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CMS Priorities in health system transformation:
Better Care, Smarter Spending, Healthier People

- Promote value-based payment systems
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

- Encourage the integration and coordination of services
- Improve population health
- Promote patient engagement through shared decision making

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

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

The Innovation Center portfolio aligns with transformation focus areas

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<th>Focus Areas</th>
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<td>Information</td>
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<td>• Shared decision-making required by many models</td>
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* Many CMMI programs test innovations across multiple focus areas
Models of interest at the CMS Innovation Center

- **Million Hearts Cardiovascular Disease Risk Reduction Model** will reward population-level risk management
  - *Pay-for-outcomes* approach with 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** addresses health-related social needs
  - *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

  [https://innovation.cms.gov/initiatives](https://innovation.cms.gov/initiatives)

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**FQHC Advanced Primary Care Practice Demonstration**

- Participating FQHCs receive a monthly care management fee of $6.00 for each Medicare beneficiary attributed to their practice
- This fee was *in addition to* the usual all-inclusive payment FQHCs receive for providing Medicare covered services
- Technical assistance provided to help transform into a person-centered, coordinated, seamless primary care practice
- Designed to evaluate the effect of the advanced primary care practice model

[https://innovation.cms.gov/initiatives/fqhcs/](https://innovation.cms.gov/initiatives/fqhcs/)

3-year Demonstration (ended 2014)
Comprehensive Primary Care Plus ("CPC+")

1. Advance care delivery and payment to allow practices to provide more comprehensive care that meets the needs of all patients, particularly those with complex needs.

2. Accommodate practices at different levels of transformation readiness through two program tracks, both offered in every region.

3. Achieve the Delivery System Reform core objectives of better care, smarter spending, and healthier people in primary care.

Payer Solicitation Period:
April 15 – June 1

Practice Application Period:
July 15 – September 1

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

CPC+ Practices Will Enhance Care Delivery Capabilities

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<td>Follow-up on patient ED visits</td>
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<th>Comprehensiveness and Coordination</th>
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<td>Identification of high volume/cost specialists serving population</td>
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<td>Behavioral health integration</td>
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<td>Follow-up on patient hospitalizations</td>
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<td>Psychosocial needs assessment</td>
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ACO Participation

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
Recent Medicaid Developments

- **Updates to the enrollment process**
  - Most people apply online, by phone, or at a convenient location
  - One-stop enrollment with technology that allows enrollee information to be verified electronically

- **Access to high quality physicians and other care providers**
  - Final rule takes additional steps that will more tightly align payment with better, more cost-effective care
  - Creates accountability to ensure access to care is sufficient in key specialties

- **Quality care to strengthen health outcomes**
  - Use of population-based payments, episodes of care, and quality-based payments to pay for health services

- **Support for delivery system reform**
  - Improvements to the coordination of patient care, states, with the support of CMS, are working to update legacy IT systems to ones that leverage proven IT methods

- **Medicaid Moving Forward:** [http://federalregister.gov/a/2016-09581](http://federalregister.gov/a/2016-09581)

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**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 Alternative Payment Models in Medicare.

**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.

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 3-4) by the end of 2016, and 90% by the end of 2018.

**STAKEHOLDERS:**
- Consumers | Businesses
- Payers | Providers
- State Partners

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**What is “MACRA”?**


What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in eligible alternative payment models (APMs)
Proposed Rule released April 27, 2016

Quality Payment Program: Affects clinicians who bill MEDICARE PART B

- Major Provisions of MIPS program
- Proposed models that qualify as Advanced APMs
- Timelines & Reporting Requirements

First step to a fresh start
- We’re listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric

MIPS: First Step to a Fresh Start

- MIPS is a new program
  - 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.

- MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
Advanced APMs meet certain criteria.

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

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

Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) (two-sided risk track available in 2018)
When and where do I submit comments?

Public Comment period
April 27th – June 26th 2016

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Goal to encourage new APM options for Medicare clinicians

11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary

Secretary comments on CMS website, CMS considers testing proposed model
The Health Care Payment Learning and Action Network (HCP-LAN)

- Serve as a convening body to facilitate joint implementation of new models of payment and care delivery
- Identify areas of agreement around movement toward alternative payment models and how best to analyze data and report on these new payment models
- Collaborate to generate evidence, share approaches, and remove barriers
- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, quality and performance measurement, risk adjustment, and other topics raised for discussion
- Create implementation guides for payers, purchasers, providers, and consumers.


Measure Alignment Efforts

- CMS Quality Measure Development Plan
  - Highlight known measurement gaps and develop strategy to address these
  - Promote harmonization and alignment across programs, care settings, and payers
  - Assist in prioritizing development and refinement of measures
  - Public Comment period closed March 1st, final report published May 2nd

- Core Measures Sets released February 16th
  - ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics


- CMS is already using measures from the each of the core sets
- Commercial health plans are rolling out the core measures as part of their contract cycle
Transforming Clinical Practice Initiative

- Support more than 140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing and procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled

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

Questions?

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