CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Quality and Delivery System Reform

JCIPE: InterProfessional Care for the 21st Century: Redefining Education & Practice

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CMS support of Health Care Delivery System Reform (DSR)

Public and Private sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Better. **Smarter.** *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

Delivery System Reform and Our Goals

MACRA – Quality Payment Program

CMS Innovation Center

Delivery System Reform focus areas

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

FOCUS AREAS

- Pay Providers
- Deliver Care
- Distribute Information

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

CMS has adopted a framework that categorizes payment to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Value	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality and/or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value-Based Modifier ▪ Readmissions / Hospital Acquired Conditions Reduction Program	▪ Accountable care organization ▪ Medical homes ▪ Bundled payments ▪ Comprehensive primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer accountable care organizations in years 3-5 ▪ Maryland hospitals ▪ Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

As of **January 01, 2016**, the **30% goal was achieved one year ahead of schedule.**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

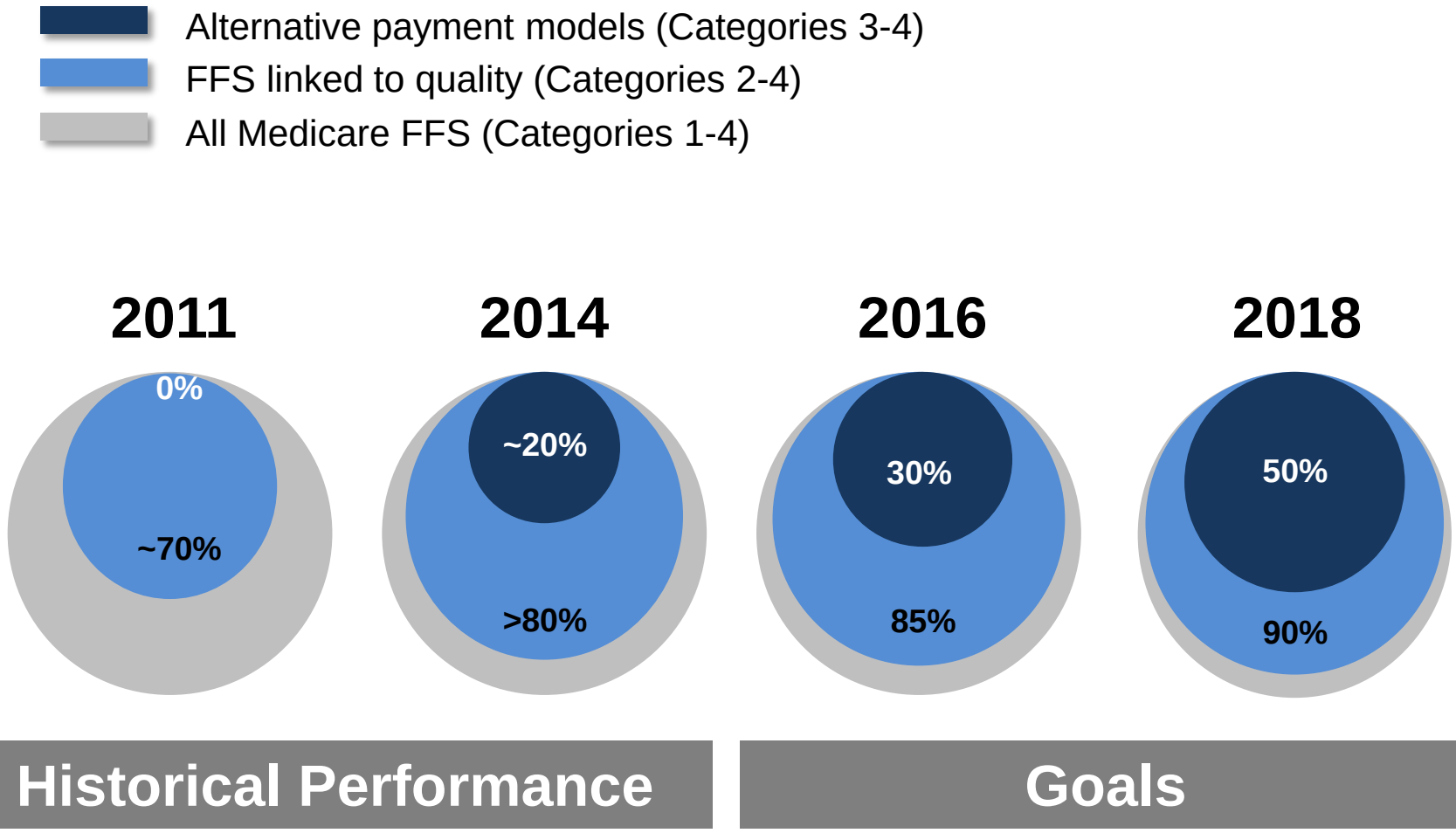
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018



Delivery System Reform and Our Goals

MACRA – Quality Payment Program

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MACRA – Quality Payment Program: What is it?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

- Now known as the ***Quality Payment Program*** **is:**
  - Bipartisan legislation **repealing** the Sustainable Growth Rate (SGR) Formula
  - Changes how Medicare **rewards** clinicians for **value** over volume

1. Created **Merit-Based Incentive Payments System (MIPS)** that streamlines three previously separate payment programs:

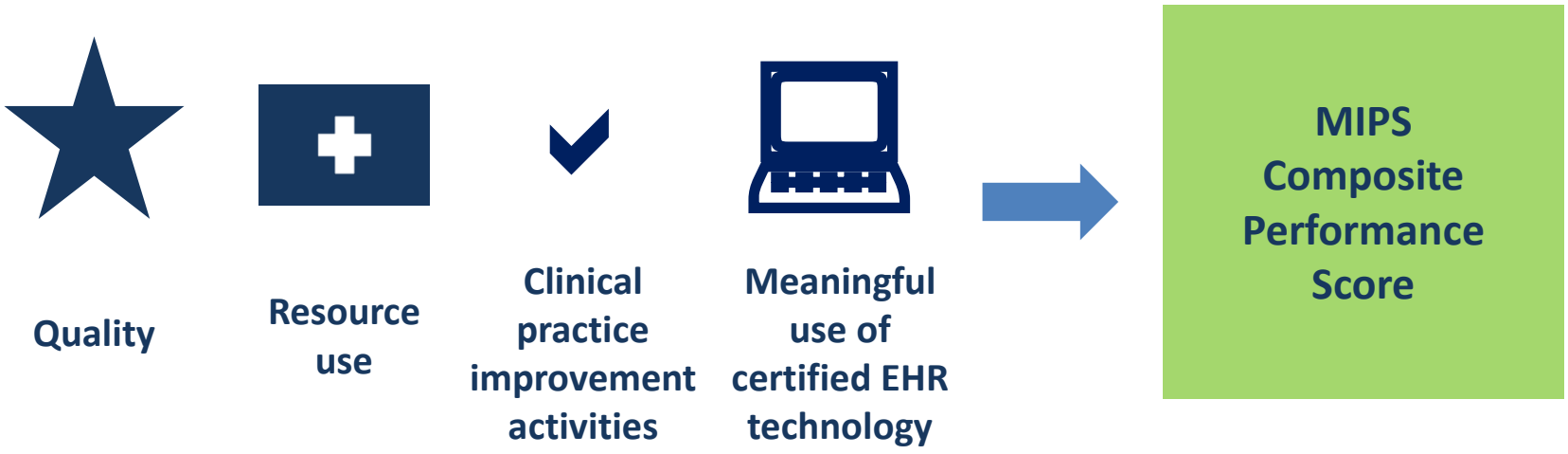
Physician Quality Reporting Program **(PQRS)**	Value-Based Payment Modifier	Medicare EHR Incentive Program

   - rewards high-value, patient-centered care

2. Provides **bonus payments** for participation in **eligible *Advanced* alternative payment models (APMs)**
   - Provides 5% bonus to clinicians as incentive to participate

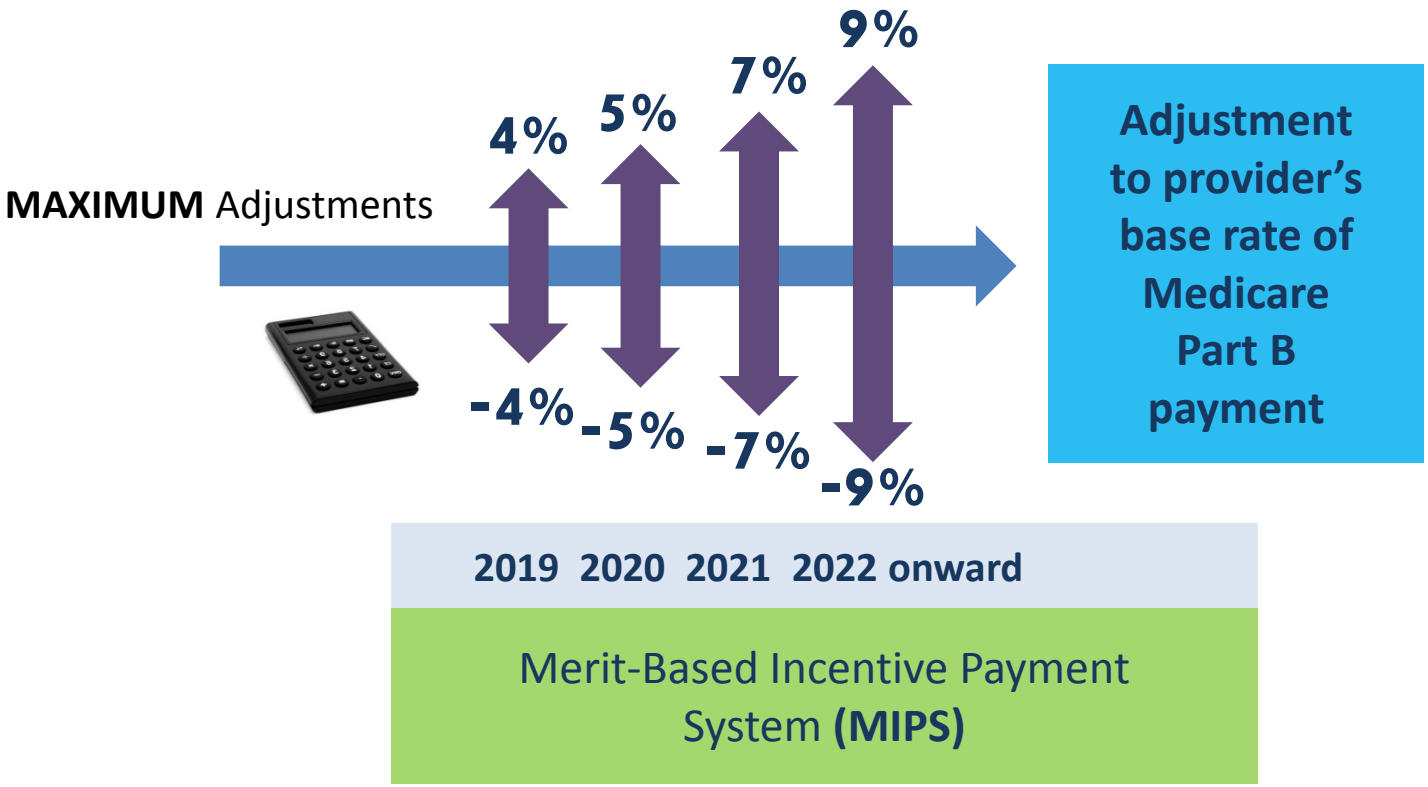
How will physicians and practitioners be scored under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories:**



How much can MIPS adjust payments?

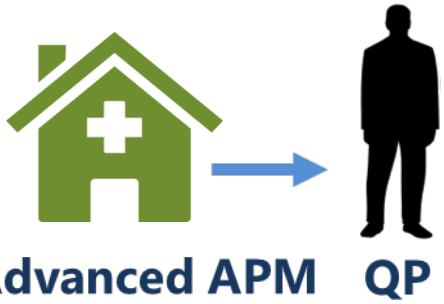
- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments **up to** the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.



Be excluded from MIPS

Receive a 5% lump sum bonus

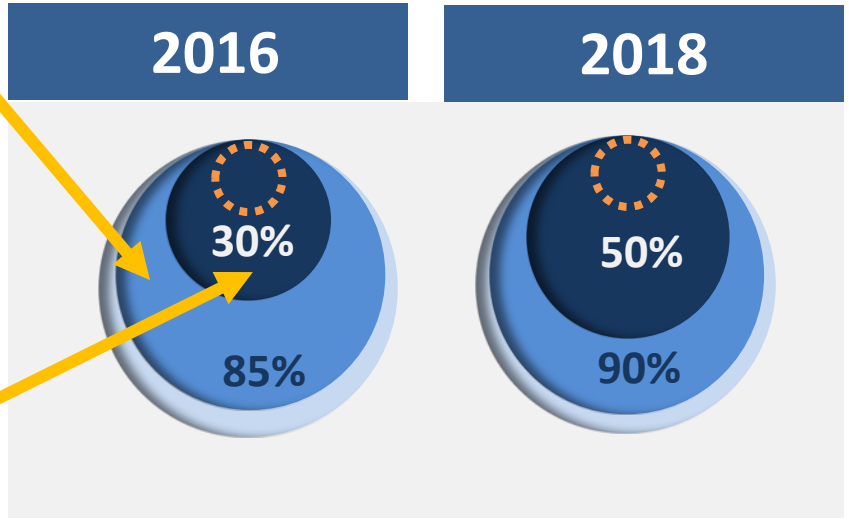
Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

How QPP gets us closer to meeting HHS payment reform goals

The Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in *Advanced* Alternative Payment Models** via the bonus payment for Qualifying APM Participants (QPs).

New HHS Goals:



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare payments to QPs in eligible APMs under MACRA - QPP

Delivery System Reform and Our Goals

MACRA – Quality Payment Program

CMS Innovation Center

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project ▪ **Bundled payment models** – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ **Initiatives Focused on the Medicaid** – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ **Dual Eligible (Medicare-Medicaid Enrollees)** – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Integrated ACO ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management ▪ **Medicare Part B Drug Payment Model**
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice – Community-Based Care Transitions ▪ **Health Care Innovation Awards** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model – Vermont All-Payer ACO Model ▪ **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ **Health Care Payment Learning and Action Network** ▪ **Information to providers in CMMI models** ▪ **Shared decision-making required by many models**

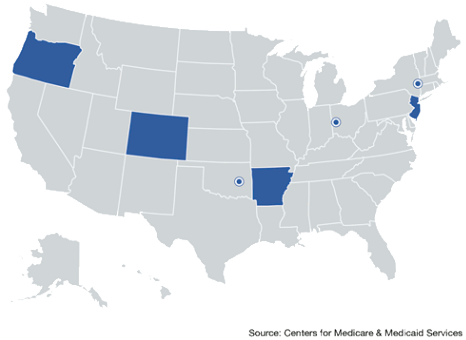
* Many CMMI programs test innovations across multiple focus areas

Comprehensive Primary Care (CPC) is showing early but positive results

CMS convenes Medicaid and commercial payers to support primary care practice transformation through enhanced, non-visit-based payments, data feedback, and learning systems

CPC
Comprehensive Primary Care

- **$11 or 1%* reduction part A and B expenditure** in the first two years (through September 2014) among all 7 CPC regions
- Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions



Source: Centers for Medicare & Medicaid Services

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients
- Duration of model test: Oct 2012 – Dec 2016

* Reductions relative to a matched comparison group and do not include the care management fees (~$20 pbpm)

Spotlight: Comprehensive Primary Care, SAMA Healthcare

SAMA Healthcare Services is an independent four-physician family practice located located in El Dorado, a town in rural southeast Arkansas

Services made possible by CPC investment

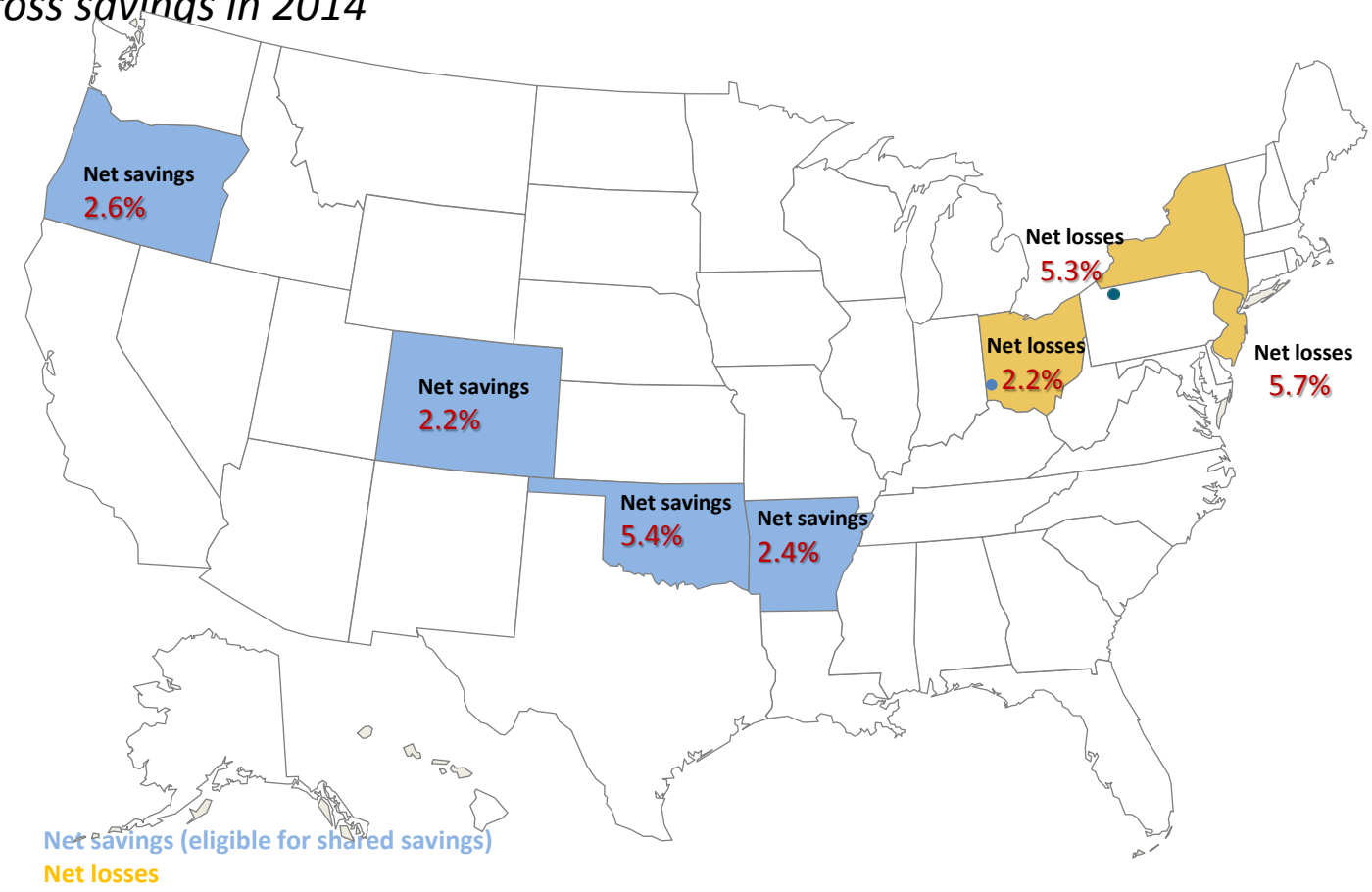
- Care management
  - Each **Care Team** consists of a doctor, a nurse practitioner, a care coordinator, and three nurses
  - Teams drive **proactive preventive care** for approximately 19,000 patients
  - Teams use Allscripts' **Clinical Decision Support** feature to alert the team to missing screenings and lab work
- Risk stratification
  - The practice implemented the **AAFP six-level risk stratification tool**
  - Nurses mark records **before the visit** and physicians **confirm stratification during the patient encounter**

-Practice Administrator

"A lot of the things we're doing now are things we wanted to do in the past… **We needed the front-end investment** of start-up money to develop our teams and our processes"

CPC has promising shared savings and quality results in 2015

95% of practices hit quality targets and 4 out of 7 regions share in savings – doubling the gross savings in 2014



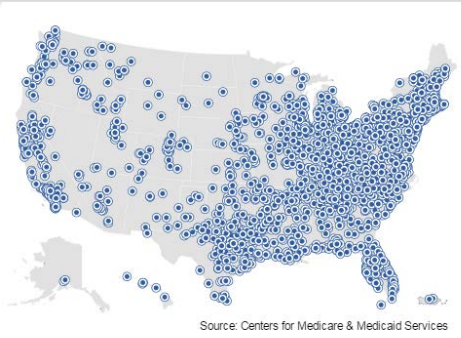
*Results based on actuarial methodology. Detailed results are available: 2015 CPC Shared Savings & Quality Results

Bundled Payments for Care Improvement is also growing rapidly

The bundled payment model targets 48 conditions with a single payment for an episode of care

- Incentivizes providers to take **accountability for both cost and quality** of care
- **Four Models**
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care
  - Model 3: Retrospective post-acute care only
  - Model 4: Prospective acute care hospital stay only

- 305 Awardees and 1143 Episode Initiators as of July 2016



Source: Centers for Medicare & Medicaid Services

- Duration of model is scheduled for 3 years:
  - Model 1: Awardees began Period of Performance in April 2013
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013

Spotlight: Bundled Payments for Care Improvement Initiative Model 2 – St. Mary Medical Center in Langhorne, PA

St. Mary's Medical Center is a 373 bed, Acute Care Hospital testing the Congestive Heart Failure (CHF) clinical episode since January 1, 2014

Care Redesign Efforts under the BPCI Initiative

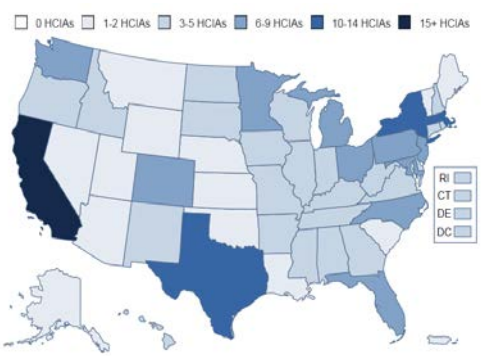
- Focused on reducing preventable hospital readmissions through **transitional nurse assistance** with medical, behavioral, psychological, social, and environmental factors
- **Monthly meetings** with top 10 Skilled Nursing Facility partners to **share quality metrics data and provide education** to Skilled Nursing Facilities staff
- Established physician-led **interdisciplinary committee** to improve physician engagement in care redesign efforts
- **Transition nurse service** expanded to provide assistance to all CHF Medicare Beneficiaries

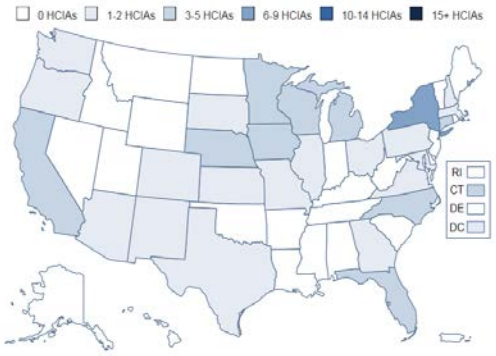
A Beneficiary Success Story

71 year old patient with CHF, CABG, sleep apnea with heavy alcohol and drug abuse history, who was estranged from family and lived alone, had no readmissions or ED visits post discharge during 90 day bundle or 6 months after clinical episode concluded

Health Care Innovation Awards: delivery system innovations

	Round 1	Round 2
Projects	107	39
Focus	Broad range of delivery system innovations	Four themes to drive innovations





The projects from HCIA Awards are:

- **generating ideas** for additional tests,
- providing promising ideas that are also being **integrated into future models**, and
- projects are spurring ideas to be adopted by the **private sector**.

Results and Metrics

- Approximately 760,000 Medicare, Medicaid, and CHIP beneficiaries served in Round One
- Projects funded in all 50 states, the District of Columbia and Puerto Rico

* Darker colors on map represent more HCIA projects in that state

Spotlight: Health Care Innovation Awards, Foundation for California Community Colleges

The Foundation for California Community Colleges (FCCC) is a Round One Health Care Innovation Awardee serving high risk/high cost Medicaid and Medicaid-eligible individuals with chronic conditions released from prison

Services made possible by HCIA investment

- Comprehensive health care system navigation
  - Project worked with the Department of Corrections to identify patients with chronic medical conditions prior to release, and used Community Health Workers (CHWs) trained by FCCC to help these individuals **navigate the healthcare system, find primary care and other medical and social services,** and **coach them in chronic disease management**

- Successful Community Health Workers
  - HCIA funding sparked continued efforts to finance CHW positions and CHW **web-based curriculum for CHW certification and continuing education**
  - Project successfully worked with Johns Hopkins to develop a **CHW training guide** (available for public download) and a **CHW focused online text book**

Success with Community Health Workers

With the help of a CHW, approximately 70% of Transition Clinic Network patients in San Francisco who sought housing in 2013 signed a lease by year's end. Here, A TCN CHW helps a newly housed patient reconcile his medications.

CMS is aligning with private sector and states to drive delivery system reform

CMS Strategies for Aligning with Private Sector and states

Convening Stakeholders

Incentivizing Providers

Partnering with States

The Health Care Payment Learning and Action Network will accelerate the transition to alternative payment models

- **Medicare alone cannot drive sustained progress** towards alternative payment models (APM)
- Success depends upon a **critical mass of partners** adopting new models
- The network will
  - **Convene** payers, purchasers, consumers, states and federal partners to establish a common pathway for success]
  - Collaborate to **generate evidence, shared approaches, and remove barriers**
  - **Develop common approaches** to core issues such as beneficiary attribution
  - Create **implementation guides** for payers and purchasers
- Accomplishments
  - Common definitions for alternative payment models and agreement to report publicly
  - Population-based payment and episode-based payment model workgroups and now focused on implementation

Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  - -30% in APM by 2016
  - -50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

Additional thoughts? Ideas? Questions?

Contact information

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