42%

CPR SCORECARD ON Medicare Payment Reform

An independent review of Medicare payments, conducted by Catalyst for Payment Reform, revealed that **42 percent** of the fee-for-service (FFS) dollars Medicare paid to health care providers in 2013 were designed to boost the value of care patients receive.

Fifty-eight (58) percent of Medicare payments were through traditional FFS, paying providers for the amount of services they perform regardless of the quality or outcome. CPR did not examine the payment approach taken by Medicare Advantage (MA) plans as information about how these plans pay providers is not readily available.

The use of value-oriented payment is growing rapidly; now we need to determine when and how it improves the quality and affordability of health care.

How Much Has Been Spent on Health Information Technology and Meaningful Use?

CPR categorizes health information (HIT) technology investments as payments for "non-visit functions." Such investments are made to improve health care quality and reduce the fragmentation of care for patients. HIT can help providers to track the data and health records of Medicare beneficiaries. The Electronic Health Record (EHR) Incentive Programs for eligible hospitals and professionals are meant to encourage meaningful use of EHR technology; hospitals and professionals must demonstrate meaningful use and meet all requirements to receive Medicare EHR Incentive Program payments.

$3.6B
in hospital payments in 2013

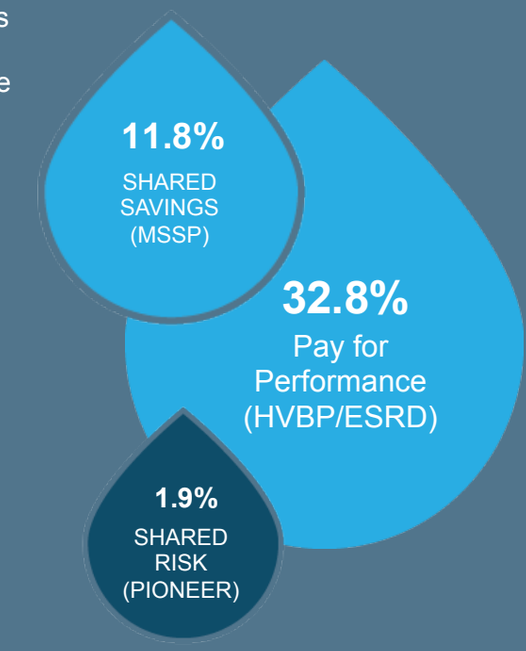
$2.2B
in physician payments in 2013

$19.6B
in total Medicare EHR payments to hospitals and physicians since May 2011

REPRESENTS PAYMENTS THAT DO NOT PUT THE PROVIDER AT FINANCIAL RISK

REPRESENTS PAYMENTS THAT PUT THE PROVIDER AT FINANCIAL RISK

**Overlapping drops represent an overlap in payments. For illustrative purposes only.*



42%
of FFS Medicare payments are value-oriented.*

** The sum of the drops does not equal 42%. The 42% adjusts for any double counting that occur between the various program dollars. See accompanying methodology document for more information.*

CATALYST FOR PAYMENT REFORM
OUR HEALTH CARE SYSTEM NEEDS CPR

Benchmarks for Future Trending

Is Payment Reform Reaching Patients? Attributed Beneficiaries

14.9% MEDICARE BENEFICIARIES

Percent of Medicare FFS beneficiaries attributed to the Medicare Shared Savings Program (MSSP) or Pioneer ACO program in 2013.

Hospital Readmissions

17.9%

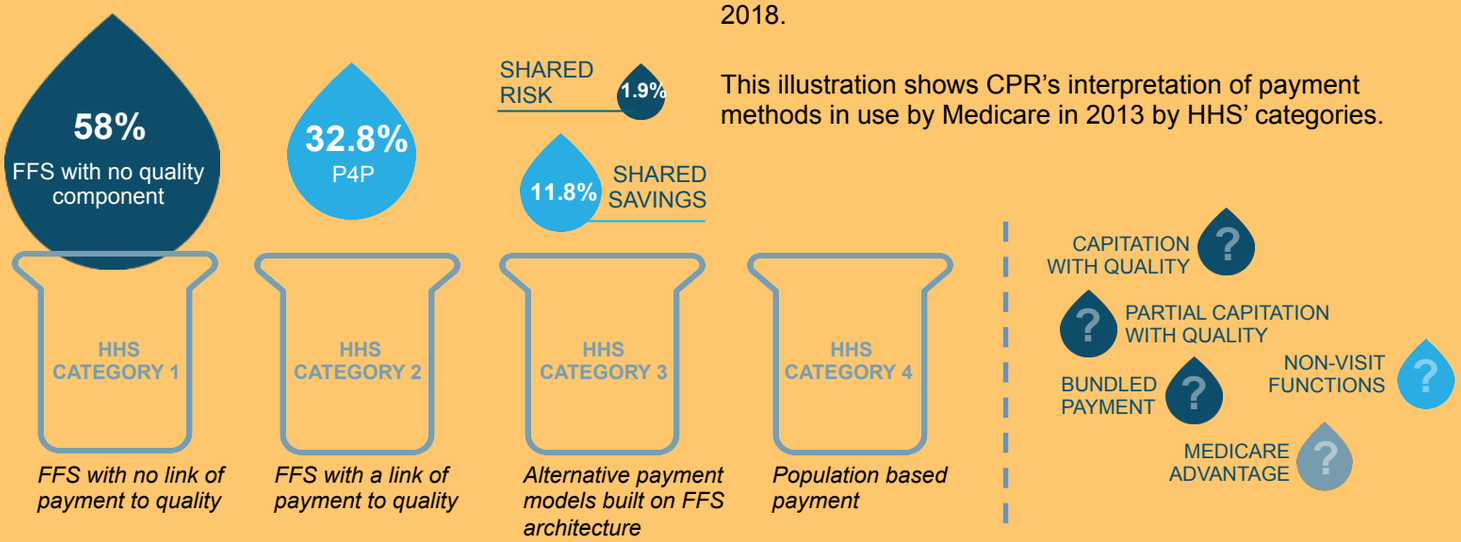
of FFS hospital admissions are readmissions
for any diagnosis within 30 days of discharge, down from 19% in 2011.

High readmission rates can be an indicator of poor quality care. The Affordable Care Act required CMS to reduce payments to certain hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. CPR included this measure as a quality indicator that can be tracked over time as a potential correlate to the changes in payment methods.

In What HHS Categories was FFS Medicare Payment in 2013?

CPR defined a range of value-oriented payment methods in 2012, prior to HHS' announcement of its goals and related categories in early 2015. One goal set by HHS is that 50 percent of traditional Medicare payments will be tied to quality or value through alternative payment models by the end of 2018.

This illustration shows CPR's interpretation of payment methods in use by Medicare in 2013 by HHS' categories.



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