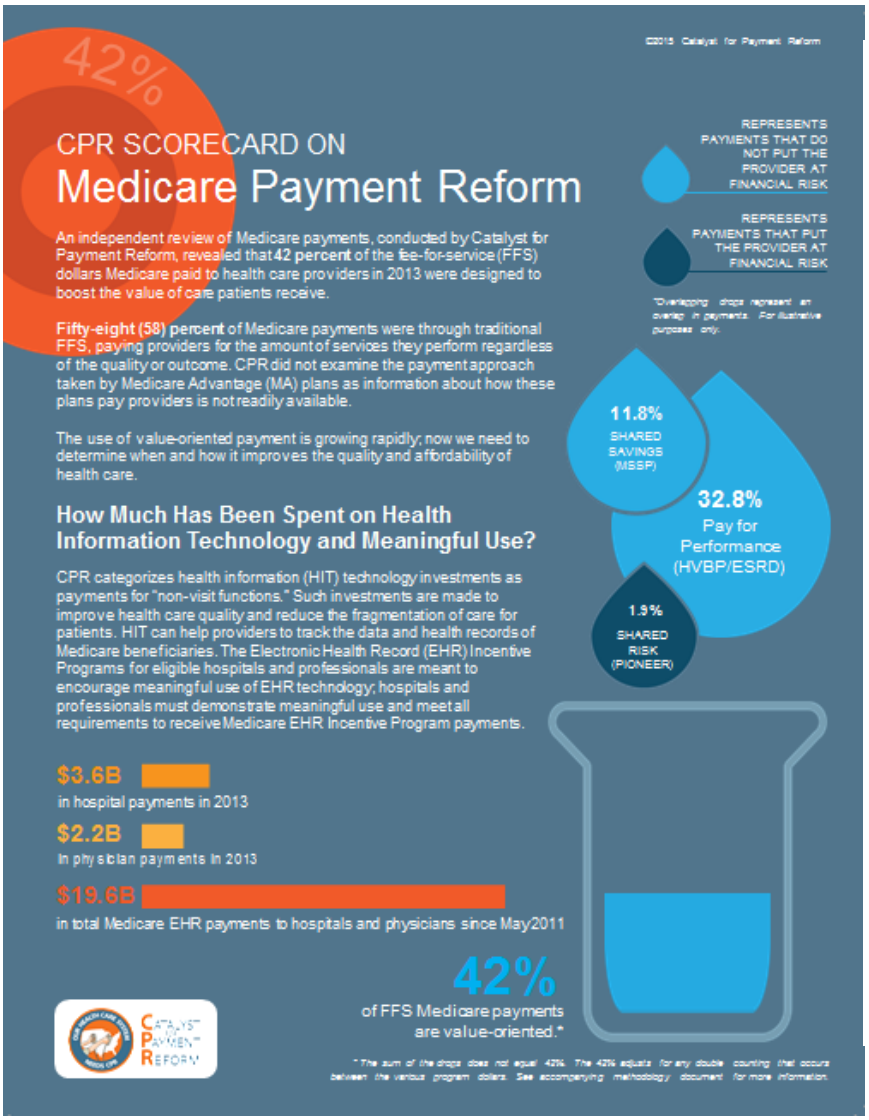
2015 Scorecard on Medicare Payment Reform: Methodology



Background

Payment reform is a powerful strategy to improve the value of health care; thus we need to assure that fundamental and effective changes to payment take hold in both the public and private sectors and expand over time.

Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S. CPR provides thought leadership to and coordination among large health care purchasers, including the large private employers and state Medicaid, employee and retiree agencies in its membership. In 2010, CPR set the goal that by 2020 at least 20 percent of payments to doctors and hospitals would be made through payment methods proven to improve the quality and affordability of health care.

In September 2014, CPR issued its second National Scorecard on Payment Reform and California Scorecard on Payment Reform (the first Scorecards were released in 2013). Through support from The Commonwealth Fund and the California HealthCare Foundation, these Scorecards were the first of their kind in tracking the nation's progress in implementing reforms to health care payment.

CPR's evaluation of payment reform within Medicare started in August of 2014. In late January of 2015, the U.S. Department of Health and Human Services (HHS) announced its goals for tying an increasing proportion of Medicare payments to quality or value over the next several years. CPR welcomes these goals. We hope that we can work together to evaluate which alternative payment models prove to be most effective, and spread those practices as we look to reform payment methods across the country. This report provides a first step by creating a baseline for measuring for progress in Medicare.

It is critical that both the private and public sectors experiment boldly with new methods of payment that move us away from the traditional fee-for-service model, which pays providers for the services they deliver regardless of quality or outcome and neglects to pay for other services that might improve care.

As is the case with all of CPR's Scorecards on Payment Reform, the metrics quantify the dollars paid through various payment methods. The Scorecard metrics do not evaluate whether different payment methods successfully improve quality or reduce costs. In 2014, CPR's National Scorecard on Payment Reform documented that 40 percent of commercial health plan payments were made through payment methods designed to improve quality and reduce waste. uHowever, there must be further evaluation before determining which of these "value-oriented" payment methods truly lead to better, more affordable care.

The Scorecard on Medicare Payment Reform was generously funded by The Commonwealth Fund. CPR contracted with Karen Milgate to assist on this project. We thank her for sharing her expertise on Medicare and helping us navigate the complexities of the Medicare program. CPR also wishes to thank

the Advisory Committee to the Scorecard on Medicare Payment Reform. Advisory Committee members included (in alphabetical order):

- Robert Berenson, Institute Fellow, Health Policy Center, The Urban Institute; former Vice-Chair, Medicare Payment Advisory Commission (MedPAC); former HCFA official
- Kathy Buto, Commissioner, MedPAC; former HCFA official
- Patrick Conway, Deputy Administrator for Innovation & Quality, Chief Medical Officer, Center for Medicare and Medicaid Services (CMS)
- Anna Fallieras, Program Leader, Healthcare Initiatives and Policy, GE; co-founder, CPR
- Stuart Guterman, Vice President, Medicare and Cost Control, The Commonwealth Fund; former CMS official
- Mark McClellan, Director, Health Care Innovation and Value Initiative, The Brookings Institution; former Administrator, CMS
- Mark Miller, Executive Director, MedPAC; former HCFA official

The 2015 Scorecard is the most comprehensive and current snapshot of Medicare payment reform activity. This document describes the methodology of the underlying research project, entitled "Tracking Medicare's Progress on Payment Reform."

General Methodology

General Description of Scorecard Domains and Metrics:

During 2012 and 2013, CPR assembled a multi-stakeholder National Advisory Committee, including employers, health plans, providers and payment reform experts, to provide guidance to CPR on the scope and definition of payment reform, and on what metrics would track the implementation of payment reform (see page 8).

For the purposes of this, and all other Scorecards published by CPR to date (e.g. National, California, New York commercial, New York Medicaid), CPR defines payment reform as *"a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers."* CPR defines value-oriented payment as *"payment that reflects the performance (especially the quality and safety) of care that providers deliver; payment methods that are designed to spur efficiency and reduce unnecessary spending. If a payment method only addresses efficiency, it is not considered value-oriented. It must include a quality component."*

The metrics developed by CPR with input from the National Advisory Committee fell into six domains. However, two domains developed by CPR and the National Advisory Committee were not applicable to evaluating payment reform in the Medicare program.[1] As such, the focus of the Scorecard on Medicare Payment Reform centers on the following four domains:

1) Public Dollars Paid – Reports the total dollars paid to providers through Medicare programs. The total dollars paid to providers on behalf of Medicare beneficiaries in the fee-for-service (FFS) program provides the denominator for Domain 2.
2) Characteristics of the Payment Reform Environment – These metrics measure traditional forms of payment, including fee-for-service and other payment methods that do not include incentives to increase value (quality or cost), as well as payment reform methods, such as pay for performance, shared savings, shared risk, capitation, bundled payment, and others that include quality.
3) Medicare Beneficiaries Attributed to ACOs – This metric measures the number of Medicare beneficiaries attributed to a Medicare-sponsored accountable care organization (ACO) program in which participating providers are accountable for the health care for specific Medicare beneficiaries.
4) Quality Indicator – The all-cause readmissions measure is an indicator of both quality and efficiency that the Scorecard can track over time as a potential correlate to the changes in payment methods.

[1] The two domains CPR excluded from the Scorecard on Medicare Payment Reform were: 1) Provider Participation – metrics showing the proportion of payments made to hospitals and physicians in the outpatient setting that are value-oriented; and 2) Building Blocks of Payment Reform – metrics on consumer transparency tools. CPR excluded the provider participation metrics due to a lack of publicly available information with the necessary proportional breakdown. CPR excluded the transparency metrics because, while Medicare offers quality comparison and drug pricing tools, shopping for health care based on price is not as applicable to Medicare beneficiaries as it is to commercial plan members who are subject to various and more significant cost sharing arrangements.

Scope:

For the purposes of the Scorecard on Medicare Payment Reform, there are three areas of Medicare spending that CPR determined to be out of scope. They are:

1. Medicare Advantage (MA): CMS provides payments to health plans through a capitated per beneficiary per month model for beneficiaries who choose this option. Approximately 30 percent of Medicare beneficiaries are enrolled in MA plans. These payments vary by geography and by each MA plan's Star rating, which is a composite of a variety of quality measures. While the payment CMS makes to MA plans is "capitation," and the amount varies based on each MA plan's performance on quality metrics, the Scorecard measures value-oriented payments to providers. After interviews with experts on Medicare Advantage plans and evaluating existing data, CPR could not make reasonable assumptions about how MA plans contract with participating Medicare providers. Without data from MA plans on how they pay Medicare providers, CPR opted not to include Medicare Advantage spending in the Scorecard. MA data could easily be added to a future Scorecard if there is a mechanism for gathering that information from MA plans.
2. Part D: CPR determined that Medicare Part D (prescription drug) spending should be outside the scope of this project for two reasons. First, CPR did not include prescription drug spending in its National Scorecard on Payment Reform. From a methodological standpoint, this allows for greater consistency between the two scorecards. Second, there were no value-based payment initiatives implemented in Part D in 2013. It is possible that CPR could include Part D in future years, but it would require significant analysis about how value-oriented payments are made. For instance, are the value-oriented payments made to the plan, the pharmacy benefit manager (PBM), the pharmacist or the pharmacy?
3. Pay for Reporting: Given the Scorecard's focus on the methods with which Medicare pays providers for delivering health care, CPR does not consider payments to providers for reporting their performance to be value-oriented payments, per se.

Data Sources and Data Collection Method:

CPR collected data for the Scorecard on Medicare Payment Reform from public data sources and asked subject matter experts at the Centers for Medicare and Medicaid Services (CMS) and, particularly, in the Center for Medicare and Medicaid Innovation (CMMI) both to verify our findings and to provide additional data directly.

To collect the data, CPR:

1. Researched CMS programs and CMMI demonstrations and developed a comprehensive list of all programs.
2. Determined whether the payment mechanism of the program or demonstration was "value-oriented," based on its definition.

3. Determined whether the value-oriented programs were active during the data collection year (2013). If the program was planned or in the implementation phase, but CMS had not paid providers through the program in 2013, CPR did not include it.
4. Categorized each program and demonstration into CPR's payment reform categories. Definitions of these categories are at the end of this document.
5. Researched whether there was publicly available information on the dollars paid to providers through the programs or demonstrations that were active in 2013.
    - CPR either used actual dollars paid as publicly reported; or
    - CPR calculated the dollars paid using publicly available sources whenever possible and had CMS/CMMI verify the calculations. In some instances, CMS/CMMI provided data to CPR directly.

Data Analysis:

For calendar year 2013, CPR determined there were primarily six active programs or demonstrations with payment methods that meet CPR's definition of value-oriented:

1) Hospital Value Based Purchasing (HVBP);
2) End Stage Renal Disease (ESRD) Quality Incentive Program (QIP);
3) Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs);
4) Medicare Pioneer ACO;
5) Electronic Health Record Incentive Payments for Eligible Hospitals; and,
6) Electronic Health Record Incentive Payments for Eligible Professionals.[2]

CMS was also active in many other quality improvement activities that did not utilize payment incentives, such as the Partnership for Patients, the Quality Improvement Organization program, and other provider-specific efforts.

The value-oriented payment information CPR collected represents the *total* dollars paid through payment reform programs, not just the incentive portion of the payment when quality and efficiency measures are met. See Scorecard Metrics Methodology for additional information.

Limitations:

1) Potential double counting of Medicare dollars: A percentage of Medicare's HVBP and ESRD QIP program bonus or incentive dollars go to facilities that see beneficiaries that may be aligned with or "attributed to" other innovations, such as the MSSP and Pioneer ACO programs. Therefore, dollars paid through HVBP and alternative payment models could be inadvertently counted twice. Without data suggesting otherwise, it is reasonable to assume that the proportion of hospital/ESRD value-oriented payment spending in the general Medicare population is similar to the proportion of hospital/ESRD spending in an alternative payment model. To avoid the issue of double counting, CPR assumed that the percentage of per capita spending for hospitals and dialysis facilities in ACO populations is comparable to the general FFS

[2] Items five and six are not funded by Medicare. They are included in the scope of this project as a way to highlight non-visit incentive payments that are intended to improve quality.

population. Using this assumption, CPR discounted the dollars going to the MSSP and Pioneer programs by the percentage of payments that go to hospitals and dialysis facilities in the value-based purchasing programs. See Metric Methodology for additional detail.

2) Post-Acute Care: Post-acute care accounts for a large portion of Medicare spending. While several post-acute care settings have well-defined quality metrics that are publicly reported, Medicare did not make any value-based payments to post-acute care programs in 2013. To the extent that Medicare extends its payment reform efforts to post-acute care in the future, CPR could include them in the calculations.

3) CMMI Innovations/Demonstrations: While information related to program administrative expenses is available, it is challenging to obtain information on dollars spent through CMMI, such as the Bundled Payment for Care Improvement (BPCI) initiative. Very few CMMI demonstrations or innovations made payments to providers in 2013, and thus would have accounted for a small percentage of Medicare's overall value-oriented payment. The exception is the Pioneer ACO CMMI model, which CPR included alongside the MSSP ACO model. For more information on CMMI Innovations/Demonstrations, please see CMMI's Report to Congress.

The Future of Payment Reform in Medicare:

Unlike the commercial market, the public has some line of sight into the future of payment reform in the Medicare program. CMS and CMMI have developed payment reforms and/or initiatives and demonstrations that are either in active implementation or scheduled to be implemented by Medicare in future years. Many are models that meet CPR's definition of value-oriented and may be included in future analyses. One such reform is the Physician Value-Based Payment Modifier (VBM), which will be folded into the Merit-Based Incentive Payment System (MIPS), beginning in 2019. The MIPS was established by Congress in HR. 2, the Medicare Access and CHIP Reauthorization Act of 2015. Under MIP, the EHR incentive program, the VBM and metrics of resource use will all be merged into one program that varies payment for eligible professionals based on their performance on quality and resource use metrics. The legislation also provides financial incentives for participation in alternative payment mechanisms that go beyond the pay-for-performance program established in MIPs.

CMMI is also implementing a variety of models that incorporate payment incentives for quality improvements. Some examples include the Comprehensive Primary Care (CPC) initiative which uses both a care management fee and shared savings as incentives for improved quality through patient-centered medical homes, and the Bundled Payment for Care Improvement (BPCI) model which uses bundled payments to encourage better coordination around a hospital stay. CMMI is also testing new approaches to shared savings and shared risk through new ACO models – Next Generation ACO and ACO Investment models – that could improve the effectiveness of the CMS's ACO programs. As we look ahead to the future of Medicare's value-oriented payments, more payment reforms are in the pipeline.

Metric Methodology
Detail, Sources, and Results

Metric	Numerator Denominator	Numerator Figure (in billions) and Sources Denominator Figure (in billions) and Sources	Results
1. Total dollars paid to providers through pay-for-performance (P4P)[3] programs in 2013.	Total dollars paid to providers through FFS plus P4P programs in 2013.	$109.5 HVBP Geographic Variation Public Use File 2013 + $8.5 ESRD Geographic Variation Public Use File 2013 $109.5 + $8.5 = $118.	**32.8%**
	Total FFS dollars paid to providers for Medicare beneficiaries in 2013.	$360[4]. 2014 Trustees Report Table II.B1.	
2. Total dollars paid to providers through shared-risk programs with quality components in 2013.	Total dollars paid to providers through shared-risk programs with quality components in 2013 (Pioneer ACO program).	$7.1. Medicare Pioneer ACO Model Performance Year 1 and Performance Year 2 Financial Results and CMS directly[5].	**1.9%**
	Total FFS dollars paid to providers for Medicare beneficiaries in 2013.	$360. 2014 Trustees Report Table II.B1.	
3. Total dollars paid to providers through shared-savings programs with quality	Total dollars paid to providers through shared-savings programs with quality components in 2013 (MSSP).	$42.3. Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results[6].	**11.8%**

[3] The federal statute and CMS refer to this as "value-based purchasing."
[4] Does not include $8 billion in Medicare federal administrative costs.
[5] The Medicare Pioneer ACO Model Performance Year 1 and Year 2 Financial Results provide information for 20 of 23 Pioneer ACOs. CMMI provided information for the remaining 3 participating ACOs. CMMI provided $7.05 billion as the total expenditures. CPR rounded this to $7.1 billion. Rounding did not change the percentage of value-oriented payment.
[6] CPR calculation derived from CMS 2013 data, which includes some 2012 expenditures for ACOs that started in 2012.

components in 2013.	Total FFS dollars paid to providers for Medicare beneficiaries in 2013.	$360. 2014 Trustees Report Table II.B1.	
4. Total dollars paid to providers through shared risk and shared savings programs in 2013. *Discounted for HVBP/ESRD payments to remove double counting.*	Total dollars paid to providers through shared risk and shared savings programs with quality components in 2013, discounted for HBVP/ESRD payments of 32.8%.[7]	$7.1 Pioneer + $42.3 MSSP = $49.5 Pioneer ACO Results, MSSP ACO Results and CMS directly. $49.5 * 0.672 = $33.3	**Not a stand-alone metric. Calculation is used to determine part of the numerator for Metric 5.**
5. Total Value-oriented Payments in Medicare (HVBP, ESRD, Shared Risk or Shared Savings).	Total dollars paid to providers through FFS plus P4P plus through shared risk and shared savings programs with quality components in 2013, credited for HBVP/ESRD payments of 32.8%.	$109.5 HVBP Geographic Variation Public Use File 2013 + $8.5 ESRD Geographic Variation Public Use File 2013 = $118. $33.3 for discounted shared risk/shared savings (calculation in 4). Pioneer ACO Results, MSSP ACO Results and CMS directly. $118 + $33.3 = $151.3	**42%**
	Total FFS dollars paid to providers for Medicare beneficiaries in 2013.	$360. 2014 Trustees Report Table II.B1.	
6. Total dollars paid to providers through traditional FFS with no quality component in	Total dollars paid to providers through FFS with no quality component.	$360 (FFS A+B) - $151.3 (Discounted HVBP/ESRD + shared risk and shared savings) = $208.7 Calculations using sources from metric 5.	**58%**

[7] Total dollars paid to hospitals and dialysis facilities for value-based payments equal $118 (109.5 + 8.5). This represents 32.8 percent of all FFS dollars ($118/360). See Metric 1. We assume that the percentage of per capita spending for hospitals and dialysis facilities in the ACO populations is comparable to the general FFS population. Therefore, we discount the total dollars going to the ACOs by 32.8 percent.

2013.	Total FFS dollars paid to providers for Medicare beneficiaries in 2013.	$360. 2014 Trustees Report Table II.B1.	
7. Total dollars paid for non-visit functions (see definitions for examples) in 2013.	Total dollars paid for non-visit functions in 2013 (includes HIT/MU spending).	Hospital = $3.6 Physician = $2.2 Program-to-Date Total = $19.6 Medicare Incentive Payments.	**Hospital = $3.6 billion Physician = $2.2 billion Program-to-Date Total = $19.6 billion**
	N/A. Not using Medicare denominator as Medicare funds did not finance the HIT-MU payments.		
8. Provide the total number of non-MA Medicare beneficiaries attributed to a provider in an ACO.	Total number of non-MA Medicare beneficiaries assigned to or attributed to a provider in an ACO.	Total beneficiaries in Pioneer or MSSP = 5.6 million beneficiaries. 09/14 Press release: Medicare ACOs continue to succeed in improving care, lowering cost growth.	**14.9%**
	Number of beneficiaries in FFS Medicare in 2013.	37.7 million total beneficiaries. 52.3 million total beneficiaries in all of Medicare; 28 percent of Medicare beneficiaries were in MA plans in 2013. 52.3 * 0.72 = 37.7 beneficiaries 2014 Medicare Trustees Report.	
9. 2013 Medicare 30-day all cause readmission rate as calculated and reported by CMS.		CMS Presentation. Publicly reported data.	**17.9%**[8]

[8] From 2007-2011, the rate was approximately 19 percent. It was approximately 18.5 percent in 2012. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

Definitions for the 2015 Scorecard on Medicare Payment Reform

Terms	Definition
Attribution	Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purpose of calculating health care costs/savings or quality of care scores for that population. "Attributed" patients can include those who choose to enroll in, or do not opt-out-of, an accountable care organization (ACO), patient centered medical home (PCMH), or other delivery models in which patients are attributed to a provider with a payment reform contract. For the purpose of CPR's Scorecard on Medicare Payment Reform, attribution includes Medicare beneficiaries attributed to providers participating in the Pioneer or MSSP ACO programs.
Bonus payments based on measures of quality and/or efficiency	Payments made that reward providers for performance in quality and/or efficiency relative to predetermined benchmarks, such as meeting pre-established performance targets, demonstrating improved performance, or performing better than peers. Bonus payments can include programs that pay providers lump sum payments for achieving performance targets (quality and/or efficiency metrics). Bonus payments can also include payments tied to a provider's annual percentage increase in FFS payments based on their achievement of performance metrics. Bonus payments do NOT include payments made under shared savings arrangements that give providers an increased share of the savings based on performance.
Bundled payment	Also known as "episode-based payment," bundled payment means a single payment to providers or healthcare facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.
Dollars paid	Claims and incentives that were paid to providers (including individual physicians, IPAs, medical groups, and/or inpatient and outpatient facilities) for services delivered to health plan participants in the past year, during the 12 month reporting period, regardless of the time period when the claim or incentive payment was/is due (i.e., regardless of when the claim was received or when the service was rendered or period when performance was measured). For example, incentive payments that were paid in calendar year 2013 for the performance in a different calendar year should be reported. Claims for 2013 services that are in adjudication and not yet paid during the reporting period should not be included.
Episode-based payment	See definition for "bundled payment."
FFS-based payment	Payment model where providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. For the purposes of the CPR Scorecard, DRGs, case rates, and per diem hospital payments are considered FFS-based payment.
Medicare Beneficiary	A person who has health care insurance through the Medicare program.
Non-visit function	Includes but is not limited to payment for outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists.
Past year (in definition for dollars paid)	Means calendar year 2013 or the most current 12 month period for which payment information can be reported. See also definition of "reporting period."
Pay-for-performance	Provides incentives (typically financial) to providers to achieve improved performance by increasing the quality of care and potentially also for reducing costs. Incentives are typically paid on top of fee-for-service payments. The financial incentive payment that is given for achieving certain performance levels is sometimes also referred to as a bonus payment. See "bonus payment" definition.
Payment reform	Refers to a range of health care payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.
Primary care physicians	A primary care physician is a generalist physician who provides care to patients at the point of first contact and takes continuing responsibility for managing the patient's care. Such a physician must have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. For the purposes of this data collection, PCPs are not specialists. See definition of "specialists."

Primary care services	Refers to the services a patient receives at first contact with the health care system, usually involving coordination of care and continuity across providers and settings over time. Primary care services include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care services are performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. There are providers of health care other than physicians who render some primary care services; such as nurse practitioners, physician assistants and some other health care providers. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services and involves effective communication with patients and encourages the role of the patient as a partner in health care.
Providers	Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities, including ancillary providers.
Quality/quality components	The component of a payment reform program that incentivizes, requires, or rewards the provision of safe, timely, patient centered, effective, efficient, and/or equitable health care.
Shared risk	Refers to arrangements in which providers accept some financial liability for not meeting specified financial targets. It may also include arrangements in which providers accept some financial liability for not meeting specified quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; and, withholds that are retained and adjustments to fee schedules. For the purposes of this data collection, shared-risk programs that include shared-savings as well as downside risk should only be included in the shared-risk category. Shared-risk programs are based on a FFS payment system and for the purposes of the CPR Scorecard, shared risk does not include bundled payment, full capitation, or partial or condition-specific capitation.
Shared savings	Provides an upside-only financial incentive for providers or provider entities to reduce health care spending, ideally unnecessary spending, for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings. It may also include arrangements in which providers may share in savings only after meeting specified quality targets. "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared-savings programs can be based on a FFS payment system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and will vary based on provider performance.
Specialists	Specialist physicians have a recognized expertise in a specific area of medicine. They have undergone formal residency and/or fellowship training programs and have passed the specialty board examination in that field. Examples include oncologists, ENTs, cardiologists, OB-GYNs, etc. For the purposes of this data collection, specialists are not PCPs. See definition of "primary care physicians."