CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Payment Primer

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CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Public and Private sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

> *Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.*

FOCUS AREAS

- Pay Providers
- Deliver Care
- Distribute Information

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

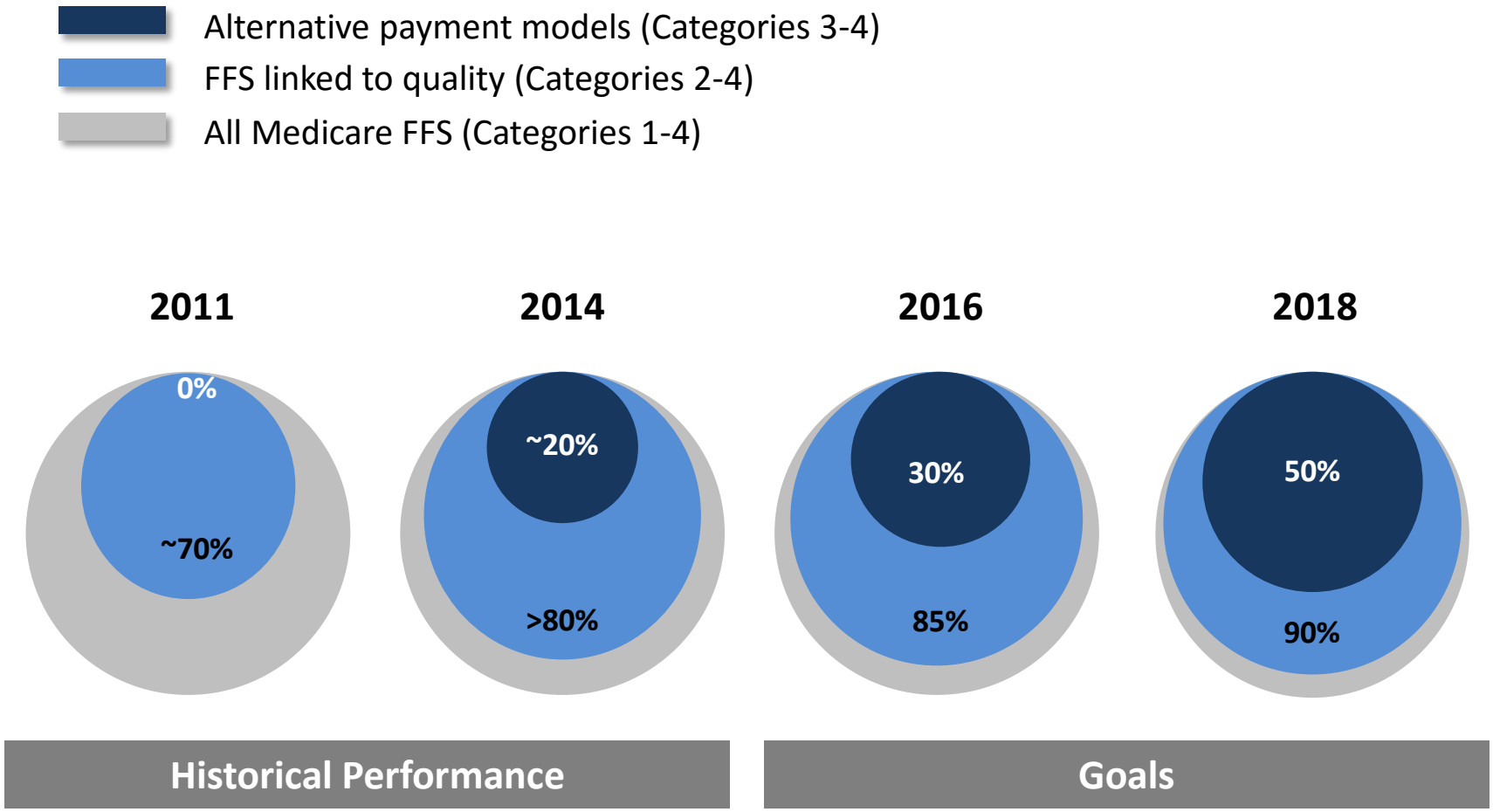
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

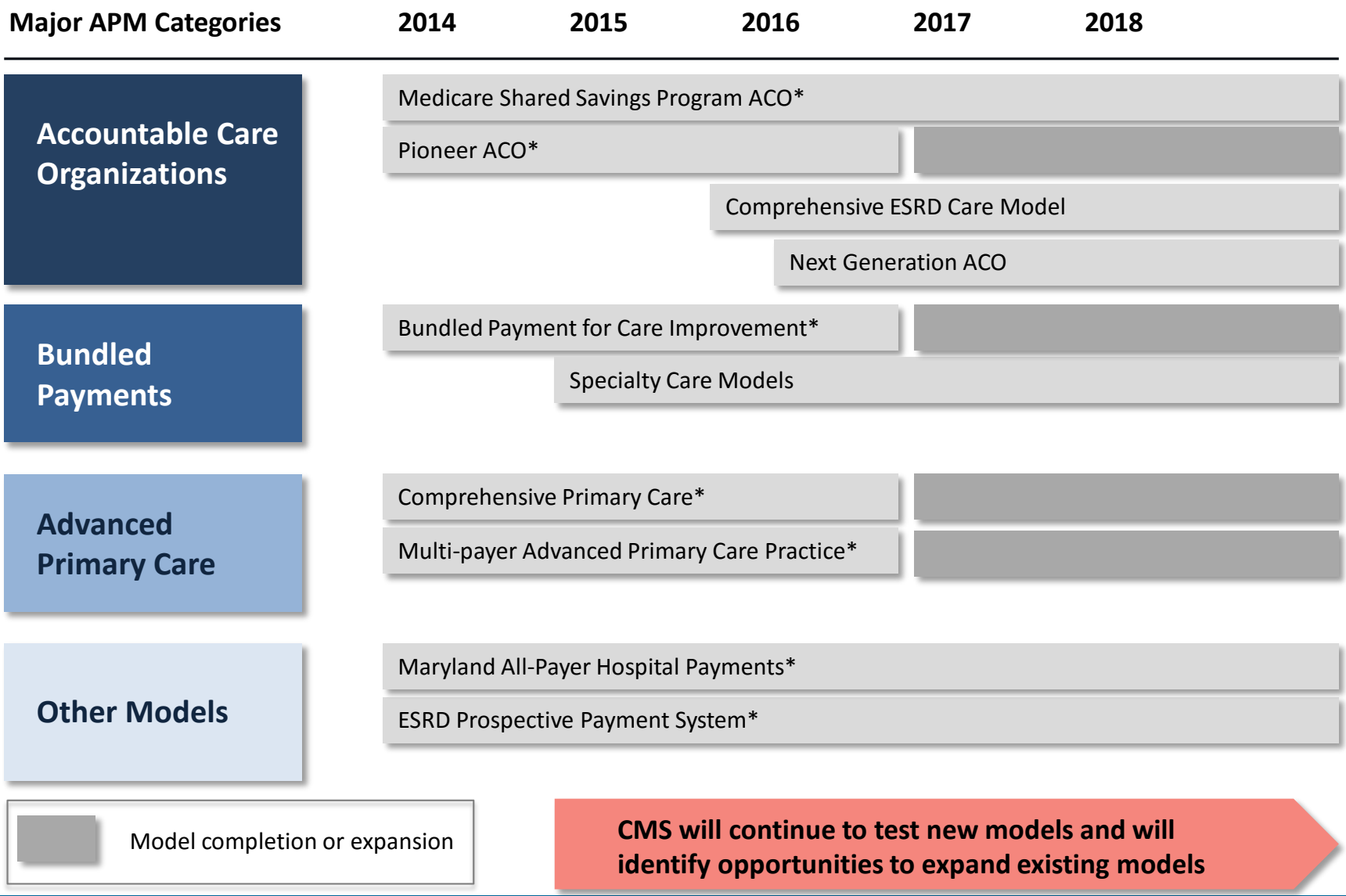
Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018



CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality



* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

The Health Care Payment Learning and Action Network (LAN) will accelerate the transition to alternative payment models

- **Medicare alone cannot drive sustained progress** towards alternative payment models (APM)
- Success depends upon a **critical mass of partners** adopting new models
- The network will
  - **Convene** payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  - **Identify areas of agreement** around movement to APMs
  - Collaborate to **generate evidence, shared approaches, and remove barriers**
  - **Develop common approaches** to core issues such as beneficiary attribution
  - Create **implementation guides** for payers and purchasers

Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  - -30% in APM by 2016
  - -50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

The LAN Guiding Committee Has Developed these Initial Priorities

- **Define terms and concepts** associated with alternative payments (e.g. definition of value, types of models)
- **Develop consistent and aligned payment mechanisms** that includes agreement on APM technical components (outcomes measures, attribution approaches, data sharing, etc.)
- **Drive agreement, adoption, and action** among stakeholders
- **Share best practices, early results and learning**, and information that informs the transition process
- **Design solutions and approaches** that work for high-risk, complex populations and for low-income, vulnerable populations
- **Establish a framework and measure progress** toward goals of increasing U.S. health care payments linked to quality and value

LAN Operational Model

Convene

Convene health plans, purchasers, providers, consumers, states, and federal partners to establish a common pathway for success

Agree

Identify areas of agreement around movement to APMs

Collaborate

Collaborate with partners and LAN participants to identify and use existing successes, best practices, and lessons learned

Develop Approaches

Develop and agree on approaches to core issues, such as risk adjustment, benchmarking, and attribution

Drive Adoption

Collaborate with partners to adopt models and measure progress

Examples of CMS payment methods by category

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
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Medicare Fee-for-Service examples	▪ Rural Health Clinics ▪ Clinical Laboratories ▪ Durable medical equipment	▪ DRG; Inpatient Quality Reporting (2a) ▪ Physician Fee Schedule; Value Based Modifier (2b)	▪ Medicare Shared Savings Program (MSSP) ACO, Track 1 (3a) ▪ Comprehensive Primary Care Initiative (3a) ▪ Medicare Shared Savings Program, Tracks 2 &3 (3b) ▪ CMS Bundles (3b)	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

CMS payments that are not readily classified

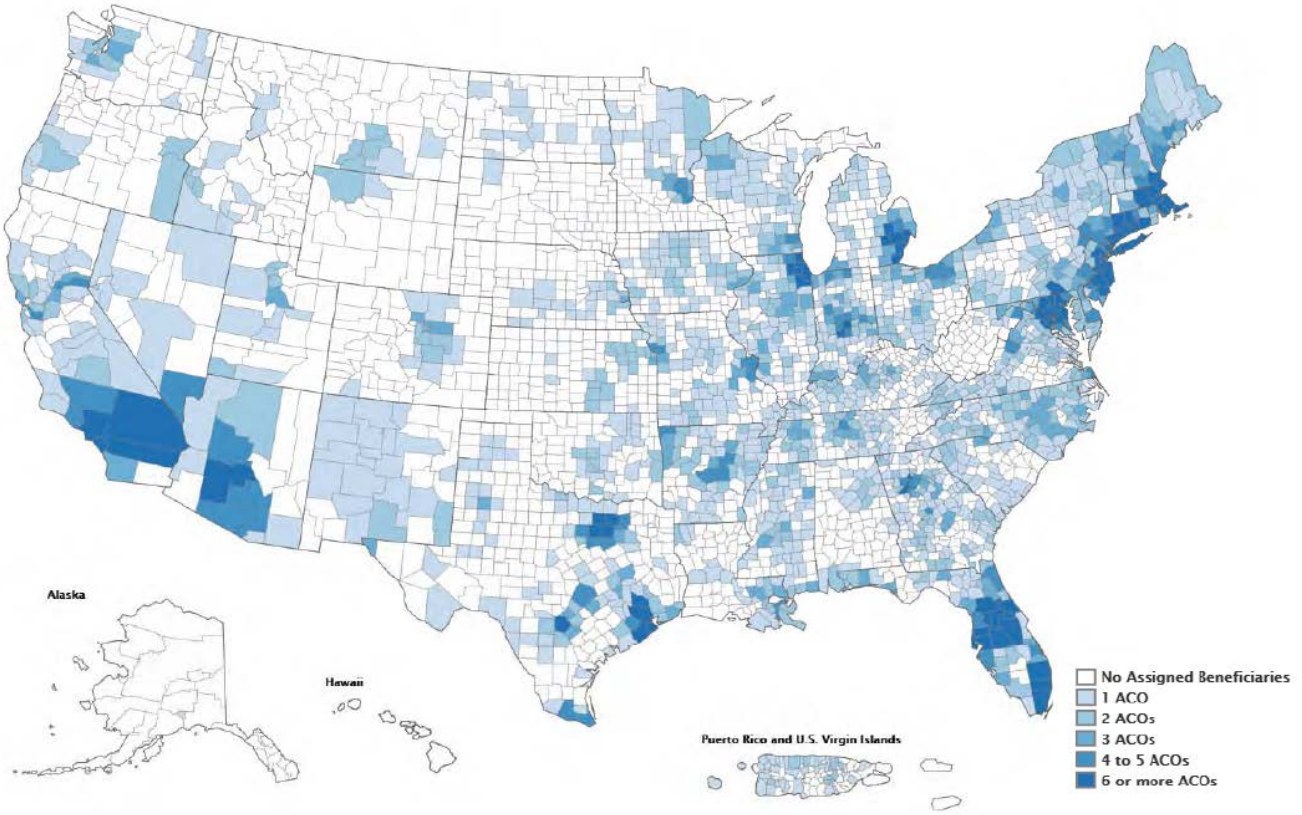
- Medicare Advantage (Part C) – Payment to insurer
- Part D drugs – Payment to insurer
- Gainsharing – Arrangement between providers

Appendix

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **423 ACOs** have been established in the MSSP and Pioneer ACO programs*
- **7.9 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County



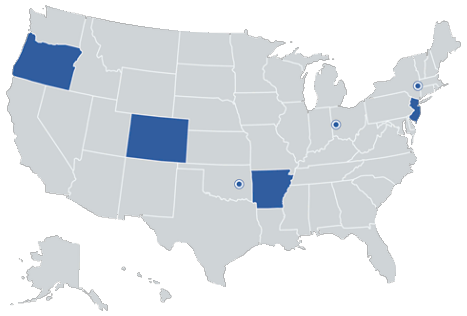
* April 2015

Comprehensive Primary Care (CPC) is showing early positive results

- CMS convenes Medicaid and commercial payers to support primary care practice transformation through enhanced, non-visit-based payments, data feedback, and learning systems

CPC
Comprehensive Primary Care

- In program year 1 across all 7 regions, CPC **reduced Medicare Part A and B expenditures** per beneficiary by $14 or 2%*
  - Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions



Source: Centers for Medicare & Medicaid Services

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients
- Duration of model test: Oct 2012 – Dec 2016

* Reductions relative to a matched comparison group and do not include the care management fees (~$20 pbpm)

Spotlight: Comprehensive Primary Care, SAMA Healthcare

SAMA Healthcare Services is an independent four-physician family practice located located in El Dorado, a town in rural southeast Arkansas

Services made possible by CPC investment

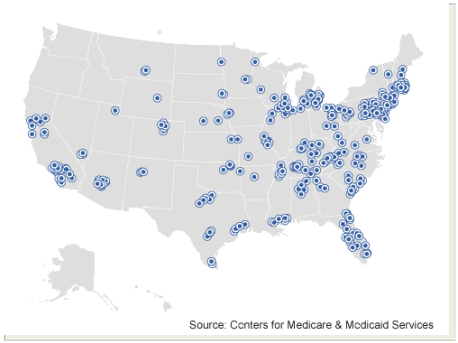
- Care management
  - Each **Care Team** consists of a doctor, a nurse practitioner, a care coordinator, and three nurses
  - Teams drive **proactive preventive care** for approximately 19,000 patients
  - Teams use Allscripts' **Clinical Decision Support** feature to alert the team to missing screenings and lab work
- Risk stratification
  - The practice implemented the **AAFP six-level risk stratification tool**
  - Nurses mark records **before the visit** and physicians **confirm stratification during the patient encounter**

-Practice Administrator

"A lot of the things we're doing now are things we wanted to do in the past… **We needed the front-end investment** of start-up money to develop our teams and our processes"

Bundled Payments for Care Improvement is also growing rapidly

- The bundled payment model targets 48 conditions with a single payment for an episode of care
  - Incentivizes providers to take **accountability for both cost and quality** of care
  - **Four Models**
    - Model 1: Retrospective acute care hospital stay only
    - Model 2: Retrospective acute care hospital stay plus post-acute care
    - Model 3: Retrospective post-acute care only
    - Model 4: Acute care hospital stay only
- 360 Awardees and 1755 Episode Initiators in Phase 2 as of July 2015

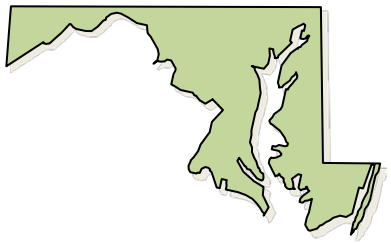


- Duration of model is scheduled for 3 years:
  - Model 1: April 2013 to present
  - Models 2, 3, 4: October 2013 to present

* Current until July 2015

Maryland is testing an innovative All-Payer Payment Model

- Maryland is the nation's only **all-payer hospital rate regulation system**
- Model will test whether effective accountability for both cost and quality can be achieved within all-payer system based upon **per capita total hospital cost growth**
- **Quality of care** will be measured through
  - Readmissions
  - Hospital Acquired Conditions
  - Population Health



- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013

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Final Remarks and Closing

Transition to Grand Ballroom

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