Driving Patient-Centered Triple Aim Care

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Medical Home Summit

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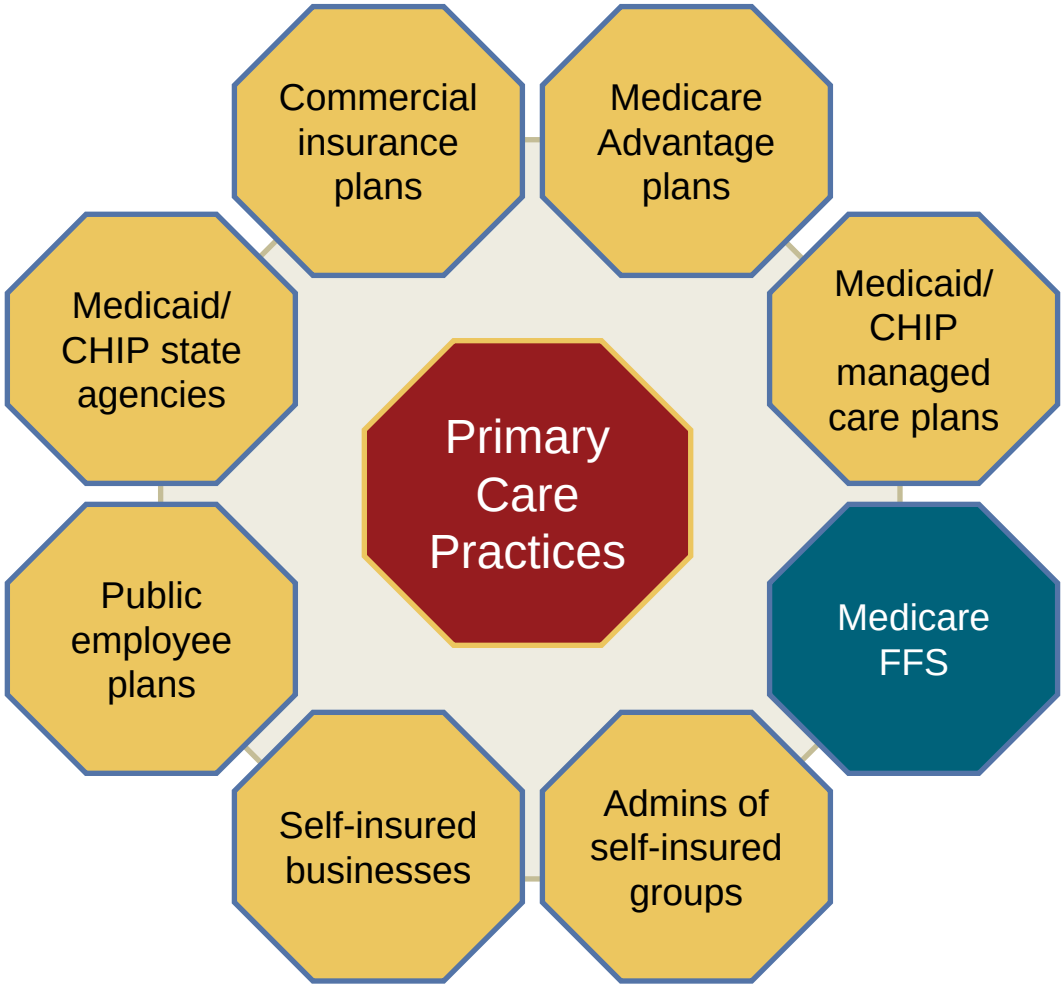
Medicare's Vision for Triple Aim Care

Medicare's Vision for Triple Aim Care: Innovation Center Models

Multi-Payer Aligned Payment Reform



Actionable and Timely Data Feedback

Multi-Payer Aligned Data Feedback

Beneficiary Attribution

- List of Medicare FFS beneficiaries attributed to the practice, by risk tier
- Quarterly financial support amounts

Patient-Level Cost and Utilization

- **Expenditures**: professional services, inpatient, outpatient, labs, imaging, SNFs
- **Utilization**: inpatient, 30-day readmission, ED utilization

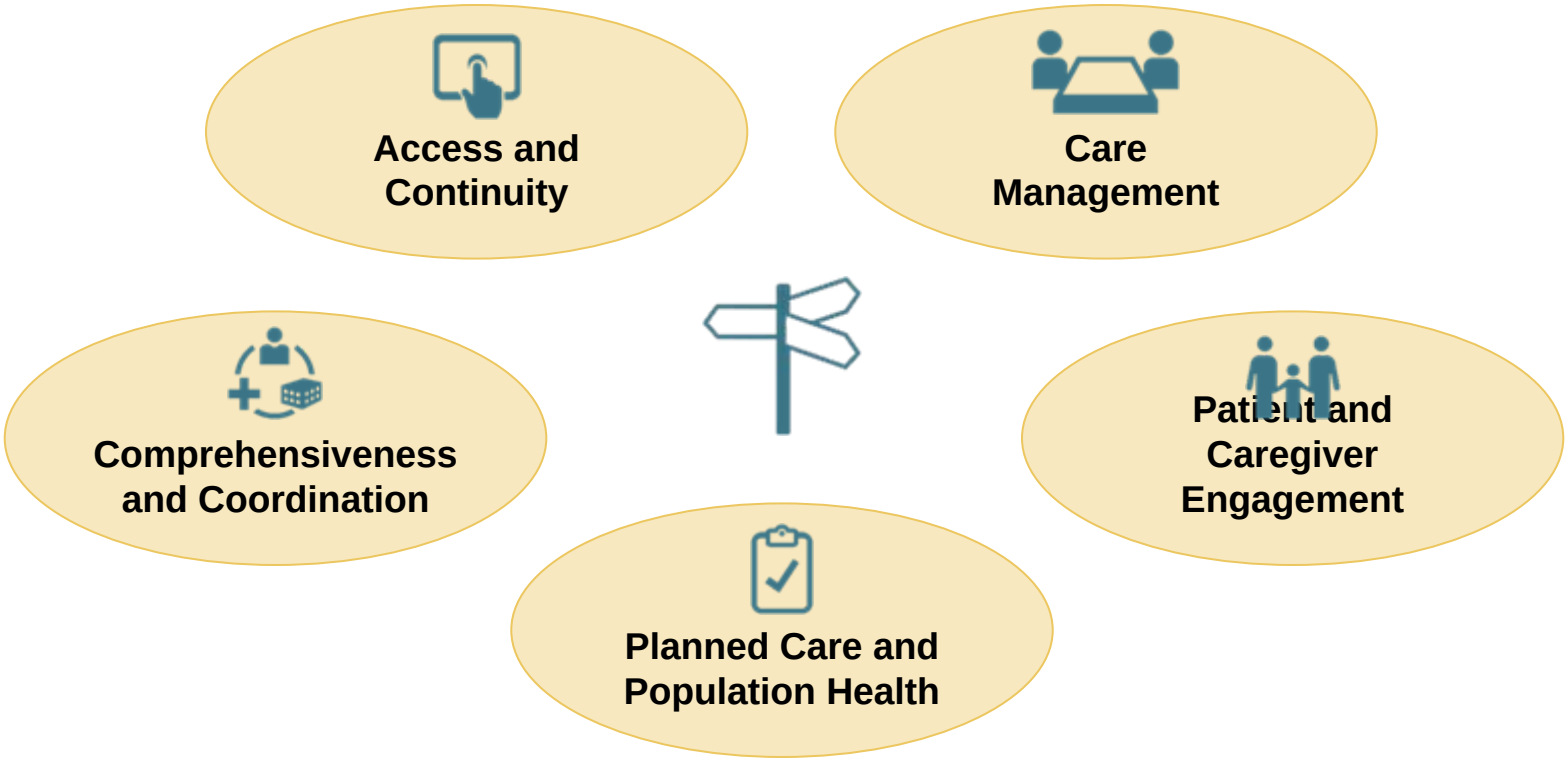
Practice Financial and Quality Performance

- eCQM and patient experience results
- Expenditures and utilization results

Practice and Region-Level Cost and Utilization

- Quarterly report comparing practice to regional performance
- Quarterly report comparing each region to other regions' performance

Practice Transformation Guided By Comprehensive Primary Care Functions



Engaging Health Information Technology Vendors

Practices

Vendors

(Track 2 only)

Both tracks require use of **certified health IT**.

Track 2 practices will apply with a **letter of support from an health IT vendor** to facilitate the use of emerging health IT capabilities.

Health IT vendors can sign a **Memorandum of Understanding** with CMS.

Health IT vendors are invited to participate in relevant **Learning System activities** with practices and payers.

Patient-Centered Care Supported Through Enhanced Health IT

- Risk stratify the practice site patient population
- Screen for social and community support needs and link the identified need(s) to practice identified resources
- Empanel patients to the practice site care team
- Produce and display eCQM results at the practice level to support continuous feedback
- Establish patient focused care plans to guide care management
- Document and track patient reported outcomes

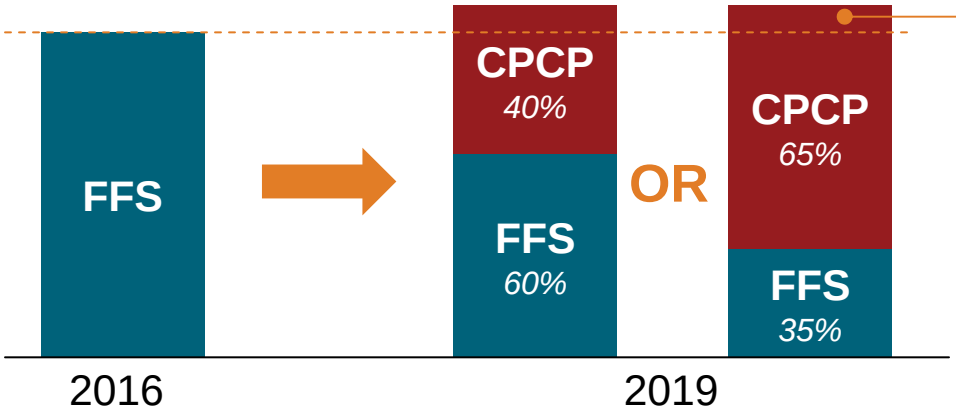
Optional: Practice site care delivery and care touch documentation

Three Payment Innovations Support Practice Transformation

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1	$15 average	$2.50 opportunity	Standard FFS
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

Comprehensive Primary Care Payment Increases Flexibility in Care Delivery

Hybrid FFS and FFS Rollup (CPCP)
"Comprehensive Primary Care Payment"



CPCP is ~10% larger than historical FFS to compensate for more comprehensive services

- May allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome
- Practices select the pace at which they will progress towards one of two hybrid payment options by 2019

Medicare's Vision for Triple Aim Care: Delivery System Reform

Medicare's Transition to Value

Medicare Fee-for-Service

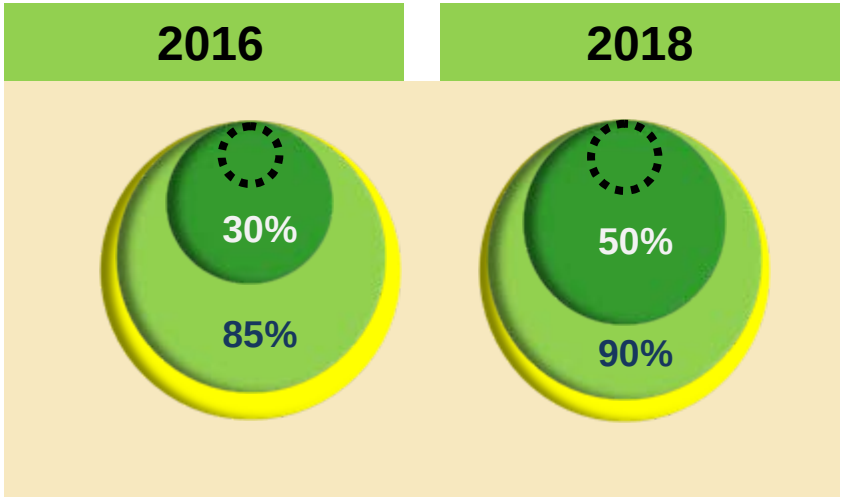
GOAL 1: **30%**

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

Department of Health and Human Services Goals



All Medicare fee-for-service (FFS) payments

Medicare **FFS** payments **linked to quality and value**

Medicare payments linked to quality and value via **APMs**

Medicare payments to those in the most highly **"Advanced APMs"**

Images not drawn to scale

Financial Rewards Under the Proposed Medicare Quality Payment Program

Merit-based Incentive Payment System (MIPS)

OR

Significant participation in Advanced Alternative Payment Model (APM)

For most clinicians, with payment based on:

- Quality
- Advancing Care Information (Health IT)
- Clinical Practice Improvement Activities
- Cost

For Qualified Participants in an Advanced APM, defined by:

- Payment based on quality
- Use of certified EHR technology
- Bears more than nominal financial risk or be a medical home model expanded under CMMI authority

Payment:

MIPS score adjustments + APM-specific rewards

For any providers in **"regular" APMs** (still in MIPS)

Payment:

5% lump sum bonus + APM-specific rewards

CPC+ is a Proposed Advanced APM

Excerpt from Proposed Rule

TABLE 32: APM List Based on Proposed Criteria

APM and Abbreviation	Qualifies as a MIPS APM for APM Scoring Standard under II.E.3.h	Medical Home Model	Use of CEHRT Criterion	Quality Measures Criterion	Financial Risk Criterion	Advanced APM
Bundled Payment for Care Improvement Model 2 (BPCI)	NO	NO	NO	NO	YES	NO
Bundled Payment for Care Improvement Model 3 (BPCI)	NO	NO	NO	NO	YES	NO
Bundled Payment for Care Improvement Model 4 (BPCI)	NO	NO	NO	NO	YES	NO
Comprehensive Care for Joint Replacement (CJR)	NO	NO	NO	NO	YES	NO
Comprehensive ESRD Care (CEC) (LDO arrangement)	YES	NO	YES	YES	YES	YES
Comprehensive ESRD Care (CEC) (non- LDO arrangement)	YES	NO	YES	YES	NO	NO
Comprehensive Primary Care Plus (CPC Plus)	YES	YES	YES	YES	YES	YES
Frontier Community Health Integration Program	NO	NO	NO	NO	NO	NO

Released 4/27/16; available at: https://www.regulations.gov/#!documentDetail;D=CMS-2016-0060-0068

Special Rules Proposed to Accommodate Medical Home Models

Excerpt from Proposed Rule

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…In particular, we propose specific standards that would apply for Medical Home Models. We believe that, given the unique financial risk and nominal amount standards we are proposing for Medical Home Models in this section below, it would be appropriate to impose size and composition limits for the Medical Home Models to which the **unique standards** would apply in order to ensure that the focus is on organizations with a limited capacity for bearing the same magnitude of financial risk as larger APM Entities do. We propose that beginning in the second QP Performance Period (proposed to be 2018), the Medical Home Model financial risk standard and nominal amount standard, described in section II.F.4.b.(4) of this preamble, would only apply to APM Entities that participate in Medical Home Models and that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated. **Thus, in a Medical Home Model that is an Advanced APM, the proposed Medical Home Model financial risk and nominal amount standards would only apply to those APM Entities owned and operated by organizations with 50 or fewer eligible clinicians.** We believe it is appropriate to use eligible clinicians, rather than physicians, when setting this threshold as the number of eligible clinicians both reflects organizational resources and capacity and also may fluctuate widely around a specific number of physicians.

Proposed rule is available for public comment through June 27 at: http://federalregister.gov/a/2016-10032

Learn more about Triple Aim Care

Delivery System Reform

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html

Quality Payment Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html

Comprehensive Primary Care Plus (CPC+)

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus