# What is value-based payment and why are health centers considering payment reform?

## Introduction to value-based payment

**Value-based payment** rewards the cost-effective improvement of the health and well-being of a population. This systematic method of paying for care shifts away from pure volume-based payment (e.g., fee-for-service) to payments that incentivize the Triple Aim (better health, better experience of care, lower total cost of care per capita). Because value-based payment models are aimed at strengthening the link between health outcomes and payment, they are encouraging providers to take into account the social, behavioral and economic factors that influence health.

**Payment reform** is the process of changing the current, predominantly volume-based payment system to **alternative payment models (APMs)** that more closely link provider and health system payments to outcomes, and align financial incentives with providing value.

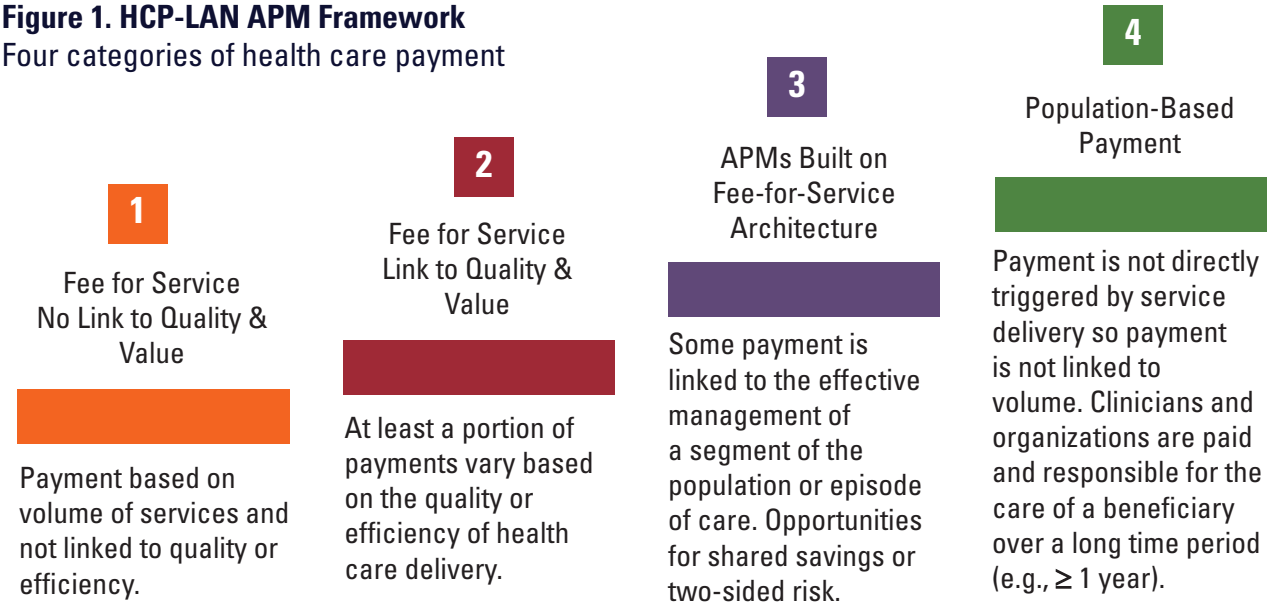
To shift to APMs, the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) has adopted the Health Care Payment Learning and Action Network (HCP-LAN) framework that categorizes health care payment into four categories according to how providers receive payment (see Figure 1).[1]

### Key Shifts


## Isn't there a health center-specific definition of APM?

Yes. Much as the prospective payment system (PPS) is a unique payment methodology for health centers, the Social Security Act also outlines an health-center specific definition of an Alternative Payment Methodology (APM) for health center payment.[2] A health center APM: must be mutually agreed upon by the State and health center; must result in payment to the center of an amount that is at least equal to the amount otherwise required under PPS; and must be defined in a State Plan Amendment. This definition leaves ample opportunity for health centers to engage in value-based payment reforms.

**Figure 1. HCP-LAN APM Framework**
Four categories of health care payment




1. See HCP-LAN APM Framework: https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf
2. Social Security Act, Section 1902. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

## Why engage in payment reform?

Many health centers are at the crossroads of needing to invest in updating their care model so they can engage in the evolution of the health care system, and maintaining financial sustainability in what remains largely a fee-for-service world. By helping to shape value-based payment models in their services areas, health centers can lay a foundation for financial sustainability, high quality of care, and engaged staff in the future.

### Reasons for Engaging in Payment Reform

### Flexibility to provide patient-centered care

Today most health centers only receive payment when there is a face-to-face encounter with a billable provider. Payment reform can provide health centers an opportunity to more fully realize a team-based model of care. These models can improve integration of behavioral health and primary care, and support flexibility to deliver care in the most appropriate patient-centered ways, such as using virtual care (e.g., via phone and patient portals), and providers not eligible for PPS payment, such as health coaches or clinical pharmacists. Such flexibility can increase both patient and provider satisfaction.

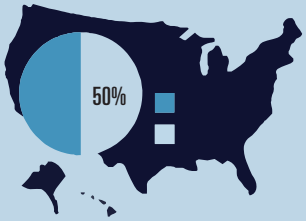
### Alignment with Medicaid managed care

With almost three quarters of Medicaid beneficiaries enrolled in managed care,[5] health centers have an opportunity to negotiate for performance-based payments if they are effective in population health management and demonstrate quality and cost outcomes. Currently, the Uniform Data System (UDS) focuses on patients' outcomes, while health plan measures tend to focus on HEDIS metrics for all members. The key difference between a patient population and a managed care member population is that not all assigned members are actually health center patients even though they might be assigned to a health center as their primary care provider (PCP). Payment reforms can increase alignment of health center financial incentives and practice with the managed care system while also rewarding health centers for helping plans achieve cost and quality goals.

### Increased capacity to address complex needs

Since the implementation of the Affordable Care Act, 15 million new beneficiaries have gained insurance coverage under Medicaid or CHIP.[3] There is also a growing recognition that care management for some of the most complex patients is best delivered by providers rather than payers.[4] Payment reforms such as patient-centered health home supplemental payments and care management fees can provide health centers with additional resources to provide some of the neediest Medicaid beneficiaries with the care and coordination of services that they require.

### Alignment with multi-payer goals




HHS is setting ambitious goals of shifting Medicare payments into APMs (50 percent of Medicare payments will be in categories 3 and 4 by the end of 2018). The HCP-LAN has set the same goal for all U.S. health care payments. Health centers have an opportunity to shape new value-based payment arrangements as Medicaid and other payers adopt similar goals.

Icons created for the Noun Project by Sergey Demushkin, Gregor Cresnar, and icon 54

3. Medicaid and CHIP Enrollment Data. https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html
4. Powers BW, Chaguturu SK, Ferris TG. Optimizing High-Risk Care Management. JAMA. 2015; 313(8):795-796
5. https://www.macpac.gov/subtopic/managed-care/

## How should primary care be paid going forward?

As thought leaders and CMS alike have considered this question, the answer consistently involves multiple complementary payment models including:[6,7,8]

1. Maintaining some fee-for-service payments (e.g., for prevention and some specialty services),
2. Converting some traditional FFS revenue to per-member-per-month (PMPM) payments that provide flexibility in how care is delivered,
3. New dollars for new services and/or increased capabilities, and
4. New dollars tied directly to cost and/or quality outcomes.

To successfully transition to value based payment, health centers may need to invest some of their current revenue while attracting new dollars. Many of these investments will be tied to using data for population health management and reporting under value-based payment models. Table 1 shows various components of payment models for primary care, beginning with a base payment. A health center could pursue any or all of the following payment components.

**Table 1. Payment Models for Primary Care**

| | Base payment (PPS or health center APM) | | | Additional dollars for new services | Additional dollars or penalties tied directly to cost and quality performance | |
|---|---|---|---|---|---|---|
| **HCP-LAN category** | 1<br>**Fee For Service (FFS)** (No Link to Quality and Value) | 3<br>**PPS** | 4<br>**Population - Based Payment** | 3<br>**Alternative Payment Models Built on FFS** | 2<br>**FFS with Link to Quality and Value** | 3<br>**Alternative Payment Models Built on FFS** |
| **Description** | FFS payments for face-to-face visits with a provider for primary care, preventive services and specialty care | Some view the PPS as a bundled payment with UDS reporting being the link to quality | Per-member-per-month (PMPM) payment to deliver majority of health center primary care services during a given time period | Supplemental payments for providing new services such as care coordination, integrated ancillary services, and case management | Retrospective payments from payers for achieving quality and/or total health system resource use targets in a given timeframe | System savings and/or downside risk for providers contingent on the total cost of care and quality outcomes for an assigned or attributed patient population |
| **Current Examples** | Fees for services not covered by PPS | | Health center-specific APM, Oregon (implementing) and California (piloting) | PCMH, 2703, care transitions pilots, long term services and supports pilots, HRSA delivery system health information investments | Pay for Performance (P4P), HRSA Quality Improvement Awards | Medicare Shared Savings Programs; Next Generation Accountable Care Organizations |
| **How does this differ compared to health center payment under PPS?** | No change | | Same level of revenue per member. More flexibility in care delivery methods (such as using health coaches and virtual visits) | New dollars with additional expectations for added capabilities and services | Additional dollars contingent on performance | Additional dollars or financial penalty contingent on performance |

6. Mark McClellan, MD, PhD. Engelberg Center for Health Care Reform at Brookings. https://www.pcpcc.org/sites/default/files/McClellan%20Slides.pdf
7. Bailit Health, Value-Based Payment Models for Medicaid Child Health Services, July 2016. https://www.uhfnyc.org/assets/1503
8. Center for Medicare and Medicaid Services Comprehensive Primary Care Plus. Available at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus.

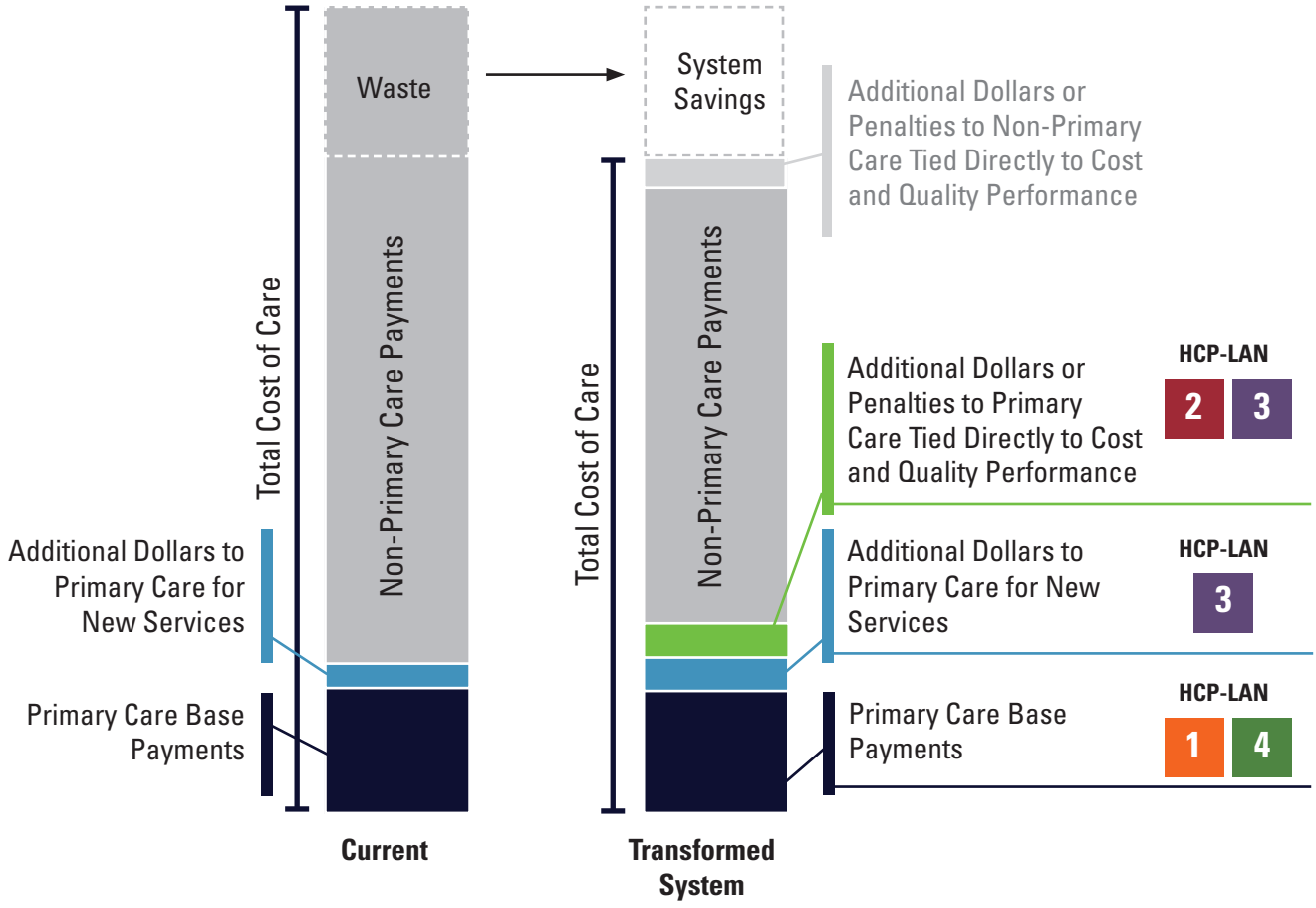
## Transitioning to value-based care and the health center value proposition

Health centers have long believed that investing in strong primary care that takes into account the social, economic and behavioral needs of an individual in concert with medical needs is the best strategy for keeping people healthy and out of the hospital. In fact, research shows that health center patients across 13 states have lower hospital utilization than a comparison group of non-health center patients.[9]

Health centers are using this baseline "value proposition" to negotiate for future payment models that provide additional flexibility in delivering care within the health center model, attract new investment, and tie a portion of payment to quality and total health system costs.

**Value-Based Payment and Care Are Data Driven**
Regardless of the specific model(s) health centers may pursue, the HITEQ Center recognizes that primary care data and data exchanged with primary care from the rest of the health system are essential for assessing payment reform options and for being successful in managing population health under new payment models.

**Figure 2. Transitioning to Value-Based Payment**




9. Nocon R, Lee S, Sharma R, Ngo-Metzger Q, Mukamel D, Gao Y, et al. Health Care Use and Spending for Medicaid Enrollees in Federally Qualifed Health Centers Versus Other Primary Care Settings. **American Journal of Public Health.** 2016:e1-19.