

Suggestions for RFA Components

Rationale/Background

- The three-part aim of better health, better health care, and reduced expenditures through continuous improvement for Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries will optimally be achieved through aligned financial incentives to support transformational health care change.
- To achieve the congressional charge of the Center for Innovation and improve health care quality (for Medicaid, Medicare, and SCHIP beneficiaries), reform must attempt to involve as many payors as possible to align financial incentives for change.
- Under Section 1115A of the Social Security Act, the Center for Medicare and Medicaid Innovation (Innovation Center) is authorized to test innovative payment and service delivery models that have the potential to reduce program expenditures while maintaining or improving the quality of care for beneficiaries.
- Opportunities exist for state Medicaid programs to partner with CMS on behalf of Medicare beneficiaries and/or private sector insurers to achieve coordination of incentives to transform the delivery system.
- “Bundled” payment approaches, which would combine payment for physician, hospital, and other provider services into a single **bundled payment** of a predetermined amount for all services furnished to a beneficiary during an episode of care, have been advocated as a way of aligning provider incentives with three-part aim outcomes.
- States are uniquely positioned to convene payor strategies to develop, test, and deploy bundled payment strategies in coordination with Medicare and/or private payor entities.

Goals and Objectives

- Design a strategy to create broad-scale lasting changes that effects Medicare, Medicaid, and third-party payors.
- Create partnerships between states, payors and CMS to create statewide system changes for payment design and exploration.
- Support and encourage providers who are interested in continuously reengineering care to deliver three-part aim outcomes.
- Create a virtuous cycle that leads to continually decreasing the cost of an acute or chronic episode of care while fostering quality improvement.
- Develop and test payment models that create extended accountability for three-part aim outcomes for acute and chronic medical care.
- Shorten the cycle time for adoption of evidence-based care.
- Create environments that stimulate rapid development of new evidence-based knowledge – the Learning Health Care System.

General Approach

CMS has already released an RFA seeking applications from **providers** in the following four broad categories of models:

Model 1: Retrospective payment models for the acute inpatient hospital stay only.

Model 2: Retrospective bundled payment models for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.

Model 3: Retrospective bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay.

Model 4: Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only.

Another method for developing financial incentives and transforming health care payments is to consider supporting applications from **payors**, inclusive of the **state**, building off of the previous models proposed. In this method, the applicant, in combination with Medicare and/or private sector payors, can examine health care system performance and identify opportunities to transform systems from care delivery models reliant on fee-for-service volume to models more focused on optimizing outcomes of care. Through coordinated financial signals, this method of developing payment strategies is expected to include care redesign and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination.

CMS has articulated a vision for the right care for every person every time through CMS' three-part aim – better health care for individuals, better health for populations, and reduced expenditures. CMS seeks to achieve this by being a major force and trustworthy partner for the continual improvement of health and health care for all Americans. As part of its Bundled Payments for Care Improvement initiative, CMS should be open to strategies that fit within these categories, and to partnering with payors working in different market and organizational contexts. CMS should seek to support transformational change that encourages providers to reengineer care and deliver three-part aim outcomes, creating a virtuous cycle that leads to continual decreases in the cost of delivering episodes of care and improving quality of care, and creating environments that stimulate rapid development of new evidence-based knowledge as a Learning Health Care System.

This solicitation could seek innovative proposals that will build on the success of previous CMS demonstrations and private sector initiatives. Through this support, CMS could seek proposals that:

- involve states as fiduciary agents for Medicaid and SCHIP programs;
- affect broad categories of conditions;
- reach many beneficiaries;
- offer significant savings to Medicare and states;
- are designed to be scalable and replicable by similar health systems around the country;
- already or could rapidly involve participation by other payors; and
- are able to be implemented on aggressive timelines.

This model, based upon payor leadership, could encompass existing models #1–3 and proposed models #5–8 of the existing RFA (Bundled Payments for Care Improvement Initiative). In addition, Medicaid in partnership with Medicare could consider long-term care and social support components of the delivery system for transformational change.

Eligibility Requirements

Eligible Entities

States or sub-state geopolitical entities responsible for Medicaid and/or SCHIP eligible programs should be deemed eligible to apply. Requirements should include demonstrated commitment to collaborate with Medicare and/or private sector payors representing a majority of privately covered lives in the geopolitical region. Political and/or corporate commitment and stability should be demonstrated.

Preferred Applicant Criteria

Applicants with the following should be preferred:

- Available data and empiric analytic capacity
- Proposals that involve Medicare in payment reform
- Development of models that can be broadly adopted universally by all providers in private, Medicare, and Medicaid
- Models that define and require state commitment, e.g., descriptions of how state Medicaid programs will change to conform to payment strategy; state commitment to convene, coordinate and engage private insurers and Medicare

Payor-Led Development of Model Payment Strategies

Through a combination of payor knowledge regarding system performance, provider engagement to achieve enhanced efficiency, and consumer interest in quality outcomes, an opportunity exists to combine units of care currently paid as fee for service into episodes of treatment with aligned incentives to achieve high-quality, coordinated, efficient care. Development, definition, and evaluation of these episodes across multiple payors are necessary to avoid consumer access barriers, provider network disruption, or cost shifting between payor groups.

Bundled Payment Model

Key considerations for development of multi-payor bundled payment strategies include the following:

- Magnitude and cost of conditions
- Potential inefficiencies and/or gaps in quality care
- Variability in delivery system practice
- Opportunities for improved care coordination and/or clinical best practices
- Impact on clinical providers
- Opportunities for patient engagement in care management
- Requirements for information technology adoption
- Clinical provider availability across proposed geographic area
- Ability to risk stratify for episode determination and/or risk adjust for payment adjudication
- Payment strategy (retrospective, prospective) and impact on gainsharing

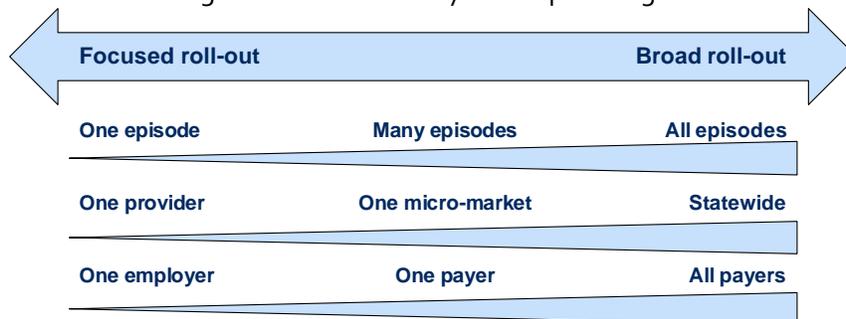
While health system transformation will likely be optimized through multi-payor participation, allocation and distribution of gainsharing between payors, patients, and consumers requires modeling the business impact of proposed changes from multiple perspectives. We propose a gainsharing strategy between Medicaid and Medicare to be developed, proposed, and approved by both. If private

payors participate, gainsharing should extend to both the private payors and beneficiary. Alternative gainsharing strategies could be explored.

Roll-out and Scale-up Options

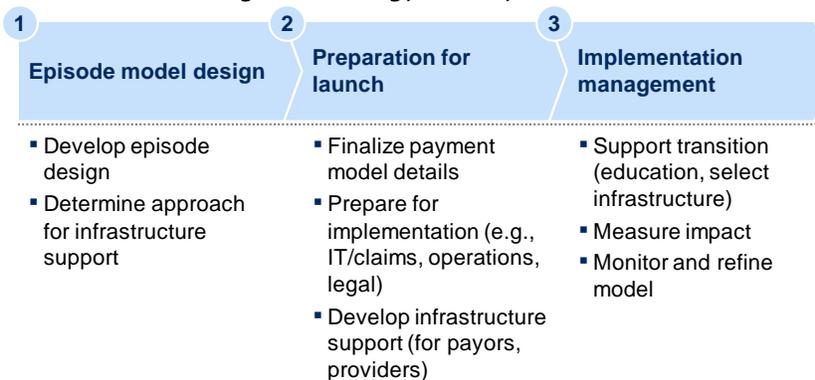
Range of Options

Applicants can consider a range of strategies from focused roll-out of one bundled-payment episode at a time to a broad roll-out of bundled payments that cover all episodes. This continuum applies to providers and payors as well as shown in the illustration below. Applicants should consider various benefits and risks for where along this continuum they develop strategies.



Development and Implementation Phases

Applicants could consider various stages of strategy development as shown below.



Sequenced Roll-out

Based upon the applicants' selection of one or more episodes, providers, or payor, staged approaches involving multiple waves of roll outs are possible.

Evaluation

An evaluation of lessons learned will be ongoing; including, quality improvement strategies, clinical outcomes and an estimate of the health care costs avoided through use of this new payment approach and used to inform continued work.

Requirements of CMS

For all-payor bundled payment strategies to be successful, CMS support and engagement will be required in one or more of the following ways:

- Data availability and support to create multi-payor datasets to use in health care system assessment and episode-related bundled payment development
- Analytic support to evaluate alternative episode-based bundled payment strategies; assess potential opportunities and risk; and analyze clinical and financial impact on consumers, clinical providers, and payors
- Available expertise from within CMS, its congressionally authorized institutions (e.g., MEDPAC), and subcontractors who could inform bundled payment episode development
- Visible engagement and partnership of CMS with states undertaking payor-led transformational strategies
- Significant financial support from congressionally authorized funds of the Center for Medicare and Medicaid Innovation
- Convening of national panels to share learning opportunities, assure consumer and provider engagement, and generate additional payor involvement
- Development of a collaborative waiver process with multi-payor demonstration projects, inclusive of Medicaid, Medicare, and/or SCHIP

Activities and Funding Needs

Activities required for roll-out of episode model are as follows:

- Research and design—Development of episode payment model and pricing mechanisms
- Analytics—Application of grouper technology to claims data and analyses to inform episode model design
- Evaluation/ refinement of episodes—Monitor episode performance and develop model refinements as needed
- Provider transition support—Provide support to providers (e.g., clinical infrastructure, other transition costs); not gain-sharing
- Payor infrastructure—Develop and sustain claims, IT, informatics, and other operations infrastructure
- Stakeholder engagement—Engage and gather input from patients, providers, and others

Funding is needed to support the following:

- Hire additional state staff capacity
- Contract with local organizations/providers
- Contract with 3rd parties (e.g., market research vendors, data vendors, consultants)
- Obtain data technology subscriptions

Costs to be covered through the RFA should include the following expense categories:

- Infrastructure development but not gainsharing
- Provider support costs (e.g., business models)
- Support for transition of practices

Suggested funding components

We anticipate that for successful system transformation a successful initiation followed by a longer term implementation strategy is required. Our experience suggests that four phases are required and include: conceptual design, planning, implementation, operational support. As described “waves” of implementation are the approach we believe most likely to be successful.

Support for a multi-payor perspective is necessary to include specific activities not currently conducted in the day-to-day operations of public and/or private sector programs. We anticipate that transformation of a state or geopolitical unit would take up to 5 years and cost approximately 1% of the state expenditure on health care. This 1% expenditure (of both public and private funds) will result in a bending of the cost curve and avoidance of future cost growth attributed to fragmented, volume-based reimbursement.

To support Medicaid, SCHIP, and Medicare payment reform and system transformation, we suggest a federal support level to states of \$30-100m over a 3-5 year period - depending on the size of the state initiative or other factors. This funding could be split into planning and implementation phases. However, in wave roll-out as described within this document, once implementation of Wave 1 was initiated, planning and development of subsequent waves should be included within implementation funding. Deliverables and monitoring should be included and consist of proposed payment reform strategies for public review and adoption by non-funded entities.

With respect to considered of distribution of funds, we believe the following to be critical components:

Public and provider engagement (5-15%): transformation of the magnitude proposed requires consumer and provider engagement with public processes for information, development, and support.

Implementation set-up and transition (15-25%): development of "smart" management systems will be required to support management of "episodes" with appropriate risk-adjustment and adjudication mechanisms. Through a multi-payor approach, we anticipate a public-private sector partnership to optimize the success and acceleration of system transformation.

Provider support and utility development (30-50%): system transformation linked to payment reform will require development of new capacity within provider networks (e.g., accountability systems) and likely will require development of provider systems (e.g., disease registries, etc.) to support optimal quality.

Research design and analytic support (20-30%): development of episode payment model and pricing mechanisms, application of grouper technology to claims data and analyses to inform episode model design.

Data management and surveillance (5-15%): development and maintenance of an all-payor database, combined with quality metrics, and surveillance activities is required to guide program development and monitor for system impact.

Additional components may be identified as experience dictates. We would anticipate no more than 5-10% being considered in the conceptual design and planning phase, with the majority of funding being associated with implementation and operational support.