

CMS Innovation and Health Care Delivery System Reform



*Amy Bassano
Mai Pham
Center for Medicare and
Medicaid Innovation
January 2016*

CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Historical state

Evolving future state

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

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	<ul style="list-style-type: none"> Payments are based on volume of services and not linked to quality or efficiency 	<ul style="list-style-type: none"> At least a portion of payments vary based on the quality or efficiency of health care delivery 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)
Medicare Fee-for-Service examples	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value Modifier Readmissions / Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable Care Organizations Medical homes Bundled payments Comprehensive Primary Care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer Accountable Care Organizations in years 3-5 Maryland hospitals

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

Medicare Fee-for-Service

GOAL 1:

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

30% 

GOAL 2:

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

85% 
 



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set **internal** goals for HHS



Invite **private sector** payers to match or exceed HHS goals

NEXT STEPS:

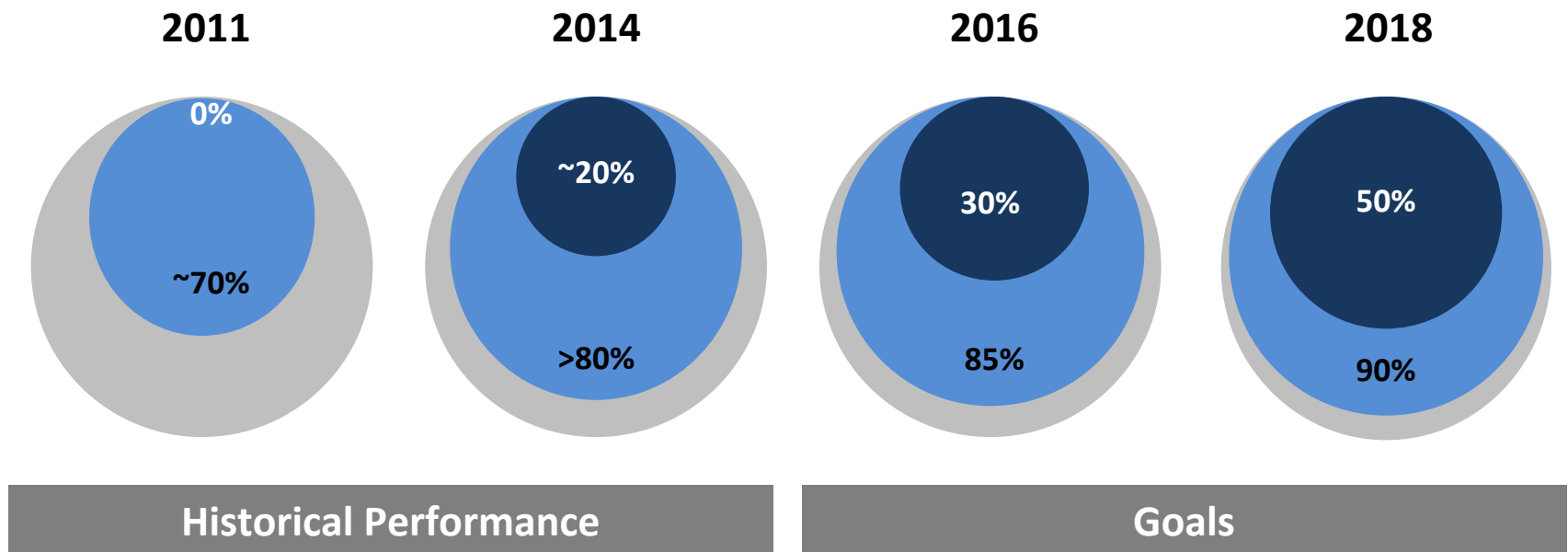


Testing of new models and expansion of existing models will be critical to reaching incentive goals

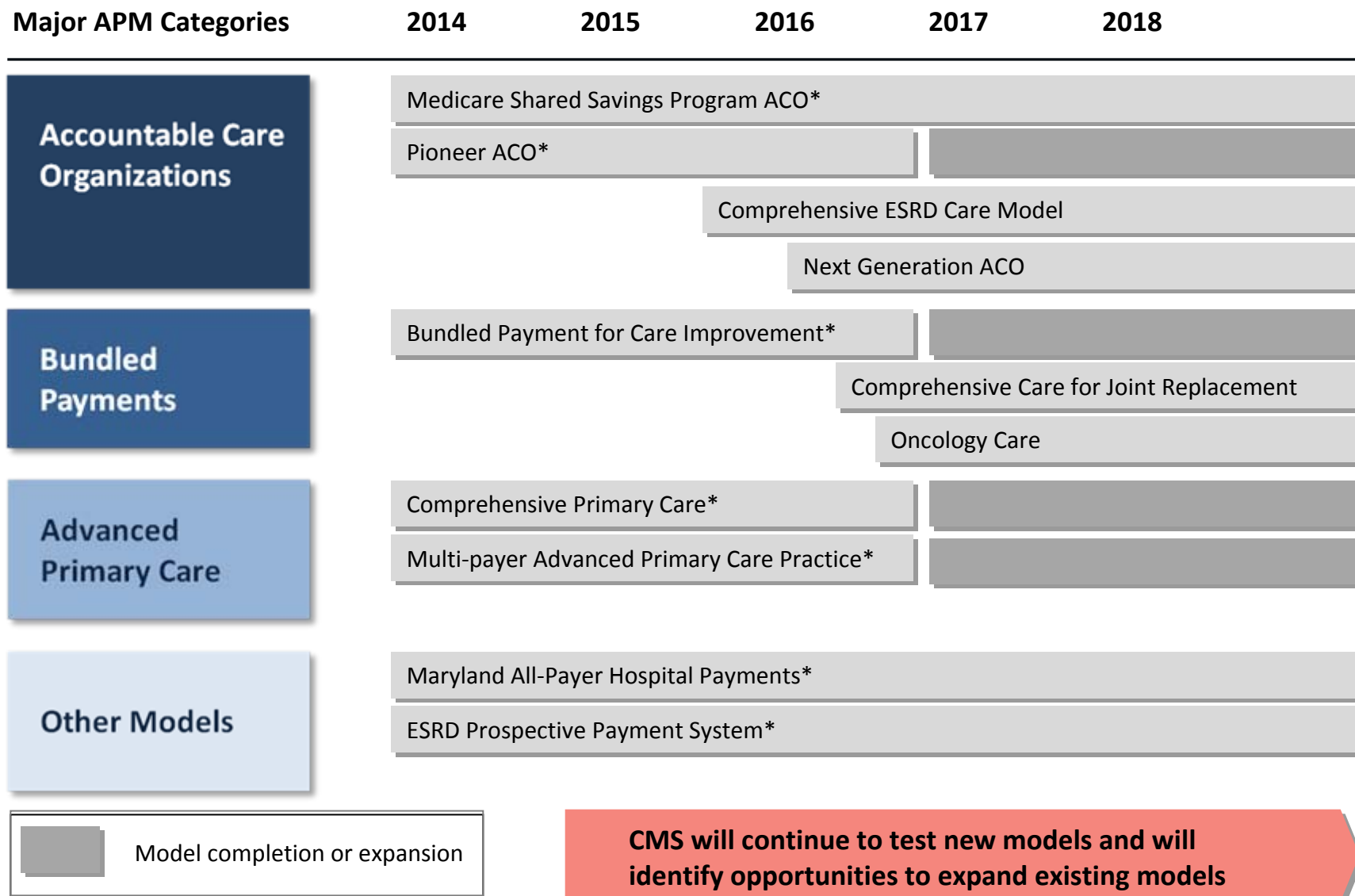
Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

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

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

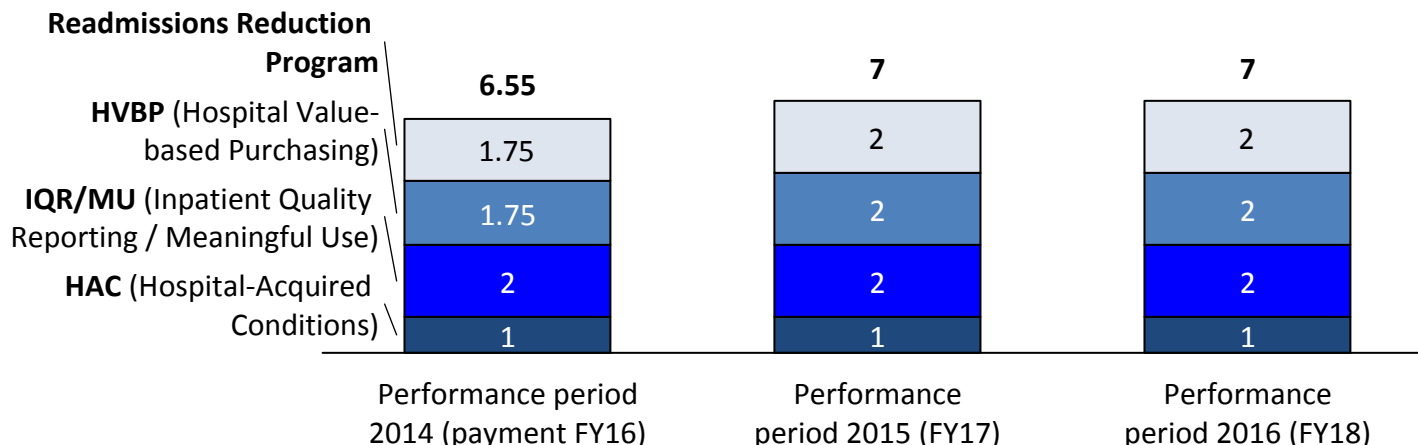


CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality

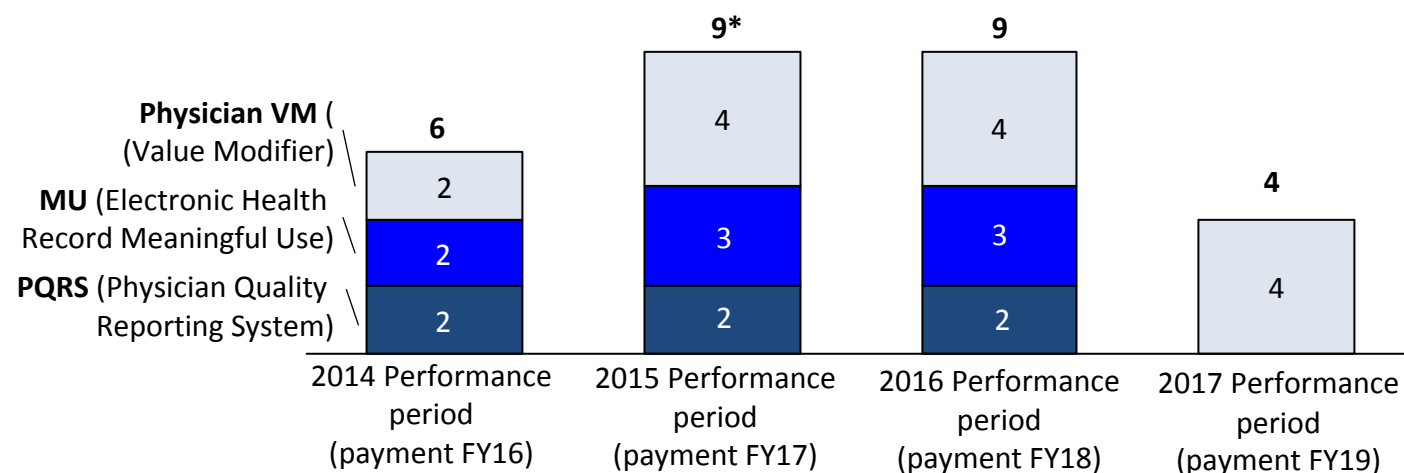


CMS will reach Goal 2 through more linkage of FFS payments to quality or value

Hospitals, % of FFS payment at risk (maximum downside)



Physician, % of FFS payment at risk (maximum downside)



* Physician VM adjustment depends upon group size and can range from 2% to 4%

The CIVIS 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

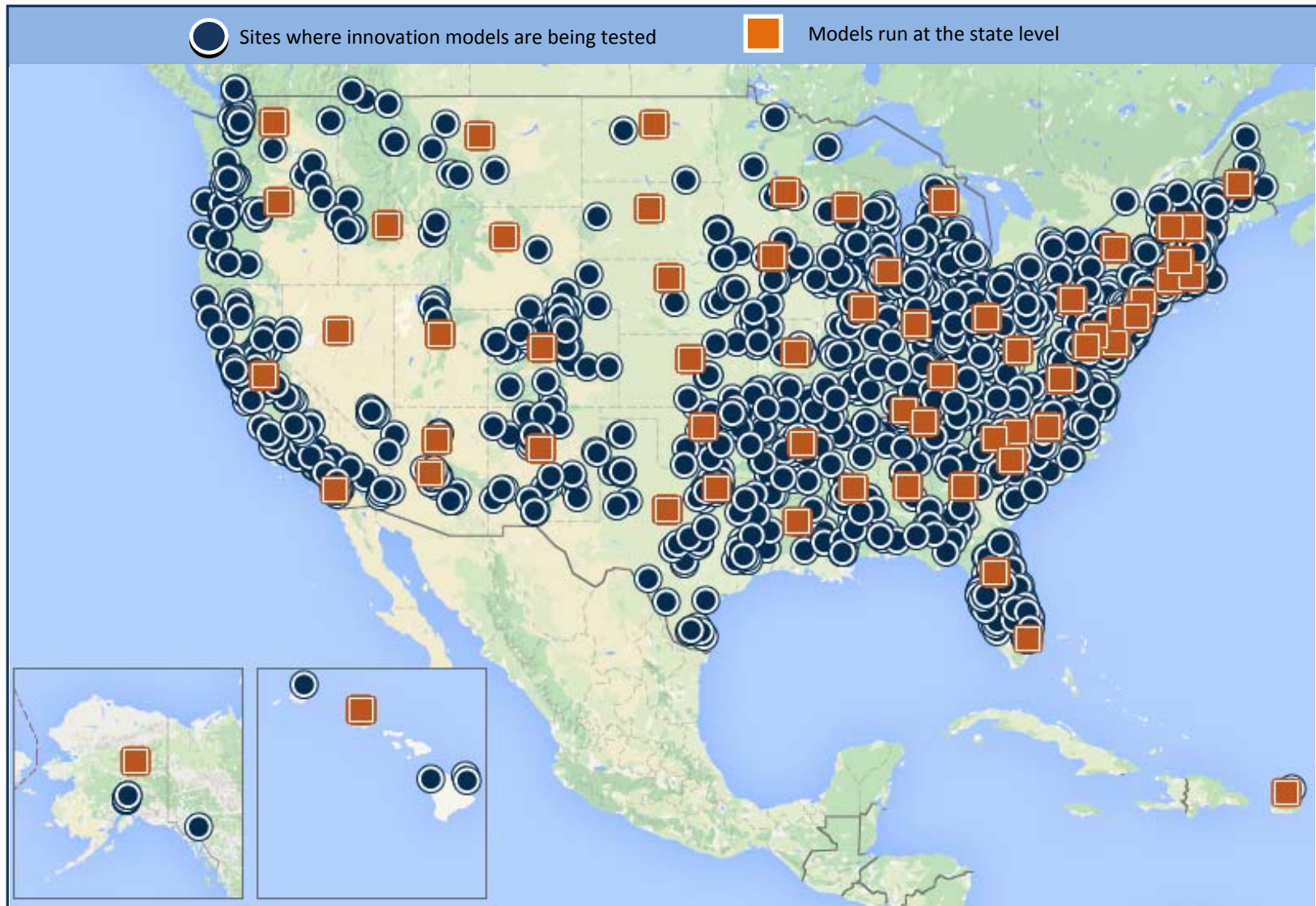


The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	<p><u>Test and expand alternative payment models</u></p> <ul style="list-style-type: none"> ▪ Accountable Care <ul style="list-style-type: none"> – 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 <ul style="list-style-type: none"> – Comprehensive Primary Care Initiative (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 ▪ Bundled payment models <ul style="list-style-type: none"> – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ Initiatives Focused on the Medicaid <ul style="list-style-type: none"> – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ Dual Eligible (Medicare-Medicaid Enrollees) <ul style="list-style-type: none"> – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents ▪ Medicare Advantage (Part C) and Part D <ul style="list-style-type: none"> – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management
Deliver Care	<p><u>Support providers and states to improve the delivery of care</u></p> <ul style="list-style-type: none"> ▪ Learning and Diffusion <ul style="list-style-type: none"> – Partnership for Patients – Transforming Clinical Practice – Community-Based Care Transitions ▪ Health Care Innovation Awards ▪ Accountable Health Communities ▪ State Innovation Models Initiative <ul style="list-style-type: none"> – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model ▪ Million Hearts Cardiovascular Risk Reduction Model
Distribute Information	<p><u>Increase information available for effective informed decision-making by consumers and providers</u></p> <ul style="list-style-type: none"> ▪ 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

CMS has engaged the health care delivery system and invested in innovation across the country

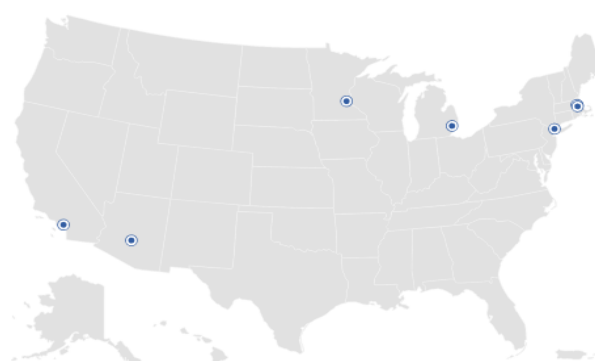
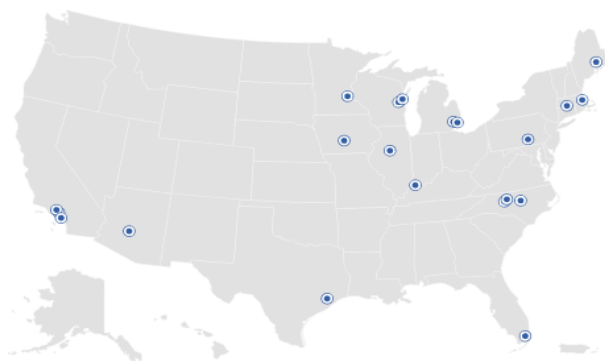


Next Generation ACO Model builds upon successes from Pioneer and MSSP ACOs

Designed for **ACOs experienced** coordinating care for patient populations

- **21** ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- Model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth & skilled nursing facilities)

Next Generation ACO	Pioneer ACO
21 ACOs spread among 13 states	9 ACOs spread among 7 states



Model Principles

- Prospective attribution
- Financial model for long-term stability (smooth cash flow, improved investment capability)
- Reward quality
- Benefit enhancements that improve patient experience & protect freedom of choice
- Allow beneficiaries to choose alignment

Bundled Payments for Care Improvement is also growing rapidly

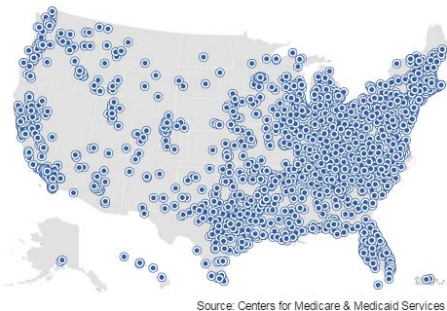
The bundled payment model targets 48 conditions with a single payment for an episode of care

➤ 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

■ 337 Awardees and 1254 Episode Initiators as of January 2016



- 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

Oncology Care Model: new emphasis on specialty care

- 1.6 million people annually diagnosed with cancer; majority are over 65 years
- Major opportunity to improve care and reduce cost with expected start July 2016
- Model Objective: Provide beneficiaries with **higher intensity coordination to improve quality and decrease cost**
- Key features
 - Implement 6 part **practice transformation**
 - Create two part **financial incentive** with \$160 pbpm, payment and performance based payment
 - Institute robust **quality** measurement
 - Engage **multiple payers**

Practice Transformation

1. Patient navigation
2. Care plan with 13 components based on IOM Care Management Plan
3. 24/7 access to clinician and real time access to medical records
4. Use of therapies consistent with national guidelines
5. Data driven continuous quality improvement
6. ONC certified electronic health record and stage 2 meaningful use by year 3

Comprehensive Care for Joint Replacement (CJR) will test a bundled payment model across a broad cross section of hospitals

- The model tests bundled payment of **lower extremity joint replacement (LEJR) episodes**, including approximately **20% of all Medicare LEJR procedures**

800 Inpatient Prospective Payment System Hospitals participating in **67** **selected Metropolitan Statistical Areas (MSAs)** where **30%** U.S. population resides

- The model will have 5 performance years, with the first beginning **April 1, 2016**
- Participant hospitals that achieve spending and quality goals will be **eligible to receive a reconciliation payment from Medicare** or will be held accountable for spending above a pre-determined target beginning in Year 2
- Pay-for-performance methodology will include **2 required quality measures and voluntary submission of patient-reported outcomes data**

Comprehensive ESRD Care will improve patient centered coordination of care

CEC model will improve care coordination through the **creation of ESRD Seamless Care Organizations (ESCO)** that will include dialysis providers, nephrologist, and other medical providers

■ CEC Model launched on 10/1/2015 with 13 ESCOs serving 15,000+ beneficiaries nationwide, including 12 LDOs and 1 non-LDO

■ Goal is to test an ACO model centered solely around ESRD patients

■ ESRD patients = **1.1%** of Medicare beneficiaries account for **5.6%** of payments

Dialysis costs account for approximately **33% of total cost of care** for ESRD patients

- Opportunity exist to improve patient centered care that **coordinates dialysis care with care outside of dialysis**

Care Model

- Improve care coordination
 - Clinical and support services
 - Data driven, population care management
- Enhance communication between providers
 - Whole-patient care management
 - EHR information exchange among providers
- Increase access to care
 - After hours call-in line; extended business hours
 - Enhanced convenience through on-site 'rounding'

Million Hearts Cardiovascular Disease Risk Reduction Model will reward population-level risk management

- Heart attacks and strokes are a **leading cause of death and disability** in the United States
 - Prevention of cardiovascular disease can significantly reduce both CVD-related and all-cause mortality
- Participant responsibilities
 - Systematic beneficiary **risk calculation*** and **stratification**
 - **Shared decision making** and evidence-based **risk modification**
 - **Population health management** strategies
 - **Reporting of risk score** through certified data registry
- Eligible applicants
 - General/family practice, internal medicine, geriatric medicine, multi-specialty care, nephrology, cardiology
 - Private practices, community health centers, hospital-owned practices, hospital/physician organizations

Payment Model

- Pay-for-outcomes approach
- Disease risk assessment payment
 - One time payment to risk stratify eligible beneficiary
 - \$10 per beneficiary
- Care management payment
 - Monthly payment to support management, monitoring, and care of beneficiaries identified as high-risk
 - Amount varies based upon population-level risk reduction

Accountable Health Communities Model addressing health-related social needs

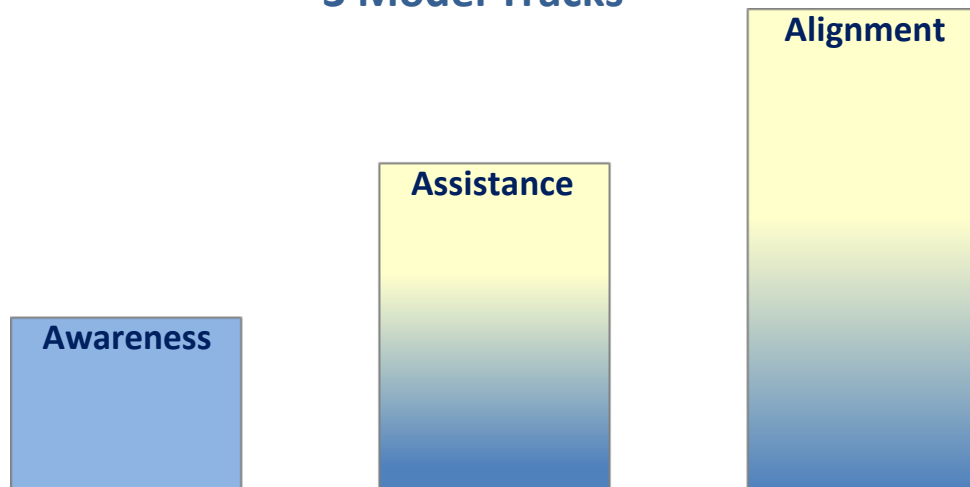
Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** and **community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

Total
Investment > **\$157**
million

44 Anticipated Award Sites

3 Model Tracks



Track 1 Awareness – Increase beneficiary **awareness** of available community services through information dissemination and referral

Track 2 Assistance – Provide community service navigation services to **assist** high-risk beneficiaries with accessing services

Track 3 Alignment – Encourage partner **alignment** to ensure that community services are available and responsive to the needs of beneficiaries

Medicare Care Choices Model (MCCM) provides new options for hospice patients

- MCCM allows Medicare beneficiaries who qualify for hospice to receive **palliative care services and curative care at the same time**. Evidence from private market that can concurrent care can improve outcomes, patient and family experience, and lower costs.
- MCCM is designed to
 - **Increase access to supportive care** services provided by hospice;
 - **Improve quality of life** and patient/family satisfaction;
 - Inform new payment systems for the Medicare and Medicaid programs.
- Model characteristics
 - **Hospices receive \$400 PBPM** for providing services for 15 days or more per month
 - 5 year model
 - Model will be phased in over 2 years with participants randomly assigned to phase 1 or 2

Services

The following services are available 24 hours a day, 7 days a week

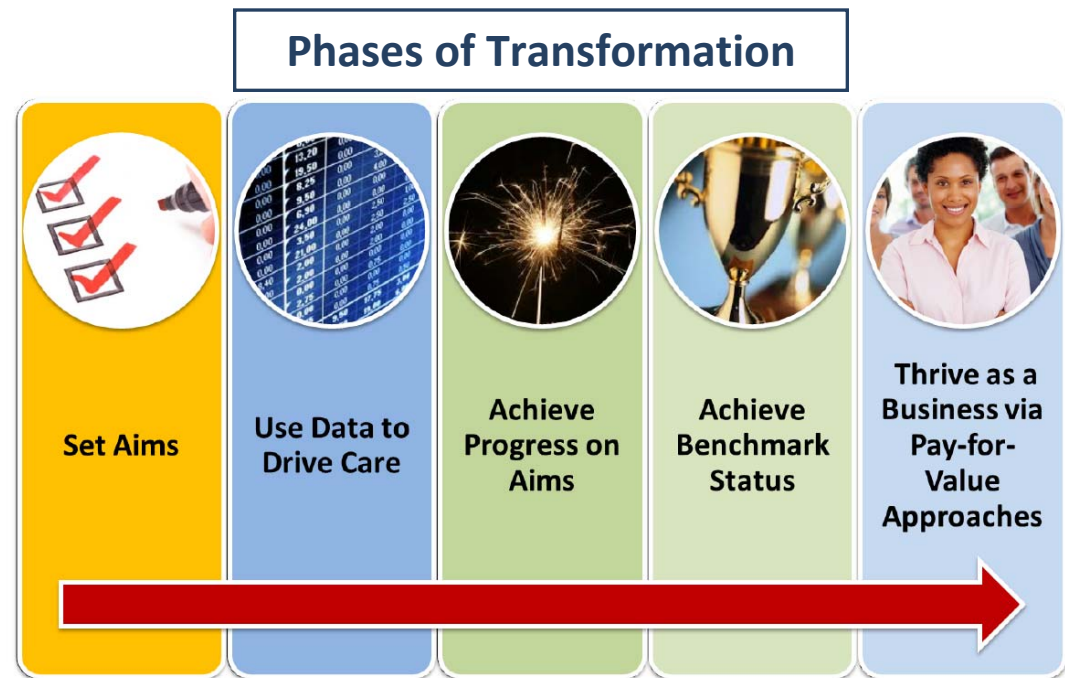
- Nursing
- Social work
- Hospice aide
- Hospice homemaker
- Volunteer services
- Chaplain services
- Bereavement services
- Nutritional support
- Respite care

Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **140,000 clinician practices** over the next four years to **improve on quality and enter alternative payment models**
- Two network systems will be created

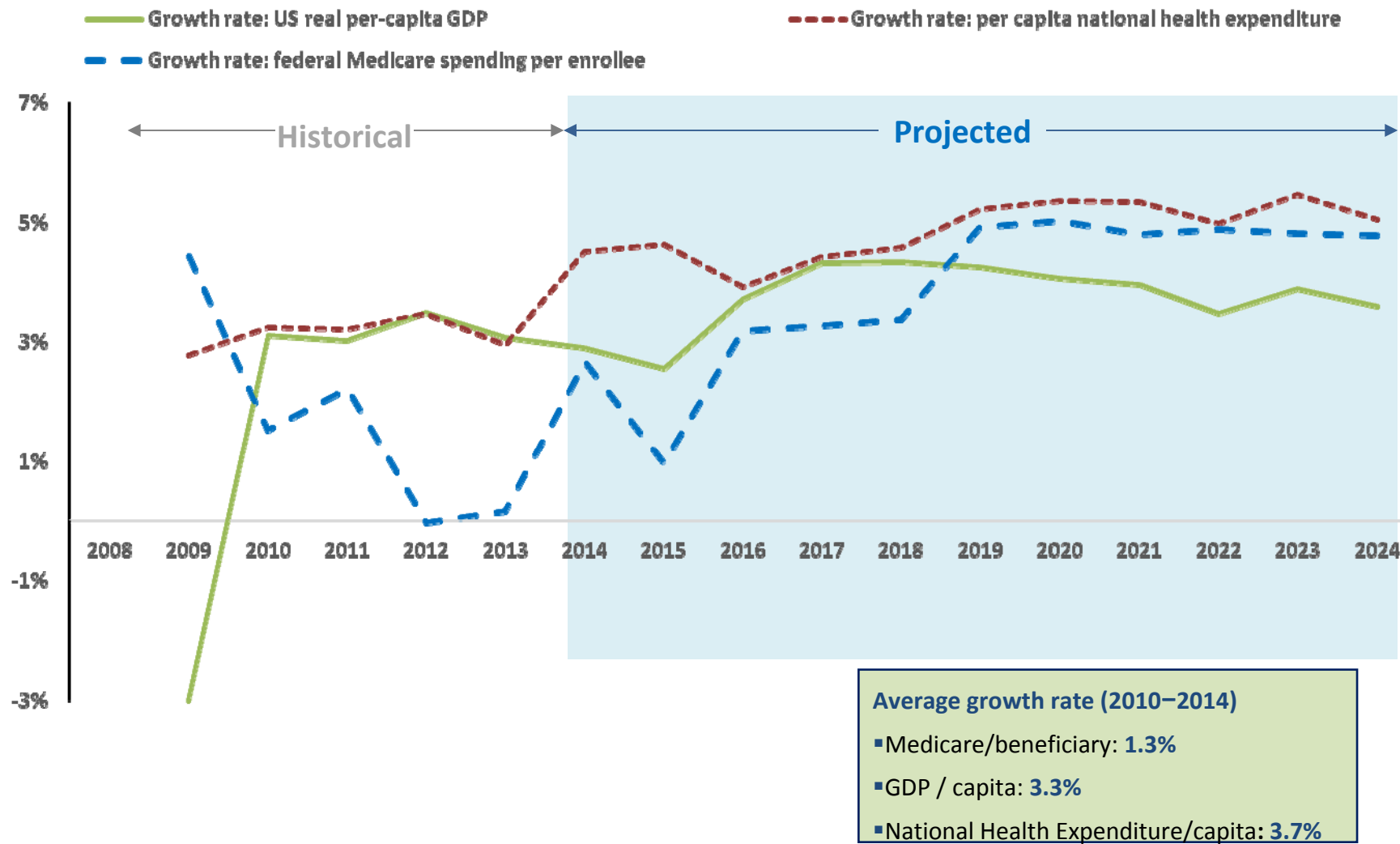
1) **Practice Transformation Networks:** peer-based learning networks designed to coach, mentor, and assist

2) **Support and Alignment Networks:** provides a system for workforce development utilizing professional associations and public-private partnerships



Medicare growth has fallen below GDP growth and national health expenditure growth since 2010 due, in part, to CMS policy changes and new models of care

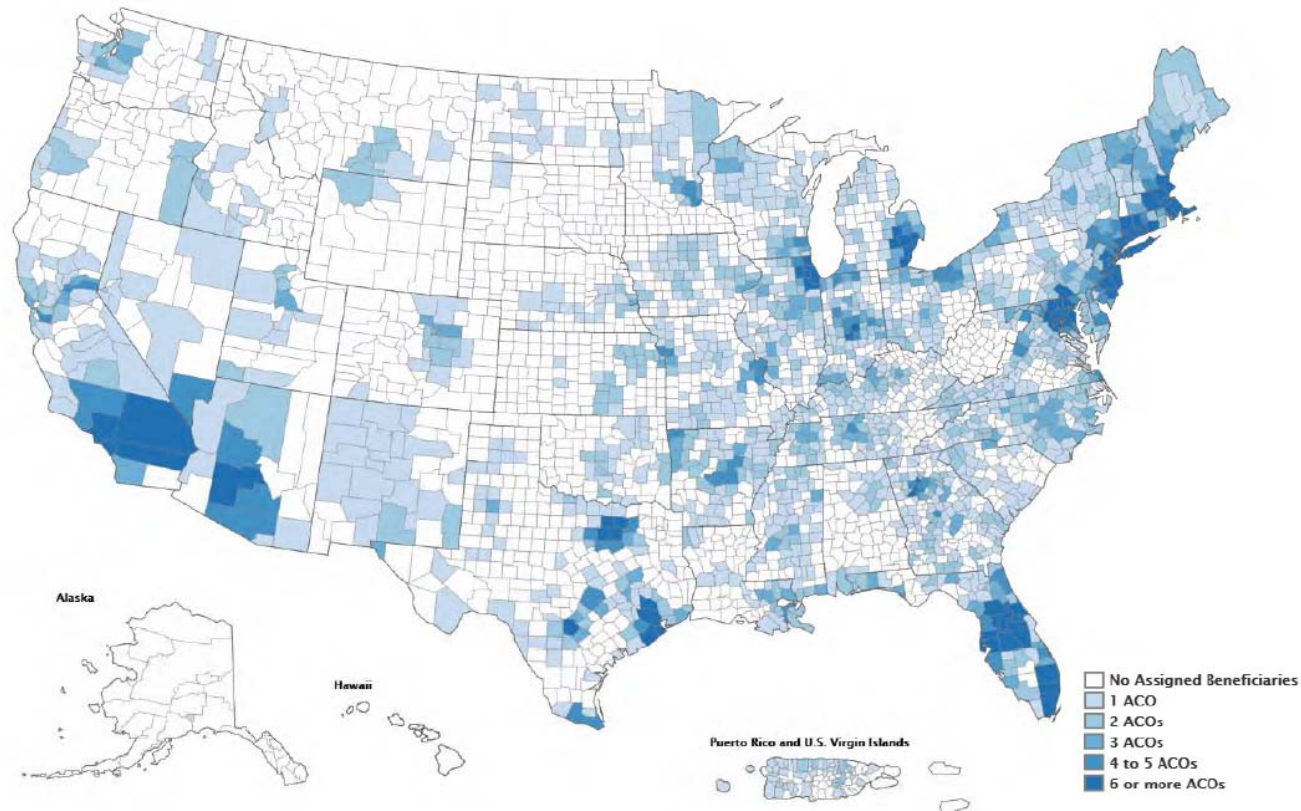
Gap between growth in federal Medicare spending, GDP growth and national health expenditure growth



Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **477 ACOs** have been established in the MSSP, Pioneer ACO, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **121 new ACOS** in 2016 of which **64 are risk-bearing** covering **8.9 million assigned beneficiaries** across 49 states & Washington, DC

ACO-Assigned Beneficiaries by County**



* January 2016

** Last updated April 2015

Independence at Home (IAH) Demonstration saved more than \$3,000 per beneficiary

- IAH tests a service delivery and shared savings model using **home-based primary care** to improve health outcomes and reduce expenditures for **Medicare beneficiaries with multiple chronic conditions**
- In year 1, demo produced more than **\$25 million in savings**, an average of \$3,070 per participating beneficiary per year
- CMS awarded **incentive payments of \$11.7 million to nine practices** that produced savings and met the designated quality measures for the first year
- All 17 participating practices **improved quality in at least three of the six** quality measures



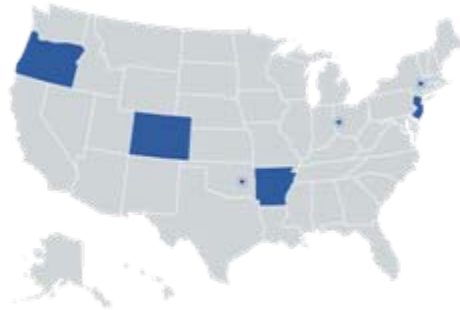
- There are 14 total practices, including 1 consortium, participating in the model
- Approximately 8,400 patients enrolled in the first year
- Duration of initial model test: 2012 - 2015

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



- **\$14 or 2%* reduction part A and B expenditure** in year 1 among all 7 CPC regions
- Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions

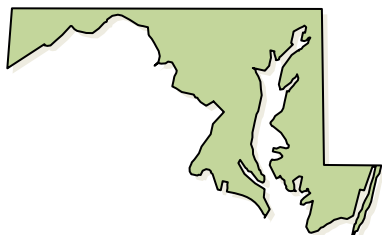


Source: Centers for Medicare & Medicaid Services

- 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

Maryland All-Payer Payment Model achieves \$116 million in cost savings during first year

- Maryland is the nation's only **all-payer hospital rate regulation system**
- Model will test whether effective accountability for both cost and quality can be achieved within all-payer system based upon **per capita total hospital cost growth**
- The All Payer Model had very positive **year 1 results** (CY 2014)
 - **\$116 million in Medicare savings**
 - **1.47% in all-payer total hospital per capita cost growth**
 - 30-day all cause **readmission rate reduced from 1.2% to 1% above national average**



- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
 - 95% of Maryland hospital revenue will be in global budgets
 - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

MACRA: What is it?

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

- Bipartisan legislation **repealing** the Sustainable Growth Rate (SGR) Formula
- Changes how Medicare **rewards** clinicians for **value** over volume
- 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

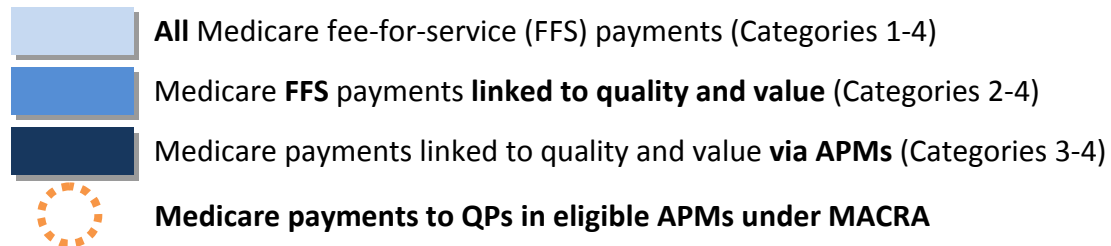
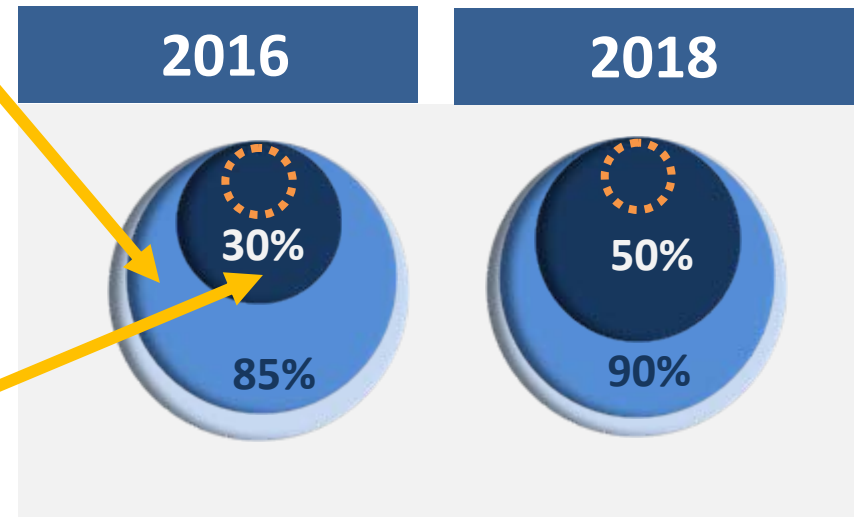
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

How MACRA 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 Alternative Payment Models** via the bonus payment for Qualifying APM Participants (QPs) and favorable scoring in MIPS for APM participants who are not QPs.

New HHS Goals:



Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

According
to MACRA
law, APMs
include:

- ✓ **CMS Innovation Center model**
(under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by Federal Law

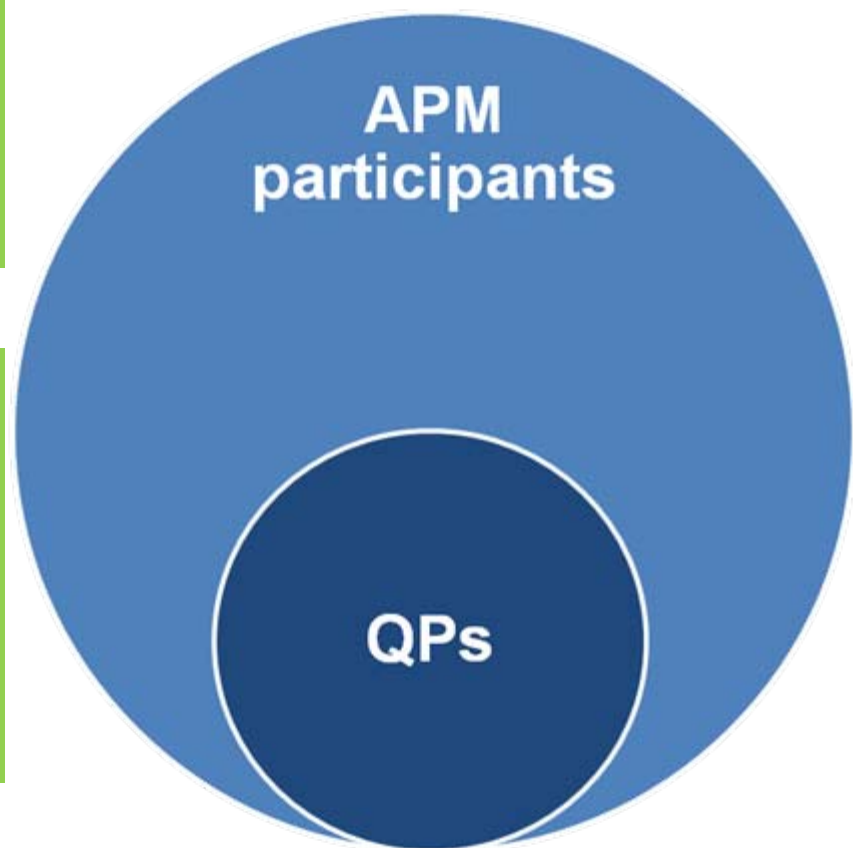
- MACRA **does not change how any particular APM rewards value**.
- APM participants who are not “QPs” will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **eligible** APMs.

How does MACRA provide additional rewards for participation in APMs?

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive **favorable scoring** under the MIPS clinical practice improvement activities performance category.

Those who participate in **the most advanced** APMs may be determined to be **qualifying APM participants (“QPs”)**. As a result, QPs:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward



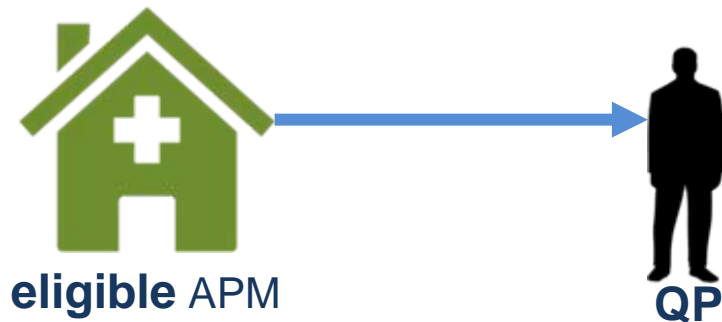
What is an **eligible** APM?



Eligible APMs are the **most advanced** APMs that meet the following criteria according to the MACRA law:

- ✓ **Base payment on quality** measures comparable to those in MIPS
- ✓ Require use of certified **EHR** technology
- ✓ Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

How do I become a **qualifying** APM participant (QP)?



QPs are physicians and practitioners who have a certain **% of their patients or payments** through an **eligible** APM.

Beginning in 2021, this threshold % may be reached through a **combination** of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

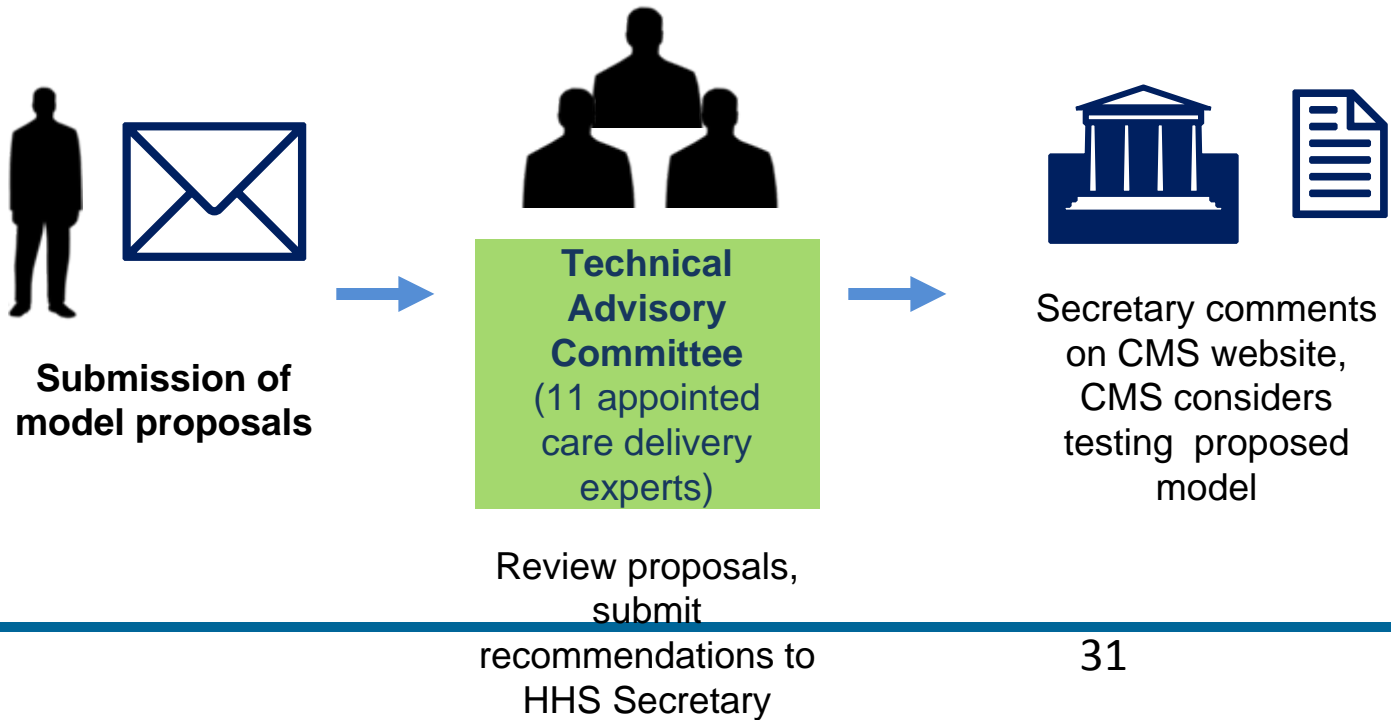
QPs:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward

Independent PFPM Technical Advisory Committee

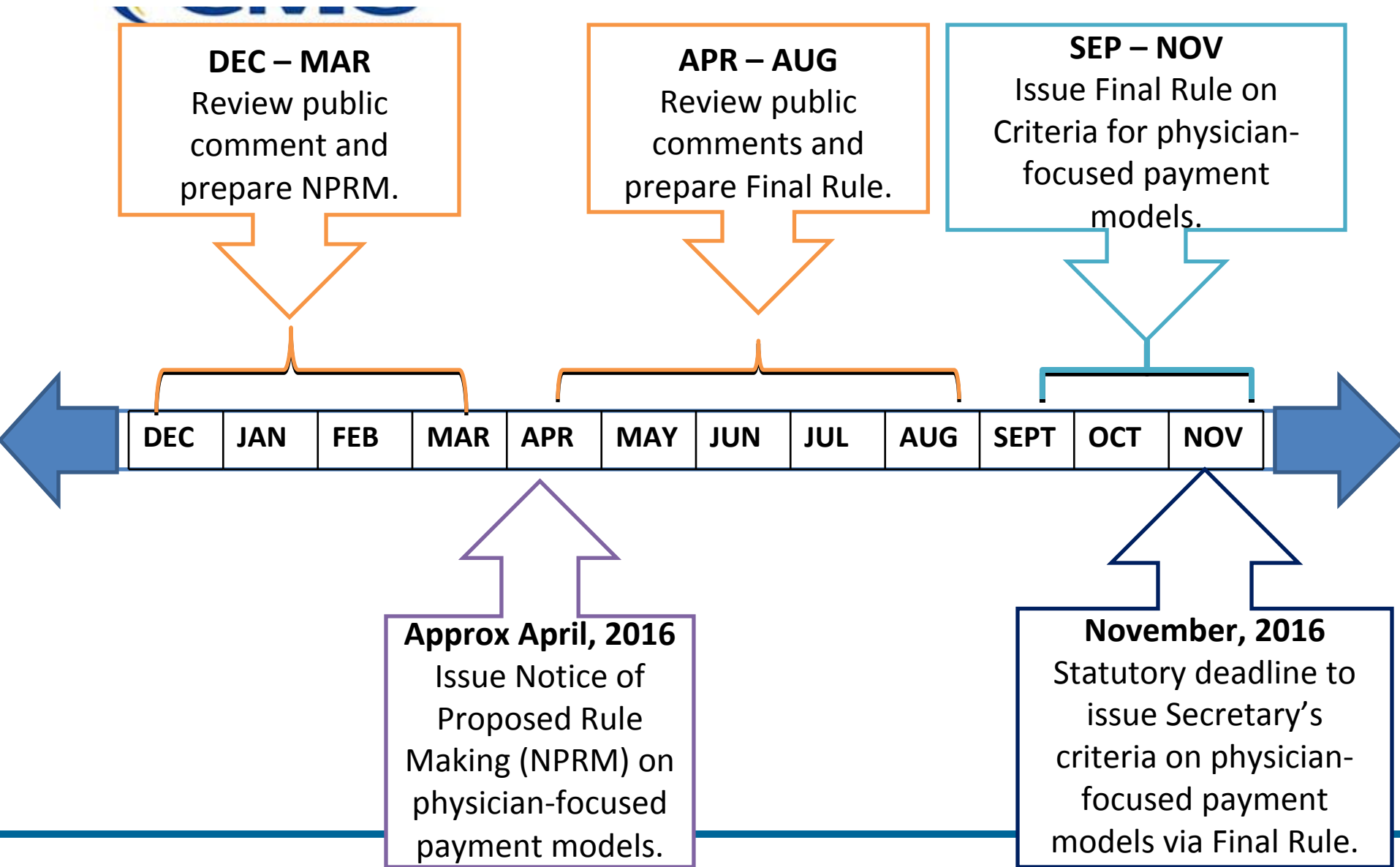
PFPM = Physician-Focused Payment Model

Encourage new **APM options** for Medicare physicians and practitioners.





APPROXIMATE TIMELINE FOR RULEMAKING ON CRITERIA FOR PHYSICIAN-FOCUSED PAYMENT MODELS



We are focused on:

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio