New Directions for Payment Innovation

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Learning Objectives

• Define CMMI’s role in promoting new payment and care delivery models in Medicare and Medicaid programs

• Describe new guiding principles and focus areas proposed for CMMI’s future efforts

• Identify components of payment and service delivery models that best serve the needs of patients and providers
CMMI’s Purpose

“The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals under such titles”

Section 3021 of Affordable Care Act

Three scenarios for success

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

Source: Amy Bassano, Acting Director, Center for Medicare & Medicaid Innovation, Presentation, HFMA Thought Leadership Retreat, Oct. 5, 2017
A Full Portfolio

- ACO Investment Model
- Accountable Health Communities Model
- Advance Payment ACO Model
- Advanced Primary Care Initiatives
- Beneficiary Engagement and Incentives: DDS & SDM Models
- Bundled Payments for Care Improvement Models 1-4
- BPCI Advanced
- Cardiac Rehabilitation (CR) Incentive Payment Model
- Community-based Care Transitions Program
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model
- Comprehensive Primary Care Initiative
- Comprehensive Primary Care Plus + Round 2
- Episode Payment Models: AMI, CABG, CR, SHFFT
- Financial Alignment Initiative for Medicare-Medicaid Enrollees
- FQHC Advanced Primary Care Practice Demonstration
- Frontier Community Health Integration Project Demonstration
- Frontier Extended Stay Clinic Demonstration
- Graduate Nurse Education Demonstration
- Health Care Innovation Awards: Round 1, Round 2
- Health Plan Innovation Initiatives
- Hispanic Health Services Research Grant Program
- Historically Black Colleges and Universities Research Grant Program
- Home Health Value-Based Purchasing Model
- Independence at Home Demonstration
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase Two
- Innovation Advisors Program
- Maryland All-Payer Model
- Medicaid Incentives for the Prevention of Chronic Diseases Model
- Medicare Acute Care Episode (ACE) Demonstration
- Medicare Advantage Value-Based Insurance Design Model
- Medicare Care Choices Model
- Medicare Coordinated Care Demonstration
- Medicare Diabetes Prevention Program
- Medicare Health Care Quality Demonstration
- Medicare Hospital Gainsharing Demonstration
- Medicare Imaging Demonstration
- Medicaid Incentives for the Prevention of Chronic Diseases Model
- Medicare Innovation Accelerator Program
- Million Hearts
- Million Hearts: Cardiovascular Disease Risk Reduction Model
- Multi-Payer Advanced Primary Care Practice
- Next Generation ACO Model
- Nursing Home Value-Based Purchasing Demonstration
- Oncology Care Model
- Part D Enhanced Medication Therapy Management Model
- Physician Group Practice Transition Demonstration
- Physician Hospital Collaboration Demonstration
- Pioneer ACO Model
- Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE)
- Regional Budget Payment Concept
- Rural Community Hospital Demonstration
- Specialty Practitioner Payment Model Opportunities
- State Innovation Models Initiatives
- Strong Start for Mothers and Newborns Initiatives
- Transforming Clinical Practice Initiative
- Vermont All-Payer Model

Source: Amy Bassano, Acting Director, Center for Medicare & Medicaid Innovation, Presentation, HFMA Thought Leadership Retreat, Oct. 5, 2017
Examples of Current CMMI Initiatives

- Comprehensive Primary Care Plus (CPC+)
- Next Generation Accountable Care Organizations (NextGen ACOs)
- Bundled Payments for Care Improvement (BPCI) Initiative
- Oncology Care Model (OCM)
- Medicare Advantage Value-Based Insurance Design (MA VBID) Model
Comprehensive Primary Care Plus (CPC+)

- **Goals**
  - Strengthen primary care
  - Support clinicians ability to provide comprehensive care
  - Improve quality, access, and efficiency of care

- **Participants**
  - Multi-payer (Medicare & commercial health plans)
  - Two rounds
    - Round 1: 2,893 practices in 14 regions (2017-2021)
    - Round 2: 1,000 practices in 4 regions (2018-2022)
  - Two tracks
    - Track 2 receives hybrid payments

- **Program Attributes**
  - Practices receive per-beneficiary per-month risk-adjusted care management fees
  - Practices can also qualify for performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care.
  - For Track 2 practices, payment is a hybrid of reduced fee-for-service payments and upfront “Comprehensive Primary Care Payments.” The upfront payment is intended to offer flexibility in delivering care outside traditional office visits.
Next Generation ACOs

• **Goal**
  – Test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare FFS beneficiaries
  – Builds upon Pioneer ACO model

• **Participants**
  – 44 ACOs in 20 states
  – In year one, of 18 initial participants, 11 earned savings and 7 had losses
  – Average annual gross savings per beneficiary was just over $100

• **Program Attributes**
  – Two models (80% upside or downside risk or 100% upside or downside risk), with “first dollar” participation in savings below or losses above a discounted benchmark.
  – Available benefit enhancements including
    ▪ Telehealth expansion waiver
    ▪ Post-discharge home visit waiver
    ▪ Three-day skilled nursing facility waiver
  – Voluntary alignment of beneficiary option (which supersedes claims-based attribution)
  – Opportunity to provide beneficiary reward payments for participating in the ACO
Bundled Payment for Care Improvements (BPCI)

- **Goal**
  - Improve accountability for both cost and quality of care

- **Participants**
  - 261 awardees (risk-bearing) and 983 episode initiators as of July 2017
  - 48 conditions available for bundled payments

- **Program Attributes**
  - Voluntary participation
  - Four models:
    1. Retrospective acute care hospital stay only (no longer active)
    2. Retrospective acute care hospital stay plus post-acute care
    3. Retrospective post-acute care only
    4. Prospective acute care hospital stay only (very low participation)
  - No utilization controls
  - Single payment based on discounted IPPS
  - For Model 2, waiver of three-day-hospital-stay requirement for SNF payment is available
New Addition – BPCI Advanced

**Goal**
- Improve accountability for both cost and quality of care; provide APM option

**Participants**
- Both Acute Care Hospitals and Physician Group Practices can serve as Convener Participants
- All participants (Convener and Non-Convener) must bear downside risk
- Application portal is open until 3/12/2018
- Target prices to applicants in May 2018, and participant agreements to applicants in June, with signed agreements due back to CMS by August

**Program Attributes**
- Voluntary Model
- A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as an Advanced APM
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided in advance of the first Performance Period of each Model Year
- As with BPCI, no utilization controls
The Other Bundled Payment Model: Comprehensive Care for Joint Replacement (CJR)

- Mandatory participation bundled payment model in 67 metropolitan statistical areas (including 6 in Texas), involving approximately 800 hospitals
- 382 hospitals across the 67 MSAs qualified for reconciliation payments (i.e., had actual episode price below target price and met composite quality score requirements) in the first performance year
- Combined, these providers completed 33,152 episodes and received $37,594,131 in payments (approximately $1,134 per episode)
- Under new administration, number of mandatory markets cut in half
Oncology Care Model (OCM)

• **Goal**
  – Promote whole practice transformation through aligned financial incentives
  – Improve health outcomes and produce higher quality care at same or lower cost to Medicare

• **Participants**
  – 192 practices
  – 14 payers

• **Program Attributes**
  – New emphasis on specialty care
  – Multi-payer model to align payment incentives
  – Requires participating practices to:
    ▪ Provide core functions of patient navigation
    ▪ Follow a care plan following 13 components of IOM’s care management plan for cancer care
    ▪ Provide 24/7 patient access to a clinician with real-time access to EHR
    ▪ Treat with therapies consistent with nationally recognized guidelines
    ▪ Use data to drive continuous quality improvement
    ▪ Use certified EHR technology
  – Payment is FFS, plus
    ▪ $160 per beneficiary per month for OCM enhanced services
    ▪ Performance-based payment based on quality and efficiency metrics
Medicare Advantage Value-Based Insurance Design (MA VBID)

• **Goal**
  – Test hypothesis that giving MA plans flexibility to offer supplemental benefits to targeted groups of enrollees with certain chronic conditions to encourage use of high-value services will lead to higher quality and more cost-efficient care.

• **Participants**
  – 9 MA plans in MA, PA, and IN for 2017

• **Conditions**
  – Diabetes
  – COPD
  – CHF
  – Patient with Past Stroke
  – Hypertension
  – Coronary Artery Disease
  – Mood Disorders
  – Rheumatoid Arthritis (as of 2018)
  – Dementia (as of 2018)

• **Program Attributes**
  – MA plans have flexibility to form “multiple comorbidity” groups and establish tailored VBID interventions for them.
  – Can select one or more plan modifications from a menu of four approaches:
    ▪ Reduced cost-sharing for high-value service
    ▪ Reduced cost-sharing for high-value providers
    ▪ Reduced cost sharing for enrollees participating in disease management or related programs
    ▪ Coverage of additional supplemental benefits (e.g., supplemental tobacco cessation assistance for COPD enrollees)
New Direction: Proposed Guiding Principles for Future CMMI Programs

- Choice and competition in the market (for consumers)
- Provider choice (voluntary participation) and incentives (reduced regulatory burdens)
- Patient-centered care (employer beneficiaries to take ownership of care; provide information needed to make care choices)
- Benefit design and price transparency (data-driven insights on cost effectiveness)
- Transparent model design and evaluation (partnerships with public stakeholders; broad input into proposed models)
- Small-scale testing
Discussion: How Would You Give Shape to CMMI’s Guiding Principles?

Assuming an overall goal of high quality, cost-effective health care (and drawing from your own experiences):

1. What competitive structure would best serve consumers in a market? What would this structure look like on the provider side? On the payer side?

2. Is there a role for mandatory payment models, or should participation in new payment models be voluntary only?

3. What do you think are the greatest regulatory burdens in health care today? If you could remove or relax one regulation, what would it be and why?

4. What should consumers’ ownership of their health care look like? What information or other tools does a consumer need to take ownership?

5. What is the relationship between benefit design and price transparency? What benefit designs do you think would best encourage consumers to seek out and account for price information in their care decisions?

6. Who do you think are the most valuable public or community partners in improving the quality and cost-effectiveness of health care? What makes them valuable? How could payment models better support the formation of public/community partnerships?