CMS Update:
Delivery and Payment System Reform

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HHS Mission

- To help more Americans achieve the security of quality, affordable health care for themselves and for their families;
- To keep food and medical products safe;
- To protect against chronic and infectious diseases;
- To help Americans find jobs;
- To help parents access affordable child care;
- To explore the frontiers of cutting-edge biomedical research; and
- To fulfill our obligations to tribal communities for health care and human services.

THE CMS STRATEGY

OUR STRATEGIC GOALS

BETTER CARE, ACCESS TO COVERAGE AND IMPROVED HEALTH

The CMS Strategy is Built on Four Main Goals:

GOAL 1
Better Care *and* Lower Costs

Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

GOAL 2
Prevention *and* Population Health

All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

GOAL 3
Expanded Health Care Coverage

All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.

GOAL 4
Enterprise Excellence

We will have achieved "Enterprise Excellence" when CMS' high quality, diverse workforce develops, supports and utilizes innovative strategies, tools and processes, and collaborates effectively with its partners and agents to reach its goals.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

50

MEDICARE

1965-2015

MEDICAID

ANNIVERSARY

REGION IX

The Way We Were

1960s	1970s	1980s	1990s	2000s
1965: Medicare enacted 1966: Medicare implemented	1972: Medicare eligibility extended 1972: additional Medicare authority to conduct demonstration programs 1973: HMO Act	1982: Tax Equity and Fiscal Responsibility Act 1983: inpatient acute care hospital prospective payment system adopted to replace cost-based payments 1988: Medicare Catastrophic Coverage Act of 1988 enacted (parts repealed in 1989) 1989: new Medicare fee schedule for physician and other professional services	1997: Balanced Budget Act of 1997; Children's Health Insurance Program (CHIP)	2000: Benefits Improvement and Protection Act (BIPA) 2003: Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

1960s

1960s

1965: Medicare enacted

1966: Medicare implemented

Over 19 million individuals enrolled by July 1, 1966.

Medicare provided hospital, post-hospital extended care, and home health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board).

In 1965, seniors were the population group most likely to be living in poverty; about half had health insurance coverage.

1970s

1970s

1972: Medicare eligibility extended

1972: additional Medicare authority to conduct demonstration programs

1973: HMO Act

Individuals under age 65 with long-term disabilities and individuals with end-stage renal disease (ESRD) became eligible for Medicare.

The HMO Act provided start-up funding for the development of health maintenance organizations (HMOs). The Medicare statute was also amended to provide for HMOs to contract to provide Medicare benefits to beneficiaries who choose to enroll.

1980s

1980s

1982: Tax Equity and Fiscal Responsibility Act

1983: inpatient acute care hospital prospective payment system adopted to replace cost-based payments

1988: Medicare Catastrophic Coverage Act of 1988 enacted (parts repealed in 1989)

1989: new Medicare fee schedule for physician and other professional services

TEFRA made it easier for HMOs to contract with the Medicare program providing for Medicare payments on a full-risk basis.

MCCA improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability. The Medicare drug benefit and other coverage enhancements were repealed after higher-income seniors protested new premiums.

A resource-based relative value scale replaced charge-based payments.

1990s

1990s

1997: Balanced Budget Act of 1997; Children's Health Insurance Program (CHIP)

BBA established new Medicare managed care and other private health plan choices for beneficiaries.

HCFA (now CMS) implemented five new prospective payment systems for Medicare services for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services.

BBA allowed for the testing of innovative approaches to payment and service delivery through research and demonstrations.

2000s

2000s

2000: Benefits Improvement and Protection Act (BIPA)

2003: Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

BIPA increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary co-payments, and improved Medicare coverage of preventive services.

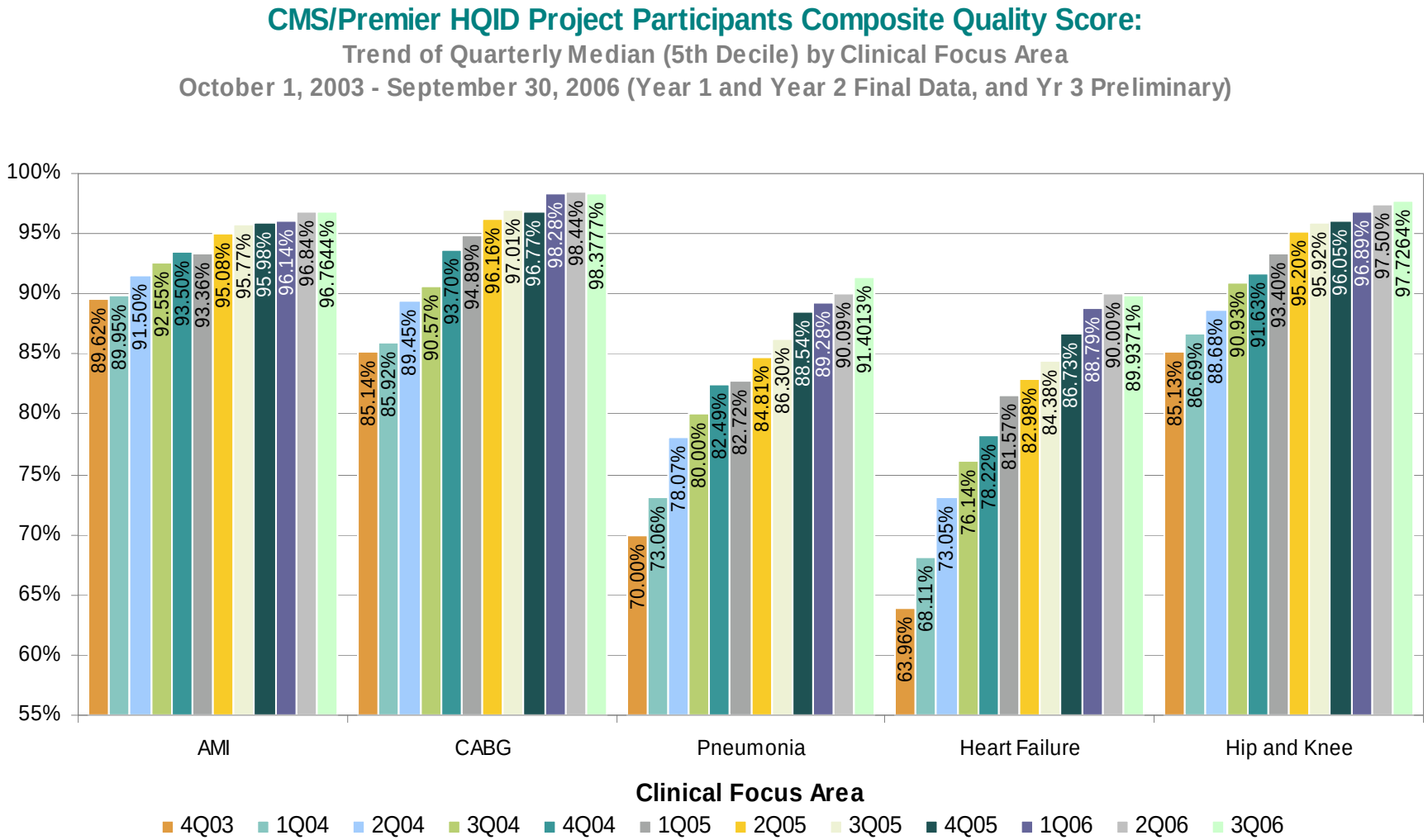
BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs).

MMA created a new optional outpatient prescription drug benefit (Part D), effective in 2006 for 39 million beneficiaries.

VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay for Performance Demonstration

Premier Hospital Quality Incentive Demonstration



VBP Demonstrations and Pilots

- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Accountable Care Episode (ACE) Demonstration
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration

VBP Programs

- Hospital Quality Initiative: Inpatient & Outpatient Pay for Reporting
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator Reporting
- Physician Quality Reporting Initiative
- Physician Resource Use Reporting
- Home Health Care Pay for Reporting
- ESRD Pay for Performance
- Medicaid

The Here and Now

2010s

2010: Patient Protection and Affordable Care Act (ACA)

2015: Medicare Access and CHIP Reauthorization Act (MACRA)

The ACA prohibits health insurance companies from denying or charging more for coverage based on an individual's health status, provides for expansion of the Medicaid program, and offers subsidies for insurance purchased through health insurance marketplaces to ensure that private insurance is affordable.

Other insurance reforms include new preventive benefit requirements, prohibitions on dollar limits, and expanded Medicare drug and preventive services benefits.

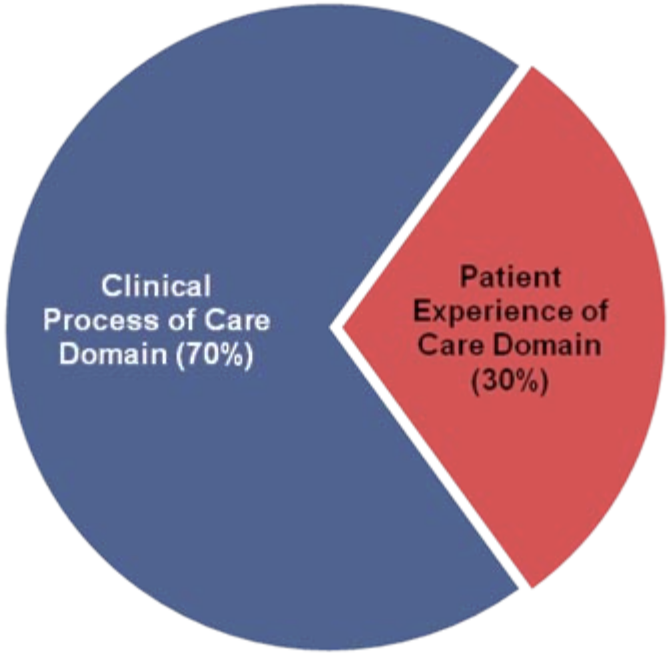
The ACA established the CMS Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center has flexibility to select and test the most promising innovative payment and service delivery models. The ACA provided $10 billion in direct funding for fiscal years 2011 through 2019.

FY2013 HVBP measures

12 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received Within 90 Minutes of Hospital Arrival
3. HF-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
10. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
11. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours

Weighted Value of Each Domain



8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness & Quietness
7. Discharge Information
8. Overall Hospital Rating

Fiscal Year (FY) 2016 Hospital Value-Based Purchasing Program

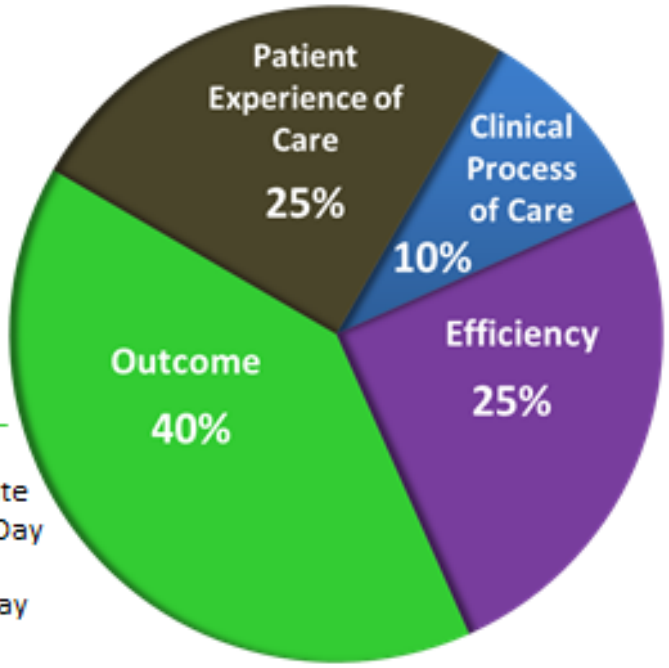
Patient Experience of Care

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Overall Rating of Hospital

Outcome

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
1. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
2. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
3. **AHRQ PSI-90**: Complication/patient safety for selected indicators (composite)
5. **CAUTI***: Catheter-Associated Urinary Tract Infection
6. **CLABSI**: Central Line-Associated Blood Stream Infection
7. **SSI***: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy



An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.

Clinical Process of Care

1. **AMI-7a**: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
2. **IMM-2***: Influenza Immunization
3. **PN-6**: Initial Antibiotic Selection for CAP in Immunocompetent Patient
4. **SCIP-Card-2**: Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
5. **SCIP-Inf-2**: Prophylactic Antibiotic Selection for Surgical Patients
6. **SCIP-Inf-3**: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
7. **SCIP-Inf-9**: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
8. **SCIP-VTE-2**: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

Efficiency

1. **MSPB-1:** Medicare Spending per Beneficiary (MSPB)

Fiscal Year (FY) 2017 Hospital Value-Based Purchasing Program

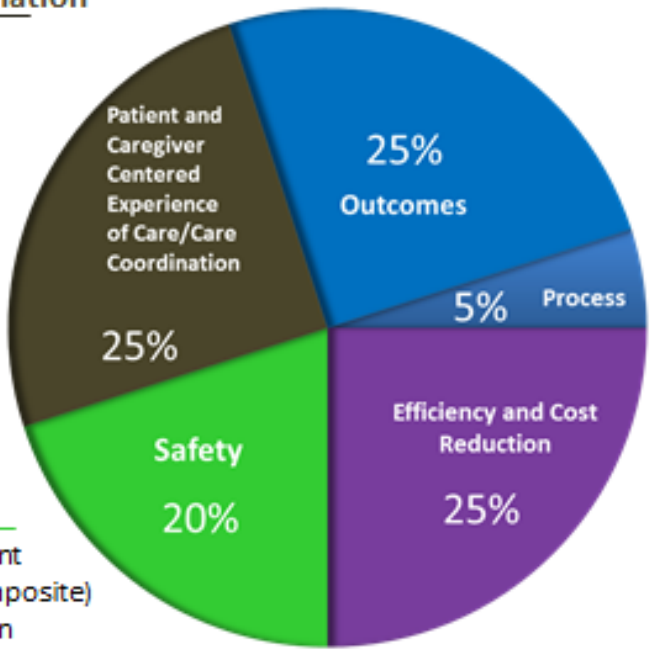
Patient and Caregiver Centered Experience of Care/Care Coordination

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Overall Rating of Hospital

Safety

1. **AHRQ PSI-90**: Complication/patient safety for selected indicators (composite)
2. **CDI***: Clostridium difficile Infection
3. **CAUTI**: Catheter-Associated Urinary Tract Infection
4. **CLABSI**: Central Line-Associated Blood Stream Infection
5. **MRSA***: Methicillin-Resistant Staphylococcus aureus Bacteremia
6. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy



An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.

Clinical Care Outcomes

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate

Clinical Care Process

1. **AMI-7a**: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
2. **PC-01***: Elective Delivery Prior to 39 Completed Weeks Gestation
3. **IMM-2**: Influenza Immunization

Efficiency and Cost Reduction

1. **MSPB-1:** Medicare Spending per Beneficiary (MSPB)

PQRI/S

- PQRI is a voluntary reporting program that began in 2007 pursuant to statute with modest 2% financial bonus
- Expanded measures and reporting options over time to facilitate reporting by broad array of eligible professionals (EPs) and groups
- CMS collects data from health care professionals on quality of care provided to to Medicare beneficiaries in various clinical settings via claims data or registry submission

What is the Value-Based Payment Modifier (VM)?

- The VM assesses the quality of care and cost of care furnished to Medicare Fee-for-Service beneficiaries during a performance period
- The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule (PFS)
- The VM is calculated at the Taxpayer Identification Number (TIN) level, and in 2016, will apply to physicians in groups with 10 or more eligible professionals (EPs) based on performance in 2014
- In 2016, the VM will not apply to groups with one or more physicians that participated in the Medicare Shared Savings Program (Shared Savings Program), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative in 2014

2015 PQRS and the 2017 Value Modifier

CY 2017 VM payment adjustment, for physicians in groups with 2+ EPs and physician solo practitioners

PQRS Reporters – 3 types

1a. Group reporters : Register for a PQRS GPRO (Web Interface, registry, or EHR) AND meet the criteria to avoid the 2017 PQRS payment adjustment

OR

1b.Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment

2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Physicians in groups with 2-9 EPs and physician solo practitioners

Upward or no VM adjustment based on quality-tiering (+0.0% to +2.0x)

Physician in groups with 10+ EPs

Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)

Non-PQRS Reporters

1. Groups: Do not avoid the 2017 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo practitioners: Do not avoid the 2017 PQRS payment adjustment as individuals

-2.0% (for physicians in groups with 2-9 EPs and physician solo practitioners)
-4.0% (for physicians in groups with 10+ EPs)
(Automatic VM downward adjustment)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

How does the VM work?

1. CMS Collects Cost, Quality Data

- Providers report performance on PQRS[1], CG-CAHPs[2] measures
- CMS track per capita costs for Medicare parts A and B

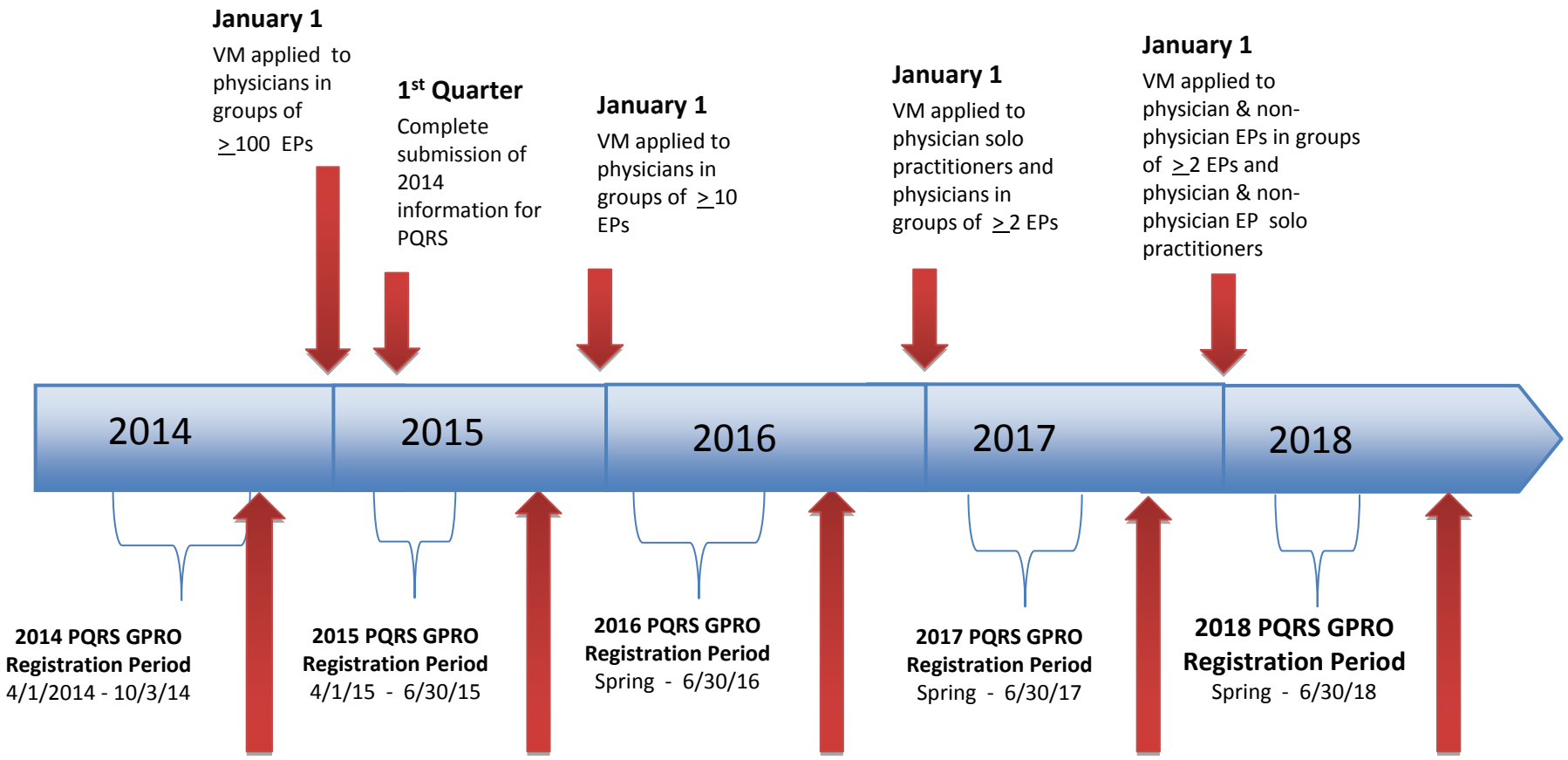
2. CMS Groups Providers into Quality Tiers

- Provider, group performance risk-adjusted, compared to national averages
- Final scores tiered, assigned modifiers

3. Medicare Payment Adjusted Based on Tiering

- High performing groups will receive payment boosts, low performers will see payment reduction
- Failure to participate in PQRS results in maximum penalty

Timeline for Phasing-in the Value Modifier



September 30, 2014

Retrieve 2013 QRUR that includes 2015 VM adjustment information

(All physician groups and physician solo practitoners)

Late Summer 2015

Retrieve 2014 QRUR that includes 2016 VM adjustment information

(All groups and solo practitioners)

Late Summer 2016

Retrieve 2015 QRUR that includes 2017 VM adjustment information

(All groups and solo practitoners)

Late Summer 2017

Retrieve 2016 QRUR that includes 2018 VM adjustment information

(All groups and solo practitoners)

Late Summer 2018

Retrieve 2017 QRUR that includes 2019 VM adjustment information

(All groups and solo practitoners)

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

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) – 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** – 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 ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management
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 ▪ **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

Spotlight: Health Care Innovation Awards, The YMCA

The Young Men's Christian Association (YMCA) is a Round One Health Care Innovation Awardee serving overweight adults with a Diabetes Prevention Program.

Services made possible by HCIA investment

- Diabetes prevention
  - Teaches patients how to incorporate healthier eating, moderate physical activity, problem-solving, and coping skills into their daily lives
  - When compared to national averages for participants in the YMCA's Diabetes Prevention Program, CMMI participants achieved stronger outcomes
- Collaboration Success
  - The CMMI Project provided a platform for several of the nation's leading public health organizations to join forces and help those at risk for type 2 diabetes, including: American Diabetes Assoc., American Heart Assoc., and American Medical Assoc.

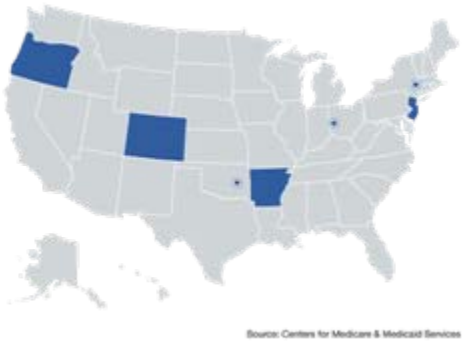
Participant Feedback

Chuck and Carol, who were at risk for type 2 diabetes. After starting in the program, Carol said, "I feel better and I have more energy." Chuck said, "My A1c has gone from 5.7 to 4.9…everyone of my tests came back improved."

Comprehensive Primary Care (CPC) is showing early 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



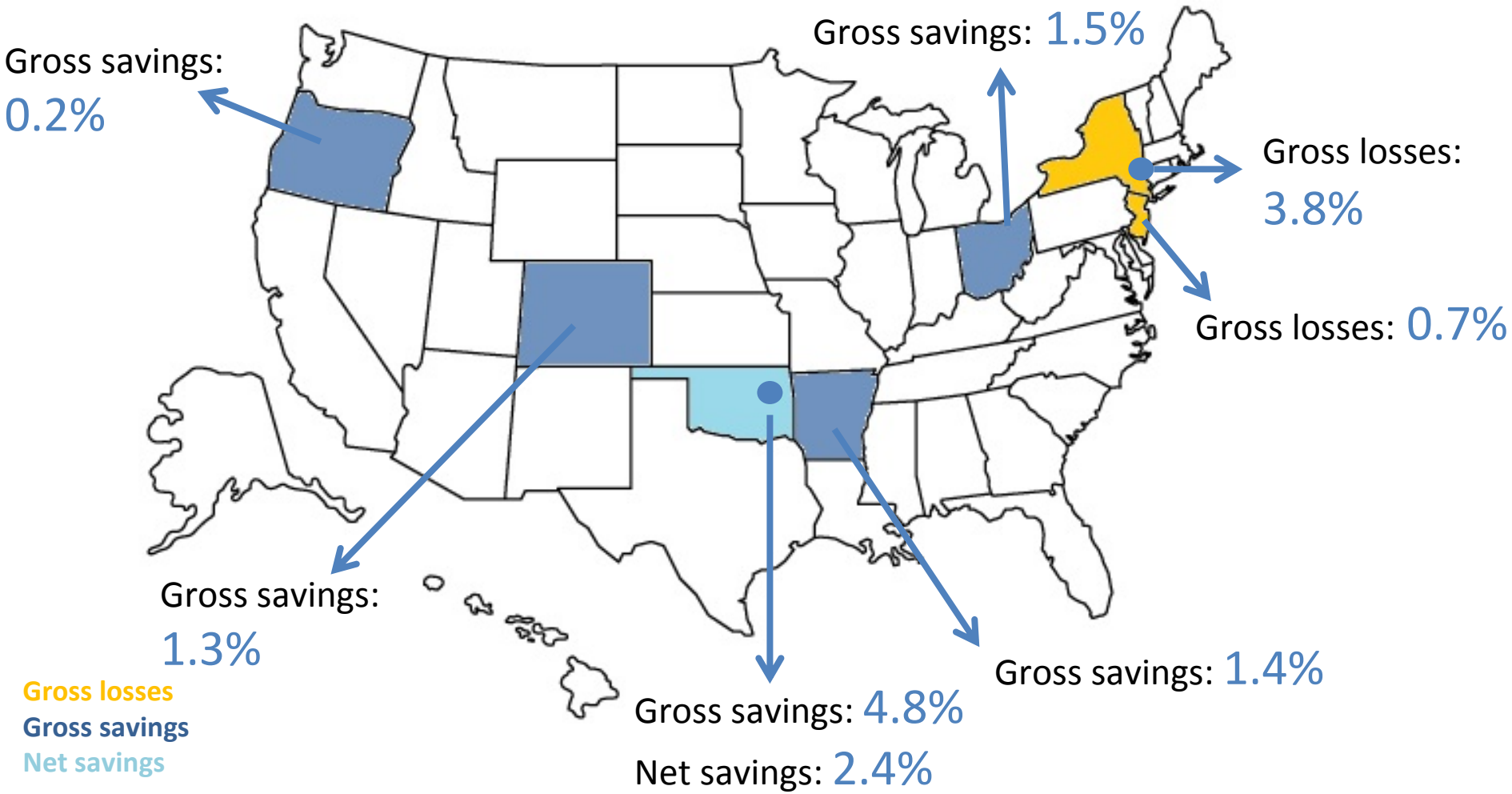
Source: Centers for Medicare & Medicaid Services

- 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

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

CPC shared savings results for 2014 (performance year 2*) varied

Results based on actuarial benchmarking methodology



*2014 CPC Shared Savings & Quality Results

Spotlight:
Comprehensive Primary Care, SAMA Healthcare

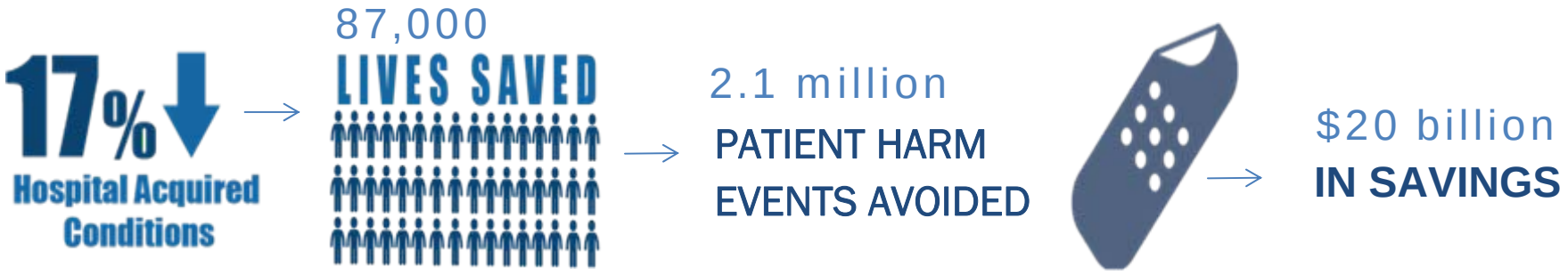
SAMA Healthcare Services is an independent four-physician family practice located located in El Dorado, a town in rural southeast Arkansas

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**

Partnership for Patients contributes to quality improvements

Data shows from 2010 to 2014…



Leading Indicators, change from 2010 to 2013

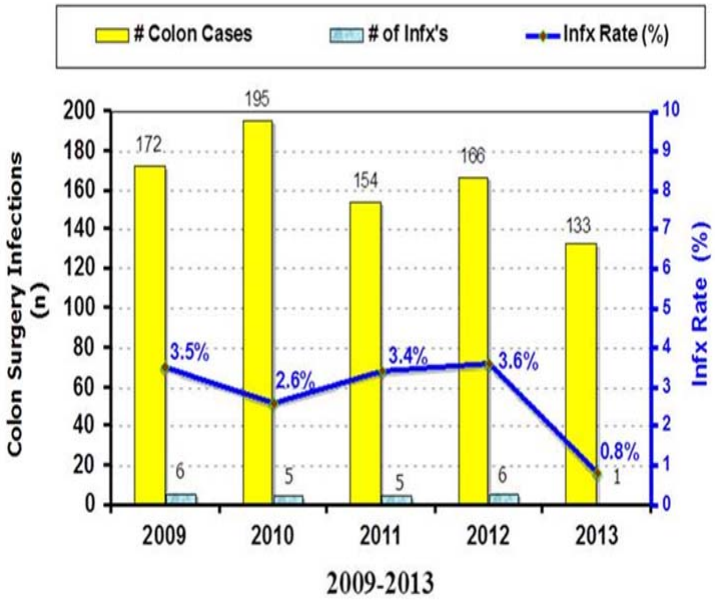
Ventilator-Associated Pneumonia	Early Elective Delivery	Central Line-Associated Blood Stream Infections	Venous thromboembolic complications	Re-admissions
62.4% ↓	70.4% ↓	12.3% ↓	14.2% ↓	7.3% ↓

Spotlight: Partnership for Patients (PFP), Lutheran Medical Center Brooklyn NY

Lutheran Medical Center is a 450 bed "safety net" Level I Trauma hospital *(large uninsured, Medicaid and diverse vulnerable population).* PFP 1.0 New York Hospital Engagement Network

Outcomes made possible in reducing surgical site infections (SSI)

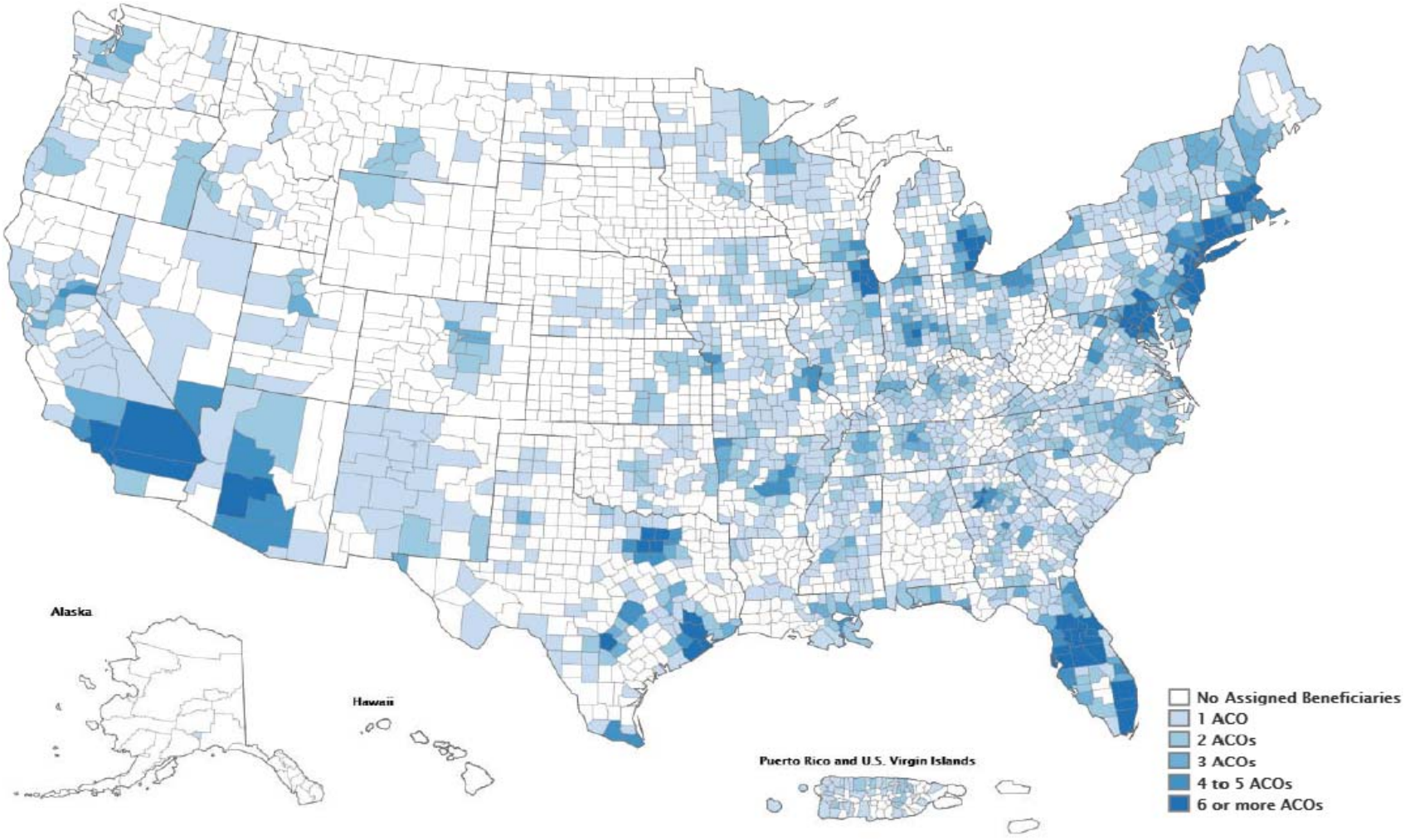
- Safer colon surgery
  - Has reduced the number of Colon Surgical Site Infections from 3.5% to 0.8%.
- Strategy
  - **Culture change:** Inter-departmental "all levels of providers" (no hierarchy), open forum monthly SSI meetings
  - **Process change:**
    - Advanced colon bundles (tight glucose control, active warming, hyper O_2, clean closures, etc.)
    - Creation functional and replicable process
    - Nurse driven protocols
    - Use cheap timers for antibiotics
    - Antibiotic selection posters and education to all providers



Lutheran Medical shows that it doesn't take Expensive tools to keep patients safe

ACO Participation

ACO-Assigned Beneficiaries by County



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

- Designed for **ACOs that are experienced** in coordinating care for populations of patients
- These ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- The model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth and skilled nursing facilities)
- More **predictable financial targets**

Model Principles

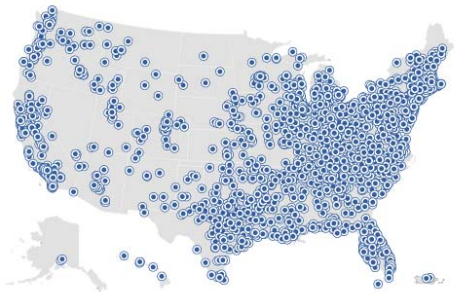
- Prospective attribution
- Financial model for long-term stability
- Reward quality
- Benefit enhancements that improve patient experience
- Protect freedom of choice
- Allow beneficiaries to choose alignment with ACO
- Smooth ACO cash flow and improved investment capabilities

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 1237 Episode Initiators as of January 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

A Beneficiary Success Story

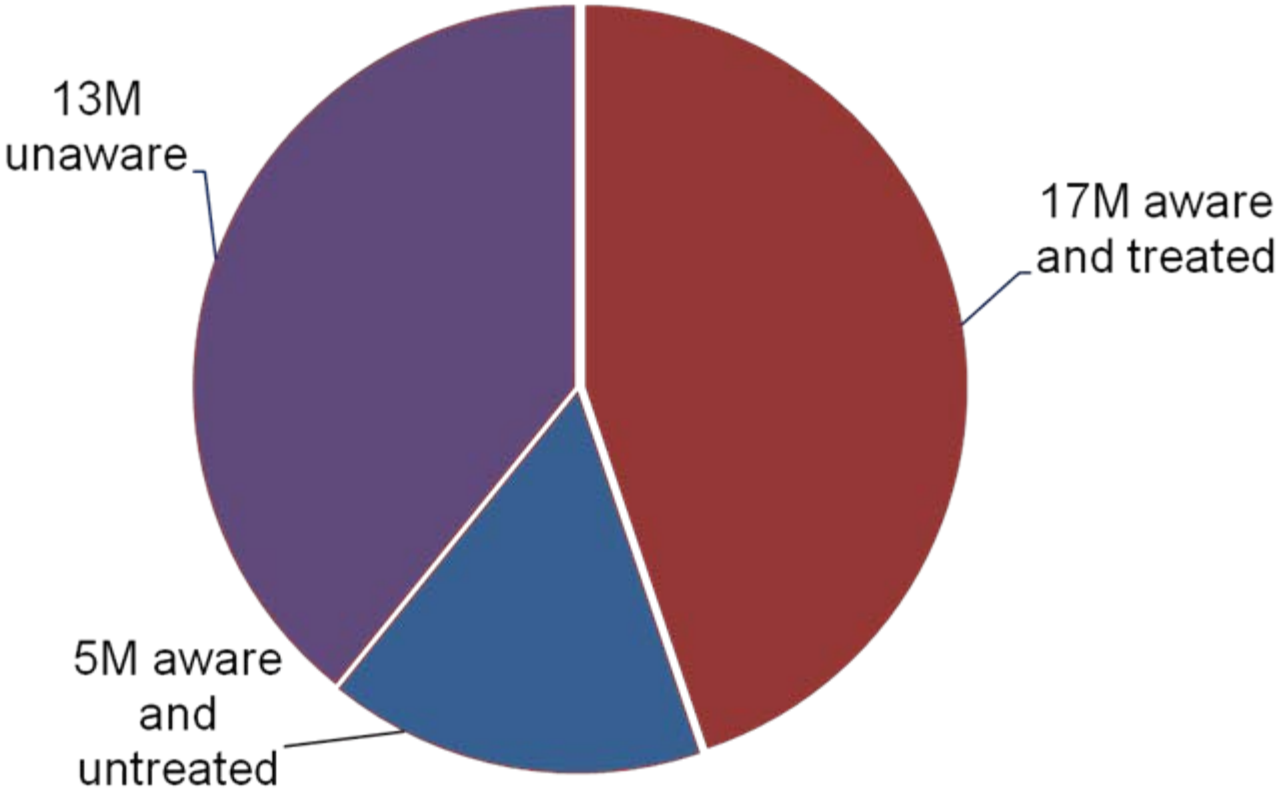
71 year old patient with CHF, CABG, sleep apnea with heavy alcohol and drug abuse history, who was estranged from family and lived alone, had no readmissions or ED visits post discharge during 90 bundle or 6 months after clinical episode concluded

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

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

Focus on Population Health: 34M Adults With Uncontrolled Hypertension (by Awareness And Treatment Status)



Source: 2009-2010 National Health and Nutrition Examination Survey
Data may not add due to 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

*Uses American College of Cardiology/American Heart Association (ACA/AUA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

Focus on Social Determinants of Health: Addressing Social Needs

- Hospital Readmission Reduction…what's the problem?
  - **High re-admission rates could indicate breakdowns in care delivery systems**
    - Payment systems incentivized fragmentation
    - More complicated cases = more "hands in the pot"
    - Expectation of patients to self-manage is great

Clinician-patient interaction
→Episodic treatment
→Unmanaged condition worsening
→Use of suboptimal medication regiments
→Lack of primary care or social support

→Return to ER

No community infrastructure to achieve common care goals
→Lack of standard communication
→Unreliable information transfer
→Unsupported patient/family engagement during transfers
→Lack of follow-up to address prevention

Accountable Health Communities Model addresses health-related social needs

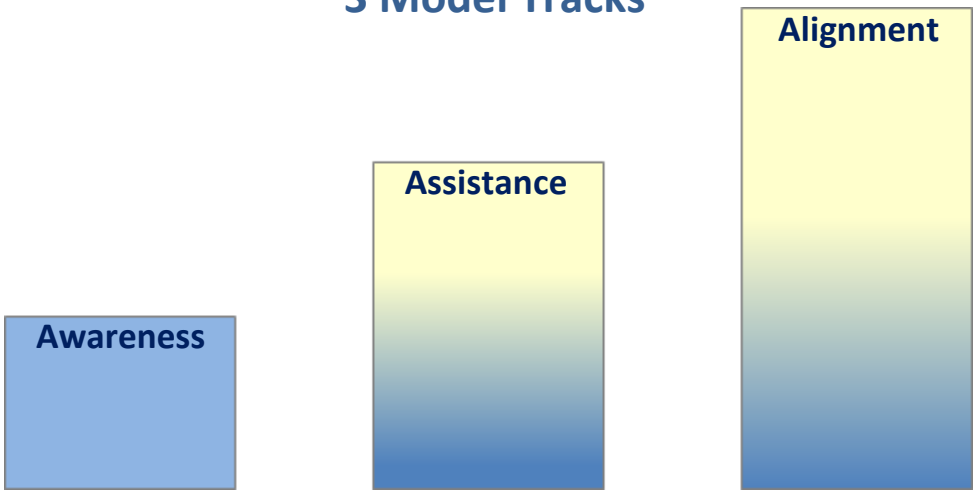
Key Innovations

- **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

https://innovation.cms.gov/initiatives/ahcm

CMS Health Equity Plan for Medicare

Priority 1: Expand the Collection, Reporting, and Analysis of **Standardized Data**

Priority 2: Evaluate **Disparities Impacts** and Integrate Equity Solutions Across CMS Programs

Priority 3: Develop and Disseminate **Promising Approaches** to Reduce Health Disparities

Priority 4: Increase the Ability of the **Health Care Workforce** to Meet the Needs of Vulnerable Populations

Priority 5: Improve **Communication & Language Access** for Individuals with LEP & Persons with Disabilities

Priority 6: Increase **Physical Accessibility** of Health Care Facilities

Key CMS Priorities in health system transformation

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on 3 areas

Incentives

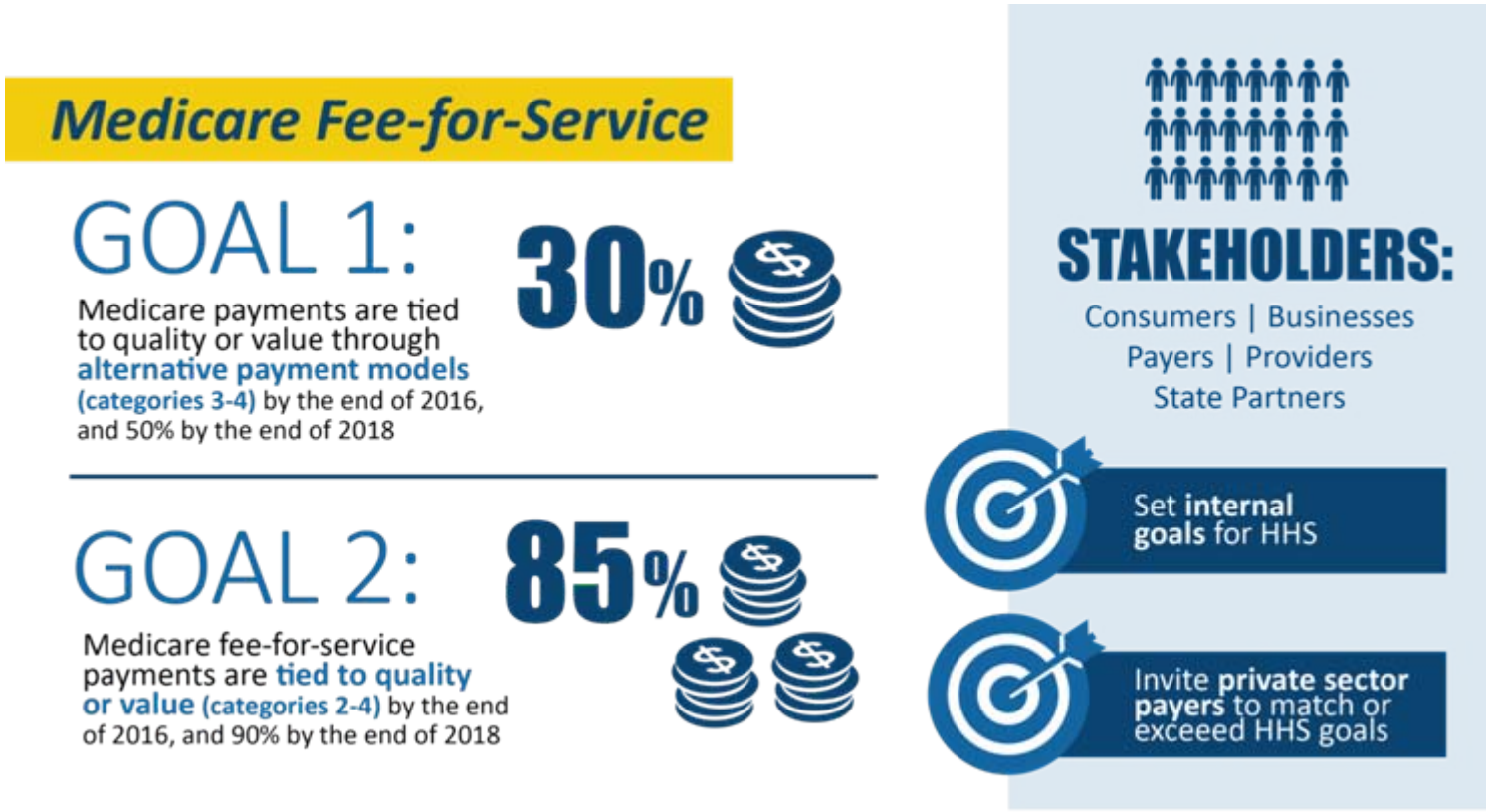
Care Delivery

Information Sharing

Affordable Care Act → **MACRA**

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**



What is “MACRA”?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

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

MACRA streamlines those programs into **MIPS**:

Merit-Based Incentive Payment System **(MIPS)**

How will physicians and practitioners be scored under MIPS?

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

Quality

Resource use

Clinical practice improvement activities

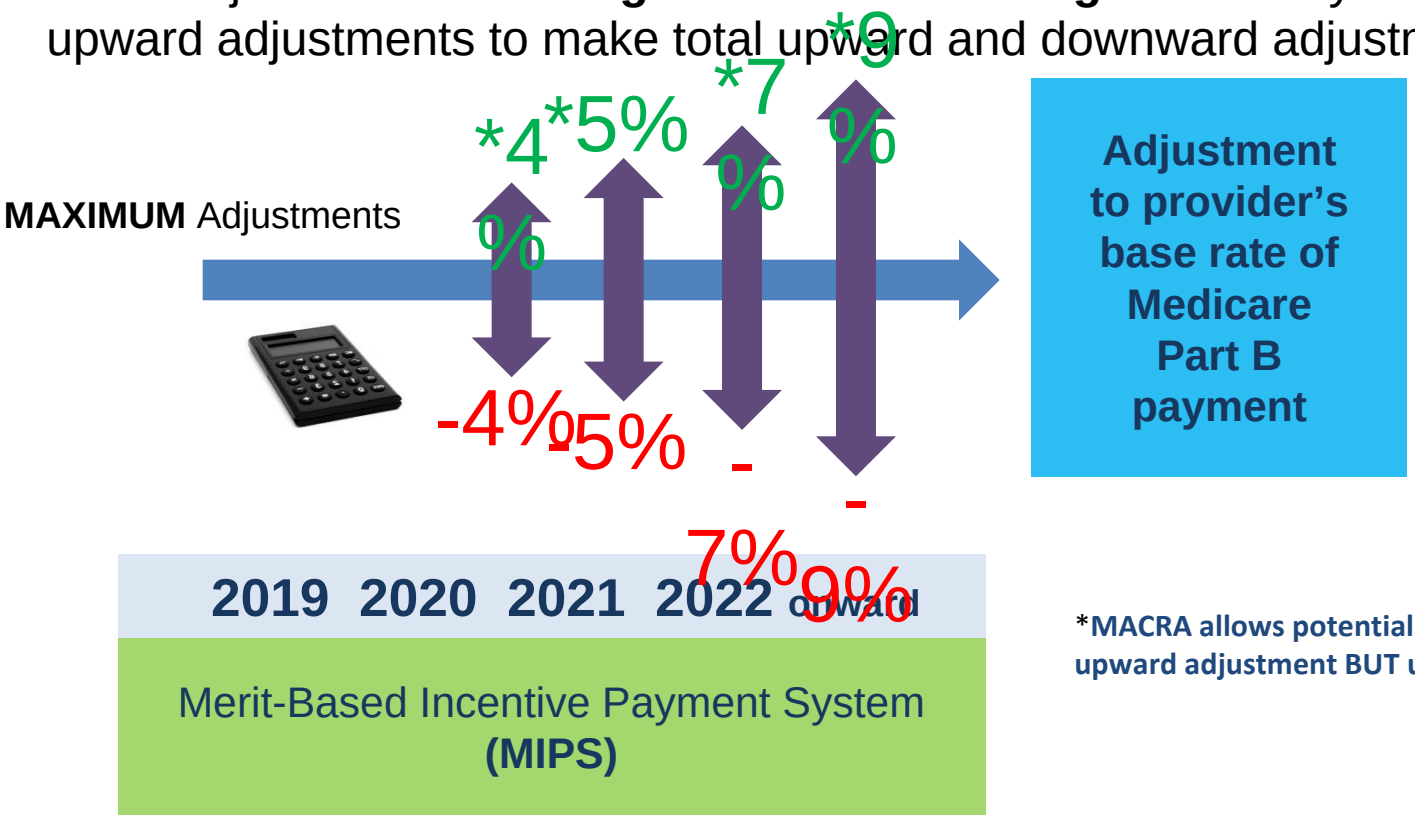
Meaningful use of certified EHR technology

MIPS Composite Performance Score

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.



Are there any exceptions to MIPS adjustments?

There are **3 groups** of physicians and practitioners who will NOT be subject to MIPS:

FIRST year of Medicare participation

Participants in eligible Alternative Payment Models who qualify for the bonus payment

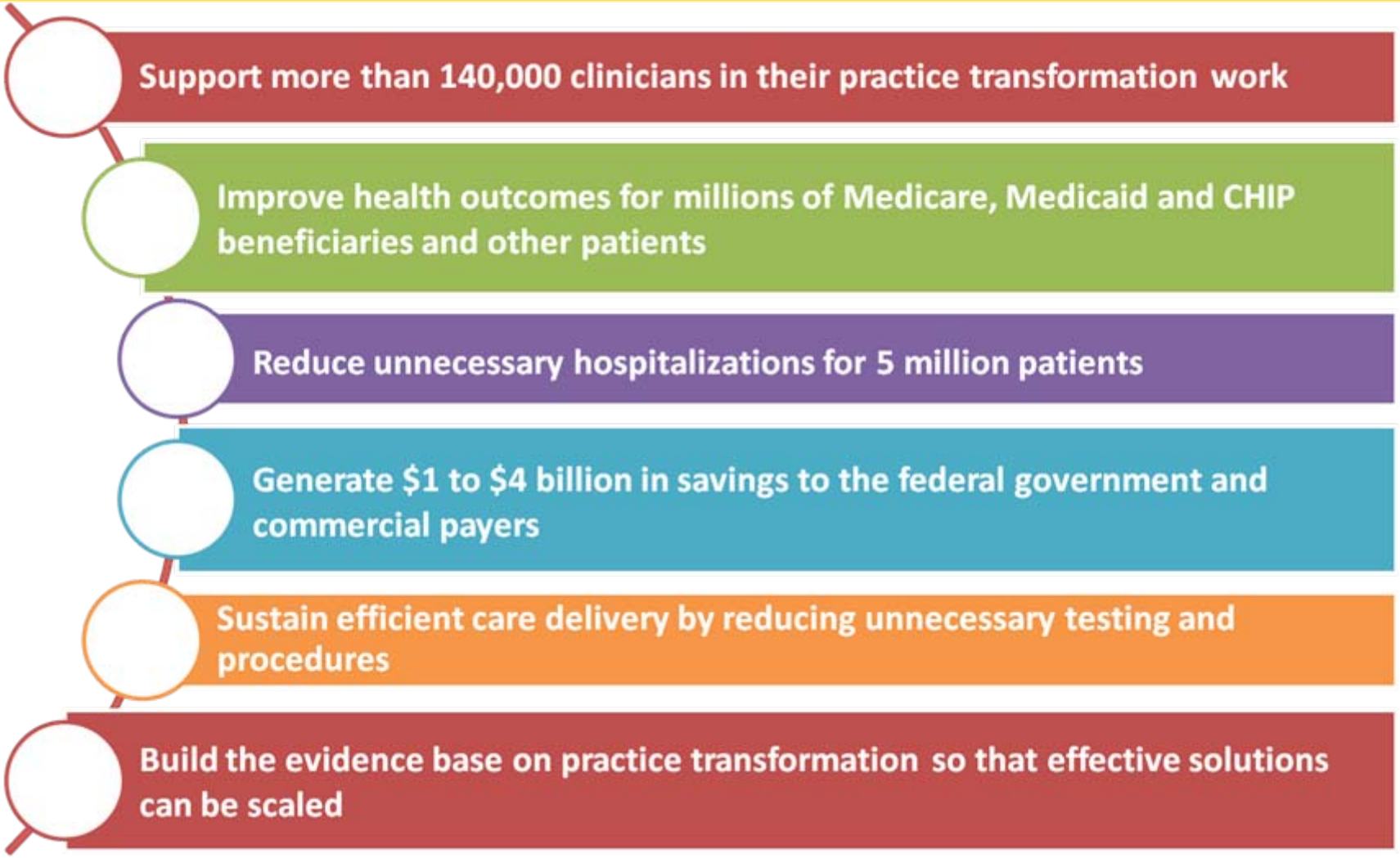
Below low volume threshold

Note: MIPS **does not** apply to hospitals or facilities (i.e., FQHCs)

What should I do to prepare for MACRA?

- Look for future educational activities
- Look for a proposed rule in spring 2016 and provide comments on the proposals.
- Final rule targeted for early fall 2016
- Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.

Transforming Clinical Practice Initiative



Practice Transformation Networks (PTNs) In Region 9

- Arizona Health-e Connection
- Children's Hospital of Orange County
- Local Initiative Health Authority of Los Angeles County
- National Rural Accountable Care Consortium
- Pacific Business Group on Health
- VHA/UHC Alliance Newco, Inc.

Support and Alignment Networks (SANs)

- American College of Emergency Physicians
- American College of Physicians
- HCD International, Inc.
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium

References & Further Reading

Health Care Payment Learning and Action Network
http://innovationgov.force.com/hcplan

CMS Innovation Center
https://innovation.cms.gov/

CMS Draft Quality Measures Development Plan
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-CMS-Quality-Measure-Development-Plan-MDP.pdf

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

CMS Health Equity Plan
https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

Contact information for the Transforming Clinical Practice Initiative
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx

Questions?

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