



Payment Reform Action Plan

Meeting the New Medicare Payment Reform Target

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The Affordable Care Act, or ACA, included a variety of reforms intended to lay the groundwork for a fundamental shift in how our nation pays for health care, with the goal of rewarding quality, improving outcomes, and containing the growth in costs. Traditionally, as is the case today, most health care payments are made on a fee-for-service basis, which incentivizes overuse, promotes waste and inefficiency, and pays little attention to accountability for quality of care. The ACA offered the opportunity to test alternative payment models that pay health providers based on the value of care rather than volume.

The models implemented under the ACA incentivize health providers to improve patient outcomes and reduce costs through a variety of approaches, including shared savings, financial risk, and enhanced payments for care coordination and service integration. Patient-centered medical homes, bundled payments, and accountable care organizations are key examples of these new models. Combined with requiring providers to reduce hospital readmissions and incentivizing meaningful use of health information technology, or IT, these alternative models are showing promise to meet the goals of improved quality and reduced cost.

Now is the time to move aggressively and apply these new payment models more widely in order to ensure America's health care dollars are spent effectively and efficiently, while improving health outcomes for Americans.

A few short weeks ago, on January 26, 2015, Health and Human Services, or HHS, Secretary Sylvia Mathews Burwell took a major step toward realizing that vision by setting specific goals for the use of new payment models under Medicare. The Center for American Progress commends Secretary Burwell's official target of having 50 percent of fee-for-service Medicare payments made through alternative payment models by 2018.¹ In addition, CAP believes that HHS should promote payment reform among Medicare Advantage plans, some of which pay providers on a fee-for-service basis despite being paid by the Medicare program through capitation. CAP, having previously recommended a goal of having 75 percent of Medicare payments made through alternative models by 2022, believes the secretary's commitment to a specific target represents a significant milestone in transforming payment incentives and moving providers as well as private payers away from fee-for-service.²

Setting this target is a strong starting point. It is now crucial that HHS outline the concrete steps it will take to achieve this goal. A clearly delineated set of next steps will better ensure HHS's success in meeting this goal and will serve as a strong signal to the private insurance market and to medical providers of the direction and certainty of Medicare payment reform. Greater confidence that these payment reforms will be the standard for the future should help to spur action by providers and insurers.

To encourage and support this effort by HHS, CAP calls on HHS to consider the policy actions outlined in this issue brief as specific steps to best achieve the new payment reform targets.

Expand bundled payments

The expectation of cost-control reforms has likely already started to change provider behavior, contributing to the recent slowdown in the growth of health care spending. However, if these reforms do not fully materialize soon, there is the danger that providers may revert to business as usual. We believe the new HHS goal has helped enormously in alleviating that likelihood by re-affirming the Obama administration's commitment to payment reform.

However, it is critically important that the administration expand at least one payment reform nationwide before President Barack Obama leaves office. Thanks to the ACA, Secretary Burwell has the authority to expand successful payment reform demonstrations to the full Medicare program without additional legislative action. Given the length of time needed both for rulemaking and in order to get necessary certifications from the Office of the Actuary, the policymaking process must begin now.

Right now, the best candidate for nationwide expansion is Medicare's Acute Care Episode, or ACE, program, which replaced fee-for-service payments with discounted, fixed payments for a bundle of services for cardiac and orthopedic procedures. The ACE program—which lasted for three years and involved five hospital sites in four states—has been proven to reduce costs and maintain or improve the quality of care.³ The expansion of ACE could be phased in by starting with orthopedic bundles—which produced the greatest savings in the ACE program and raised no other concerns—or by starting in the South and Southeast regions of the country, where the program was tested and where Medicare per-beneficiary spending is highest.

Launch payment reform for cancer treatment

Cancer is one of the most expensive diseases to treat. Fee-for-service payment and Medicare's payment formula for chemotherapy encourage the overuse of both high-cost drugs and high-cost imaging, as well as hospitalization for preventable complications of chemotherapy and disease progression. Cancer is well suited for bundled payments because there are well-defined episodes of care; extensive, evidence-based, professional guidelines; and clear process and outcomes measures of the quality of care. Evidence suggests that cancer-payment bundling could produce substantial savings, reducing costs by as much as one-third.⁴

A cancer consortium convened by CAP and composed of oncologists, hospital representatives, patient advocates, payers, and other experts has been working together for the past 18 months to advance cancer-payment bundling by identifying the following information:

- Cancers well suited to bundling based on high frequency of occurrence, high cost of treatment and care, and high-quality treatment guidelines
- Quality metrics
- Definitions of episodes of care
- A payment model

In February 2015, HHS announced a new multi-payer bundled payment initiative for oncology care, which was informed substantially by the consortium's work. We applaud this commitment and recommend that HHS prioritize this demonstration project. HHS should work carefully with stakeholders to further develop the details, including the quality metrics, to ensure an effective launch and implementation of bundled cancer payments.⁵

Learn from accountable care organizations' experience

Accountable care organizations, or ACOs, have been a central component of alternative payment models to date. However, ACOs have demonstrated mixed results over the first two years of implementation and the majority of savings were concentrated in a small number of ACOs in the Pioneer ACO Model.⁶ The Pioneer program is the more ambitious of the two major Medicare ACO programs, meant for more advanced health providers who were already experienced in patient care coordination. Of the 23 ACOs that participated in the second year of the Pioneer program, only 11 earned shared savings while 6 generated more than \$25 million in gross losses.⁷ The net federal savings of about \$41 million from the second year of the Pioneer program represent only about 0.008 percent of net Medicare spending in 2013.⁸

Despite the small savings, there is still great potential for the Pioneer program. Even though all participants were already experienced in delivering coordinated care, it will take time for all Pioneers to achieve significant savings given the need to invest in infrastructure, restructure their delivery of care, and adapt to changed payment incentives. Pioneers that are not achieving savings should learn from and adopt the best practices of their peers that have been more successful. HHS should also adopt reforms to improve the performance of the Pioneer program and provide support and encouragement to Pioneers to remain in the program.

Create Accountable Care States that undertake comprehensive multi-payer reforms

Because health care issues have become so polarized, states must play a leadership role on cost control. The current State Innovation Model Initiative, however, is not nearly bold enough: Not enough money is at stake to motivate politically moderate states, and many of the reforms that states are proposing are marginal. Moreover, while payment reforms—such as ACOs, patient-centered medical homes, and bundled payments—hold great potential, reforms that only address utilization without addressing provider prices may not adequately control costs on their own.⁹

HHS should seize the opportunity to create a handful of what we term, Accountable Care States.¹⁰ Participating states would voluntarily set a target for total health care spending. If states successfully meet this target—while also meeting quality targets—they would receive a share of the federal savings on Medicare, Medicaid, and ACA subsidies.

One idea would be to replicate and expand upon Maryland’s all-payer system—the nation’s most comprehensive multi-payer reform to date. Under this system, payment rates are the same for both public and private payers, and providers operate under a budget that constrains both price and volume.¹¹ Maryland’s model is unique because it aggressively controls both excessive prices and excessive utilization for all payers, thereby preventing cost shifting from one payer to another. Another approach could emulate recent payment reforms in Arkansas, where the state Medicaid program is partnering with private insurers with the goal of shifting from fee-for-service almost entirely in the next few years, primarily through bundled payments.¹² Payments to states of \$100 million to \$700 million would clearly incentivize a handful of states to adopt systems such as these.

This type of program is possible without legislation because the Center for Medicare and Medicaid Innovation, or CMMI, is explicitly authorized to work with states to test “systems of all-payer payment reform.”¹³ Participating states’ share of federal savings would be paid out from CMMI funds, and several billion dollars should be reserved for this program. If even five states participate, they will serve as models and test cases to inform future reform efforts.

Congressional Sustainable Growth Rate reform

Preventing the implementation of the failed policy of Medicare provider payment cuts under the Medicare Sustainable Growth Rate, or SGR, requires action again in March 2015. While it is not clear that the action in March will be more than another short-term patch to prevent the cuts, it nevertheless represents an important opportunity to build on the successful work of House and Senate committees in the last session on payment reform. Certainly, every effort should be made by the Obama administration to encourage legislative action on payment reform this year, not only to support the efforts by HHS but also to codify the changes to be made in the coming years.

The payment reform language in the 2014 consensus bill appropriately offered positive incentives for providers to adopt alternative payment models. Congress should also consider including disincentives for remaining in the fee-for-service model in order to further encourage providers to move to value-based payment. In addition, while offering flexibility for providers to choose payment models, the language in the consensus bill should be strengthened to better ensure that the payment models available to providers strongly encourage them to offer care that is significantly more accountable for quality and cost rather than allowing them to choose models most likely to maintain the status quo.

Payment reform through SGR reform should enhance the achievement of the already agreed to goal of moving payments from fee-for-service to value-based payments. As Congress prepares to debate SGR repeal again this year, it should build on last year's progress by structuring payment reform incentives to maximize their effectiveness.

Provide price transparency

To facilitate the transition to alternative payment models, HHS should work to improve price transparency. More transparency would prove enormously helpful for providers using bundled payments by enabling the primary provider responsible for coordinating a patient's care to make better referrals to high-value specialists and thus keep overall costs lower. Although improved transparency may seem less critical for ACOs—where in-network providers are part of the same organization—it would still be important to help inform referrals to out-of-network providers.

Price transparency is also important for consumers. Evidence suggests that providing price information to patients can lead them to select lower-priced options. A recent study on price transparency for MRI scans, for instance, found that informing patients of price differences between providers reduced costs-per-test by nearly 20 percent and increased price competition.¹⁴ Fortunately, the ACA already provides the authority necessary to provide price information to enrollees. Section 1311(e)(3)(C) requires exchange plans to provide the dollar amount that an enrollee would pay for a specific

treatment by a specific in-network provider through a website. Section 2715A extends this requirement to all employer plans. Yet, to date, HHS and the U.S. Department of Labor have not implemented or enforced these requirements.

Specific guidance should require the following information:

- Price information for an entire episode of care, which includes all of the costs of a procedure or treatment, such as the costs of tests, physician fees, medical devices, and facility charges
- Standardized definitions for an episode of care and other terms necessary for consumers to understand the information
- Easy access to information about provider networks and covered medications¹⁵

Test shared decision-making

Shared decision-making uses patient decision aids—including written materials, videos, or interactive electronic tools—to inform patients of the risks and benefits of alternative treatments, which in turn empowers them to make choices that align with their preferences and values. Strong evidence exists that shared decision-making would reduce costs and help patients make choices that reflect their preferences rather than physician payment incentives.¹⁶ The Centers for Medicare and Medicaid Services has authority to rapidly certify patient-decision aids and test their use. CAP recommends a demonstration for orthopedic procedures, which would complement an expansion of the ACE program.

Conclusion

HHS's target date to have 50 percent of Medicare payments made through alternative payment models by 2018 represents a major formal commitment to payment reform. Next, HHS should identify the specific actions it will take to reach this goal. The proposals outlined in this issue brief should serve as next steps for implementing value-based payment reform that will improve patient care while making our nation's health care spending more sustainable for the long term.

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Endnotes

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