Health IT within the Current Landscape and Future of Innovative Payment Models

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John Rancourt, Deputy Director, Office of Care Transformation, ONC (@johnrancourt)
Alex Baker, Public Health Analyst, Office of Care Transformation, ONC
Conflicts of Interest

• John Rancourt, MPA

  Has no real or apparent conflicts of interest to report.

• Alex Baker, MPP

  Has no real or apparent conflicts of interest to report.
Agenda

• Interoperability and Delivery System Reform are Interdependent
  » Interoperability Roadmap
  » HHS Delivery System Reform Goals
  » Convening Stakeholders in support of Delivery System Reform
  » Partnering With States in Support of Delivery System Reform
• Promising Alternative Payment Models and the Role of HIT
• MACRA
Learning Objectives

• Understand how interoperability and delivery system reform are interdependent.

• Understand key aspects of the Shared Nationwide Interoperability Roadmap.

• Understand HHS’ delivery system reform goals and how HHS is convening stakeholders and partnering with states to support Delivery System Reform.

• Understand Promising Alternative Payment Models and the Role of HIT in them.

• Learn the basics of MACRA.
Interoperability and Delivery System Reform are Interdependent
The business case for health information exchange and interoperability is delivery system reform, including SIM and MACRA.

**Interoperability**
- Shared Nationwide Interoperability Roadmap Version 1.0
- Interoperability Standards Advisory
- ONC 2015 Certification Rule

**Delivery System Reform**
- State Innovation Models Initiative
- HHS Delivery System Reform Goals
- Medicare Access & CHIP Reauthorization (MACRA)
The Interoperability Roadmap was published by ONC in January 2015 to guide the nation towards meeting the goal of sharing information more broadly across providers, consumers and others.

The Roadmap focuses on how the government in collaboration with the private sector can take actions that will enable a majority of individuals and providers across the care continuum to send, receive, find and use a common set of electronic clinical information at the nationwide level by the end of 2017.

Driver: A Supportive Payment and Regulatory Environment

“Rules that govern how health and care are paid for must create a context in which interoperability is not just a way to improve care, but is a good business decision.”
Delivery System Reform Focus Areas

“Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system...”

- 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 clinical care 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 first.
HHS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

### Key characteristics - Historical state
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

### Systems and Policies - Historical state
- Fee-For-Service Payment Systems

### Key characteristics - Evolving future state
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

### Systems and Policies - Evolving future state
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

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Public and Private sectors
CMS has adopted a framework that categorizes payments to providers.

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
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<tr>
<td></td>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
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<td>Medicare Fee-for-Service examples</td>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
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<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
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<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
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<td>Hospital value-based purchasing</td>
<td>Accountable Care Organizations</td>
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<td>Maryland hospitals</td>
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<td>Medical homes</td>
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<td>Physician Value Modifier</td>
<td>Bundled payments</td>
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<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
<td>Comprehensive Primary Care initiative</td>
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<td>Comprehensive ESRD</td>
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<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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HHS goals for Medicare value-based payments

**Medicare Fee-for-Service**

**GOAL 1:** 30%
Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

**GOAL 2:** 85%
Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

**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

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

Set internal goals for HHS

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

### Historical Performance

- **2011**
  - All Medicare FFS: 0%
  - FFS linked to quality: ~70%
  - Alternative payment models: 0%

- **2014**
  - All Medicare FFS: 0%
  - FFS linked to quality: ~20%
  - Alternative payment models: 0%

- **2016**
  - All Medicare FFS: 0%
  - FFS linked to quality: >80%
  - Alternative payment models: 30%

- **2018**
  - All Medicare FFS: 0%
  - FFS linked to quality: 85%
  - Alternative payment models: 50%

### Goals

- **2016**
  - All Medicare FFS: 0%
  - FFS linked to quality: 85%
  - Alternative payment models: 30%

- **2018**
  - All Medicare FFS: 0%
  - FFS linked to quality: 90%
  - Alternative payment models: 50%
HHS/CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td><strong>Accountable Care Organizations</strong></td>
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<td>Medicare Shared Savings Program ACO*</td>
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<td>Pioneer ACO*</td>
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<td>Comprehensive ESRD Care Model</td>
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<td>Next Generation ACO</td>
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<td><strong>Bundled Payments</strong></td>
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<td>Bundled Payment for Care Improvement*</td>
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<td>Comprehensive Care for Joint Replacement</td>
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<td>Oncology Care</td>
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<td><strong>Advanced Primary Care</strong></td>
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<td>Comprehensive Primary Care*</td>
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<td>Multi-payer Advanced Primary Care Practice*</td>
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<td><strong>Other Models</strong></td>
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<td>Maryland All-Payer Hospital Payments*</td>
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<td>ESRD Prospective Payment System*</td>
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CMS will continue to test new models and will identify opportunities to expand existing models.

* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011
HHS will reach Goal 2 through more linkage of FFS payments to quality or value

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

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (FY17)</th>
<th>2016 Performance period (FY18)</th>
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<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
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<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
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<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
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**Physician, % of FFS payment at risk (maximum downside)**

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<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (FY17)</th>
<th>2016 Performance period (FY18)</th>
<th>2017 Performance period (payment FY19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VM (Value Modifier)</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
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<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

*Physician VM adjustment depends upon group size and can range from 2% to 4%
HHS is aligning with private sector and states to drive delivery system reform

HHS Strategies for Aligning with Private Sector and States

Convening Stakeholders

Incentivizing Providers

Partnering with States
Convening Stakeholders in Support of Delivery System Reform
Convening Stakeholders: 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
  - Identify areas of agreement around movement to APMs
  - 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

Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  - 30% in APM by 2016
  - 50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design
Convening Stakeholders: The Health Care Payment Learning and Action Network will accelerate the transition to alternative payment models (Continued)

- **50+ organizations** have committed support, including Optum, Evolent Health, AARP, Anthem, Humana, National Partnership for Women & Families, Partners Healthcare, Rite Aid, Walgreens, Walmart, States of MA and NY, and many others including **8 of the 10 largest payers** based on national market share.

  + **4,800** registered participants

Work Groups have formed with multiple work products underway:

<table>
<thead>
<tr>
<th>White Papers</th>
<th>Status</th>
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<tbody>
<tr>
<td>Alternative Payment Model (APM) Framework</td>
<td>Published</td>
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<tr>
<td>Patient Attribution in Population-Based Payment Models</td>
<td>In development</td>
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<tr>
<td>Financial Benchmarking in Population-Based Payment Models</td>
<td>In development</td>
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<tr>
<td>Data Sharing in Population-Based Payment Models</td>
<td>In development</td>
</tr>
<tr>
<td>Quality Measurement in Population-Based Payment Models</td>
<td>In development</td>
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<tr>
<td>Accelerating &amp; Aligning Elective Joint Replacement Episode Payment</td>
<td>In development</td>
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</table>
Partnering With States in Support of State Delivery System Reform
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
Round 1 States testing APMs

<table>
<thead>
<tr>
<th>Patient centered medical homes</th>
<th>Health homes</th>
<th>Accountable care</th>
<th>Episodes</th>
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<tbody>
<tr>
<td>Arkansas</td>
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<td>Maine</td>
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<td>Massachusetts</td>
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<td>Minnesota</td>
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<td>Oregon</td>
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<td>Vermont</td>
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Round 2 States designing interventions

- **Near term CMMI objectives**
  - Establish project milestones and success metrics
  - Support development of states’ stakeholder engagement plans
  - Support development and refinement of operational plans
ONC Support of the State Innovation Models Initiative

- ONC is providing technical assistance to CMS and State Innovation Model States.

- This involves one-on-one subject matter expertise as well as the creation of tools and resources that can be leveraged to support health IT innovation in care delivery and payment systems.

- Materials Cover:
  - Privacy and Security
  - Alerting
  - ID Management
  - Behavioral Health
  - Provider Directories

- Materials are published at: https://www.healthit.gov/providers-professionals/state-innovation-model-health-it-resource-center
### Health IT Modular Functions for Value-based Payment Models

<table>
<thead>
<tr>
<th>Reporting Services</th>
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<tbody>
<tr>
<td><strong>Analytics Services</strong></td>
<td><strong>Consumer Tools</strong></td>
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<td><strong>Notification Services</strong></td>
<td><strong>Provider Portal</strong></td>
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<td><strong>Exchange Services</strong></td>
<td><strong>Patient Attribution</strong></td>
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</table>

#### Data Extraction
- Data Transport and Load
- Data Aggregation

#### Data Quality & Provenance
- Identity Management
- Provider Directory/Registry
- Consent Management

#### Governance
- Policy/Legal

#### Financing
- Business Operations
HIT Modular Functions for VBP – In the context of data sources/providers and payers/other stakeholders

Providers & Data Sources
- Health Care Provider Systems
- Other Non-Health Care Provider Systems
- EHR
- Registries
- Other Non-Provider Systems

Claims Data
Clinical Data

Information

Data Quality & Provenance
ID Management
Data Aggregation
Data Transport and Load
Data Extraction

Security
Consent Mngt
PD/Registry

Exchange Services
Notification Services
Analytics Services
Reporting Services

Consumer Tools
Provider Portal
Patient Attribution

Governance
Financing
Policy/Legal
Business Operations

Payers and Other VBP Stakeholders
- Private Purchasers
- CMS & Other Federal Agencies
- Medicaid & Other State Agencies
- ACOs – MCOs - APMs
- Public Health
- Other

Various Reporting Formats
Medicaid and Health IT Interoperability

- ONC and the Center for Medicaid and CHIP Services are working closely together to achieve the following vision and goals.

- **Vision**: State Medicaid Agencies have a unified approach to Health IT across all their programs and data systems.

- **Goals**:

  1) All relevant planning activities have shared and aligned strategies for health IT systems and their governance (including State Medicaid Health IT Plans, SIM Plans, State Plan Amendments, and Demonstrations/Waivers, and other relevant work).

  2) Offer incentives for adoption and use of interoperable health IT among all providers (including long term care and behavioral health).

  3) Require or encourage health IT use and information exchange where feasible (through MCO or APM participation requirements).

  4) Enable electronic quality data collection for performance feedback and ideally for the basis of payment.
State Policies also Drive DSR and Interoperability

- States have a wide range of authorities that can be applied in support of DSR and interoperability. For example:
  - HIE Connection of Interoperability Mandate (MD, VT, MN, TX)
  - Credentialing Policies (OR)
  - Provider Licensure (CO, MA)

- ONC’s State Health IT Policy Levers Compendium includes:
  - **Policy levers directory** of 32 distinct policy levers and a description of how they can be used to promote health IT and advance interoperability.
  - **An example activities catalogue** with nearly 300 examples of actual or proposed uses of such levers.
  - **A list of state points of contact** who can be contacted for more information about the policy levers in their state.
The 2015 rule makes it simpler for certified health IT to be referenced by other public programs and private entities.

A number of programs currently point to certified health IT and/or the ONC Health IT Certification Program. Here are a few:

- SAMHSA Certified Community Behavioral Health Clinics Grants
- CMS chronic care management services (included in 2015 and 2016 Physician Fee Schedule rulemakings)
- Department of Defense Healthcare Management System Modernization Program
- The Joint Commission for performance measurement initiative (“ORYX vendor” – eCQMs for hospitals)

There are also other HHS rulemakings encouraging the use of certified health IT or proposing required alignment with adopted standards (see the 2015 Edition final rule for details).
ONC Certification Can Be Referenced By State Policies and Programs (cont.)

**State Action Items:**
- State managed care contracts can require that providers use ONC certified health IT
  - Medicaid, CHIP, State employee benefit plan contracts.
  - [Interoperability Roadmap](#) makes this call to action: “States with managed care contracts should increasingly require adoption and use of interoperable health IT and [HIE].”
- Multi-payer efforts (e.g., via SIM) can drive provider use of certified health IT through requirements/incentives in private payer accountable care contracts.
- States can require use of ONC certified technology in State procurements.
  - E.g., state can require that prison system EHRs are ONC certified.
  - The [ONC State Health IT Policy Levers Compendium](#) has other examples.
- Other State programs can require or incentive use of ONC Certification.
  - E.g., State grants to behavioral health clinics can require adopt ONC certified health IT.
- States can also reference the ONC Interoperability Standards Advisory.

**Benefit for the State:**
- Providers in a State will have incentives to use more interoperable technology to support care coordination, quality reporting/improvement, and to improve efficiency of care delivery.
- Systems procured by the State will be more interoperable.
Promising Alternative Payment Models and the Role of HIT
The Innovation Center portfolio aligns with delivery system reform focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
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<tbody>
<tr>
<td>Pay Providers</td>
<td>Test and expand alternative payment models</td>
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<td>▪ Accountable Care</td>
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<td>‒ Pioneer ACO Model</td>
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<td>‒ Medicare Shared Savings Program (housed in Center for Medicare)</td>
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<td>‒ Advance Payment ACO Model</td>
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<td>‒ Comprehensive ERSD Care Initiative</td>
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<td>‒ Next Generation ACO</td>
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<td>▪ Primary Care Transformation</td>
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<td>‒ Comprehensive Primary Care Initiative (CPC)</td>
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<td>‒ Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<td>‒ Independence at Home Demonstration</td>
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<td>‒ Graduate Nurse Education Demonstration</td>
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<td>‒ Home Health Value Based Purchasing</td>
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<td>‒ Medicare Care Choices</td>
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<td>▪ Bundled payment models</td>
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<td>‒ Bundled Payment for Care Improvement Models 1-4</td>
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<td>‒ Oncology Care Model</td>
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<td>‒ Comprehensive Care for Joint Replacement</td>
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<td>▪ Initiatives Focused on the Medicaid</td>
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<td>‒ Medicaid Incentives for Prevention of Chronic Diseases</td>
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<td>‒ Strong Start Initiative</td>
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<td>‒ Medicaid Innovation Accelerator Program</td>
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<td>‒ Financial Alignment Initiative</td>
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<td>‒ Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td>▪ Medicare Advantage (Part C) and Part D</td>
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<td></td>
<td>‒ Medicare Advantage Value-Based Insurance Design model</td>
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<td>‒ Part D Enhanced Medication Therapy Management</td>
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<td>Deliver Care</td>
<td>Support providers and states to improve the delivery of care</td>
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<td>‒ Partnership for Patients</td>
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<td>‒ Transforming Clinical Practice</td>
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<td>‒ Community-Based Care Transitions</td>
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<td>▪ Health Care Innovation Awards</td>
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<td>▪ Accountable Health Communities</td>
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<td>▪ State Innovation Models Initiative</td>
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<td>‒ SIM Round 1</td>
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<td>‒ SIM Round 2</td>
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<td>‒ Maryland All-Payer Model</td>
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<td>▪ Million Hearts Cardiovascular Risk Reduction Model</td>
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<td>Distribute Information</td>
<td>Increase information available for effective informed decision-making by consumers and providers</td>
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<td>▪ Health Care Payment Learning and Action Network</td>
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<td>‒ Information to providers in CMMI models</td>
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<td>▪ Shared decision-making required by many models</td>
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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
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)

**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

<table>
<thead>
<tr>
<th>Next Generation ACO</th>
<th>Pioneer ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 ACOs spread among 13 states</td>
<td>9 ACOs spread among 7 states</td>
</tr>
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</table>
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

<table>
<thead>
<tr>
<th>Total Investment  &gt;</th>
<th>$157 million</th>
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<tbody>
<tr>
<td>Anticipated Award Sites</td>
<td>44</td>
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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
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

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients

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

**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 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 and includes approximately 20% of all Medicare LEJR procedures.

- 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.
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
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

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**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

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*Risk calculation is an essential component of the Million Hearts model, ensuring accurate risk assessment for effective management strategies.**
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
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)**
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
Eligible APMs under MACRA

Definition of APM

- A Centers for Medicare and Medicaid Innovation (CMMI) model
- Medicare Shared Savings Program Accountable Care Organizations
- A CMS demonstration under section 1866C of the SSA; or required by Federal law

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
PFPM = Physician-Focused Payment Model

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

**PFPM Technical Advisory Committee**
11 appointed care delivery experts

Submission of model proposals → Technical Advisory Committee (11 appointed care delivery experts) → Review proposals, submit recommendations to HHS Secretary → Secretary comments on CMS website, CMS considers testing proposed model
HIT Capabilities for APMs – where are the gaps?

Based on an extensive literature review, interviews, and input from Technical Expert Panel participants, ONC has identified several market gaps around health IT capabilities, including:

- Up to date care plan in standardized format (within ACO) with patient goals and results accessible by providers & case managers
- Receive and incorporate notifications of referral status, including if appointment is not kept.
- Identify providers by specialty, commitment to care coordination, patient preference, patient’s health plan network
- Ability to cross reference the organization’s preferred providers to provider networks identified by the patient, health plan, or provider system.
MACRA alone will not drive interoperability

- APMs offer a number of opportunities to reinforce the adoption of health information exchange capabilities and HIT tools that are instrumental to providers succeeding within these models.

- APMs can incentivize or require basic adoption of certified HIT, for instance, requiring a certain percentage of participating providers to have attested for meaningful use stage 1 (e.g., CMMI's Pioneer ACO program), or including use of certified HIT as a quality measure (e.g., the Medicare Shared Savings Program).

- Multi-payer alignment of incentives or requirements for interoperability will drive provider behavior and uniform adoption of standards through certification.

- State policies will also reinforce interoperability through Medicaid waivers, State Plan Amendments (e.g., health home requirements), Managed Care Contract requirements, Medicaid matching fund policies, and other state driven mandates or incentives.
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:

- **2016**
  - 30% All Medicare fee-for-service (FFS) payments (Categories 1-4)
  - 85% Medicare FFS payments linked to quality and value (Categories 2-4)
  - 50% Medicare payments linked to quality and value via APMs (Categories 3-4)
  - 90% Medicare payments to QPs in eligible APMs under MACRA

- **2018**
  - 50%
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Contacts:

John Rancourt
John.Rancourt@hhs.gov
@johnrancourt

Alex Baker
Alex.Baker@hhs.gov