PREPARING FOR

VALUE-BASED CARE:

A GUIDE FOR

HEALTH CENTERS
ABOUT THE NATIONAL NURSE-LED CARE CONSORTIUM

The National Nurse-Led Care Consortium (NNCC) is a national leader supporting and advocating on behalf of nurse leaders. NNCC is a nonprofit member-supported organization, and provide a wide range of services to educate and support both nurses and other primary health care professionals. NNCC advances the quality of health care through policy, consultation, and programs to reduce health disparities and meet people’s primary care and wellness needs. NNCC is an affiliate of Public Health Management Corporation (PHMC).
INTRODUCTION

As the healthcare landscape continues to rapidly evolve and value based care becomes the method for reimbursement, primary health care is re-envisioning modalities by which care is delivered. Primary care providers are tasked with responding to a payer environment that emphasizes quality outcomes and reduced costs over patient volume. A team-based model of care is an integral component to competing and succeeding in a value-based payment landscape.

Health centers have long been at the forefront of healthcare innovation, partnering with community agencies, patients, and families to provide care that accounts for social determinants of health and the holistic needs of the people they serve. Health center providers are well-positioned to advance value-based care by improving upon policies already in place, such as co-located dental, vision, and behavioral health services, case management, and outcome tracking through the Uniform Data System (UDS) report. Most critically, community health centers are comprised of interdisciplinary teams tasked with the delivery of coordinated care to low-income, high-risk patients and communities. Roughly 92% of all health center patients are at or below 200% of the federal poverty limit, and health centers serve special populations (such as residents of public housing) that are statistically at a higher risk for a myriad of chronic and acute conditions.¹ To best serve this population and meet the demands of a value-based payment environment, health center staff must form and optimize care teams designed to reduce costs and improve patient outcomes.

WHAT IS VALUE-BASED CARE?

The inception of the Patient Protection and Affordable Care Act of 2010 formalized what many providers (and payers) have long suggested: that care should be delivered holistically, centered around quality, and funded based on patient outcomes. Value-based models emphasize the need for providers to administer care based on reimbursable quality metrics and benchmarks. Unlike the prospective payment system (PPS) rate, value-based payments are designed to compensate for services that address the chronic needs of health center patients. As health centers offer more services through non-traditional settings and modalities, value-based payment models are poised to sustain patient-centered care and promote efficient, effective approaches to achieving optimal patient health.

WHY VALUE-BASED CARE?

Community health centers serve over twenty-seven million patients nationwide. As of the 2017 UDS report, approximately 50% of patients served at health centers are insured by Medicaid. Consequently, health center administrators and providers must be prepared to adapt to changing guidelines from the Centers for Medicare and Medicaid (CMS), including recent value-based Medicare trends. Private insurers are also moving away from volume-based payment models, developing contracts and agreements with providers that underscore quality goals for patients.
Early pilots of value-based care programs show promise. CMS’ Physician Group Practice Demonstration realized $137.8 million in savings and resulted in positive patient outcomes across an array of disease states, including diabetes and hypertension. A pay-for-performance model implemented across health center sites in Chicago demonstrated improved provider compliance with HbA1c testing recommendations.

Initial successes in quality-based payment and resulting legislative changes have ushered in a transformative environment for many providers, especially those with large Medicare and Medicaid populations. CMS, for example, is required to funnel reimbursement through one of two mechanisms as part of a quality payment program: merit-based incentive programs (MIPs) and advanced alternative payment models (APMs). This change necessitates advanced planning among health center providers to prepare for payments that reward value, not volume. More than half of all health center patients are insured via Medicaid (49.64%) or Medicare (9.40%), positioning health center staff to be particularly affected by changes in CMS reimbursement policies.

**VALUE-BASED DESIGNS**

There are a variety of value-based payment mechanisms in place throughout the U.S., including those spearheaded by CMS. Other value-based designs include pay for performance, accountable care organizations, and bundled payments. While by no means exhaustive, this list of mechanisms includes trends in payment that are already in effect for some health centers, and may be on the horizon for others.

**Pay for Performance (Value-Based Purchasing)**

The premise of a pay-for-performance value-based care design involves financial penalties and bonuses for providers based upon their commitment to and provision of high-quality care. These payment adjustments are allocated dependent upon pre-determined, program-specific measures of quality, often including patients’ clinical outcomes and experiences. Pay-for-performance programs show unique promise in that incentives can be designed to emphasize the explicit needs of patients and payers in certain healthcare systems.

**Accountable care organizations**

Accountable care organizations (ACO’s) are comprised of teams of providers who coordinate high-quality healthcare services for Medicare beneficiaries, while concurrently creating care settings that limit unnecessary costs for the insurance program. Patients are at the center of their own care, while clinicians and healthcare organizations share information that might contribute to any decisions to be made regarding the patient’s health. ACO’s encourage a focus on preventative care because there is more substantial financial incentive in avoiding illness than in treating illness.

**Bundled payments**

Bundled payment models allow Medicare to provide a single, set-rate reimbursement to several providers across specialties during one episode of care for a patient. Bundled payments encourage coordination of care between clinicians to increase quality of care, while also discouraging needless care expenditures to reduce Medicare costs.
WHAT DOES THIS MEAN FOR YOUR HEALTH CENTER?

What to expect

**Value Based Programs**

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**LEGISLATION**
- **ACA**: Affordable Care Act
- **MACRA**: The Medicare Access & CHIP Reauthorization Act Of 2015
- **MIPPA**: Medicare Improvements For Patients And Providers Act
- **PAMA**: Protecting Access To Medicare Act

**PROGRAM**
- **APMs**: Alternative Payment Models
- **ESRD-QIP**: End-Stage Renal Disease Quality Incentive Program
- **HACRP**: Hospital-Acquired Condition Reduction Program
- **HRRP**: Hospital Readmissions Reduction Program
- **HIVBP**: Hospital Value–Based Purchasing Program
- **MIPS**: Merit-Based Incentive Payment System
- **VM**: Value Modifier Or Physician Value-Based Modifier (PVBM)
- **SNF-VBP**: Skilled Nursing Facility Value-Based Purchasing Program

Source: Centers for Medicare and Medicaid

Value-based care is here. The passage of the Affordable Care Act in 2010 and, subsequently, the Medicare Access and CHIP Reauthorization Act of 2015 legislated mandatory changes for CMS, including movement away from volume-based care toward value-based models. By 2019, all providers seeing Medicaid and/or Medicare patients will be reimbursed through APMs or MIPS. In the private market, insurance companies are increasingly negotiating contracts with providers that emphasize the importance of quality and patient outcomes. Many insurers are investing in ACOs, bundled payments, and pay-for-performance programs.

**The Solution: Team-Based Care**

**WHY TEAM-BASED CARE?**

Interdisciplinary care teams promote patient-centered care by instituting enhanced communication, role optimization, and the streamlined use of health-IT. Care teams are better able to track a patient’s trajectory along the cascade of care through both acute and chronic care management.

Providing patients with team-based care has been shown to increase their satisfaction, engagement, self-care, and diabetes-specific outcomes (See Table 1). However, the benefits of care teams extend beyond the patients-- team members see improved satisfaction, productivity, accuracy, and turnover rates as well.
### Table 1. Outcomes associated with effective, multidisciplinary team medical care identified through a literature review of care team interventions (N=15). Patient outcomes include increases in satisfaction, engagement, adherence/self-care, and positive diabetes-specific clinical outcomes\(^2\) (HbA1c and blood pressure improvement). Team outcomes include increases in satisfaction\(^3\), productivity/efficiency\(^4\), accuracy\(^5\), and fewer turnovers\(^6\).

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<th>Patient Outcomes (% change)</th>
<th>Care Team Outcomes (% change)</th>
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<tr>
<td><strong>Satisfaction</strong></td>
<td><strong>Productivity/Efficiency</strong></td>
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<tr>
<td>50% n=4</td>
<td>43% n=3</td>
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<tr>
<td>13% n=1</td>
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<td>25% n=2</td>
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In fact, care teams are central to many value-based payment models, including Patient-Centered Medical Home programs and Joint Commission standards. Care teams function optimally when team members practice at the top of their license, reduce waste and duplication, and utilize cost-saving communication to streamline patient care.

### What Next?

What should your health center do to prepare for and capitalize on a value-based environment?

1. **Assess your health center staff, capacity, and benchmarks**
   
   To adequately prepare for value-based care, health center staff can assess the current capacity to meet the changing demands of a rapidly-evolving healthcare environment. Benchmarking health center performance based on UDS data, Health Center Controlled Network (HCCN) measures, and patient satisfaction surveys provides staff with a set of priorities and goals that can shape healthcare delivery to de-emphasize volume and highlight successful patient outcomes and experiences. You can also use a pre-developed assessment tool, such as the Value-Based Health Care Strategic Planning Tool from the [National Rural Health Resource Center](https://www.nrhrcenter.org).

2. **Accreditation**
   
   Joint Commission accreditation indicates that a health center has demonstrated commitment to patient safety, high-quality care, and data optimization. Many of the standards included in the Joint Commission’s ambulatory care accreditation process underscore competencies for value-based care, including care continuity, provider performance, and improved patient outcomes.

**Care team formation and optimization**

As discussed, interdisciplinary care teams promote patient-centered care by instituting enhanced communication, role optimization, and the streamlined use of health-IT. Care teams are better able to track a patient’s trajectory along the cascade of care through both acute and chronic care management. To learn more about care teams, read our publication, *Integrating Team-Based Care to Improve Clinical Outcomes: A Guide for Health Centers.*
CONCLUSION

Health centers are primed to meet the demands of a value-based healthcare delivery landscape. As the providers of choice for over twenty-seven million patients, health centers play a critical role in the advancement of patient-centered, efficient care that both reduces cost and increases quality. By understanding the complex value-based care environment and taking steps to form and optimize care teams, health center staff can create a path to success that sustains the vital services they provide to communities throughout the country.
Endnotes


Endnotes


