CENTERS FOR MEDICARE & MEDICAID SERVICES
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Health System Transformation
Federal Initiatives in Value Based Payments

Patrick Conway, MD, MSc

Acting Administrator and Deputy Administrator for Innovation and Quality

Director, Center for Medicare and Medicaid Innovation

Center for Medicare and Medicaid Services (CMS)

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

Key characteristics

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

Key characteristics

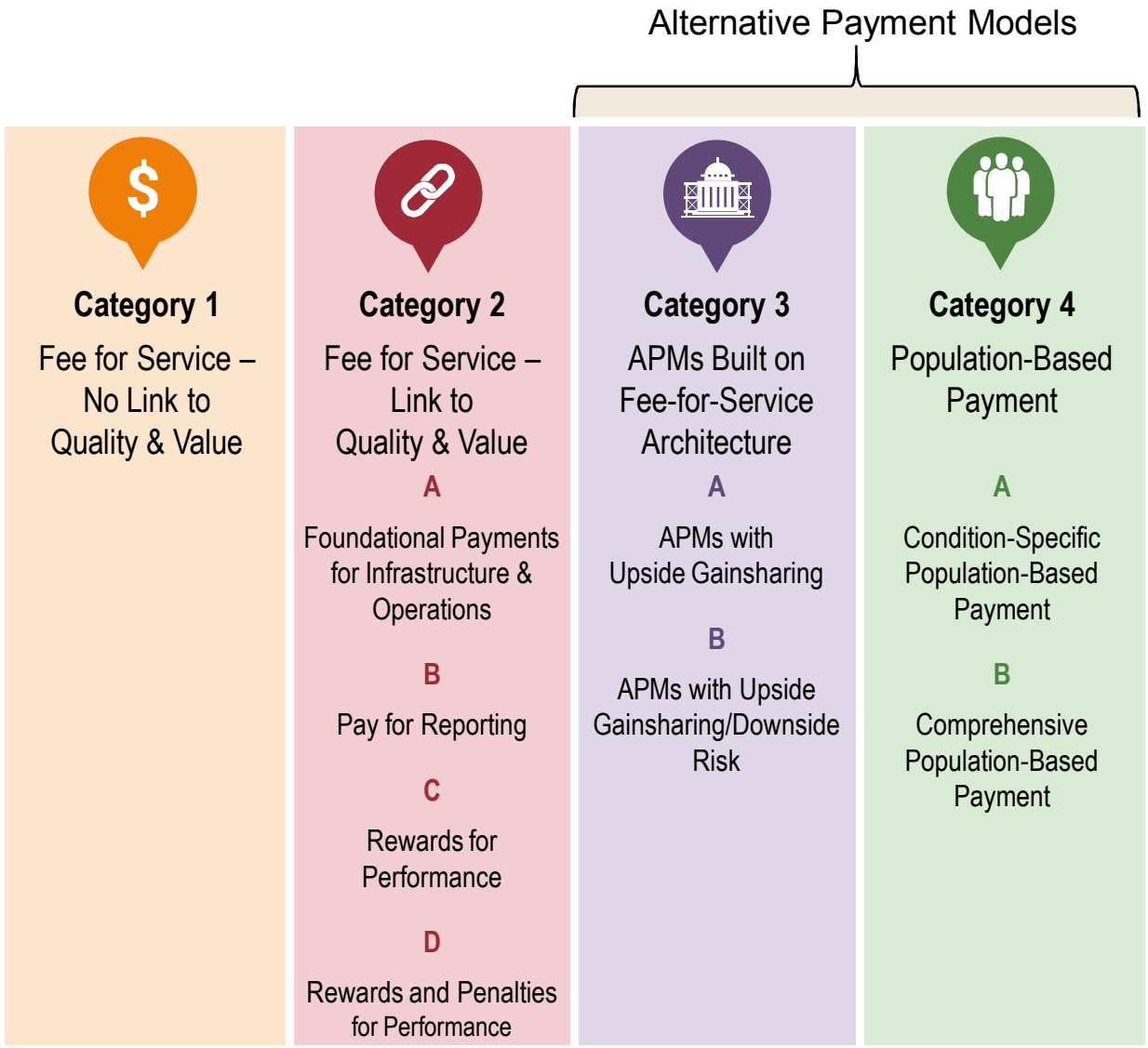
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

APM FRAMEWORK

At-a-Glance

The framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities



The framework situates existing and potential APMs into a series of categories.

HCP LAN
Health Care Payment Learning & Action Network

January 2015 – HHS announced goals for **value-based payments** within **Medicare FFS system**

March 2016 – HHS announced that goal of 30% payments tied to quality through APMs achieved one year ahead of schedule

Medicare Fee-for Service

GOAL: 30%

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

Next Steps

1. **Testing of new models**
2. **Health Care Payment Learning and Action Network**

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
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

National Results on Patient Safety
Substantial progress thru 2014, compared to 2010 baseline

- **21 percent decline in overall harm**
- **125,000 lives saved**
- **$28B in cost savings from harms avoided**
- **3.1M fewer harms over 5 years**

Source: Agency for Healthcare Research & Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update. Interim Data From National Efforts To Make Care Safer, 2010-2014." December 1, 2015.

The Innovation Center portfolio aligns with delivery system reform focus areas

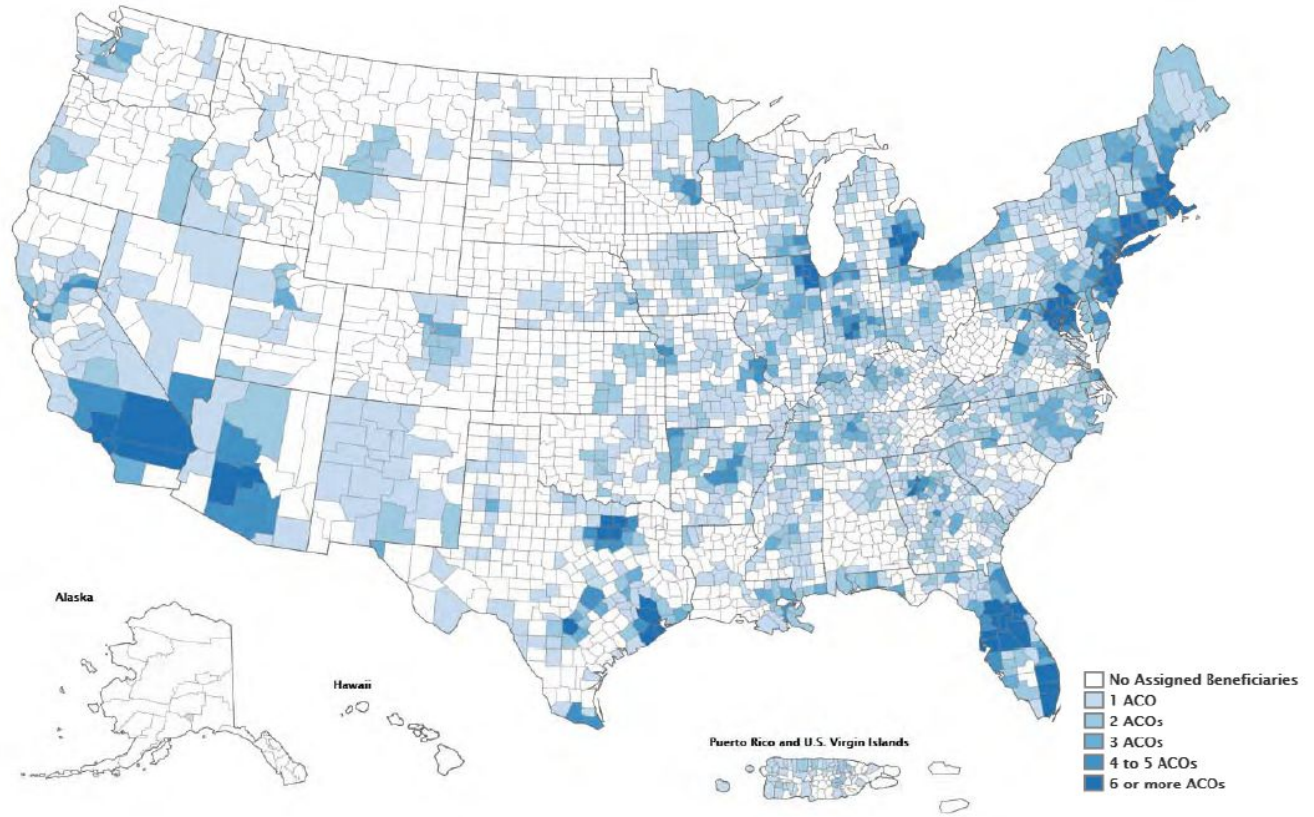
Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Comprehensive ERSD Care Initiative – Next Generation ACO ▪ **Primary 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 – Medicare Diabetes Prevention Program ▪ **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
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice ▪ **Health Care Innovation Awards** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health 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** ▪ **Information to providers in CMMI models** ▪ **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **562 ACOs** have been established in the MSSP, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **121 new ACOS** in 2017 **(of which 121 are risk-bearing)** covering **12.3 million assigned beneficiaries.**

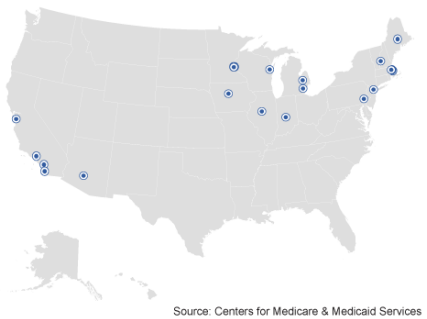
ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

Pioneer ACOs meet requirement for expansion after two years and continued to generate savings in performance year 3

- Pioneer ACOs were designed for **organizations with experience in coordinated care** and ACO-like contracts
- Pioneer ACOs **generated savings for three years in a row**
  - **Total savings** of $92 million in PY1, $96 million in PY2, and $120 million in PY3‡
  - **Average savings per ACO increased** from $2.7 million in PY1 to $4.2 million in PY2 to $6.0 million in PY3‡
- Pioneer ACOs showed **improved quality outcomes**
  - **Mean quality score increased** from 72% to 85% to 87% from 2012–2014
  - Average performance score **improved in 28 of 33 (85%) quality measures** in PY3
- Elements of the Pioneer ACO have been **incorporated into track 3 of the MSSP ACO**



Source: Centers for Medicare & Medicaid Services

- 19 ACOs operating in 12 states (AZ, CA, IA, IL, MA, ME, MI, MN, NH, NY, VT, WI) reaching over 600,000 Medicare fee-for-service beneficiaries
- Duration of model test: January 2012 – December 2014; 19 ACOs extended for 2 additional years

‡ Results from actuarial analysis

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

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

- **45** ACOs will assume **higher levels of financial risk and reward** than other Medicare ACO initiatives
- 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)

Source: Centers for Medicare & Medicaid Services

45 ACOs spread among 20 states

Model Principles

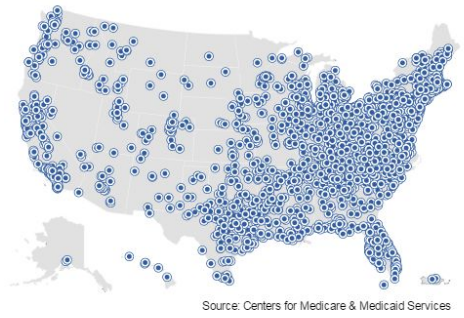
- Prospective attribution
- Financial model for long-term stability (smooth cash flow, improved investment capability)
- Rewards quality
- Benefit enhancements that improve patient experience & protect freedom of choice
- Allows beneficiaries to choose alignment

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

- 305 Awardees and over 1143 Episode Initiators as of July 2016



Source: Centers for Medicare & Medicaid Services

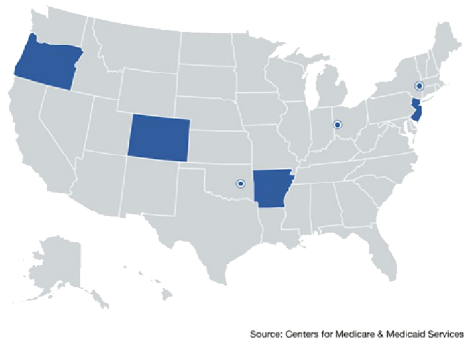
- Duration of model is scheduled for 3 years:
  - Model 1: Awardees began Period of Performance in April 2013
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013

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

CPC Comprehensive Primary Care

- **$11 or 1%* reduction part A and B expenditure** in the first 2 years (through 9/2014) among all 7 CPC
- 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)

Comprehensive Primary Care Plus (CPC+)

CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

Goals

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Empower practices to provide comprehensive care that meets the needs of all patients.
3. Improve quality of care, improve patients' health, and spend health care dollars more wisely.

Participants and Partners

- 5 year model: 2017-2021
- Up to 5,000 practices in up to 20 regions
- Two tracks depending on practice readiness for transformation and commitment to advanced care delivery for patients with complex needs
- Public and private payers in CPC+ regions
- HIT vendors (official partners for Track 2 only)

Care Transformation Functions


Access and continuity


Care management


Comprehensiveness and coordination


Patient and caregiver engagement


Planned care and population health

Payment Redesign Components


PBPM risk-adjusted care management fees

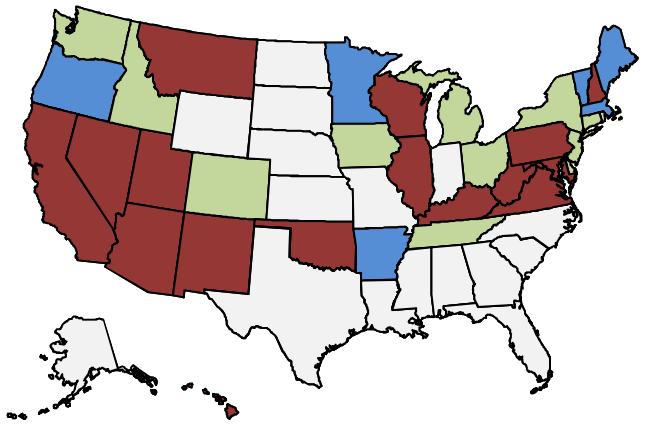

Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care


For Track 2, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to offer flexibility in delivering care outside traditional office visits

State Innovation Model grants have been awarded in two rounds

- CMS is testing the ability of **state governments to utilize policy and regulatory levers** to accelerate health care transformation

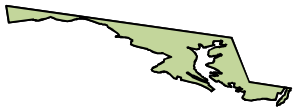
- Primary objectives include
  - Improving the **quality of care** delivered
  - Improving **population health**
  - Increasing **cost efficiency** and expand **value-based payment**



- Six round 1 model **test states**
- Eleven round 2 model **test states**
- Twenty one round 2 model **design states**

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) in NEJM
  - **$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

* US census bureau estimate for 2013

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

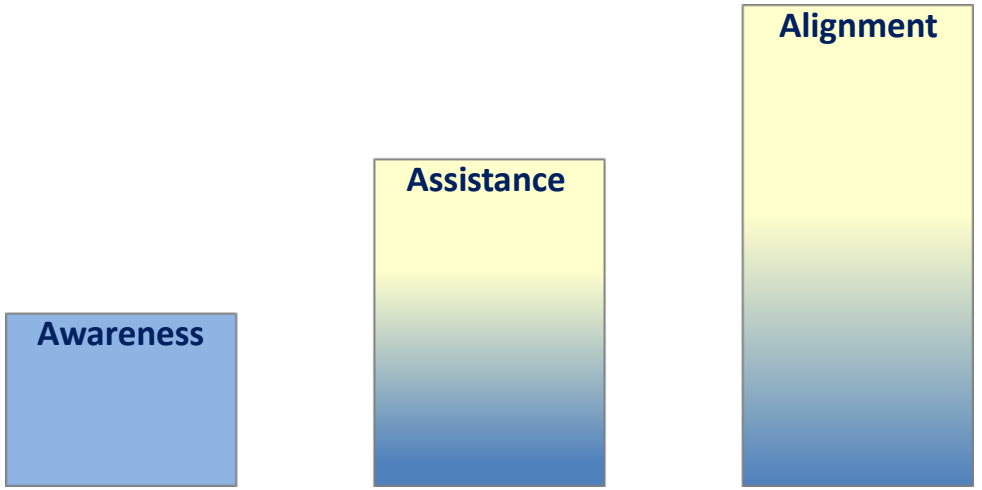
Accountable Health Communities Model

Population Health 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
Anticipated Number of Award Sites: 44



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

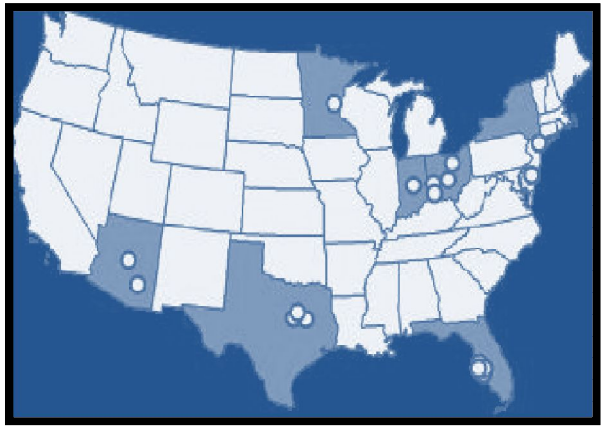
Track 3 **Alignment –** Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

HCIA: Diabetes Prevention Program (DPP) meets criteria for expansion

DPP **reduces the incidence of diabetes** through a structured health behavior change program delivered in community settings.

Timeline:

2012 – CMS Innovation Center awarded Health Care Innovation Award to The Young Men's Christian Association of the USA (YMCA) to test the DPP in **>7,000 Medicare beneficiaries with pre-diabetes** across 17 sites nationwide.



March 2016 – HHS announced **DPP as the first ever prevention program to meet CMMI model expansion criteria.** CMS determined that DPP:

- *Improves quality of care* ➡ *beneficiaries lost about five percent body weight*
- *Certified by the Office of the Actuary as cost-saving* ➡ *up to estimated $2,650 savings per enrollee over 15 months*
- *Does not alter the coverage or provision of benefits*

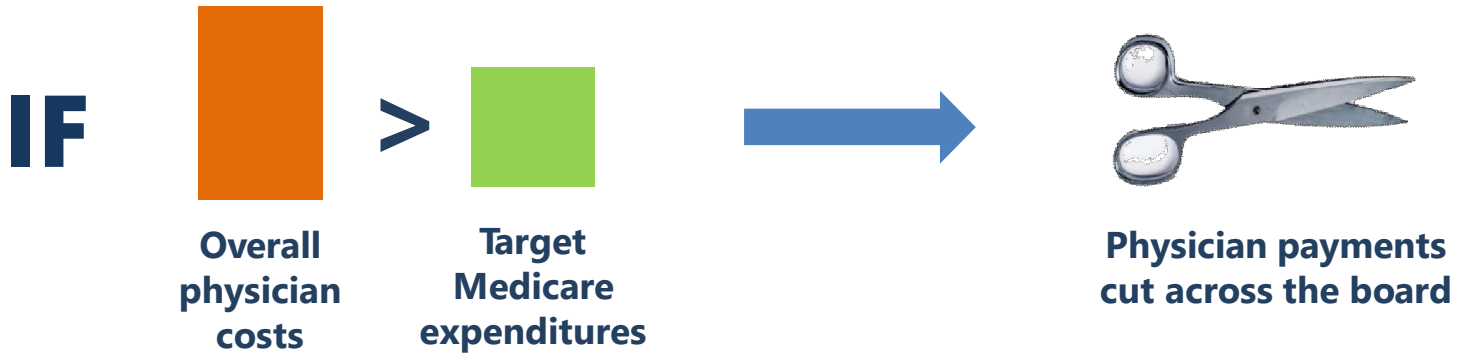
Details of the expansion will be developed through notice and public comment rulemaking.

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

MIPS: First Step to a Fresh Start

- ✓ **MIPS:**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Advanced APMs

Currently, the following models are Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 - CEHRT)

In future, the following models are expected to become advanced APMs

- Shared Savings Program Track 1+
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Medicare-Medicaid ACO Model (for participants in SSP Tracks 2 and 3)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- New Voluntary Bundled Payment Models
  - Acute Myocardial Infarction (AMI) Track 1 CEHRT
  - Coronary Artery Bypass Graft (CABG) Track 1 CEHRT
  - Surgical Hip/Femur Fracture Treatment (SHFFT) Track 1 CEHRT

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.

Keep in mind: The Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and assess proposals for Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

What can you do to help our system achieve the goals of Better Care, Smarter Spending, and Healthier People?

- **Eliminate** patient harm
- **Focus** on better care, smarter spending, and healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Help us** develop specialty physician payment and service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Future of Health System

- Alternative payment models greater than 50% of payments
  - ACOs
  - Bundled Payments
  - Comprehensive Primary Care
  - Other APMs
- Private payer and CMS collaboration critical
- States and communities driving Innovation and delivery system reform
- Increasing integration of public health and population health with health care delivery system
- Patient-centered, coordinated care is the norm
- Focus on quality and outcomes