

BEYOND MEDICAL CARE FACT SHEET

Paying for value over volume through payment reform



What is paying for value over volume?

U.S. healthcare is built on a fee-for-service (FFS) system, which pays a provider for each specific service delivered to a patient. FFS often incentivizes providers to deliver a greater volume of services to patients, without accounting for efficiency, cost or quality of care. Driven by widespread dissatisfaction with high healthcare costs, poor health outcomes and fragmented healthcare services under FFS, and accelerated by provisions in the Affordable Care Act (ACA), the U.S. healthcare system is gradually transitioning away from FFS to a value-based payment system.

In an ideal environment, a value-based payment system accounts for quality of care, outcomes, and cost, and incentivizes integrated and coordinated care for patients.

What is payment reform?

Although FFS is still the most common payment system in Ohio and in the nation, many changes are underway.¹ Payment reform or innovation refers to policy and system changes designed to shift from paying for volume to paying for value. Payment reform includes a continuum of payment mechanisms that differ in the extent to which providers are held financially accountable for performance (see Figure 1).

The continuum of payment reform mechanisms described in Figure 1 are often used in combination with one another. Transition along the payment reform continuum is not always linear. Nationally in 2014, approximately forty percent of commercial in-network payments were tied to value. Of this 40% of value-oriented payments, 53% put the provider at financial risk based on performance.²

Changes in payment mechanisms can also accompany changes in healthcare delivery models and vice versa. For example, Patient Centered Medical Homes (PCMH) receive care coordination payments in exchange for delivering enhanced primary care services to patients and meeting set performance objectives. Accountable Care Organizations (ACOs), which are integrated networks of providers that manage the care of a defined

patient population, may enter into global payment and shared savings/risk arrangements with payers. Under a shared savings/risk arrangement, providers share in "savings" if the cost of managing their patient population is less than a set global payment amount and/or risk financial loss if the cost of care is above a set amount.

What does payment reform have to do with prevention?

As providers take on increased financial risk and are held accountable for good health outcomes, they are seeking out new ways to help patients stay healthy.

Figure 2, the U.S. Health System Transformation 3.0 Framework, was envisioned by health policy experts to describe the transition away from a FFS "sick care system" to a "community-integrated health system."

In Era 3.0, providers and payers are encouraged to consider the health of tomorrow's potential patients in addition to today's patients, driving greater investment in upstream primary prevention strategies. The 3.0 era "community-integrated health system" pays for value and measures success based on the health outcomes of geographic populations, such as the health status of residents of an entire county or state, rather than specific patient populations.³ In this environment, providers are incentivized to go beyond managing a diabetic patient's A1C levels, for example, and instead hold shared accountability for reducing the overall prevalence of type 2 diabetes within a geographic population.



What are the potential policy mechanisms to accelerate payment reform?

The federal Centers for Medicare and Medicaid Innovation (CMMI), within the Centers for Medicare and Medicaid Services (CMS), has advanced many payment reform initiatives across the nation to explore what works to improve healthcare value. These initiatives, ranging from developing ACOs and episode-based payment models to primary care transformation, provide states with valuable opportunities to substantially increase investments in prevention. Visit the [CMS innovation website](http://www.cms.gov/innovation) for more information on these initiatives.

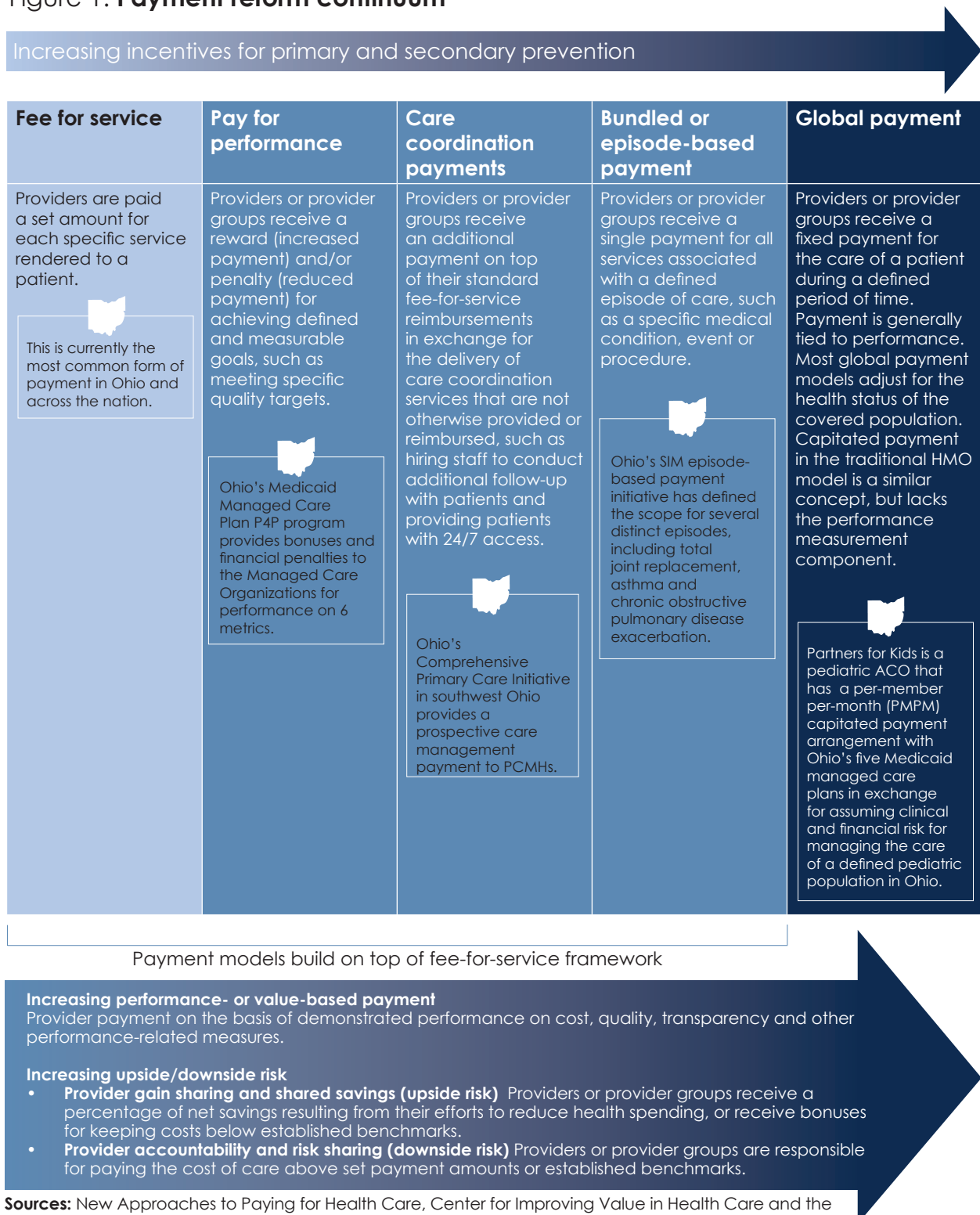


State governments also are accelerating the transition to value-based payment systems that incentivize prevention through strategies such as:

- **Medicaid payment for prevention activities:** Using federal options, such as section 1115 waivers, to expand the type of services covered by Medicaid, including community-based interventions. Waivers must be budget neutral, and are approved for a five year period. For example, Texas used a waiver to support health improvement efforts, including prevention activities.⁴

- **Accountable care models:** Encouraging and supporting the spread of accountable care models. Accountable Care Communities and Accountable Communities for Health take the ACO model one step further to include entities outside the healthcare system, such as community-based social service and public health organizations. For example, Oregon established Coordinated Care Organizations (CCOs). CCOs assume global risk for Medicaid patients in a geographic region and have flexibility to pay providers in innovative ways that allow for greater investments in community-based prevention.⁵

Figure 1. **Payment reform continuum**



Sources: New Approaches to Paying for Health Care, Center for Improving Value in Health Care and the Colorado Health Institute; The Payment Reform Glossary, Healthcare Quality and Payment Reform; 2014 National Scorecard on Payment Reform and Definitions of Payment Model Terms, Catalyst for Payment Reform

Figure 2. U.S. health system transformation 3.0 framework

Health system characteristic	Era 1.0 Sick care system	Era 2.0 Coordinated health care system	Era 3.0 Community-integrated health system
Objective	Acute care and infectious disease focused	<ul style="list-style-type: none"> • Patient-centered care • Coordinating episodes of care across levels of care and managing chronic conditions 	<ul style="list-style-type: none"> • Population and community health outcomes • Optimizing the health of populations over the life span and across generations
Payment methodology	<ul style="list-style-type: none"> • Fee-for-service • Rewards volume of services 	<ul style="list-style-type: none"> • Value-based payments • Health care provider rewarded for better patient outcomes, better patient experience of care, and lower total cost of care 	<ul style="list-style-type: none"> • Recognize value with long-term time horizons and capture multisector financial impacts outside of health care cost • Sustainable financing alternatives such as population-based global budgets
Population health improvement	Not addressed	Focused on health of patients/clients only	Focused on health outcomes for geographically defined population, including upstream socioeconomic and developmental correlates of health

Source: Abridged version of Exhibit 2 in *Applying a 3.0 transformation framework to guide large-scale health system reform*. Halfon, et al. *Health Affairs*, 2014.

- **Upstream PCMH:** Encouraging and supporting the spread of PCMH models that link clinical and community resources in order to actively address contributors to health that are outside of the healthcare system. Community Health Teams, for example, use social workers and community health workers to help patients connect to social services. They may also advocate for population-level policy change, such as housing code enforcement to improve asthma outcomes. Minnesota, North Carolina, Vermont, Iowa and Rhode Island are using Community Health Teams to coordinate care to address the underlying conditions that lead to poor health.⁶

Ohio's State Innovation Model (SIM) initiative

CMS' State Innovation Model (SIM) initiative awards federal grants to states to design and test new healthcare delivery and payment system models.

In February of 2013, CMS awarded Ohio \$3 million for a SIM Round One Model Design grant. As a result, Ohio developed a plan to accelerate health system transformation in the state through the implementation of PCMHs and episode-based payment models.⁷ In December 2014, CMS awarded Ohio an additional \$75 million for a Round Two Model Test grant for implementation of episode-based payments and roll-out of a state-wide PCMH model over a four-year time-frame.

Round Two Model Test awardees are required to develop a state-wide plan to improve population health. As part of this plan, states must identify opportunities that maximize the impact of proposed health system transformation activities on population health, as well as on healthcare cost and quality. The SIM initiative provides a unique opportunity for Ohio to invest deeply in prevention as a vehicle to improve population health or community building.

What's the landscape in Ohio?

Providers in Ohio are involved in a number of CMMI initiatives related to payment reform and healthcare system transformation. In addition, Ohio has many private-led initiatives that pilot and implement a wide range of payment reform activities including PCMHs, ACOs and pay-for-performance arrangements.

Ohio's payment reform goals

Capitalizing on Ohio's SIM activities and other public and private payment reform initiatives in the state, Ohio's Office of Health Transformation has laid out a 5-year goal for payment innovation. Starting in 2014, the state aims to have 80-90% of Ohio's population in value-based payment models within five years with participation across both Medicaid and commercial payers.

In addition, the 2016-17 state budget requires Medicaid managed care plans ensure that at least 50% of payments to providers are value-based by July 2020.⁸

Figure 3. Ohio's 5-year goal for payment innovation

	Patient-centered medical homes	Episode-based payments
Year one (2014)	Focus on Comprehensive Primary Care Initiative (CPCi)	State leads design of six episodes: Asthma acute exacerbation, COPD exacerbation, perinatal, acute non-acute PCI and joint replacement
Year two	Collaborate with payers on design decisions and prepare a roll-out strategy	State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD and colonoscopy
Year four	<ul style="list-style-type: none"> • Model rolled out to all major markets • 50% of patients are enrolled 	20 episodes defined and launched across payers, including behavioral health
Year five	<ul style="list-style-type: none"> • Scale achieved state-wide • 80% of patients are enrolled 	50+ episodes defined and launched across payers

Source: Governor's Office of Health Transformation, April 2015



Payment reform recommendations

The following strategies would accelerate the transition from volume to value in a way that incentivizes investments in prevention.

Public and private payers can:

1. Tie payment arrangements to performance on risk-adjusted outcomes measures (such as percent of patients who successfully quit smoking), not just process or clinical-encounter measures (such as percent of patients screened for smoking status).
2. Explore shared savings arrangements that require a percent of any financial savings be reinvested into community-based prevention activities.

Ohio's Medicaid program can:

3. Continue to pursue more outcome measurement and pay-for-performance (P4P) in Medicaid managed care and explore section 1115 waivers that could allow Medicaid to cover community-based prevention interventions.
4. Encourage Medicaid managed care plans to work with local health departments, social service agencies and other community-based organizations to address non-medical issues that impact health such as housing, violence, and access to opportunities for healthy eating and active living.

Public and private healthcare leaders can:

5. Support the spread of accountable care models (ACOs, Accountable Communities for Health, etc.) that reach larger numbers of Ohioans and incentivize greater investment in community-based prevention activities.
6. Ensure that ACOs and ACO-like organizations

are specifically designed to improve health outcomes. This can be accomplished through governance and design, delivery system enhancements, tying payment to performance on population health metrics and data sharing across sectors.⁹

7. Explore ways to take the PCMH model upstream, such as care coordination fees that explicitly include coverage of Community Health Teams, Community Health Workers, and other services that actively link patients to community-based organizations that address non-medical factors such as housing and healthy food access.
8. Maximize the impact of Ohio's State Innovation Model (SIM) initiative by integrating community-based prevention into the PCMH model and other payment and delivery transformation activities, and by developing a strong SIM Population Health Plan that supports upstream prevention strategies.

Public health leaders can:

9. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local health departments and other community-based partners can help them to address health behaviors and community conditions.

Behavioral health leaders can:

10. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local behavioral health (ADAMH) boards and community-based behavioral health providers can help them to address housing, substance abuse prevention, and mental health early intervention.

Recommended resources

- **Ohio SIM initiative information**, Governor's Office of Health Transformation
- **National scorecard on payment reform**, Catalyst for Payment Reform, 2014
- **Payment reform glossary**, Center for Healthcare Quality and Payment Reform
- **New Approaches to Paying for Health Care**, Center for Improving Value in Health Care and the Colorado Health Institute, 2012

- **Opportunity knocks again for population health: Round Two in State Innovation Models**, IOM discussion paper, 2015
- **Healthy outlook: Public health resources for systems transformation**, American Public Health Association, 2015
- **Accountable Communities for Health: Opportunities and recommendations**, Prevention Institute, 2015
- **Community-Centered Health Homes: Bridging the gap between health services and community prevention**, Prevention Institute, 2011

Sources

1. Catalyst for Payment Reform. "2014 National Scorecard on Payment Reform." <http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard>
2. Ibid.
3. Halfon, et al. "Applying a 3.0 transformation framework to guide large-scale health system reform", Health Affairs, 2014, 2003-011.
4. Rosenthal, et al. "Financing Prevention, How State are Balancing Delivery System and Public Health Roles." ChangeLab Solutions, National Academy for State Health Policy, 2014.
5. Ibid.
6. Ibid. See also: NASHP State Health Reform. "Population Health Components of State Innovation Model (SIM) Plans: Round 2 Model Testing States." 2015.
7. Governor's Office of Health Transformation. "Ohio Receives Federal Grant to Advance Health Care Payment Innovation." 2013. <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=2b-iXyOqCA%3d&tabid=138>.
8. The definition of value will be specified in future rules.
9. Crawford, M. and T. McGinnis, "Population Health in Medicaid Delivery System Reforms." Milbank Memorial Fund Issue Brief. March 2015.