Community Health Centers: Putting the "Value" in VBC

Chair: Joe Pierle, Missouri Primary Care Association

PCA VBC Collaborative

Advancing Value-Based Care Through Networking and Peer Learning

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Community Health Centers: Putting the “Value” in VBC

Overview and Goals

PCA VBC Collaborative

The PCA VBC Collaborative is a national initiative designed to help PCAs advance Value-Based Care. The collaborative fosters peer learning, supports policy alignment, and drives meaningful healthcare transformation.

Establish a platform for PCA interaction on topics related to VBC preparation and advancement

Collaboration

Enabling a learning collaborative that will support didactic learning, facilitated discussions, and the promotion of best practices

Learning

Identification of national and regional focus issues well-suited for a coordinated response.

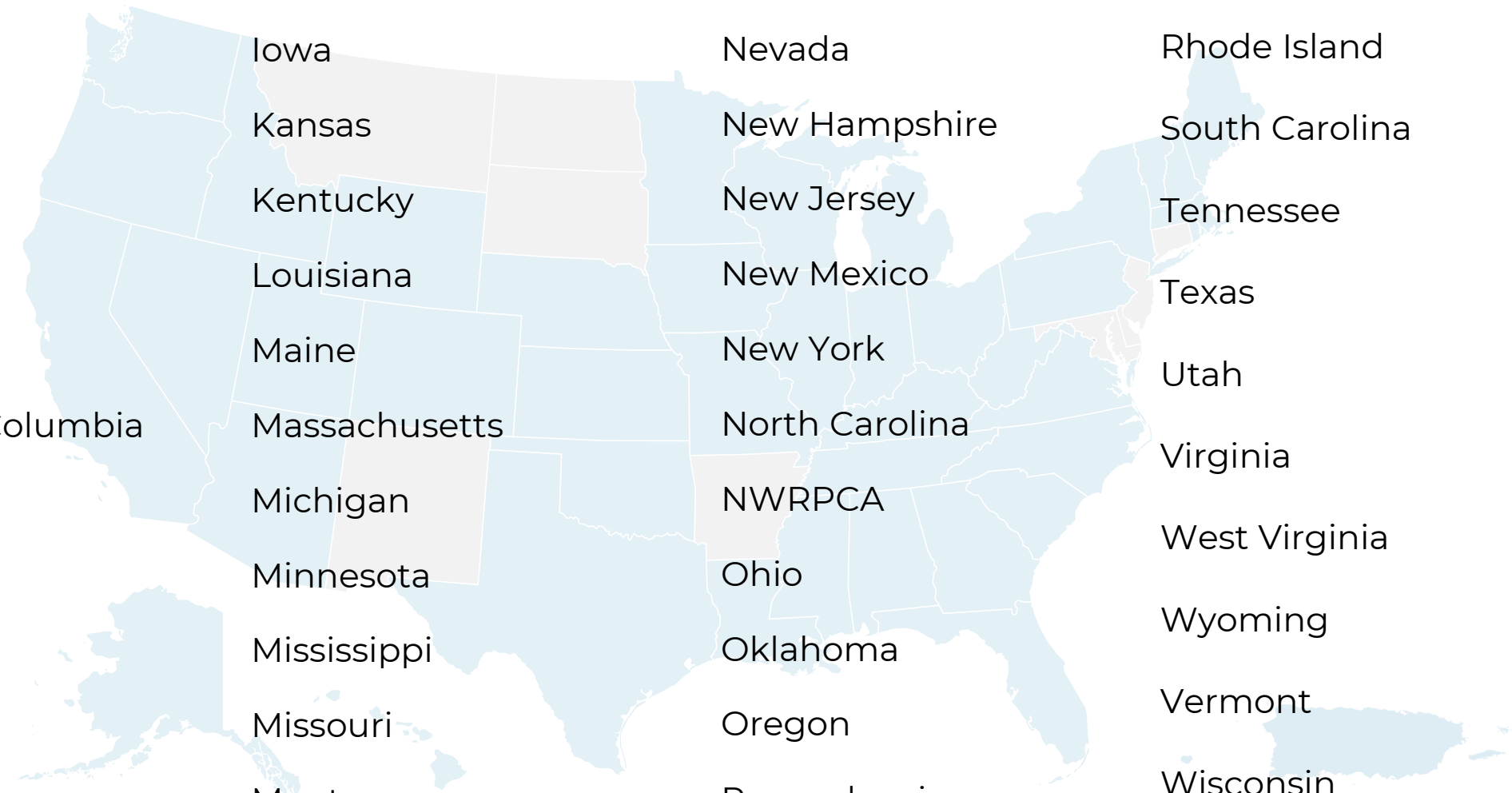
Opportunity Identification

Providing technical and operational support to PCA VBC Collaborative members through industry experts and PCA peer leaders

Technical and Operational Support

PCA VBC Collaborative Members

PCA VBC Collaborative



- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- NWRPCA
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- West Virginia
- Wyoming
- Vermont
- Wisconsin

Our Impact

PCA VBC Collaborative

Growing National Movement

- Representation across 45+ states and territories
- Expanding network of PCAs and CINs working in alignment

Advancing Value-Based Readiness

- 30% of PCAs advanced in CIN maturity since 2023
- 10% increase in ACO maturity in the past year

Building Shared Capability

- Established multi-state peer groups focused on implementation and strategy
- Created a structured learning framework spanning population health, MSSP, and payer alignment

Driving Alignment & Efficiency

- Reducing duplication across states in analytics, contracting, and operations
- Creating a stronger, unified voice in state and federal VBC policy

How We Do It

PCA VBC Collaborative

Peer Learning

Real-world problem solving through multi-state peer groups

Strategic Alignment

Coordinating approaches to value-based care across states

Tools & Frameworks

Practical resources that translate strategy into action

Policy & Advocacy

Elevating the health center voice in VBC design

Education & Capability

Building the skills needed to succeed in value-based models

CMHN NAACOS Presentation

April 23, 2026

CAROLINA MEDICAL HOME NETWORK

About NC Primary Care Association

NCCHCA (PCA) - North Carolina Community Health Center Association
- **42** FQHCs, including 5 LALs,
- Advocacy, Training/TA, Group Purchasing, Member Services
- Managing and sponsoring partner of CMHN CIN/ACO

HCCN – Health Center Controlled Network grantee
- **35** FQHC participants
- HIT & Data Analytics
- EHR User groups

CMHN (CIN/ACO) - Carolina Medical Home Network
- **25** FQHC Participants in Medicaid CIN – 132K+ assigned lives
- **12** FQHC Participants in MSSP ACO – 6,100 assigned lives
- Value based contracting & managed care services

Vacant TBD, SVP CMHN

Vacant TBD FY2026-2027
SVP Multi-State GA

Vacant TBD FY 2026-2027
SVP Talent Management

NCCHCA Board of Directors (42)

Chris Shank
President & CEO

Chris Bishop
Chief of Staff

Vacant Recruiting
Senior Executive Assistant

NCCHCA ADVOCACY DEPARTMENT
Brendan Riley
VP Govt. Rel. & External Affairs

- **BJ Ruddell** — Communication Director
- **Devin Ross** — Policy & Engagement Dir.
- **April Morgan** — Outreach and Enrollment Mgr.
- Medicaid Reg. Support Specs.

NCCHCA HUMAN RES. DEPARTMENT
Katherine Jackson
VP of HR

- **Diane Hobgood** — Office Manager
- **Karthic Radhakrishnan** — HR Generalist
- **Vacant Recruiting** — Event Coordinator
- **Josie Lane-Kuzniar** — Mgr. **Workforce** Dvlpt.,

NCCHCA MEMBER SVCS. DEPARTMENT
Alice Pollard
VP Member Services & Ops

- **Meredith Benjamin** — Member Svcs. Coordinator
- **Vacant** — Behavioral Health Coordinator
- **J'Mi Walker** — Apprenticeship Program Dir.
- (CMAs)
  - **Leigh A Brame**
  - **Aquilla Silver**
- **CMA and Dental Apprenticeship Program**
- **Admin Float Pool**

HCCN NETWORK & ANALYTICS DEPARTMENT
Sanga Krupakar VP Network & Analytics

- **Vacant** — IT Project Manager
- **Korrey Monroe** — HCCN Manager
- **Pauline Mungai** — Grants & Contract Data Analyst
- **Lauren Ray** — Network Program Asst.

CAROLINA MEDICAL HOME NETWORK

- **Vacant Recruiting** — SVP of Value-Based and Managed Care Services
- **Lytonya Alexander** — VP, Care Management and Provider Services
- **Lauren Lowery** — CMHN Ops Director
- **Vacant Recruiting** — Population Health Coordinator
- Benjamin Porco — **Program Assistant**
- **Care Management Team**
- **Regional Acct Mgrs.** **RNs**
- **Care Mgrs.** **RNs-** **Care Coors.**
- **CMHN Consultants & SMEs**

NCCHCA RISK MGMT DEPT.
Mel Goodwin-Hurley
VP Risk Mgmt & General Counsel

- **Ed Valbuena** — Compliance Director
- **Monica Cruz** — Special Populations – Community-Centered Health Program, & Emergency Preparedness Coordinator

BUSINESS DEVELOPMENT DEPARTMENT
Tim Gallagher
Head of Growth & Managed Svcs.

- **Karen Pryce** — Dir. Business Development

NCCHCA CLINICAL QUALITY IMPROV. DEPARTMENT
Dr. Arianna Keil
VP of Quality

- **Vacant Recruiting** — Process Improv. Coordinator

THIS-NC

- **Dr. Becca Hayes** — Director of Health Equity Research
- **Korrey Monroe** — Research Coordinator

Clinical Float Pool & Locum Tenens

NCCHCA FINANCE DEPARTMENT
Jeff Mckissack
Dir. of Finance

- **Carlos Boykin** — PCA Staff Accountant
- **Ronak Patel** — Accounting Controller
- **Qamar Manzoor** — Float CFO
- **Krista Ward** — Revenue Cycle Manager
- **Vacant** — Data Analyst
- **CFO Float Pool**

Key:

NCCHCA Staff: w/ PCA FTE Allocation
Workforce: J. Kuznair
SP-CCH and EP Coordinator: M. Cruz

North Carolina Community Health Center Association

NCCHCA HCCN

CAROLINA MEDICAL HOME NETWORK

THIS-NC
TRANSLATIONAL HEALTH INSTITUTE OF THE SAFETY NET

Who Leads When?

- HRSA grants (PCA, Rural Health)
- State & Federal Grants
- Technical Assistance
  - Board Trainings, HR Assessments, OSV Prep

- HRSA grants (HCCN)
- State & Federal Grants
- Analytics Platform
- Technical Assistance
  - EHR Selection, Care Gap Closures

- Foster Care (BCBS)
- Medicare ACO
- UNC Physicians Network
- Preferred Provider Arrangement (PPA)
- Technical Assistance
  - Care Management Payments
  - Assignment & Attribution

- Community Research
- HRSA grants (research)
- Academic Partnerships
  - NCCU, WFSOM, NACHC
- Free Clinic & LHD Partnership
- State & Federal Grants (prime)

Advantages of Including CHCs in VBC Networks

- Expand equitable reach to socioeconomically disadvantaged beneficiaries
- Improve preventive care quality without raising costs
- Strengthen primary care capacity, care coordination, and behavioral health integration
- Leverage longstanding care management and UDS data collection as the foundation for VBC

CAROLINA MEDICAL HOME NETWORK

Network Results

- Over $10M in Medicaid managed care shared savings in first 3 performance years (2022-2024)
- Delegated care management services, including capitation payments, with 5 managed care plans (2021-2026)
- Leveraged FQHC CIN footprint and success in care management and quality performance to establish CMHN Preferred Payer Arrangements

CAROLINA MEDICAL HOME NETWORK

Care Management Model – Performance Comparison

- Option 1: Health Center-employed Care Management model
  - Penetration Rate: 24.30%
  - Chronic Care Management (CCM) and Diabetes (DM) patients Opt-In for Care Management: 2.1%

- Option 2: CIN-employed Care Management model
  - Penetration Rate: 35.14%
  - CCM and DM patients Opt-In for Care Management: 4.6%

CAROLINA MEDICAL HOME NETWORK

Care Management Model – Performance Comparison

- For State Fiscal Year 2026, NC Medicaid anticipates that approximately 23% of beneficiaries will receive care management services. This is an average across all populations, with a higher need expected for Expansion adults.

- CMHN consistently performs at or above the State's expected penetration rate.

CAROLINA MEDICAL HOME NETWORK

VBC Impact - Preferred Payer Arrangement

- **Why** did CMHN pursue Medicaid Preferred Payer Arrangements (PPA)?
- **Significant variation in PHP contracting requirements** and processes had required CMHN & FQHCs to expend limited resources on administrative activities that do not add value to actual patient care
- **The burden of these inconsistencies was so high** that CMHN prepared to contract only with PHPs responsive to the terms we sought, which will allow CMHN and its members to better allocate resources to benefit patients and increase providers' capacity

CAROLINA MEDICAL HOME NETWORK

Impact of Medicaid Preferred Payer Arrangement RFP

- Secured infrastructure and operational funding support
- Fewer quality measures that are more closely aligned
- Consistency across the three VBC contract s
- Minimized contract disparity in shared savings arrangements while sending an aligned signal of what will be rewarded
- Improved data and reporting requirements
- Learning sessions focus on billing & coding accuracy
- Real-time tracking/monitoring of data through PPA contracts
- Stronger partnerships with preferred payers

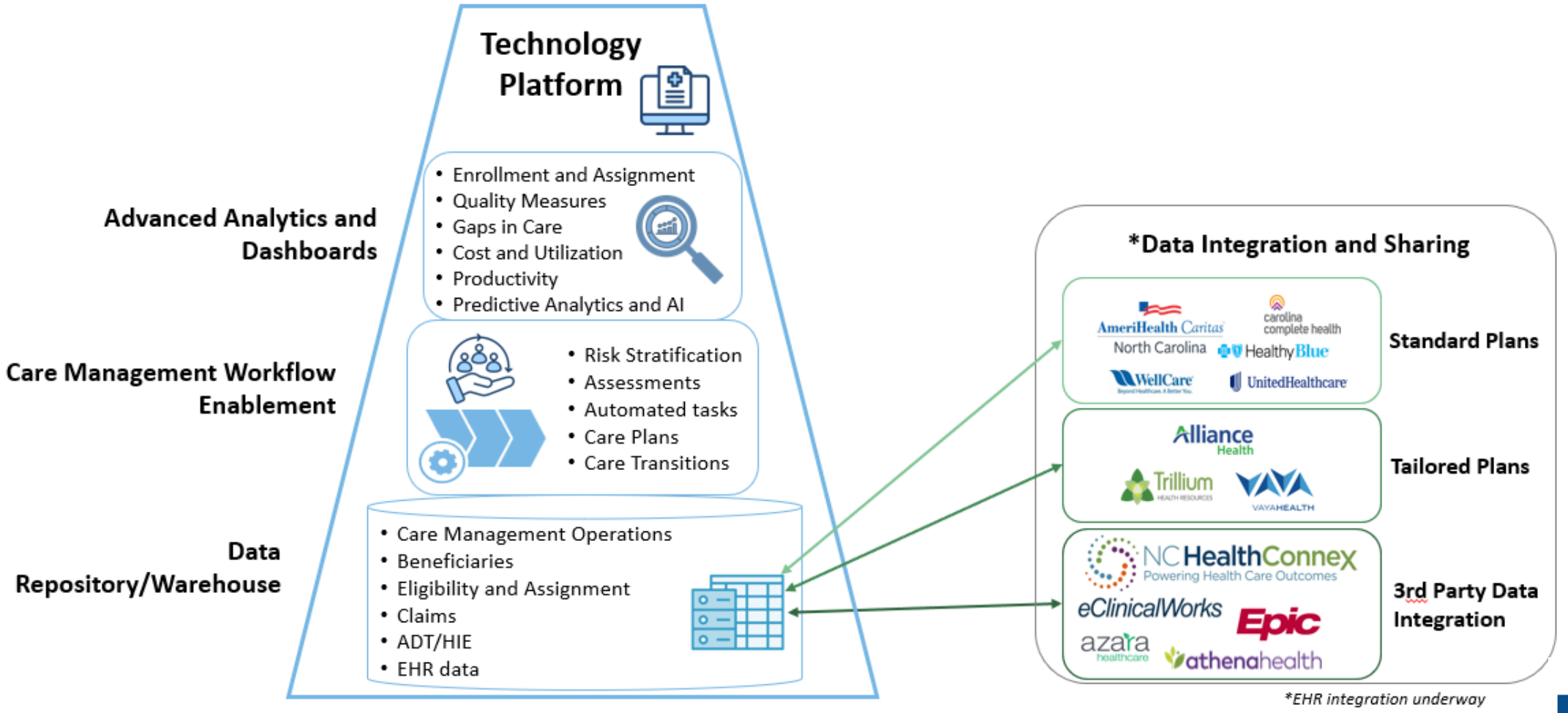
CAROLINA MEDICAL HOME NETWORK

Community Partnerships

- Community Health Workers (CHWs) - certification, training, and integration into care management teams.
- School-based health centers (SBHCs) - FQHCs partner with School-Based Health Alliance for primary care and behavioral health service co-location at elementary, middle, and high school, & some college
- Human Services Organizations (HSO) - many FQHCs have served as HSO within their community and/or partner closely with HSOs to address non-medical health needs
- Mental Health & Substance Use Disorder
- Rural Health Transformation Program (RHTP) - new NC ROOTS Hub support

CAROLINA MEDICAL HOME NETWORK

Technology and Data Supporting Performance



CAROLINA MEDICAL HOME NETWORK

Key Lessons

- Clear, regular communication with partners and vendors
- Align expectations, roles, and resourcing up front
- Do not overburden FQHCs; build on the existing data and care management workflows
- Get buy-in from providers and clinical leadership before providing coding and documentation support
- Ensure boots-on-the-ground support through practice management staffing, standardizing workflows where possible via process improvement initiatives

CAROLINA MEDICAL HOME NETWORK

Questions?

CMHN NAACOS Presentation

April 23, 2026

CAROLINA MEDICAL HOME NETWORK

CARINA HEALTH NETWORK

Community Health Centers Putting the “Value” in VBC Panel

BJ Dempsey, Director of Practice Transformation

April 23, 2026, from 11:00 am-12:30 pm

OUR JOURNEY

Colorado Community Health Network (CCHN) Established – Colorado's Primacy Care Association

1982

1994

Colorado Community Managed Care Network (CCMCN) Established - Health Center Control Network

Community Health Provider Alliance (CHPA) Established – Accountable Care Organization participating in MSSP Basic Track

2014

Performance Year 2019

Achieved first MSSP Shared Savings (and every year following)

CCMCN and CHPA Merge! And move to MSSP Enhanced Track

2025

July 14, 2025

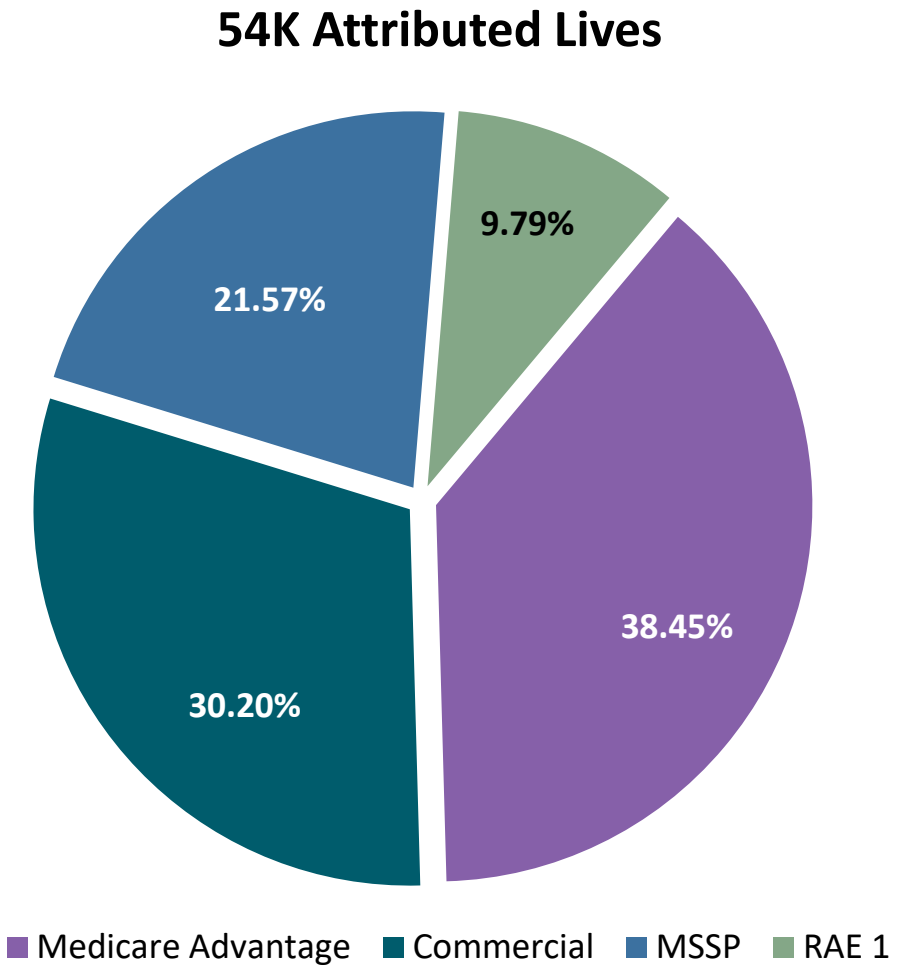
Officially operating as Carina Health Network!

Established as a Clinically Integrated Network (CIN)

2026

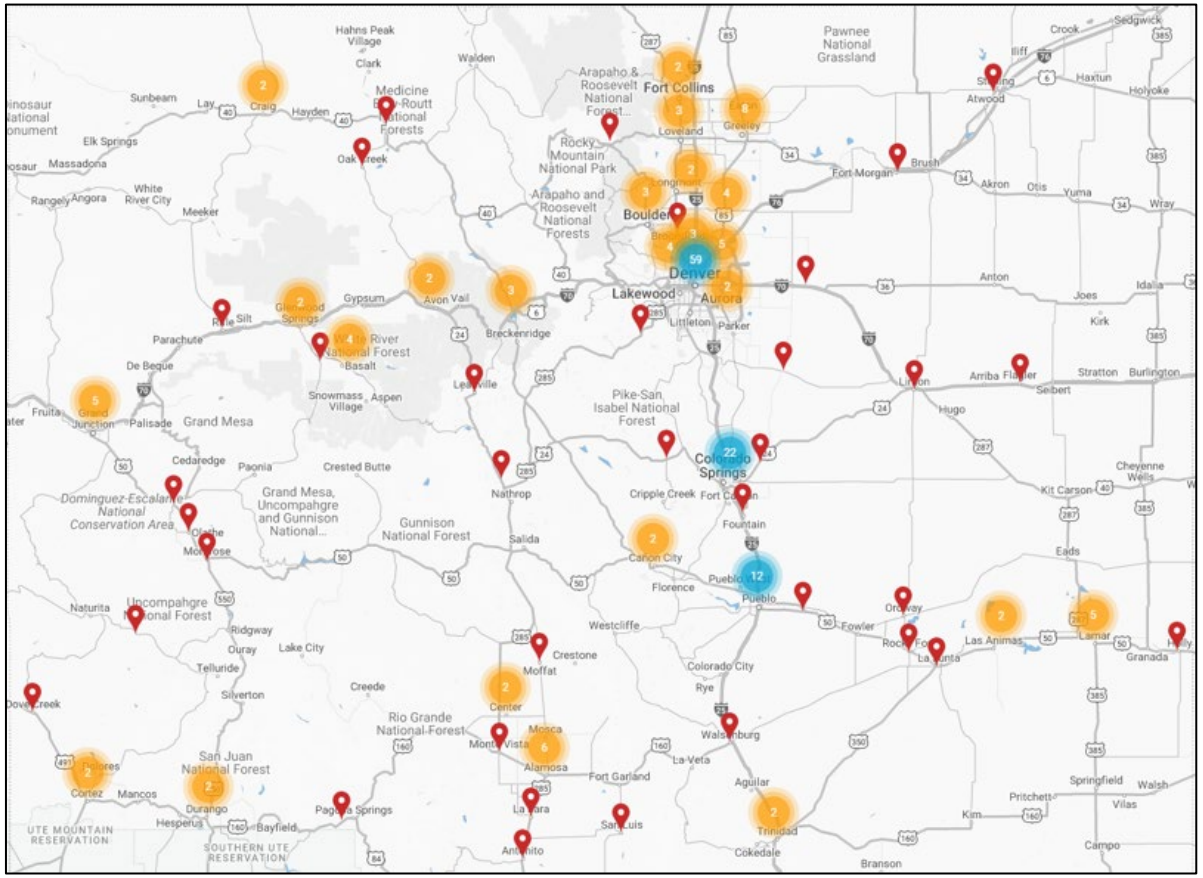
VALUE-BASED CONTRACTS

- Six Medicare Advantage Plans
- Medicare Shared Savings Program (MSSP)
- One Commercial Plan
- One Regional Accountable Entity for CO Medicaid



WHO WE ARE TODAY

- 250+ clinic sites in 47 counties throughout Colorado, most of which are medically underserved
- Serving 857,000+ patients with a large portion who are uninsured, underinsured, and under-resourced
- Fully integrated with medical, dental, and behavioral health services
- Formal recognition as a medical home (NCQA/AAAHC/JCAHO)

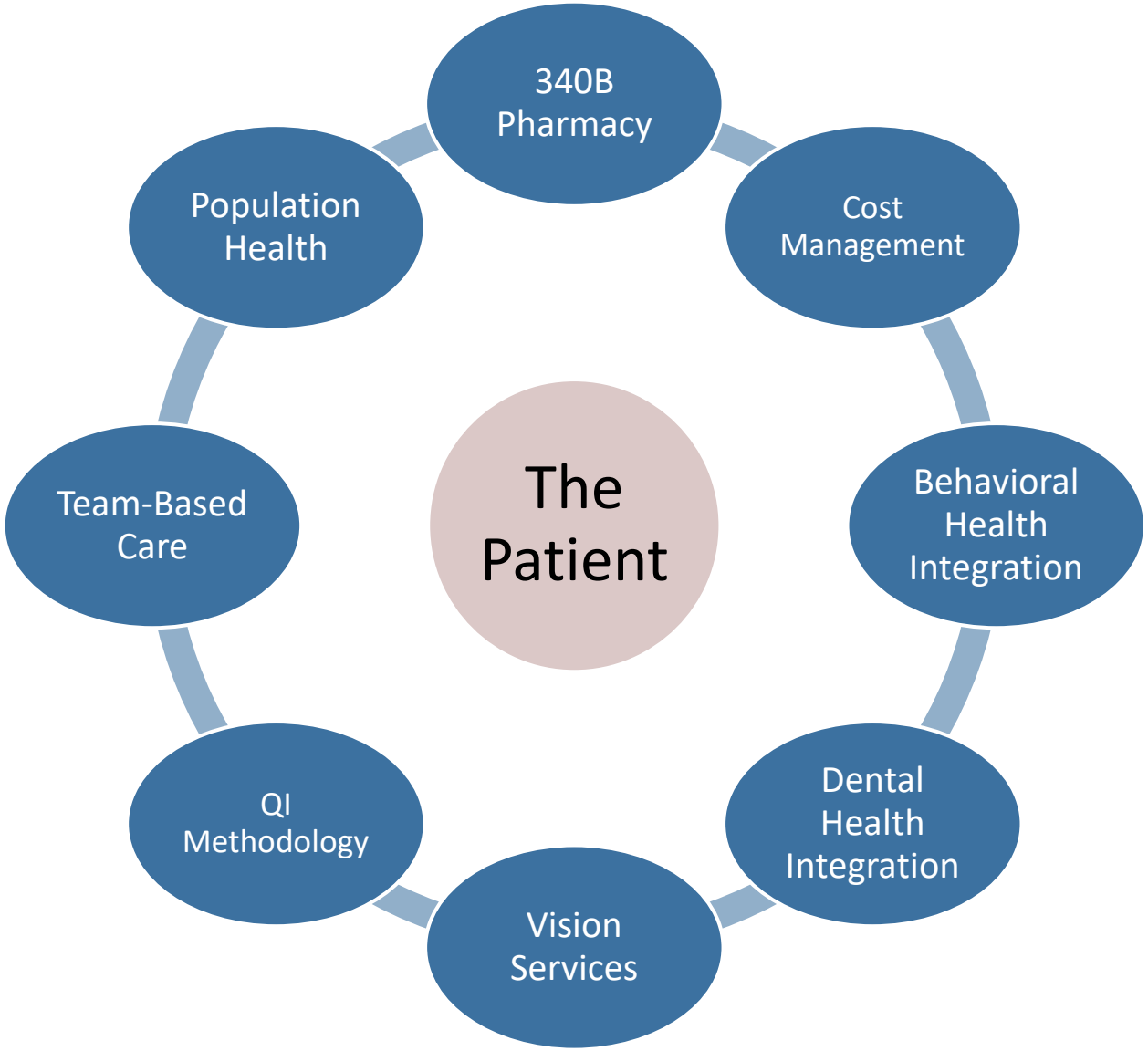


“NECESSITY IS THE MOTHER OF INVENTION”

Plato

LAYERS OF INTEGRATED CARE

How internal systems work together to support patients



EXTERNAL PARTNERS

Collaborations that create, sustain, expand, and amplify impact

TECHNOLOGY INFRASTRUCTURE

2008

- Recognized need to connect all CHCs EHRs to a single solution
- Solved reporting support for
  - UDS
  - Medicaid
  - Eventually MSSP
- Started Azara implementation for CHCs

2015

- Completed Azara implementation for all CHCs

2025-2026

- Implementation and use of Innovaccer
- Development and Utilization of Tableau Community Analytics Platform
- Utilization of Azara
- Optimization of technology suite

NETWORK IMPACT

15,700+ People	Now managing diabetes more effectively. **9.5% improvement** in diabetes control statewide.
56,100+ People	Now have their high blood pressure under control. **6.9% improvement** in hypertension control statewide.
327,000+ People	Screened for depression and connected to support. **8.5% improvement** in depression screening and follow-up.
Emergency visits reduced	From 840 to **620** (per 1,000 patients) **26.2% decrease** in emergency department visits.
$87 Million	In total cost savings for CMS and the network through the Medicare Shared Savings Program (MSSP) in 2019-2024.

ACCELERATORS TO SUCCESS

SHARED LEADERSHIP

Board of Directors

Finance Committee

Oversees finances and budget, evaluates financial risks/opportunities of Value-Based Care (VBC) contracts, and sets strategies to manage downside risk.

Value-Based Care (VBC) Committee

Leads population health, quality, and VBC contract strategy and performance. Recommends contracting, targets, reserves, and policies to the Board.

VBC Clinical Workgroup

Provides clinical direction and accountability, monitors performance, and recommends interventions. Designs the performance grading system.

VBC Performance Workgroup

Drives network performance in VBC contracts, recommends contract terms, and develops strategies and interventions for success.

OUR UNIFIED FOCUS

Big Dot Goals

- A1c 18.4%
- CBP 85%
- DSF 95%
- BCS 69%
- CCS 58%

Lead Measure

- Lead measures for each goal

Scorecards

- Monthly Practice Transformation Meetings
- VBC Clinical Workgroup
- VBC Performance Management Workgroup
- Value Based Care Committee
- Board of Directors

Accountability

- Quarterly Performance Review Meetings
- Work Groups & Committees
- Quality Action Labs
- Practice Transformation Meetings
- Distribution Dashboard

**The 4 Disciplines of Execution* authors Chris McChesney, Jim Huling, and Sean Covey

2026 DIRECT COACHING SUPPORT MODALITIES

AT-A-GLANCE

1:1 PRACTICE TRANSFORMATION (PT) MEETINGS	QUALITY ACTION LABS (QALS)	SMALL GROUP COACHING: SPECIAL TOPIC	CENTRALIZED SUPPORT	SPECIAL PROJECTS & PILOTS	USER GROUPS
Primary PT coach and member team review performance, dashboards, and quarterly coaching themes.	Group Coaching Series (eight sessions): Prevention, Chronic Condition Management, Transition of Care	Topic identified as a need for targeted work for two or more members. PT Team plans and facilitates. The number of sessions and length are individualized.	PT Team works closely with Carina Value-Based Care Division to support the delivery of MSSP Support Plan activities.	PT coaches work with members implementing pilot work not captured in the MSSP Support Plan.	PT coaches facilitate peer user groups for: eCW, NextGen, Athena, and EPIC.
Minimum four in-person meetings; most do nine.	Participate in one lab	PRN	PRN	PRN	Each user group meets bi-monthly

SUPPORTING MEMBERS TO:

- See the problem
- Solve to the root
- Support solution identification, planning, and implementation
- Share learnings

ALL COACHING SUPPORT MODALITIES:

- Roll up to big dot goals
- Are individualized
- Align efforts

carina
HEALTH NETWORK

THANK YOU.

For questions, reach out to bj.dempsey@carinahealth.org.

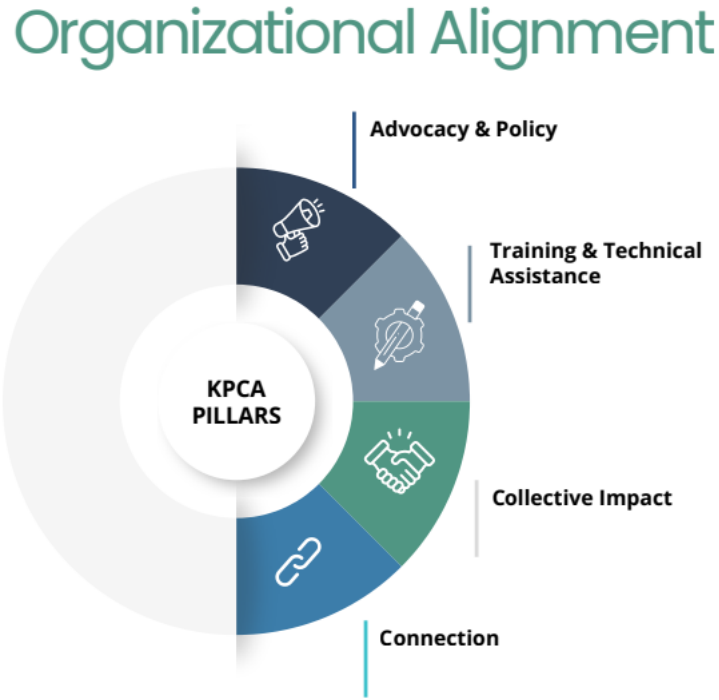
Who we are, what we do, and how we do it

Kentucky Integrated Care

KIC KENTUCKY INTEGRATED CARE

Overview of the Kentucky Primary Care Association (KPCA)

- Founded in 1976, the KPCA serves community based primary care providers across Kentucky, including Federally qualified health centers, Rural health clinics, Look Alike clinics, Partner organizations and healthcare professionals
- KPCA connects a statewide network of providers and partners working together to improve access to care in both rural and urban communities.



Source: 2025 KPCA Impact Report

KIC KENTUCKY INTEGRATED CARE

The collective impact and reach

- Kentucky's Community Health Centers provide a full spectrum of care that extends well beyond traditional medical visits.
- In the most recent reporting year, centers served more than 720,000 patients statewide through integrated and community-based services.
- Services by type include medical, dental, mental health, substance use disorder (SUD), vision, and enabling services.
- Snapshot on cancer screening and prevention per the 2025 KPCA impact report:
  - 217,000 patients screened across Kentucky's community health centers
    - 88,929 patients screened for cervical cancer
    - 45,465 patients screened for breast cancer
    - 82,938 patients screened for colorectal cancer

Source: 2025 KPCA Impact Report

KIC KENTUCKY INTEGRATED CARE

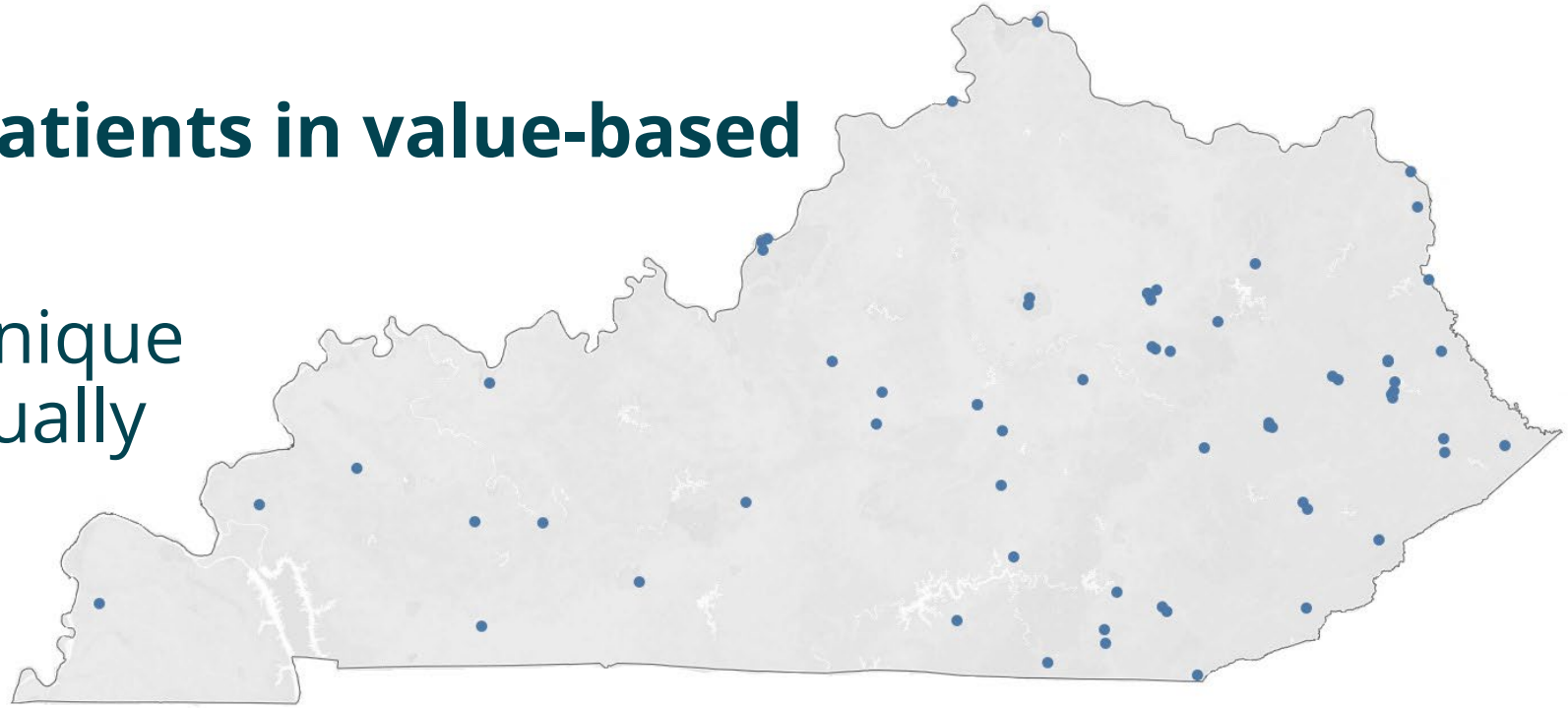
Development of the Kentucky Integrated Care (KIC) Network

- Kentucky Integrated Care (KIC) is a physician-led clinically integrated network of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and FQHC Look-Alike centers across Kentucky.
- KPCA is the organizing member and the majority of the groups are participant members.
- The network strives to deliver high-value care for its communities through participating centers and clinics in an aligned model of care.
- This model includes shared evidence-based population health and chronic disease management, care coordination, and utilization of care.

KIC KENTUCKY INTEGRATED CARE

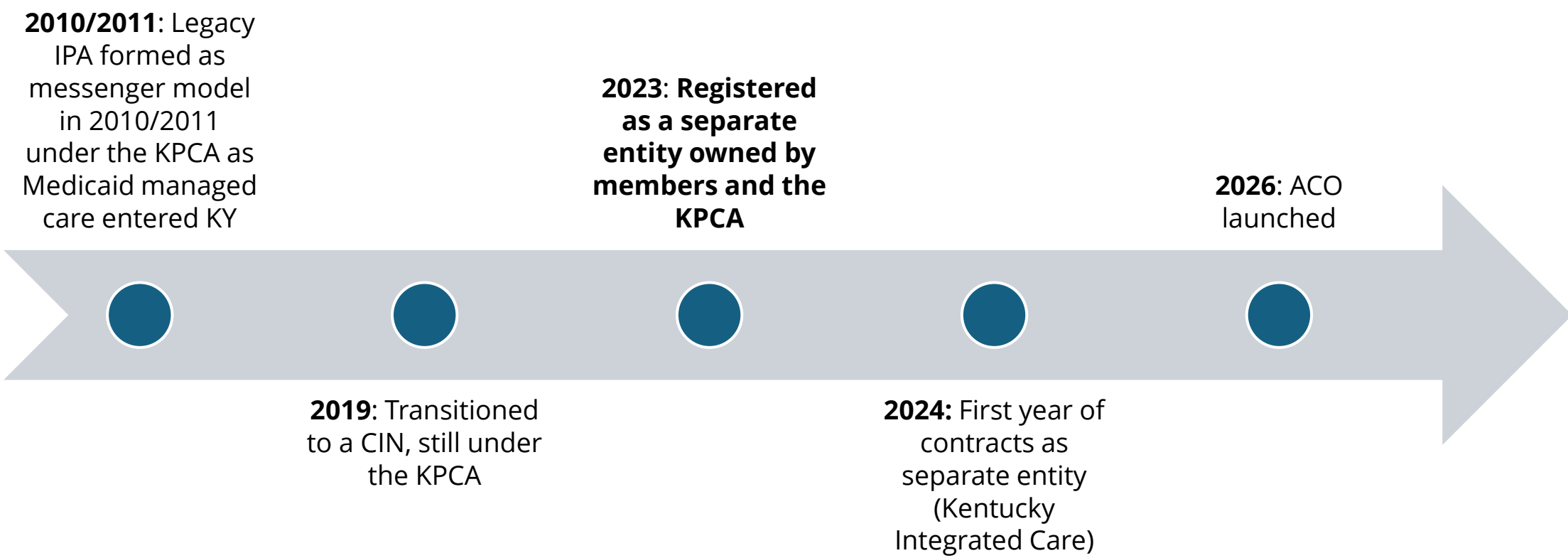
Kentucky Integrated Care (KIC)

- **50 participants** including FQHCs and RHCs representing 67 unique TINs, with more than **1,800 credentialed practitioners**
- Approximately **300K patients in value-based agreements**
- Approximately 700K unique Kentuckians seen annually by participants



KIC KENTUCKY INTEGRATED CARE

KIC's Evolution in Value-based Contracting



KIC KENTUCKY INTEGRATED CARE

KIC Environmental Scan

- 5 statewide Medicaid MCOs
  - One dominant plan
  - Second plan with dominant regional market share
  - Medicaid implemented common value-based program for all MCOs with 2% of premium withheld
- One dominant traditional commercial health plan and self-insured TPA
- Approximately 1M patients covered by Medicare or a Medicare “product”
  - Roughly 50/50 FFS vs MA/ACO
  - Small ACO penetrance to date

KIC Activities

- Contracting
- Data aggregation
- Payer relations
- Provider relations
- Credentialing
- Compliance training and oversight
- Other training and technical assistance

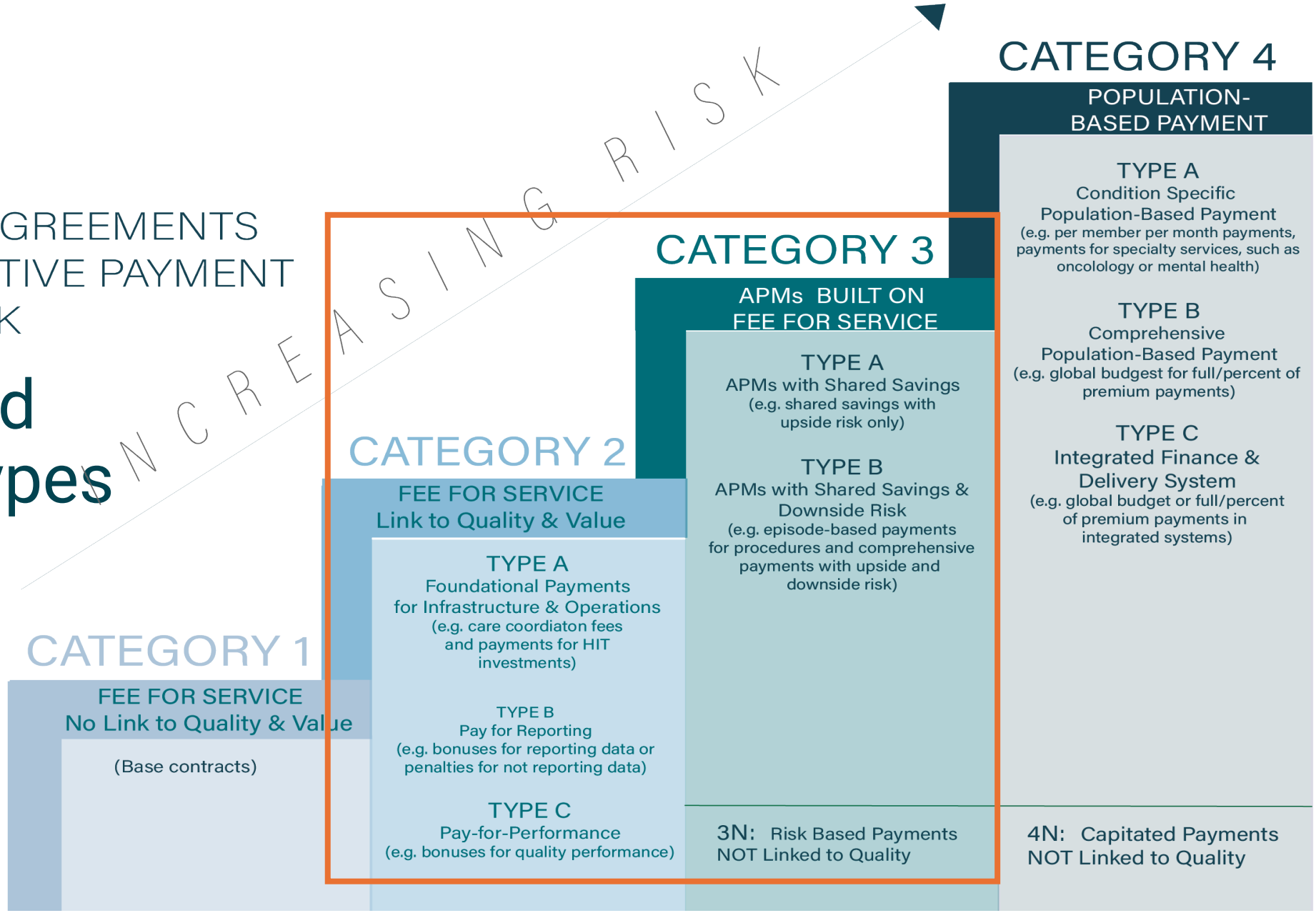
KIC KENTUCKY INTEGRATED CARE

KIC
KENTUCKY
INTEGRATED CARE

2026 CONTRACTS & AGREEMENTS WITHIN THE ALTERNATIVE PAYMENT MODELS FRAMEWORK

Value-Based Agreement Types

Contract LAN Levels



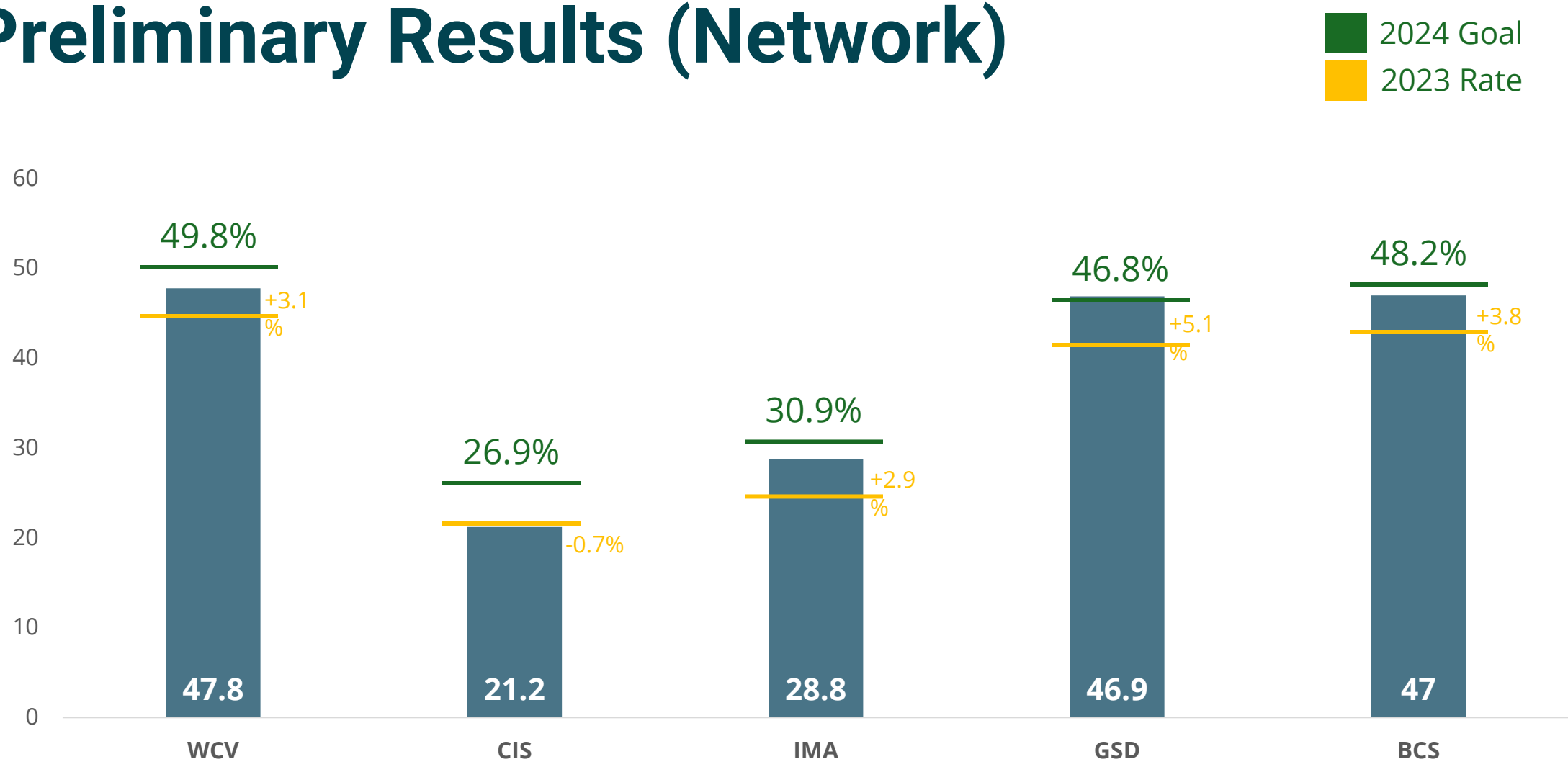
KIC KENTUCKY INTEGRATED CARE

Value-based Contracting

	Type of Contract	#Measures	Cost Component?
Plan A	Shared Savings	17	Yes
Plan B	Shared Savings	11	Yes
Plan C	Pay for Performance and Shared Savings	12	Yes
Plan D	Pay for Performance	6	No
Plan E	Pay for Performance and Shared Savings	12	Yes

KIC KENTUCKY INTEGRATED CARE

Preliminary Results (Network)



KIC KENTUCKY INTEGRATED CARE

Data infrastructure journey

- Dismantling of previous population health tool
- Implementation of Azara
- 46 organizations (representing 57 clinic TINs) are live on the platform

EHR DATA

- Clinical data
- Patient pre-visit planning
- UDS/UDS+ submission
- SDOH/PRAPARE

PAYOR INTEGRATION

- Attribution
- Care gap reconciliation
- Supplemental data certified by NCQA sent from the platform to health plans

TRANSITIONS OF CARE (HIE)

- ED/IP transition tools
- ADT alerts
- Track readmission rates

KIC KENTUCKY INTEGRATED CARE

Key Community Partnerships

- University of Kentucky
- Foundation for a Health Kentucky
- Kentuckiana Health Collaborative
- Cabinet for Health and Family Services
- Kentucky Association of Health Plans
- ARH

Lessons learned and learning

- Know your network
  - Transparency was key to building trust with members
  - Managing expectations
- Network staff and providers are on this journey together
- Don’t reinvent the wheel
- Be your strongest advocate
- Don’t let perfection be the enemy of progress
- VBA success is the responsibility of the both the network and its members
- Seeing early impact on performance and contract success

KIC KENTUCKY INTEGRATED CARE

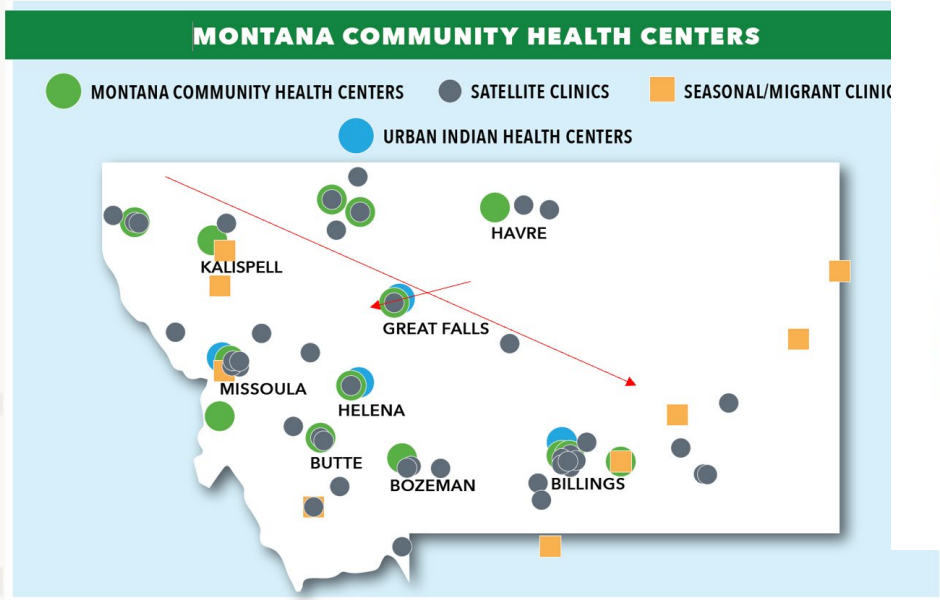
NAACOS
Spring Conference

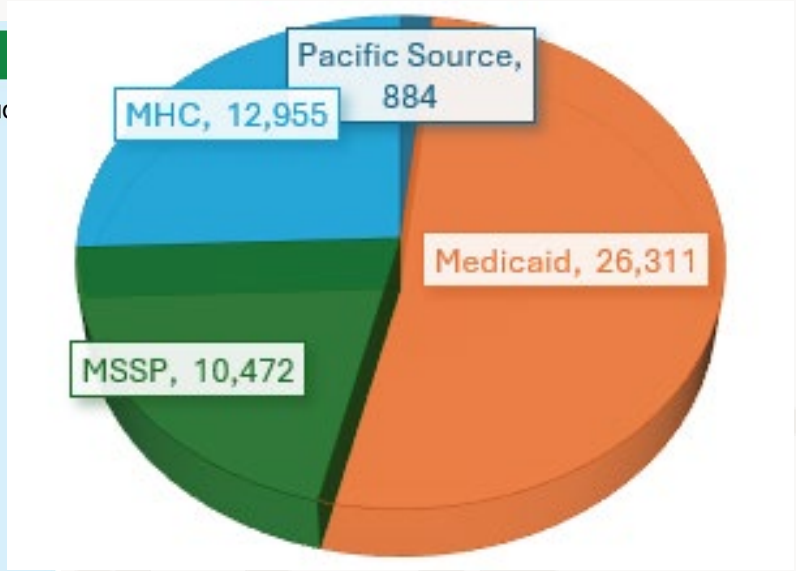
PCA Value-Based Care Collaborative

April 24th, 2026

Ensuring Access. Lowering Costs. Improving Outcomes.

MONTANA HEALTH PLUS





Established in 2018 as IPA and evolved into a CIN/ACO

Ensuring Access. Lowering Costs. Improving Outcomes.

MONTANA HEALTH PLUS

*Experience*Engagement*Integration*Aligned*

Unique Strengths

Ensuring Access. Lowering Costs. Improving Outcomes.

health+ MONTANA HEALTH PLUS

Improved Coding

TTA

1:1s

Software Integration

Impact and Data

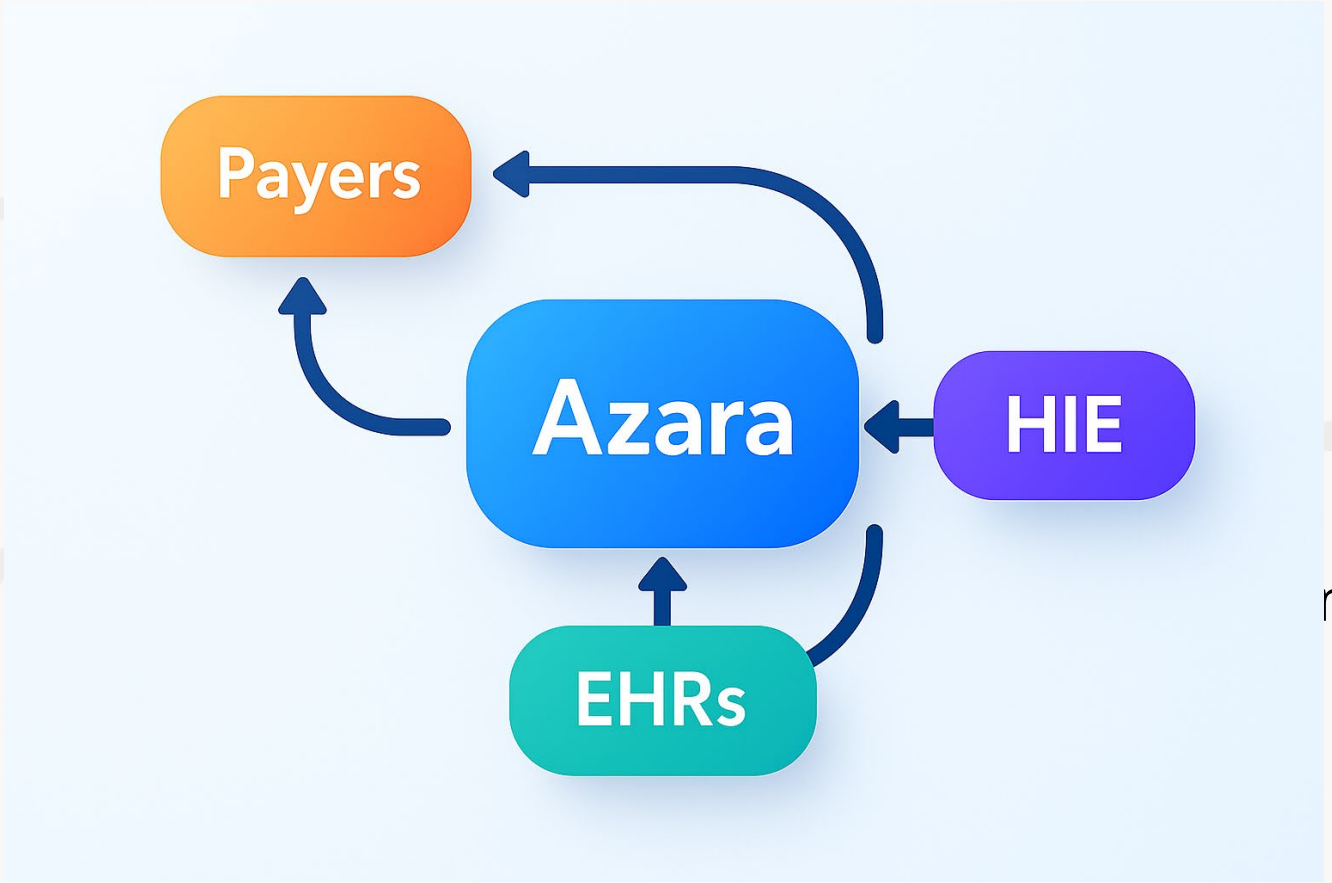
Ensuring Access. Lowering Costs. Improving Outcomes.

health+ MONTANA HEALTH PLUS

Partnerships

Ensuring Access. Lowering Costs. Improving Outcomes.

Success in Technology



health+ MONTANA HEALTH PLUS

Intentional Thoughtful Integration Teamwork

Key Lessons

Ensuring Access. Lowering Costs. Improving Outcomes.

VBC at FQHCs

Success in 2026 and Beyond

Henish Bhansali, MD, FACP

NAACOS Spring 2026

Agenda

Key levers in Medicare VBC

Fundamentals of success per lever

Clinician engagement

5 Levers of VBC

1. **Product selection**
   MSSP [and respective track], LEAD, etc.
2. **Accurate benchmark**
   Risk-adjustment
3. **Quality**
   Dependent per product (MSSP, LEAD, MA, etc.)
4. **Outcomes**
   Total costs of care
5. **Patient retention**
   Attribution

Product Selection

Which product?

MSSP, LEAD, both? Which track for MSSP?
→ **get an actuarial firm to figure it out**

Prospective vs. Retrospective Attribution

Retrospective usually has higher margins since EOL costs are lower,
but it is operationally much more challenging given QoQ patient churn

Cost Management

Risk stratification

Use for visit cadence + CM + CC

Transitions of care

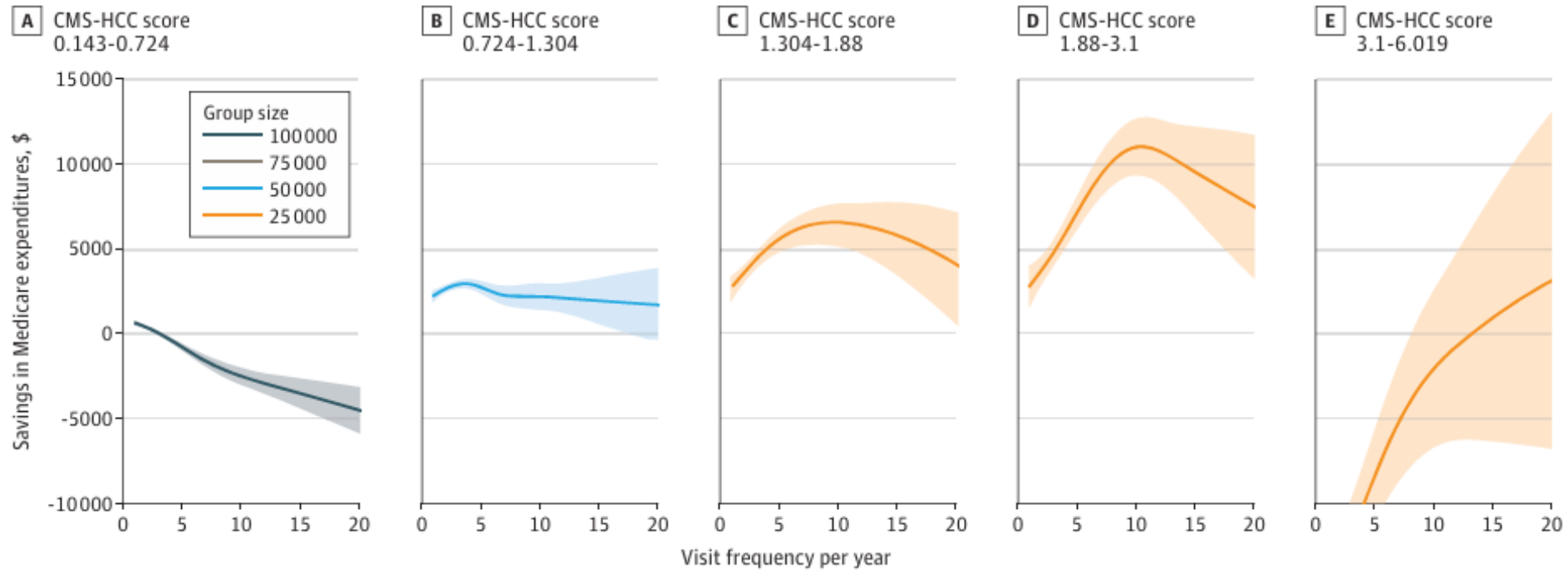
Need ADTs → HIE, vendor, BDCA, QHIN, etc.

Disease management

CHF, COPD, CKD → GDMT +/- RPM

Visit Cadence – the Evidence

Figure 2. Proactive Group Savings in Medicare Expenditures vs Frequency Stratified by Risk Adjustment Factor



An increasing number of optimal visit frequencies is found for beneficiaries with increasing risk scores when the proactive group is further divided into risk-adjusted groupings. *Proactive* refers to the group whose visits have regular frequency and high continuity. The optimal visit frequency of each risk-adjusted group by Centers for Medicare & Medicaid Services hierarchical condition category (CMS-HCC) score is 1, 3.46, 9.85, and 10.68, respectively (the top of each curve in A-D). Shading indicates 95% confidence intervals.

Quality

LEAD

Same as REACH + DM and HTN

MSSP + MA

Heavier focus on those overlapping with UDS + minimum thresholds to get earn-back

MA Contracts

Know current performance, then negotiate a contract that is improvement from current state (i.e., 2–3 stars). Also, need process of gathering and submitting supplemental file → complex, usually need a vendor

Benchmark

Getting RAF right is very hard at FQHCs because of:

- PPS billing structure → minimal documentation required → learned behavior
- High variability of EMRs & respective embedded tools
- Lack of clear incentives for clinician

Without accurate benchmarking, you cannot win in Medicare VBC without an aggregator/enabler

Investments:

Vendor	EMR optimization (embedded tool + claims)	Clinician engagement

Attribution

Prospective

Jan to June of prior year is best bet to retain patients; after that, it is no longer in the look-back period

Downside: attribution of patients that saw you once X years ago

Upside: fixed population for the year, so easier to implement programs (disease management, ACP)

Retrospective

You have whole year to see patients

Downside: churn, so you spend resources on patients that don't end up getting attributed to you

Upside: you are only responsible for patients you have seen

- Don't rely on voluntary alignment → arduous and complex + no clear patient incentive
- Rural areas → low utilizers → ensure 1 visit to retain → **critically** important
- AWVs for all

Clinician Engagement

*Medicare success is **contingent** on engaged clinicians*

Does it make my life easier?

Does it make my patient's life better?

Do I get paid more for it?

2 solutions with substantial uptake: **OpenEvidence (LLM)** and **ambient scribes**

Align these with VBC levers

Questions?

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