As the financial model and cash flow projection is built, the center will realize quickly that aside from any upfront investment required for infrastructure and technology, there may also be an operating cash shortfall given the delay in the timing of payments under value-based payment arrangements. Here is where building the financial model will help in VBP contract negotiations as payors may be willing to provide care management fees on a PMPM basis which will help ease cash flow needs. In addition, health centers should search for funding opportunities that may exist from government, foundations and payors to help defray any capital requirements.

Many centers are “stuck in the mud” today, paralyzed by the numerous assumptions required to evaluate participation in value-based payment arrangements. The cure, however, is to build the model based on the best assumptions we have today, fine tune them as we move down the road, and use the model to inform the negotiations of the payment terms under VBP.

**The time to think ahead is now**

There are still unknowns regarding value-based payment and its implementation across the country. Some states have indicated that VBP is not a new rate setting methodology or one size fits all. There will be challenges in transitioning to value-based payment and certain providers such as homeless health care providers will face additional hurdles due to their patient population.

The message to community health centers is that now is not the time to take a “wait-and-see” approach. Instead, really get to understand what drives success under value-based payment and start to assemble the requisite skill sets and core competencies. Collaborating with your sister health centers may be a solution, not only from a shared services/infrastructure perspective, but also from a “strength in numbers” perspective when it comes to negotiating contracts with payors and managing risk.

The time to act is now to determine the model of integration that works best for your patient population and the revenue model that allows continued survival and growth.

*Both with CohnReznik LLP – Peter R. Epp is Partner, Community Health Centers Practice Leader and Dionne Kearney is Senior Manager. For more information, visit www.cohnreznick.com/healthcare.*

**BOARD Q&A**

*Question:* Our health center is negotiating an agreement with a neighboring behavioral health care provider to locate a few of their clinicians at our site. Several of our board members are close friends of board members of the other organization. Is it permissible for our board members to discuss details of the proposed arrangement with their friends?

*Answer:* As a general matter, the board should confine itself to policy matters such as a decision to develop a co-location delivery model in the first place. The task of negotiating the specific terms should be left to health center management. In addition, informal communications between members of the respective boards runs the risk that confidential information will be disclosed. All board members have a fiduciary obligation to the health center to keep information confidential that the health center desires to keep confidential. This obligation is based on a board member’s duty of loyalty to the organization, which is implied by law when a person accepts a position on the board. It is a good practice to remind board members of their obligation to maintain confidences anytime sensitive information will be discussed, perhaps through a statement by the Board Chair. In addition, the health center could consider putting a confidentiality notice on documents distributed to board members.

*Board Q&A is written by Michael B. Glomb, Esq., Partner, Feldesman Tucker Leifer Fidell LLP.*