Transitioning Away from FFS: The Plan to Start

There is broad agreement that Medicare's fee-for-service (FFS) payment model is outdated and must be replaced to improve health care delivery. Our entire health care system is built around FFS and updating the current Medicare delivery structure will set the stage for an innovative, high-quality health care system. However, transitioning away from FFS will not be easy and will not happen overnight; reforming the Medicare system so that it pays for quality will require significant data collection and monitoring, updates to regulations and testing and scaling of new and innovative payment models and incentives. Advancing these objectives and facilitating a gradual shift from FFS medicine will take time and will, therefore, likely occur in stages and lead to a number of new payment model reforms.

Recently, the National Commission on Physician Payment Reform called for a phase out of the FFS model within five years. Similarly, the Partnership for the Future of Medicare (PFM) believes the FFS payment model should be phased out over the next five to seven years. However, one lesson we all know well is that the biggest challenge when making significant systemic change is plotting the course of how to move from the current state to a future one. Therefore, our advisory board has come together to develop a vision of what this transition period might look like and specific policy recommendations that will most efficiently and effectively move Medicare away from FFS and pave the way for wider adoption of new, quality-driven payment models. Of importance, we are not specifying exactly what the new reimbursement system must look like or be, but rather have created this pathway in such a way as to let good ideas develop and take root. PFM believes that effectively transitioning away from FFS will require specific policy adjustments in the following three categories:

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1. Payments

FFS is effectively a one-size-fits-all model that does not allow physicians to allocate resources to better personalize care delivery and ensure each beneficiary receives the best, most effective care. The health care system is changing; the system is facing pressure to become more collaborative, and providers are more focused on individual patients. As a result, the way providers are paid must be updated and enhanced to support these changes and enable providers to utilize new, innovative practices, such as team-based care, email consultations and self-monitoring.

We believe that Medicare can begin to move away from FFS by offering beneficiaries alternatives to the traditional model that use new payment mechanisms to incentivize more coordinated, patient-centered care, while also providing consumers with better information to make informed choices about their coverage. We also believe that these models can include incentives which help providers better coordinate care while holding them accountable for the quality of care they deliver to patients to mitigate risks from both over- and under-treatment.

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We recommend that current and new Medicare beneficiaries have access to tools that will help them select a health plan that best meets their needs in terms of cost, network, patient satisfaction and clinical outcomes. With a multitude of plans to choose from, beneficiaries are often overwhelmed and lack the right information to make informed decisions on their health. We recommend implementing tools at the beginning of the plan selection process, such as a modified health risk assessment, or other tools similar to plan finders that have successfully supported Part D plan selection. Based on their results, beneficiaries would receive information from Medicare regarding which benefits would be most valuable to either maintaining or improving their health. This information would be valuable to beneficiaries as they choose among a multitude of health plans. To provide beneficiaries greater options and be clear about the differences between plans, we recommend two overarching types of coverage:

Medicare of Tomorrow

We agree that to improve the Medicare program and contain costs, we need more care coordination and patient engagement and must allow beneficiaries the flexibility to join more integrated, patient-centered networks at their discretion. Therefore, we recommend giving beneficiaries clear information about options for more coordinated models – including Medicare Advantage (MA) plans that have demonstrated value, Accountable Care Organizations (ACOs) and Medical Homes. With a better understanding of their health needs (as mentioned above), we believe those most in need of coordinated care – particularly vulnerable populations such as the frail elderly and/or dual eligibles – will be more likely to choose plans that will work to improve their health, if provided better information.

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Enhanced Fee-For-Service Medicare

While we believe that Medicare must transition away from FFS, we also recognize that this will occur in several stages. We recommend the following transitional steps to help improve payments and, ultimately, the quality of care under the FFS model:

- Update and Enhance Physician Fee Schedule:
  - Apply annual updates to the fee schedule to include more modern care mechanisms, such as email consultation and other non-face-to-face encounters not currently recognized under telehealth.
  - Within the next two to three years, establish separate conversion factors for two distinct fee schedules in a budget neutral way with enhanced FFS growing more attractive over time – traditional FFS and an enhanced version that better supports new models of care. Relative risk should be adjusted and indexed against the quality of peers, with the total dollar amount remaining constant. Updates to the conversion factor combined with incentive-based payments to broader networks will encourage the use of delivery models that better coordinate care, focus on quality outcomes and spread risk.
- Repeal and replace the Sustainable Growth Rate (SGR): Repeal the flawed SGR formula and institute a definitive rate schedule for the following two years to allow physicians the stability necessary to determine true costs and options in the changing landscape. Given the Congressional Budget Office’s most recent projections, which lowered the cost of a permanent SGR fix by more than $100 billion, this can reasonably be done in the next year.

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2. Incentives

As a complement to adjustments in the physician fee schedule, it is important that we continue to incentivize the highest quality of care across the Medicare program. Incentive programs can be powerful tools that have the potential to not only enhance the quality of care and reveal new and innovative best practices, but also to achieve significant savings. The effectiveness of incentive programs will depend on data; data will be necessary to understand what is working or what to reward, as well as where inefficiencies exist. We believe the following are examples of the types of incentive programs that can be implemented within the next two to three years to help facilitate a successful shift away from FFS toward more value-based care:

Patient Engagement Metrics

- Support data collection and monitoring to facilitate new patient engagement metrics.
- Identify measures of patient engagement that can be successfully incorporated into new payment models and incentive plans.
  - Specifically, consider metrics that would reward adherence with treatment plans and preventive care.

Enhance Transparency and Use of Public Data

- Make public data more readily available and accessible, including both quality measures and performance.
- Enhance awareness of publicly available reports and encourage/develop specific programs to increase public use of "Medicare Compare," the upcoming "Physician Compare" and other assessment tools that will help inform patients' decisions and further incentivize plans and providers to meet quality standards.

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Expand on Existing Rating, Bonus, and Incentive Programs

- Develop specific programs that utilize quality metrics, and performance-based pay and heighten transparency by building on and expanding programs such as star ratings and quality bonus payments in MA and throughout the Medicare program.
- Collect and utilize data on mis-valued or overused services to expand disincentive programs such as the penalty for excessive hospital readmissions.
- Develop incentive programs to encourage beneficiaries to adopt and maintain healthy behaviors, particularly those that support healthy aging.

3. Scaling

Throughout the past decade we have seen a surge of innovation across the private sector, as well as within Medicare – primarily in MA plans and, more recently, with the demonstration programs newly underway at the Center for Medicare and Medicaid Innovation (CMMI). These innovations have served as a test of both delivery and payment models that could prove to be the way of the future. As work

continues on testing and identifying effective models, successful reform will depend on the ability to scale successful models to a broader population. While CMMI intends to bring current demonstrations to scale, there needs to be a greater emphasis on national implementation and perhaps stronger legislative language to hold relevant parties accountable or provide more direction around the scaling of current and future demonstrations. Scaling successful payment models will be key to transitioning away from FFS. The following represent policy options we feel should be implemented over the course of the next three to five years to help streamline processes and speed up the scaling of successful programs:

Comprehensive Care Management Access

- Provide all Medicare beneficiaries not already enrolled in an MA plan with access to care management programs and services to improve outcomes and lower costs.

Infrastructure Advancement

- Invest in and reward for advancements in infrastructure that support data transfer and information sharing necessary for greater expansion of integrated care models, such as ACOs.

Launch Targeted Pilots

- Launch new demonstration pilots for specific subsets of the population, particularly vulnerable populations or those with chronic diseases that require a high level of care management, in addition to successful provider payment reforms.

Retest Successful Programs

- Identify and expand successful programs and models by retesting them on a larger scale to prepare for national implementation.

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The Partnership for the Future of Medicare is a bi-partisan organization focused on ensuring the long-term security of Medicare. By examining key challenges, highlighting best practices, and evaluating innovations in Medicare health care delivery, we seek to foster innovation and support approaches that positively shape the future of Medicare. Despite coming from different perspectives, we collectively agree that the FFS payment model, which incentivizes volume of services rather than the quality of care delivered, is outdated and that we must transition faster to new, more flexible payment models if Medicare is to become better and more affordable. It is our hope that these preliminary recommendations will help guide policymakers as they look for ways to improve the Medicare program and set reform in motion – beginning the transition away from FFS is an important first step on the road to comprehensive reform.