

VIEWPOINT

CMS—Engaging Multiple Payers in Payment Reform

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The Affordable Care Act created the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and to enhance the quality of care that Centers for Medicare & Medicaid Services (CMS) beneficiaries receive. CMS is testing more than 20 models under this authority that create new incentives for clinicians and organizations that deliver medical care through CMS programs to deliver better care at lower cost. CMS is also supporting a variety of state efforts to create new incentives for these clinicians and organizations through the Medicaid and CHIP programs. All of these models share a common pathway for success: they hinge on getting clinicians and health care organizations to manage the health of populations and to act as good stewards of health care resources.

Data from the first performance year of the Pioneer accountable care organization (ACO) model suggest that the Pioneer ACOs generated gross savings of \$147 million and better quality results for 15 of 15 measures with published national benchmarks. However, for these models to succeed in the long term, "value-based payment and patient incentives to reward clinicians and health care organizations that offer more real value to patients must spread rapidly to other payers."¹ Long-term success will require clinicians and organizations to make fundamental changes in their day-to-day operations—and, for any individual clinician or organization, making operational changes will be attractive only if the financial incentives are large enough. The financial incentives, in turn, will be large enough only if a critical mass of payers, in addition to CMS, support payment reform.²

For CMS, engaging multiple payers in new payment models is a foundational principle. Medicare, Medicaid, and CHIP constitute only a share of any clinician's or health care organization's revenue. Therefore, signals from CMS will be strongest if they are aligned with signals from other payers. Efforts to improve quality and reduce cost are more likely to be successful if multiple payers adopt these models. The Innovation Center's statute supports this principle. The Affordable Care Act directs the secretary of Health and Human Services to consider, in selecting which models to choose for testing, "whether the model demonstrates effective linkage with other public sector or private sector payers."³

The purpose of this Viewpoint is 2-fold: (1) to describe a framework for understanding payment reform that classifies payment models according to how clinicians and health care organizations are paid and creates a common vocabulary for describing the progression of payment reform and (2) to describe what CMS is doing to lead multipayer participation in payment reform.

CMS has a long history of both testing and implementing innovative new payment and delivery models for Medicare and Medicaid. But historically, CMS has not actively sought the participation of other payers in new payment models. If new payment models deployed by CMS have improved quality and reduced cost, other payers have followed—but CMS has not typically actively engaged private payers.

One widely studied example of this approach is Medicare's implementation of the inpatient prospective payment system in 1983. Before the introduction of this system, Medicare paid for hospital services based on costs reported by hospitals, subject to limitations in later years. This provided little incentive for hospitals to operate efficiently. In 1983, the inpatient prospective payment system instituted prospectively set rates based on diagnosis. In the years following the implementation of this system, Medicare costs for hospital services declined and hospital length of stay decreased.⁴ At the same time, there was no measurable decline in the quality of hospital care. Observing this success, many commercial payers soon followed and adopted inpatient prospective payment systems of their own.

The eTable in the Supplement presents a framework for describing health care payment through the stages of transition from pure fee-for-service to alternative payment methods. This framework classifies payment models according to how clinicians and organizations are paid into 4 categories: category 1—fee-for-service with no link of payment to quality; category 2—fee-for-service with a link of payment to quality; category 3—alternative payment models built on fee-for-service architecture; and category 4—population-based payment. Some Medicare and Medicaid managed care plans still make fee-for-service payments to clinicians and organizations that have no link to quality—these payments would fall into category 1, not category 4. In general, 2 features mark the shift across these categories: (1) clinicians and organizations are increasingly accountable for both quality and total cost of care and (2) there is a greater focus on population health management as opposed to payment for specific services (eTable in the Supplement).

A primary driver of delivery system reform is to move payment systems, both for CMS and for commercial payers, toward alternative payment models and population-based payments and, at the same time, minimize fee-for-service payments that are not linked to quality or value. That is, CMS aims to move an increasingly large share of total payments to clinicians and organizations from fee-for-service with no link to quality to models that reward quality and efficiency in care delivery and to continue to learn how best to incentivize better health outcomes and lower costs.

Payment systems must be aligned to the extent necessary to provide consistent incentives to clinicians and organizations. However, alignment does not mean that all payers must enter into identical contracts with clinicians and organizations; nor does it mean that other payers must replicate CMS' payment models. Having payers experiment with different quantitative methods for establishing financial benchmarks, measuring quality, attributing patients to clinicians and organizations, and adjusting risk is a desirable attribute of this early phase of payment reform. CMS will continue to study the results of payment innovation in the commercial market to inform the design of its own new payment models. However, over time, payers should work to align both quality measures and their general approach to value-based payment and accountable care models.

Strategies for Aligning Payment Mechanisms

CMS is currently using 3 active strategies in combination to lead the broader market in transforming payment mechanisms.

CMS as Convener

In the Comprehensive Primary Care initiative, CMS convened private payers in 7 markets around the nation to make voluntary coordinated investments in approximately 500 primary care practices. Medicare works with commercial and state health insurance plans to offer per-beneficiary per-month payments to primary care practices to provide enhanced primary care for their patients. Similarly, through the State Innovation Models Initiative, CMS is providing \$300 million to state governments to support payment and delivery system transformation. CMS has set an aspirational goal for Model Testing States in the State Innovations Model initiative to work with both public and private payers to shift 80% of their population into value-based alternative payment models instead of pure fee-for-service within 5 years. As part of this program, CMS works with states to act as a convener for multiple payers, clinicians and health care organizations, and other stakeholders in each state.

Incentivize Clinicians and Organizations

In several models, CMS requires clinicians and organizations, as a requirement of participation, to bring other payers to the table. For example, applicants in Round Two of the Health Care Innovation Awards Round must describe a feasible approach for securing participation of multiple payers for their proposed models. This could include demonstrable commitments from current payers, current contracts, or letters of support. Similarly, participants in the Pioneer

ACOs model are required, by the end of their second performance year, to ensure that at least 50% of their revenue across payers comes from outcomes-based contracts that link payment to quality and value.

State-Level Reforms

In one instance, CMS has joined an all-payer payment reform initiative spearheaded by a state government in Maryland. Maryland currently operates the only surviving all-payer rate-setting system for hospital costs. All-payer rate setting is a state-based system that gives clinicians and health care organizations a common rate structure and set of payment rules.

On December 30, 2013, CMS and the state of Maryland jointly announced a statewide Innovation Center model under which Maryland will limit per capita all-payer hospital cost growth and improve quality of care for all Maryland residents. This model will serve as a platform for all-payer payment reform. Under the model, Maryland will shift virtually all of its hospital revenue over the next 5 years into global payment models, including, potentially, all-payer ACOs or medical homes. Eventually, in a second stage of the model, Maryland will transition to a limit on growth in total per capita medical expenditures for all payers. If successful, the Maryland approach could serve as a model for other states.

Many states are engaged in Medicaid payment reforms. Under one Medicaid waiver, as amended and approved on July 5, 2012, Oregon initiated a large-scale reform, transitioning the bulk of its Medicaid population into coordinated care organizations, which have features of both managed care organizations as well as ACOs. Each coordinated care organization has a financial incentive to improve the cost and quality of care for beneficiaries, and the state is also accountable for statewide improvements in quality and a 2% reduction in the growth of spending. Early results, although preliminary, all point to improvements in the cost and quality of care.

Conclusions

The goal of payment reform is to produce better care at lower cost by inducing changes in the way that clinicians and organizations deliver health care. Through these new payment systems, CMS is entering into a partnership with clinicians and organizations to manage the health of populations, cultivate teamwork across care settings, and give every patient a home for his or her care.⁵ CMS cannot and should not do this alone. All payers, clinicians, and patients have a shared interest both in learning from one another and in ensuring the success of delivery system transformation.

ARTICLE INFORMATION

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