Which of these improvements would most benefit patients at your health center?

WHAT ARE MY HEALTH CENTER’S POSSIBLE RISKS WITH PAYMENT REFORM?

<p>“Fund chasing”</p>	<p>To get “investment” dollars, some health centers will shift resources toward what payers want, but these changes may not be what staff or patients want. For example, a payer provides funds for a health center to reduce their front desk staff with a patient kiosk for patients to check in for their visits. However, these kiosks are only in English, and most patients at the health center only speak Spanish. In this example, the health center accepted these funds to do what the payer wanted, even though it did not reflect what was best for the patient.</p>
<p>More scrutiny</p>	<p>Quality of care becomes very important, so health centers will need to focus on quality measures, even if those measures are not a priority for staff. For example, providers may not be interested in using electronic health records (EHR) if they do not see how the patient benefits. However, HRSA rewards health centers that report their UDS clinical data using an EHR. Therefore, health center leadership will need to focus on ensuring that providers are “on board” with using an EHR. This new focus on quality could lead to staff turnover if they do not understand or agree with this approach.</p>
<p>Timing is everything</p>	<p>For many health centers, payers are still in a volume-based world. However, they still need to be ready for Payment Reform. To be ready, the health center may need to make changes even if there is not funding to support it currently. For example, a health center may need to hire health coaches because they see how team-based care models can bring down the per-patient cost of primary care. They may need to begin to shift toward these new models, even while their payment still depends on face-to-face visits with providers other than health coaches.</p>



Which of these risks might affect your patients the most?



Did you know that . . . NACHC has an online [Payment Reform Readiness Assessment Tool \(PRRAT\)](#)^{xi} available for health centers to assess their readiness for successful engagement in Payment Reform? It is designed for health center executive teams and staff to assess their current state of readiness and to identify areas for improvement. Ask your health center CEO if they have completed the PRRAT.

3. What is the Board's Role in Supporting the Health Center in Payment Reform?

The next section goes into more depth about how you, as a board member, play a key role in balancing the potential benefits and risks of Payment Reform. Understanding these changes will help your health center continue to provide great care to your patients. You will also be better able to lead how the community provides care in the future.

Payment Reform has significant implications for a health center's financial viability, sustainability, and mission of providing high quality, patient-centered care to underserved populations. Health center leadership must be strategic and thoughtful when taking part in Payment Reform efforts. As a health center board member, your role is to understand changes your health center is engaging in such as how services are organized, delivered, measured, and paid for, and to be aware of your role as relates to these changes.

The section below describes key considerations and questions board members should discuss with their health center's leadership throughout the Payment Reform engagement process—from preliminary discussions of the health center's interest in and/or position on Payment Reform, through the implementation of specific Payment Reform arrangements. Such discussions between board members and health center leadership help to identify areas where board members need additional information and/or the health centers need to address potential gaps before they could effectively participate in Payment Reform. Some questions may be easier to answer when a specific payment model is being considered.

Such discussions between board members and health center leadership help to identify areas where board members need additional information and/or the health centers need to address potential gaps before they could effectively participate in Payment Reform.

BOARD MEMBER CONSIDERATIONS AND QUESTIONS FOR PAYMENT REFORM PARTICIPATION

Mission, Vision, and Value

Ensure the health center's guiding framework aligns with Payment Reform arrangements

Questions:

- Does the health center have a clearly stated mission that identifies who the target population is, what the services are, and how they are delivered including access regardless of ability to pay?
- Does the health center have a clear set of values that assist in prioritizing decision-making and resource distribution?
- Does the health center have a strategic plan for where it wants to be in 3-5 years that guides decision-making? How does the strategic plan align with proposed Payment Reform arrangements?

Information Technology (IT) Infrastructure

Understand the health center's ability to use its IT infrastructure to inform decisions and reporting on Payment Reform arrangements

Questions:

- Does your health center's IT infrastructure provide data to develop a clear, timely, and reliable understanding of the health center's patient population (i.e., demographics, health needs, and utilization patterns), quality of care, and financial status?
- Does the IT infrastructure enable reporting requirements for Payment Reform arrangements?
- What resources are needed to obtain the IT infrastructure necessary to (1) understand our patient population, quality of care and financial status and/or (2) obtain the required reports for the Payment Reform arrangement?

Operational Capacity (Leadership and Staffing)

Learn how Payment Reform arrangements impact health center staff and operations

Questions:

- Is your health center participating in any type of Payment Reform arrangement that is tied to value (i.e., incentive payments, capitated payments)?
- Does your health center have other priorities that may compete with or hinder the ability to participate in Payment Reform arrangements?
- Does your health center have the leadership capacity and a process to help staff transition to new models of care delivery (known as change management)?

Board Capacity

Ensure the board has the information necessary to make informed decisions on Payment Reform

Questions:

- How will the board be involved in the health center's work on Payment Reform?
- What resources, tools, or trainings are available to help educate the board on potential Payment Reform arrangements?
- What changes are needed to make to our governing board ready to participate in Payment Reform arrangements, if any?

Contracting with Payers

Understand the health center's capacity to navigate Payment Reform contracts

Questions:

- Do you know with which payers your health center currently has contracts?
- What resources does the health center need to effectively assess and negotiate contracts with payers under Payment Reform arrangements?
- What are the potential risks to patients and/or the health center's financial status under the Payment Reform contracting arrangements?

Care Delivery Model

Ensure the Payment Reform arrangement aligns with the health center's current or desired health care delivery model

Questions:

- How does the health center's care delivery model (types and methods of services provided) align with value-based payment?
- Does the Payment Reform arrangement allow for flexibility in how the health center provides care to patients to ensure the right services are being provided to the right people at the right time?

Patient Engagement

Understand how patients (current and potential) can affect and be affected by Payment Reform arrangements

Questions:

- What potential changes would patients experience in their care (i.e., changes in providers, services, and access to care)?
- What strategies are needed to educate patients about the changes in their health care experience due to the Payment Reform arrangement?
- How does/can the health center use information from patients about their experience to transform the care delivery model?

Financial Viability

Ensure the health center is financially healthy under Payment Reform arrangements

Questions:

- What are the potential financial gains and risks for the health center under the Payment Reform arrangements?
- Is the health center in a financial position to pursue payment reform arrangements?
- What would the health center do in the case of a financial loss due to a payment reform arrangement? A financial gain?

UNDERSTANDING THE IMPACT OF PAYMENT REFORM ON PATIENTS

Changes in the Patient Population – Health centers entering into a Payment Reform arrangement may experience additional shifts in their patient population. Shifts in community characteristics, health care access, and increased (or decreased) insurance coverage always affect the center’s patient population. These shifts underscore the need for health centers to continually monitor the need and potentially modify their care delivery model to ensure access to high-quality care within the service area. Payment reform arrangements are yet another factor that may cause a shift in the health center’s patient population. A health center’s patient population may not only change demographically, but it can grow to include both patients who traditionally received services at the health center and those who have not, for example, new patients “assigned” to the health center as their medical home by a health payer or ACO. Alternatively, a shift could reduce the health center’s patient population. For example, former health center patients accessing care through different providers as the Medicaid market becomes more competitive. In either case, the health center must position itself to understand who their current patient population is and how this population could change, and this requires a comprehensive understanding of the current patient population and the service area population.

Putting it into Practice – SCENARIO:

How a board member might engage in a Payment Reform conversation about the health center’s patient population.

Recently, our health center’s patient population has changed. More patients have health coverage and the health center expanded to serve more patients. This means that we are serving more patients with different health needs. Our health center’s leadership has prioritized understanding the changing needs of our patients and reviewing and adjusting what services are provided and how.

Our changing patient population is an important factor to consider as we engage in Payment Reform. As a board member, these are some of the questions I have about our patient population and Payment Reform arrangements:

- Does the Payment Reform arrangement give us the flexibility to address the health care needs of our patients, even as they change?
- Could the Payment Reform arrangement limit access to care for our patients in any way, especially as we continue to serve more patients and their health care needs are changing?
- How do we or how can we reach out to the patients assigned to our health center or those who have not been served by the center for a long time?



How can our board ensure that the health center remains true to its mission if the patient population changes through the Payment Reform arrangement?

Changes in the Patient Experience – The patient experience will be affected when health centers transform the way they deliver care and move toward value-based care. Ideally, a patient should experience respect, partnership with their providers, involvement in decision-making, and efficiency in their health care setting. Governing boards must consider the potential changes to the patient experience, both positive and negative, through any Payment Reform arrangement. This includes:

- How patient-centered the health center is
- What services the patient can receive and how
- How patient care is coordinated inside and outside of the health center
- How the patient experience is monitored and addressed.



Did you know that . . . patient-centered care creates a partnership between providers and patients (and their families, as appropriate) to encourage health care decisions that value what patients want, need, and prefer; and seek input from patients about what they need to make decisions?^{xii}



Did you know that . . . Consumer Assessment of Healthcare Providers and Systems (CAHPS) are surveys to gauge patients' experience with care? It includes patient input on their access to care, communication with providers, and engagement in their health care decisions.^{xiii}



Identify how the health center currently engages patients in their care. Discuss how a transition to a Payment Reform arrangement can enhance and/or hinder patient engagement.

Putting it into Practice – SCENARIO:

How a board member might engage in a Payment Reform conversation about health center patients' experience.

As a consumer board member for the health center, I am aware of the potential for Payment Reform to change patients' experience at the health center. Payment reform could change how patients get health care, including use of emails to communicate with the provider, and more coordination between providers both within the health center and with outside providers, such as the hospital, when delivering care to the same patient. These changes could greatly enhance a patient's experience at the health center, but it could cause confusion for patients or even create unintended barriers to care. As a board member, these are some of the questions I have about Payment Reform and the patient experience:

- How does the health center solicit feedback from patients? What does the health center do with that information?
- How will the health center solicit patient input into the design of any changes to the delivery of care at the health center?
- Who is responsible for monitoring the patient experience when care is being coordinated with providers outside of the health center, such as hospitals?

ACTION STEPS FOR ENGAGED BOARD MEMBERS

Now that you have more information about Payment Reform and your role as a board member, you may wonder what you and the board can do about Payment Reform at your health center. Here is a list of board actions to help build a strong foundation for your health center's Payment Reform efforts:

- ✔ Ask your health center's leaders how they are positioning the health center as a leader and/or convener in the health care environment. Determine if/how this is a part of the health center's strategic plan.
- ✔ Ask health center leaders or the board's Quality Improvement/Quality Assurance Committee, if available, how the health center's value and quality is and/or can be demonstrated to patients and partners. Work with health center leadership to identify the health center's unique populations and services that will help to address patient needs and make you stand out to potential clients/partners.
- ✔ Understand how your health center is engaged with the state Primary Care Association (PCA) and Health Center Controlled Network (HCCN), including opportunities to request and participate in training and technical assistance on Payment Reform.
- ✔ Support health center leadership efforts that strengthen existing and establish new collaborative relationships with other organizations, creating new and attractive services and care delivery systems that meet the needs of the patients.
- ✔ Determine if the health center's vision and care delivery model include the integration of behavioral health and primary care services in a way that addresses the health needs of the patients.

CONCLUSION

The shift to payment arrangements intended to encourage value rather than volume provides health centers with an opportunity to provide better health care to their community at a lower cost while improving patient and staff experiences. As a board member, you bring leadership and oversight to ensure the health center provides high-quality health care for people in your community, especially during times of transition through Payment Reform. Working in collaboration with health center staff, you can ensure that any transition in health center payments align with the health center's mission, vision, and values.

GLOSSARY

Access	The ability to get care when needed.
Accountable Care Organization	A network of providers, including doctors and hospitals, that shares financial and medical responsibility for coordinating care for patients in an effort to limit unnecessary spending.
Base Payments	Funding provided to the health center for care provided within the defined scope of their federal grant.
Capitated Payments	A fixed dollar payment for each patient regardless of the number or types of services they receive.
Care Coordination	Providers working together for the common good of the patient by sharing information and mutually providing care.
Care Model	The types and methods of services provided. How care is delivered.
Change Management	Leading the process of transitioning from one way of delivering care to a different one.
Chronic Disease	Conditions that are not sudden and severe but rather extend over a period of time, for example diabetes or heart disease.
Cost	Amount of resources it takes to do something.
Cost Savings	A reduction in expenses.
Face-to-Face Visits	In-person services rather than those provided on the phone or through electronic methods like tele-health.
Federal Section 330 Grants	Grants authorized under Section 330 of the Public Health Services Act to provide funding to Health Centers.
Federally Qualified Health Centers (FQHC)	Organizations that are designated by the Centers for Medicaid and Medicare Services as able to receive payments under the Prospective Payment System (see below). Organizations funded as Health Centers or designated as Federally Qualified Health Center Look-Alikes are defined as FQHCs.

Health Coaches	Staff that provide support to patients by helping patients increase their knowledge, skills, and tools to be actively engaged in their care and to reach self-defined health goals. Health coaches often support patients with complex conditions or a need for an extra level of support. This could include home visits.
Health Resources and Services Administration Quality Improvement Awards	Funding opportunity for health centers that achieve better health outcomes in their patients.
Health Center	Public or private nonprofit entities that: (1) receive grants under Section 330 of the Public Health Service Act, including Sections 330(e), 330(f), 330(g), and 330(h) (collectively “Health Center Program Grantees”); and (2) entities that have been determined by the Department of Health and Human Services (DHHS) to meet the requirements to receive funding without actually receiving a grant (“health center look-alikes”).
Health Center Controlled Networks	Federally-funded groups of health centers working together to address operational and clinical challenges related to the use of health information technology.
Healthcare Effectiveness Data and Information Set (HEDIS)	An initiative by the National Committee on Quality Assurance to develop, collect, standardize, and report measures of health plan performances (see below). It is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care.
Information Technology Infrastructure	The overall capacity and capability of the electronic information system, including electronic health records, practice management and performance and outcome monitoring.
Integration	Providing a variety of different types of services in coordination, for example primary care and behavioral health care.
Investment Payment	Funding in addition to the health center’s base funding (see above) for doing more than is required by their federal scope of project; for example, improving the quality of care or improving health outcomes.

Incentive	Additional funding or other benefit given to a health center most commonly to improve the quality of care, change how care is delivered, or improve health outcomes.
Medicaid	Federal/state insurance program that provides coverage to people with low incomes. This includes low-income people on Medicare for nursing home and other institutional-based care.
Medicare	Federal insurance program for people age 65 and older and people with disabilities.
National Committee for Quality Assurance (NCQA)	A national organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. NCQA is the organization that provides Patient-Centered Medical Home certification (see below).
Operating Margin	The difference between the overall expense of running the health center and the overall income it has. A positive operating margin means that the health center receives more revenues than it costs to run the center.
Patient Centered Medical Home (PCMH)	A team-based health care delivery model led by a health care provider that is intended to provide comprehensive and continuous health care to patients with the goal of obtaining maximized health outcomes. Health centers may receive funding incentives to pursue PCMH certification.
Patient-Centered Care	Delivering a range of services based on the overall needs of the patient.
Patient Experience	The overall effect that a health center has on the people it serves. This could include how staff interacts with them, how care is provided, how long they have to wait in the waiting room, etc.
Patient Population	The people who are registered as receiving their health care from the health center.
Payment Reform	Changes in the way health centers are paid for services they provide to their patients.

Primary Care Association	State or regional organization made up of health centers that is funded by HRSA to provide support to the health centers in the state/region. Some PCAs also include organizations that are not federally funded or designated health centers in their memberships.
Prospective Payment System	A set Medicaid payment for each patient visit for the health center's services.
Quality Improvement/ Quality Assurance Committee	A group of staff members, often with board participation, that monitors the procedures and outcomes of the health center to ensure that care measures up to the standards and goals of the organization.
Stakeholder	Individual or organization that has an interest in how the health center operates.
Strategic Plan	A blueprint for the organization that is based on reaching goals that the leadership identifies as central to the organization's mission and vision.
Underserved Populations	People who for some reason such as lack of insurance, low income, cultural and language differences have difficulty accessing health care.
Uniform Data System (UDS)	A set of data that all health centers (among others) have to provide to HRSA on an annual basis. It includes information about whom the health center serves, the services provided, the staff, the cost of care, and health outcomes.
Value-Based Care	Focus on the benefit to the patient of how care is delivered.
Value-based Payment	Payment that is determined by the health outcomes the patients achieve.

ⁱ <http://www.nejm.org/doi/full/10.1056/NEJMs1205901>

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<http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care>

ⁱⁱⁱ Uniform Data System Report, 2015. Health Resources and Services Administration, Bureau of Primary Health Care.

<https://bphc.hrsa.gov/datareporting/index.html>

^{iv} NACHC Fact Sheet: Health Centers and Medicaid, December 2016.

http://www.nachc.org/wp-content/uploads/2016/12/Medicaid-FS_12.16.pdf

^v Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff (Millwood). 2008;27:759–69.

^{vi} Bodenheimer, T. Sinsky, C. Ann Fam Med 2014;12:573-576. doi: 10.1370/afm.1713.

<http://www.annfammed.org/content/12/6/573.full.pdf+html>

^{vii} Mark McClellan, MD, PhD. Engelberg Center for Health Care Reform at Brookings.

<https://www.pccpc.org/sites/default/files/McClellan%20Slides.pdf>

^{viii} Bailit Health, Value-Based Payment Models for Medicaid Child Health Services, July 2016.

<https://www.uhfnyc.org/assets/1503>

^{ix} Center for Medicare and Medicaid Services Comprehensive Primary Care Plus.

<https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

^x JSI, NACHC Emerging Issues #7 Health Centers and Payment Reform: A Primer, October 2013.

^{xi} JSI, NACHC Payment Reform Readiness Assessment Tool, October 2014.

<http://mylearning.nachc.com/diweb/catalog/item/id/295896>

^{xii} Institute of Medicine. Envisioning the National Health Care Quality Report. Washington, DC: National Academies Press; 2001.

^{xiii} <https://www.ahrq.gov/cahps/about-cahps/index.html>