Healthcare Payment Framework Summary

The U.S. Department of Health and Human Services (HHS) has adopted a framework that categorizes healthcare reimbursement according to how providers receive payment to provide care.

CMS introduced the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which transitions physicians and practices from a strictly fee-for-service payment structure (Category 1) to value-based models (Categories 2-3).

Category 1
Fee for Service –
No Link to Quality & Value

Payments based on volume of services and not linked to quality or efficiency.

Category 2
Fee for Service –
Link to Quality & Value

At least a portion of payments vary based on the quality or efficiency of healthcare delivery.

Category 3
APMs Built on
Fee-for-Service Architecture

Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.

Category 4
Population-Based
Payment

Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 year).

For example

Traditional commercial insurance and previous Medicare reimbursement strategies

Physicians may choose from two Quality Payment Program options, under MACRA, to derive their Medicare payments

Integration between plan and provider group

1. Merit-based Incentive Payment System (MIPS)

- Provider groups will earn a performance-based payment adjustment to their Medicare payment.
- Payment adjustment is based on evidence-based and practice-specific quality data in the following areas: Quality, Improvement Activities, Advancing Care Information, and Cost

2. Advanced Alternative Payment Models (APMs):

- A payment approach that gives added incentive payments to provide high quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- **Advanced APMs** are a subset of APMs that let practices earn more for taking on some risk related to their patients' outcomes.
  - o Oncology Care Model (OCM)

Sources:

HCP LAN Health Care Payment Learning & Action Network
Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group White Paper (2016)
https://hcp-lan.org/workproducts/apm-whitepaper.pdf

Centers for Medicare & Medicaid Services (CMS)
Quality Payment Program

Glossary of Commonly Used Terms

ACA Affordable Care Act of 2010
The comprehensive healthcare reform law enacted in March 2010 (also known as ACA, PPACA, or "Obamacare"). (3)

ACO Accountable Care Organization
A network of healthcare providers that band together to provide the full continuum of healthcare services for patients. The network would receive a payment for all care provided to a patient and would be held accountable for the quality and cost of care. (1)

APMs Alternative Payment Models
An **APM** is a payment approach that gives added incentive payments to provide high quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population. (2)
Advanced APMs are a subset of APMs that let practices earn more for taking on some risk related to their patients' outcomes. Practices may earn an incentive payment by going further in improving patient care and taking on risk through an Advanced APM. (2)

CMS Centers for Medicare & Medicaid Services
The federal agency that runs Medicare (age 65+), Medicaid (disability & low income), **Children's Health Insurance Programs (CHIP)** and the federally facilitated Marketplace. The federal agency that oversees CMS is the **Department of Health & Human Services (HHS).** (3)

Fee-For-Service
A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits. (3)

MACRA Medicare Access & CHIP Reauthorization Act
The final rule from 2016 sets out the standards for participation in the **Quality Payment Program (QPP)**, a new initiative that creates two value-based payment programs for physician reimbursement: MIPS or Advanced APM. (5)

Medical Home
A healthcare setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary and tertiary care; and have access to linguistically and culturally appropriate care. (1)

MIPS Merit-based Incentive Payment System
MACRA established **MIPS** as Medicare's default physician payment system. MIPS maintains the current fee-for-service construct for physician payment but will assess physicians on their performance across four performance categories and provide positive or negative payment adjustments based on performance relative to other professionals. (5)

OCM Oncology Care Model
CMS Innovation Center is developing new payment and delivery models designed to improve the effectiveness and efficiency of specialty care. Among those specialty models is the Oncology Care Model, which aims to provide higher quality and more highly coordinated oncology care at the same or lower cost to Medicare. (6)

OMH Oncology Medical Home
Two organizations: **The American Society of Clinical Oncology (ASCO)** and Innovative Oncology Business Solutions formed a collaboration called ASCO COME HOME, an oncology medical home program designed to transition community oncology practices from volume-based to value-based care by structuring reimbursement around the full range of services needed by patients with cancer. (4)

Pay for Performance
A healthcare payment system in which providers receive incentives for meeting or exceeding quality – and sometimes cost - benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time. (1)

Payment Bundling
A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. (1)

QOPI Quality Oncology Practice Initiative
ASCO's oncologist-led, practice-based quality assessment program designed to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. (4)

VBP Value-Based Purchasing
Linking provider payments to improved performance by healthcare providers. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers. (3)

(1) Kaiser Health Reform Glossary. Kaiser Family Foundation. http://kff.org/glossary/health-reform-glossary/. **(2)** Quality Payment Program: How do I Participate in alternative Payment Models? Centers for Medicare & Medicaid Services (CMS). https://qpp.cms.gov/learn/apms. **(3)** HealthCare.gov: Glossary. https://www.healthcare.gov/glossary/. **(4)** ASCO Launches COME HOME Initiative to Give Oncology Practices Concrete Path toward Alternative Payment System. ASCO. http://www.asco.org/about-asco/press-center/news-releases/asco-launches-come-home-initiative-give-oncology-practices. **(5)** Summary of the MACRA Final Rule with Comment Period. ASCO. http://www.asco.org/sites/new-www.asco.org/files/content-files/MACRA-Final-Rule-Summary.pdf **(6)** CMS.gov: Oncology Care Model. CMS. https://innovation.cms.gov/initiatives/oncology-care/