Payment Primer

Alex Billioux, MD, DPhil
Senior Advisor,
Center for Medicare and Medicaid Innovation

April 25, 2016

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

Historical state → Evolving future state

Public and Private sectors

Historical state

Key characteristics

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

Systems and Policies

- Fee-For-Service Payment Systems

Evolving future state

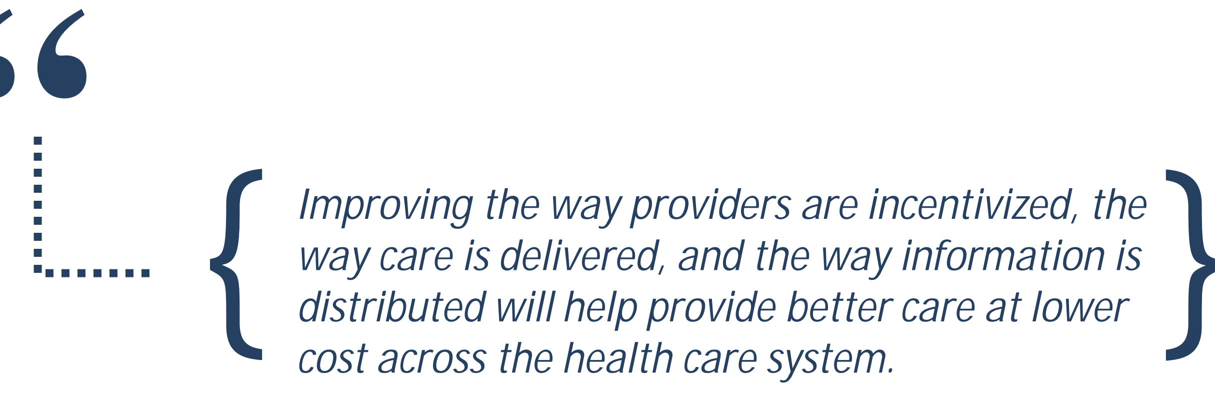
Key characteristics

- 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



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.

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

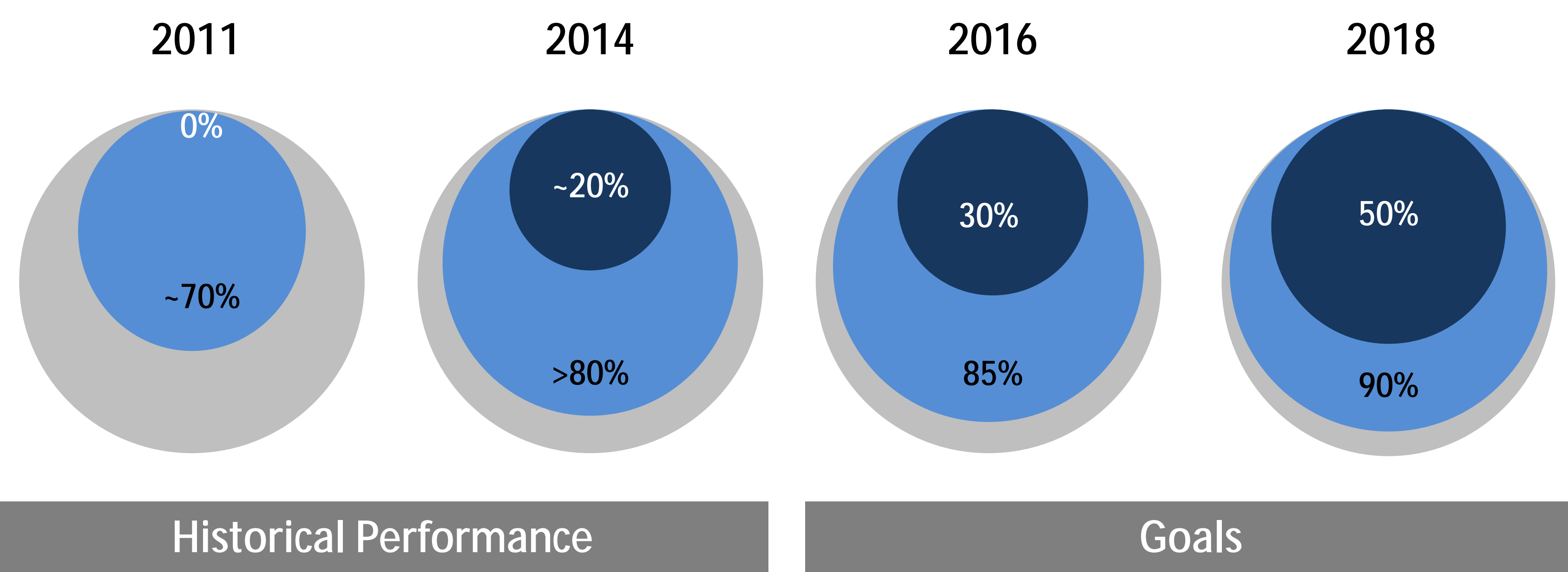
Invite **private sector payers** to match or exceeed HHS goals

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

Alternative payment models (Categories 3-4)
FFS linked to quality (Categories 2-4)
All Medicare FFS (Categories 1-4)

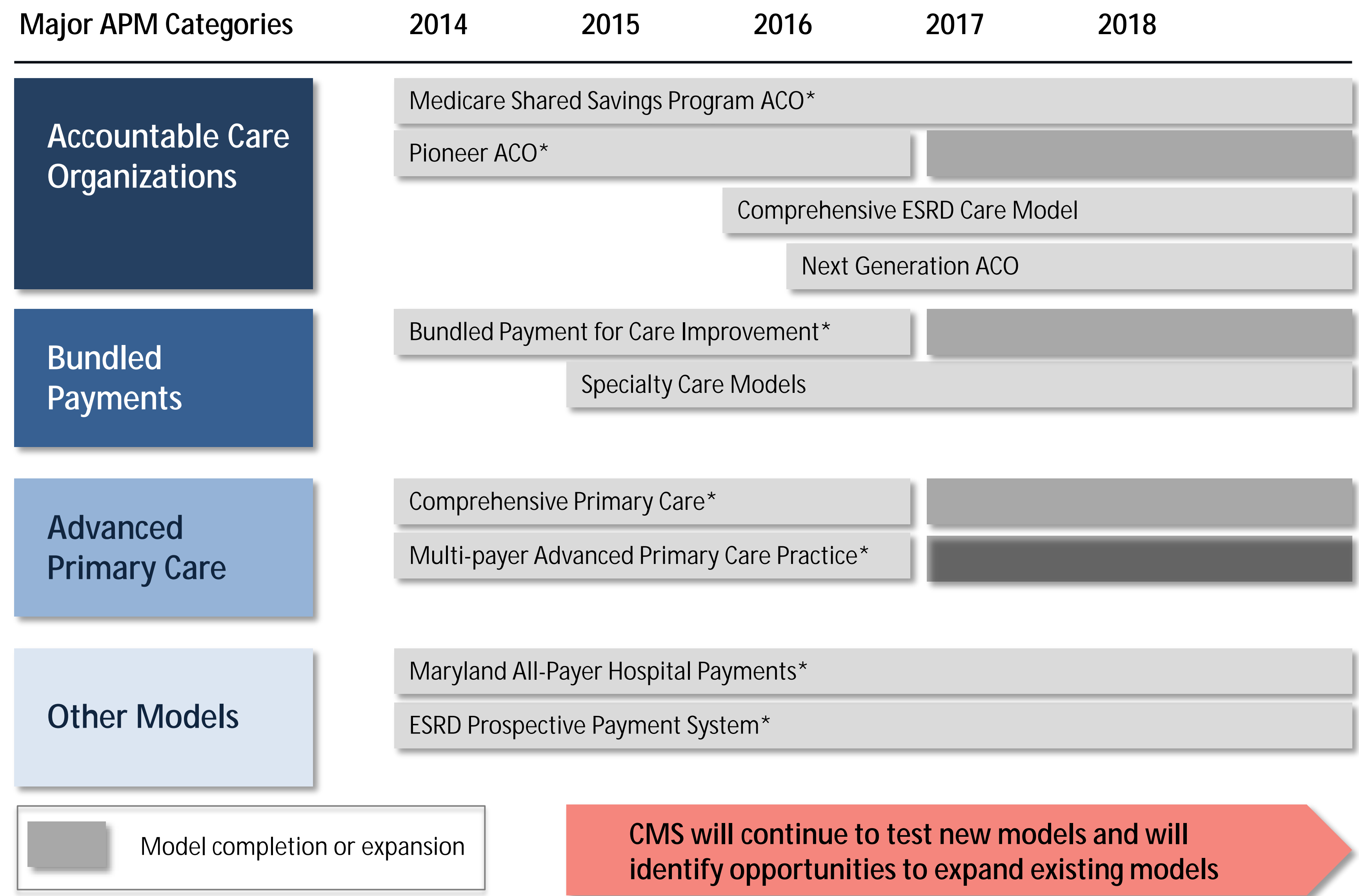


CMS has adopted a framework that categorizes payments to providers

	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.

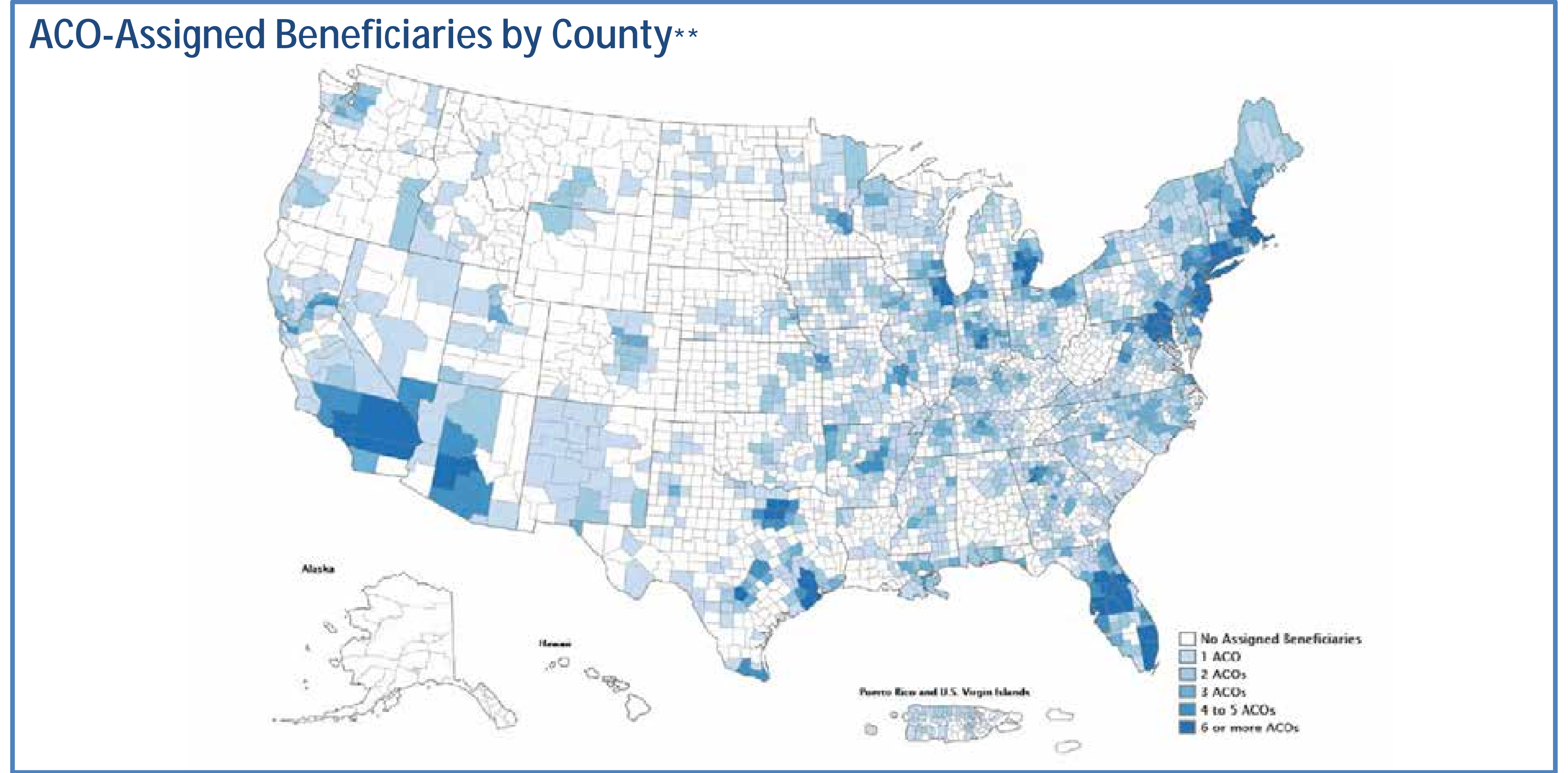
CMS has achieved Goal 1 through alternative payment models where providers are accountable for both cost and quality



* 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

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **477 ACOs** have been established in the MSSP, Pioneer ACO, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **121 new ACOS** in 2016 **(of which 64 are risk-bearing)** covering **8.9 million assigned beneficiaries** across 49 states & Washington, DC



* January 2016
** Last updated April 2015

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: Prospective acute care hospital stay only

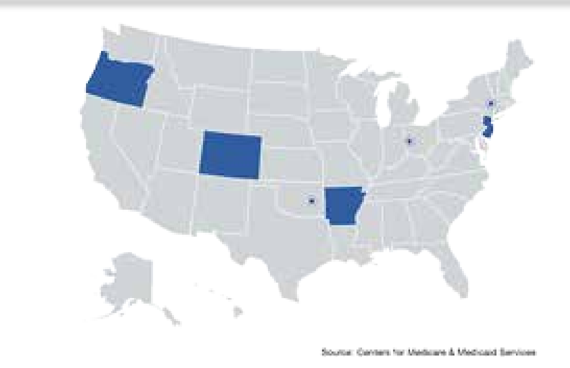
- 337 Awardees and 1237 Episode Initiators as of January 2016

- Duration of model is scheduled for 3 years:
  - Model 1: Awardees began Period of Performance in April 2013
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013

Comprehensive Primary Care (CPC) is showing early but 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

- $14 or 2%* reduction part A and B expenditure in year 1 among all 7 CPC regions
- Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions



- 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)

Comprehensive Primary Care Plus (CPC+)

CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

Goals

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Empower practices to provide comprehensive care that meets the needs of all patients.
3. Improve quality of care, improve patients' health, and spend health care dollars more wisely.

Participants and Partners

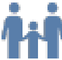
- 5 year model: 2017-2021
- Up to 5,000 practices in up to 20 regions
- Two tracks depending on practice readiness for transformation and commitment to advanced care delivery for patients with complex needs
- Public and private payers in CPC+ regions
- HIT vendors (official partners for Track 2 only)

Care Transformation Functions

Access and continuity

Care management

Comprehensiveness and coordination

 Patient and caregiver engagement

Planned care and population health

Payment Redesign Components

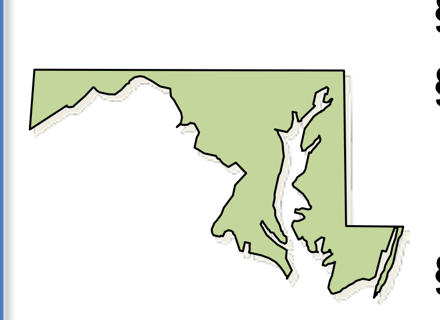
PBPM risk-adjusted care management fees

Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care

For Track 2, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to offer flexibility in delivering care outside traditional office visits

Maryland All-Payer Payment Model achieves $116 million in cost savings during first year

- 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
- The All Payer Model had very positive year 1 results (CY 2014)
  - $116 million in Medicare savings
  - 1.47% in all-payer total hospital per capita cost growth
  - 30-day all cause readmission rate reduced from 1.2% to 1% above national average

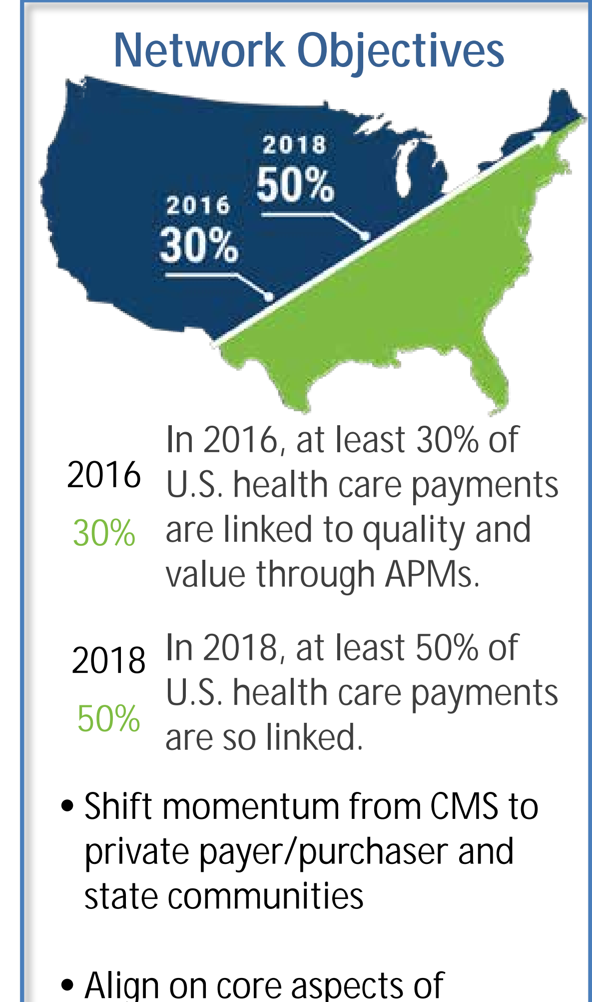


- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013

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



The LAN Guiding Committee Developed these Initial Priorities for the Work of the LAN

- **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

OPERATIONAL MODEL

Critical path to broad adoption of Alternative Payment Models (APMs)

- Leadership Groups
- Partnerships
- Research
- LAN Engagement

- APM Framework
- Guiding Principles

- Population-Based Payment Models
- Clinical Episode Payment Models

- Implementation Resources
- Learning & Sharing

- Measure & Track Progress
- Payer Collaborative
- Pilot Recommendations

KEY PRINCIPLES

APM Framework–summary of key principles

1

Empower Patients to be Partners
Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.

2

Shift to Population-Based Payments
The goal is to shift U.S. health care spending significantly toward population-based payments.

3

Incentives Should Reach Providers
Value-based incentives should ideally reach the providers who deliver care.

4

Payment Models & Quality
Payment models that do not take quality into account will be classified within the appropriate category and marked with an "N" to indicate "No Quality" and will not count as progress toward payment reform.

5

Motivate Providers
Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6

Dominant Form of Payment
APMs will be classified according to the dominant form of payment, when more than one type of payment is used.

7

Examples in the Framework
Centers of excellence, accountable care organizations, and patient-centered medical homes are examples in the Framework, rather than categories, because they are delivery systems that can be applied to and supported by a variety of payment models.

APM FRAMEWORK

At-a-Glance

The framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities

Population-Based Payment (Categories 3 and 4)

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

A: Foundational Payments for Infrastructure & Operations

B: Pay for Reporting

C: Rewards for Performance

D: Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

A: APMs with Upside Gainsharing

B: APMs with Upside Gainsharing/Downside Risk

Category 4

Population-Based Payment

A: Condition-Specific Population-Based Payment

B: Comprehensive Population-Based Payment

The framework situates existing and potential APMs into a series of categories.

APM GOALS

For Payment Reform

- Provider accountability and innovation
- Impact of payments on cost and quality performance
- Delivery system integration and coordination
- Person-centered care

Current State

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality &Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Future State

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

QUESTIONS

CONTACT US

We want to hear from you!

Website
www.hcp-lan.org | www.lansummit.org

Twitter
@Payment_Network

LinkedIn
https://www.linkedin.com/groups/8352042

YouTube
http://bit.ly/1nHSf1H

Email
PaymentNetwork@mitre.org

Appendix

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
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	§ 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.

APM FRAMEWORK

Category 1 Fee for Service – No Link to Quality & Value	Category 2 Fee for Service – Link to Quality & Value				Category 3 APMs Built on Fee-for-Service Architecture		Category 4 Population-Based Payment	
Fee-for-Service	A Foundational Payments for Infrastructure & Operations	B Pay for Reporting	C Rewards for Performance	D Rewards and Penalties for Performance	A APMs with Upside Gainsharing	B APMs with Upside Gainsharing/ Downside Risk	A Condition-Specific Population-Based Payment	B Comprehensive Population-Based Payment
Traditional FFS	Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT	Bonus payments for quality reporting	Bonus payments for quality performance	Bonus payments and penalties for quality performance	Bundled payment with upside risk only	Bundled payment with up- and downside risk	Population-based payments for specialty, condition, and facility-specific care (e.g., via an ACO, PCMH, or COE)	Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
DRGs Not linked To Quality		DRGs with rewards for quality reporting	DRGs with rewards for quality performance	DRGs with rewards and penalties for quality performance	Episode-based payments for procedure-based clinical episodes with shared savings only	Episode-based payments for procedure-based clinical episodes with shared savings and losses	Partial population-based payments for primary care	Integrated, comprehensive payment and delivery system
		FFS with rewards for quality reporting	FFS with rewards for quality performance	FFS with rewards and penalties for quality performance	Primary care PCMHs with shared savings only	Primary care PCMHs with shared savings and losses	Episode-based, population payments for clinical conditions, such as diabetes	Population-based payment for comprehensive pediatric or geriatric care
					Oncology COEs with shared savings only	Oncology COEs with shared savings and losses		
					3N Risk-based payments NOT linked to quality		4N Capitated payments NOT linked to quality	

[gray box] = example payment models will not count toward APM goal.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

CMS payments that are not readily classified

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

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"

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

.