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

Health Care Innovation Awards

Round Two: Payment Models

July 11, 2013

Agenda

- **Overview – HCIA Round Two**
- Payment Model Overview
- Elements of Payment Model Design
- Next Steps

Innovation Awards Round Two Goals

Engage innovators from the field to:

- Identify new payment and service delivery models that result in better care and lower costs for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries
- Test models in four Innovation Categories
- Develop a clear pathway to new, sustainable Medicare, Medicaid, and CHIP payment models

Key Dates

Date	Description
June 14, 2013	Application templates and user materials were available at http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html
June 28, 2013	Letters of Intent were due by 3:00 PM EDT
August 15, 2013	Application due by 3:00 PM EDT
Early 2014	Anticipated award announcements

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Payment Model Overview

An applicant must propose in the application:

Service Delivery Model

A service delivery model refers to the manner in which providers organize and deliver care to patients.

Two examples of service delivery models:

- *Medical home for oncology patients*, which aims to improve care and reduce utilization through coordination, education, and enhanced access.
- *Telemedicine care coordination*, which aims to provide improved care at lower cost by providing telephonic access to an experienced triage nurse.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Payment Models

A payment model refers to the manner in which a payer reimburses providers.

Two examples of payment models:

- *Bundled episode-of-care payments*, which encourage coordinated care and the provision of care in the most cost-effective settings within an episode.
- *Capitated payments*, including global capitation and contact capitation, which discourage unnecessary utilization and optimize care within a capitated setting over a defined period of time.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Submission of Payment Models

- The applicant must submit in the application either:
  - The **design** of a corresponding payment model, *or*
  - A **detailed and fully-developed** payment model.

- If its application does not contain a detailed and fully-developed payment model, then an awardee must submit a detailed and fully-developed payment model at some time during or by the end of the 3-year cooperative agreement period.

Multi-Payer Participation

In order for providers to have meaningful incentives to change their service delivery models, they must engage multiple payers.

- The payment model design must include Medicare, Medicaid, and/or CHIP, though it should ideally include other payers as well.
  - Applications must include a feasible approach for securing participation of multiple payers.
  - Applicants have the option of submitting with their application a list of non-CMS payers.
  - Preference will be given to applications that include participation by non-CMS payers at the outset of the model's implementation.
- Awardees must submit a list of non-CMS payers by the end of the 3-year cooperative agreement period, if they have not already done so with their application.

Multi-Payer Participation

Examples

- In the Comprehensive Primary Care Initiative, CMS collaborates with private payers in local markets who commit to similar efforts.
  - On average, approximately 60% of a CPCI practice's revenue is generated by CMS and other collaborating payers in the market.
- CMS requires Pioneer ACOs to enter into contracts with other payers based on financial and performance accountability such that more than 50% of revenues will be derived from such arrangements.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Payment Model Sustainability

Applicants must demonstrate the sustainability of the payment model. The payment model is sustainable if:

- It is scalable:
  - It can be *spread* to different or broader Medicare, Medicaid, and/or CHIP populations,
  - It can be made available to other providers, and
  - It can potentially serve as a basis for a subsequent solicitation by CMS.
- It is financially sustainable:
  - It generates a *positive financial* return for CMS, and
  - When and if put in place by CMS – and absent additional federal spending – it *incentivizes providers* to fully implement the applicant's service delivery model after the end of the three-year cooperative agreement period.

Preference will be given to applicants who can demonstrate potential for financial sustainability sooner than three years by creating a payment model that could be used during the term of the cooperative agreement, if adopted by CMS, and in a broad solicitation of other providers.

New Alternative Approaches to Payment Models

Payment models that propose new alternative approaches rather than simply expanding or supplementing fee-for-service payments will be preferred.

- One way to classify different approaches is to array them in a matrix. As an illustration, a 2x2 matrix based on the following dimensions may be of use for the provider component of payment models:
  - The degree to which providers accept accountability, and
  - The degree to which payment models require changes in the existing provider payment system.
- Using these dimensions, we construct on the next slide a framework showing examples of alternative payment models.
  - *Note that this framework is illustrative only, and is not intended to convey a preference or a preferred approach.*
- Consider also other new approaches, including models that incorporate new beneficiary incentives, and that include other non-provider types of applicants.

Framework for Examples of Provider Payment Models

Two dimensions to consider in developing new alternative approaches are the degree to which payment models shift accountability to the provider and the degree to which payment models require changes in the existing provider payment system

		Change in Payment System	
		Low	High
Provider Accountability	Low	New fee-for-service payment within existing payment system; Care management fee; Value-based payment adjustment (small magnitude)	New fee-for-service payment under new payment system
	High	Value-based payment adjustment (large magnitude); Retrospective shared savings model; Retrospective bundled payment	Prospective bundled payment; Contact capitation; Global capitation

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Elements of Payment Model Design

Some key elements of the design of a payment model:

- **Payment details:** How funds will flow under the payment model.
- **Payment principles:** How the payment model will create specific provider or beneficiary incentives.
- **Description of risk parameters:** How the payment model will adjust, shift, insure, and/or limit risk.
- **Return on investment:** How the payment model will deliver a positive return on investment for CMS.
- **Progression:** How the parameters of the payment model will progress over time.

This list is not intended to be exhaustive; other requirements apply – see Funding Opportunity Announcement for more details.

Elements of Payment Model Design

Illustrative Examples

- Transitional care management codes ("TCM")
  - Two new FFS CPT codes paying for care management services following discharge from an inpatient stay.
  - Illustrative of new FFS payment or care management fee.
- Hospital Readmissions Reduction Program ("HRR")
  - Reduction by CMS of payment to certain hospitals with excess readmissions.
  - Illustrative of value-based payment adjustment.
- Bundled payments for care improvement ("BPCI")
  - Four distinct models which test bundled payments for an episode of care.
  - These illustrative examples focus on Models 2 and 4.

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Examples are illustrative only, and not intended to convey a preference or preferred approach.

Elements of Payment Model Design

Use of some illustrative examples

- Each of these payment models—TCM, HRR, and BPCI—could support and correspond with a service delivery model designed for a similar purpose (to prevent hospital readmissions), but each of these payment models has a different design, level of accountability, and scope of change to the payment system (see "Framework," slide 14).

- Please note:
  - These models are used to illustrate elements of payment models, and are not intended to convey a preference or preferred approach.
  - Models that focus primarily on acute hospital inpatient care are excluded from consideration in HCIA Round Two.

Element #1: Payment Details

How funds will flow under the model

Some representative issues to consider
• Whom does the payer pay? • Whom does the payee pay? Will new business relationship(s) be required? Are there specific legal and operational issues related to these relationships? How will beneficiary choice be maintained? • Will the payment model operate within the existing billing and payment system framework or require a new payment mechanism? • How is quality integrated into the payment?

Element #1: Payment Details (continued)

How funds will flow under the model

Examples

- **TCM** – The Physician Fee Schedule (PFS) is maintained with the addition of new codes.
- **HRR** – The Inpatient Prospective Payment System (IPPS) is maintained with an adjustment to the amounts paid.
- **BPCI Model 2** – The current payment system remains in place. A new payment mechanism involving a reconciliation is made between CMS and the awardee, and then the awardee may have additional financial arrangements with its partners.
- **BPCI Model 4** – A single bundled payment is made by CMS to the hospital in place of the current payment system, and that hospital will then disburse payments to other providers of services in the episode.
  - Note: legal and operational issues for disbursing payments among providers are critically important in this model.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Element #2: Payment Principles

How the payment model will create specific provider or beneficiary incentives

Some representative issues to consider
• How does the payment model incentivize the service delivery model? • Does the payment model adequately ensure key elements of the service delivery model are provided? • Does the payment model provide flexibility for improvement of the service delivery model and adaptation to different circumstances? • Does the payment model incentivize unintended behaviors and how are these addressed? • Does the payment model directly incentivize beneficiary behavior?

Element #2: Payment Principles (continued)

How the payment model will create specific provider or beneficiary incentives

Examples
• **TCM** – Incentivizes care management services by providers, but narrowly defines timing and provision of those services. • **HRR** – Focus on high readmissions rate – which is an outcome measure – allows flexibility for a provider to select a service delivery model that achieves the outcome. • **BPCI** – Payment of a discounted fixed rate supports a variety of service delivery models, with monitoring for unintended consequences.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Element #3: Risk Parameters

How the payment model will adjust, shift, insure, and/or limit risk

Some representative issues to consider

- Does the payment model shift risk to providers or other entities?
- If so, what is the appropriate amount of risk for targeted providers?
- What steps should be taken to limit risk for providers (e.g. outlier policies, risk-adjustment, shared savings)?
- Do providers typically provide sufficiently high volumes of services to take on risk for the proposed payment model?
- Do providers have sufficient risk management capabilities to take on risk for the proposed payment model?
- Is the risk modeling sufficiently robust? At a minimum, relevant issues should be described along with an approach to answering these questions including data sources.

Element #3: Risk Parameters (continued)

How the payment model will adjust, shift, insure, and/or limit risk

Examples

• **TCM** – Minimal change in risk.
• **HRR** – Some risk is shifted to the hospital for high readmission rates.
• **BPCI** – Risk for payments during the episode of care are nearly entirely shifted to the provider.
  o Risk-adjustment based on the presenting clinical condition.
  o Varying outlier policies to limit risk.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Element #4: Return on Investment

How the payment model will deliver a positive return on investment for CMS

Some representative issues to consider
• How is the price determined? • What are the types of unintended behaviors that may occur due to incentives created by the payment model, and how may they jeopardize anticipated savings? • What other factors would jeopardize achievement of forecasted results? • How will results achieved during the model test be replicated?

Element #4: Return on Investment (continued)

How the payment model will deliver a positive return on investment for CMS

Examples

- **TCM** – Delivery of care transitions services during post-discharge period may result in reduced readmissions.
- **HRR** – Penalty encourages providers to engage in activities to prevent readmissions through multiple strategies, such as enhanced discharge planning.
- **BPCI** – Fixed payment for episode of care will incentivize providers to optimize care and prevent unnecessary services through multiple strategies, such as coordinating care across the continuum of an episode.
  - CMS monitors for reductions in savings from behaviors such as cost-shifting, increasing volume of episodes, and changes in case-mix.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Element #5: Progression

How parameters of the payment model will progress over time

Some representative issues to consider

- Will the structure of the payment model change over time? Along which dimensions (e.g. risk, payment mechanism)? Will there be a phased-in approach?
- How will the payment model promote continuous improvement of the service delivery model and adapt accordingly?
- What key factors, including other delivery and payment reforms, may affect this progression?

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Element #5: Progression (continued)

How parameters of the payment model will progress over time

Examples
• Change in magnitude of payment model, such as an increase in proportion of payment at risk in a pay-for-performance or shared-savings model. • Change in mechanism of payment, such as a progression from retrospective to prospective payment. • Incremental addition of components of a hybrid payment model, such as a progression from care management fee to care management fee with shared savings.

Examples are illustrative only, and not intended to convey a preference or preferred approach.

Payment Model Example

Comprehensive Primary Care Initiative

- The CPC Initiative is testing whether increased investment in primary care improves care and lower costs for Medicare patients.
- The CPCI model test is being implemented in about 500 participating primary care practices in 7 diverse geographic markets, and provides access to care, delivers preventive care, engages patients and caregivers, coordinates care across the medical neighborhood, and manages care for patients with high needs.

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Examples are illustrative only, and not intended to convey a preference or preferred approach.

Payment Model Example (continued)

Comprehensive Primary Care Initiative	
Element	**Description**
Payment details	Medicare payments to primary care practices supplement fee-for-service payments with (1) a monthly, prospectively-paid care management fee, and (2) an opportunity for shared savings.
Payment principles	Care management fees will support increase primary care practice investment in patient access and coordination. Shared savings will be calculated at the regional level, thus encouraging participating practices to work together to share best practices to achieve program goals.
Risk parameters	Participating practices share in savings, but not in increased costs. Care management fees are risk-adjusted.
Return on investment	Shared savings align providers with CMS. Care quality will be monitored. Providing comprehensive primary care is expected to achieve positive return on investment for CMS by reducing other utilization.
Progression	Care management fees will decrease in years 3 and 4, and participating practices will have the opportunity to share in Medicare savings.

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Upcoming Webinars

Webinar 7: Application Road Map

- Application Narrative
- Helpful Hints

Webinar 8: Technical Assistance for Submitting an Application

Slides, transcripts and audio will be posted at http://innovation.cms.gov

Next Steps

- Additional information regarding the Innovation Awards will be posted on http://innovation.cms.gov
- More Questions? Please Email InnovationAwards@cms.hhs.gov

Thank You!

Please use the webinar chat feature to submit questions