Health System Transformation
Post Affordable Care Act

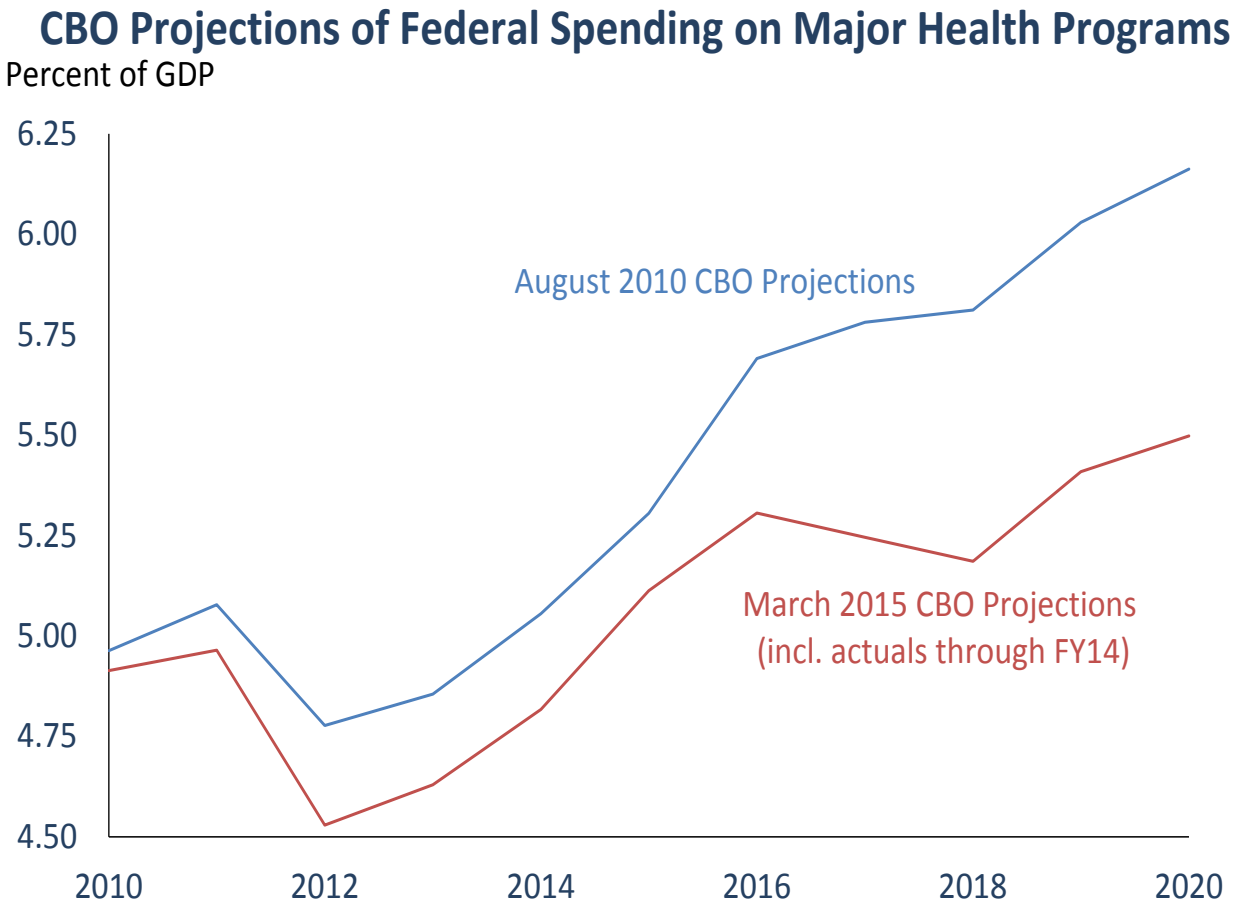
#KeepingUSHealthy

Affordable Care Act Impact

- **Expansion of Health Insurance Coverage -> Decreased Uninsured Rates**
- **Slower Growth in Health Care Costs**
- **Improved Quality of Care**

Source: Furman J, Fiedler M – Continuing the Affordable Care Act's Progress on Delivery System Reform is an Economic Imperative.

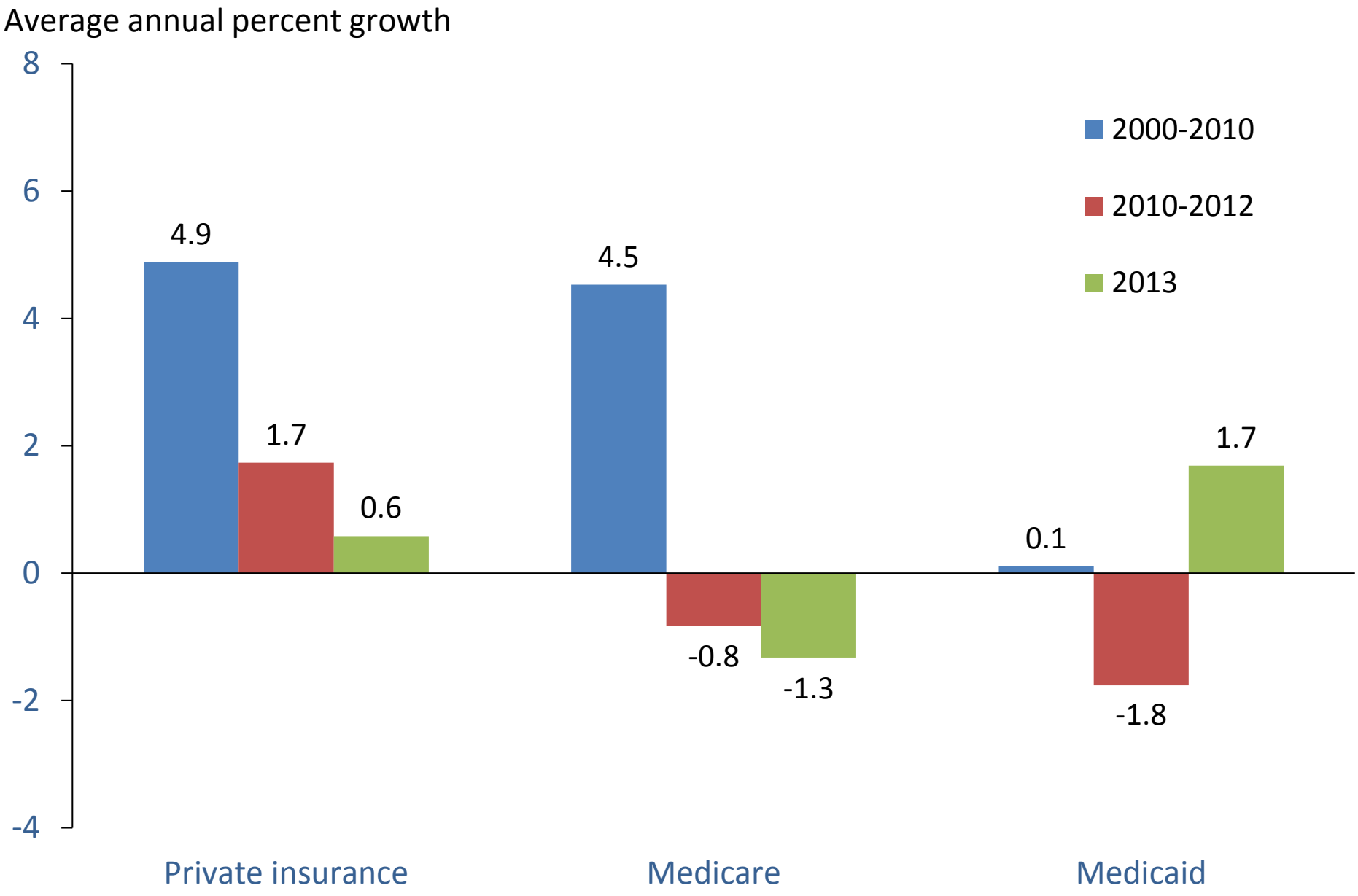
Results: Higher Value, Lower Costs



Source: Congressional Budget Office; CEA calculations.
Note: The August 2010 GDP estimates have been adjusted for major NIPA revisions in the summer of 2013. Without these revisions, the decline since August 2010 would be larger.

According to the Congressional Budget Office, federal spending on major health care programs in 2020 will be $200 Billion lower than predicted in 2010.

Growth in Real Per Enrollee Spending by Payer



Source: CMS; BEA; CEA calculations.

Better Care, Smarter Spending, Healthier People

Focus Areas	Description
Incentives	▪ 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
Care Delivery	▪ Encourage the integration and coordination of services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ 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.

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

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models where the provider is accountable for quality and total cost of care** 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** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

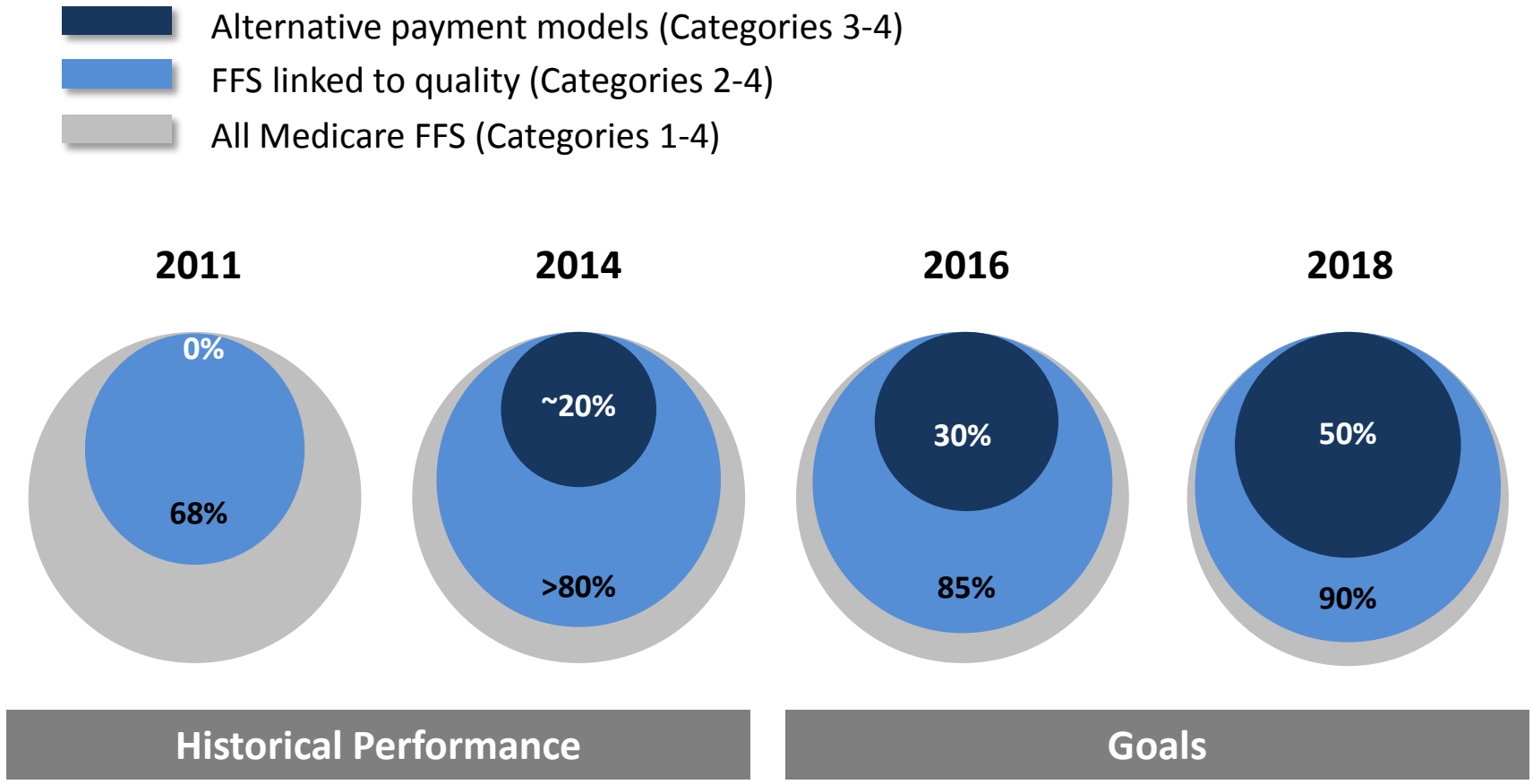
Invite **private sector players** to match or exceeed HHS goals

NEXT STEPS:

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

Creation of a Health Care Payment **Learning and Action Network** to align incentives between public and private sector players

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



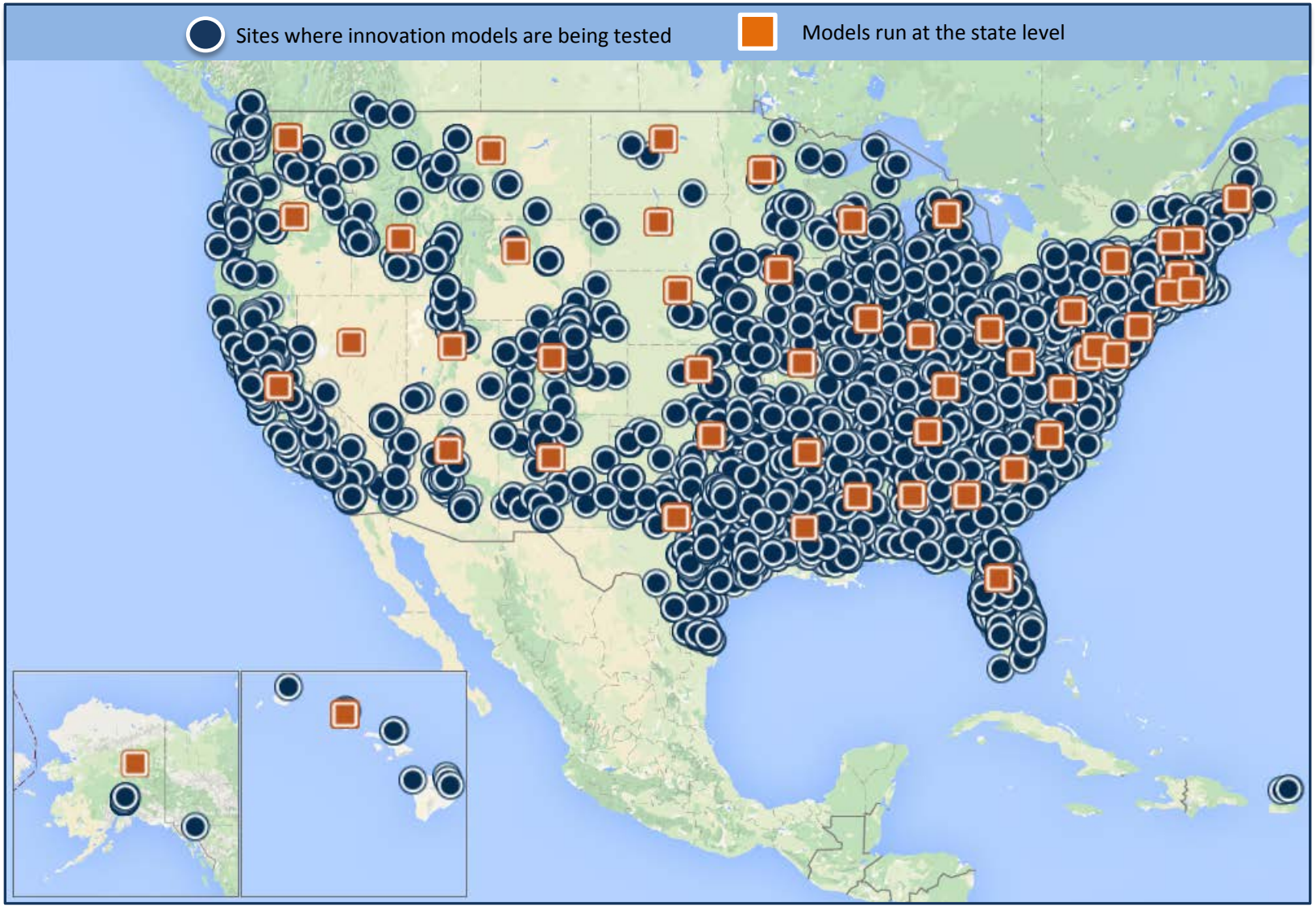
Center for Medicare and Medicaid Innovation

The CMS Innovation Center was created to develop, test, and implement new payment and service delivery models

Section 3021 of Affordable Care Act

"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."

CMS has engaged the health care delivery system and invested in innovation across the country, every state and most territories



Source: CMS Innovation Center website, January 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** – Pioneer ACO Model – Next Generation ACO – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) – Multi-Payer Advanced Primary Care Practice Demo – Home Health Value Based Purchasing – Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Medicare Care Choices Model ▪ **Episode-Based Payment Initiatives** – Bundled Payment for Care Improvement Model 1: Retrospective Acute Care Model 2: Retrospective Acute Care Episode & Post Acute Model 3: Retrospective Post Acute Care Model 4: Prospective Acute Care – Oncology Care Model – Comprehensive Care for Joint Replacement Model ▪ **Initiatives Focused on the Medicaid** – Medicaid Emergency Psychiatric Demonstration – 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
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** ▪ **State Innovation Models Initiative** – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model ▪ **Million Hearts Initiative**
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 (ACOs)

ACOs - Participation is Growing Rapidly

- **More than 400 ACOs participating in the Medicare Shared Savings Program**
- **Almost 8 million assigned beneficiaries in 49 states, plus D.C. and Puerto Rico**
- **Proposed MSSP rule seeks to build on this momentum.**

Achieving the Goals

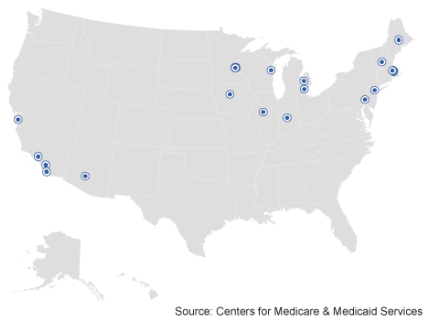
- **Accountable Care Organization (ACO) Models**
  - **Pioneer ACO Model**
  - **Next Generation ACO Model**
  - **ESRD ACO Initiative**
  - **Advance Payment Model**
  - **ACO Investment Model**
  - **Medicare Shared Savings Program – 3 Tracks**
- **Value-Based Purchasing / Value-Based Modifier**
- **Medicare Advantage also supporting ACOs**

Pioneer ACOs provided higher quality and lower cost care to Medicare beneficiaries in their first two performance years

- Pioneer ACOS were designed for **organizations with experience in coordinated care** and ACO-like contracts

- Pioneer ACOs showed **improved quality outcomes**
  - Quality **outperformed published benchmarks** in 15/15 clinical quality measures and 4/4 patient experience measures in year 1 and improved in year 2
  - **Mean quality score of 85.2% in 2013** compared to 71.8% in 2012
  - Average performance score **improved in 28 of 33 (85%) quality measures**

- Pioneer ACOs **generated savings for 2nd year in a row**
  - **$400M in program savings** combined for two years† **(Office of Actuary Certified expansion likely to reduce program expenditures)**
  - Average **savings per ACO increased** from $2.7 million in PY1 to $4.2 million in PY2‡



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
- **Model certified by Actuary as likely to reduce expenditures and model improved quality**

† Results from regression based analysis
‡ Results from actuarial analysis

Next Generation ACO Model Principles

- Prospective attribution
- Protect Medicare FFS beneficiaries' freedom of choice;
- Create a financial model with long-term sustainability;
- Rewards quality;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care;
- Allow beneficiaries a choice in their alignment with the ACO
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Primary Care

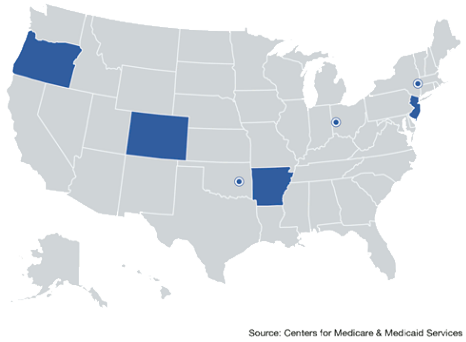
Post ACA
Primary Care Models improving Care

- Comprehensive Primary Care Initiative
- Independence at Home
- Transforming Clinical Practice Initiative
- Various Health Care Innovation Awards
- State Innovation Model
- FQHC Advanced Primary Care Practice Demonstration (Closed and being evaluated)
- Chronic Care Management
- Transitional Care Management Services

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

- Across all 7 regions, CPC **reduced Medicare Part A and B expenditures** per beneficiary by $14 or 2%*
  - Reductions appear to be driven by initiative-wide impacts on reduced 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)

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**

-Practice Administrator

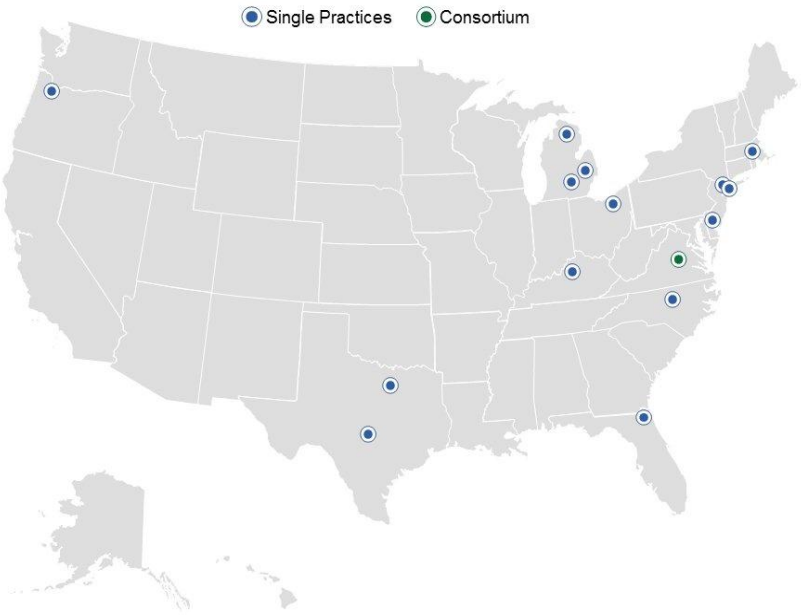
"A lot of the things we're doing now are things we wanted to do in the past… **We needed the front-end investment** of start-up money to develop our teams and our processes"

Independence at Home (IAH)

- 14 practices
- 1 consortium
- ~8,400 patients enrolled in first year
- Duration: 2012-2015

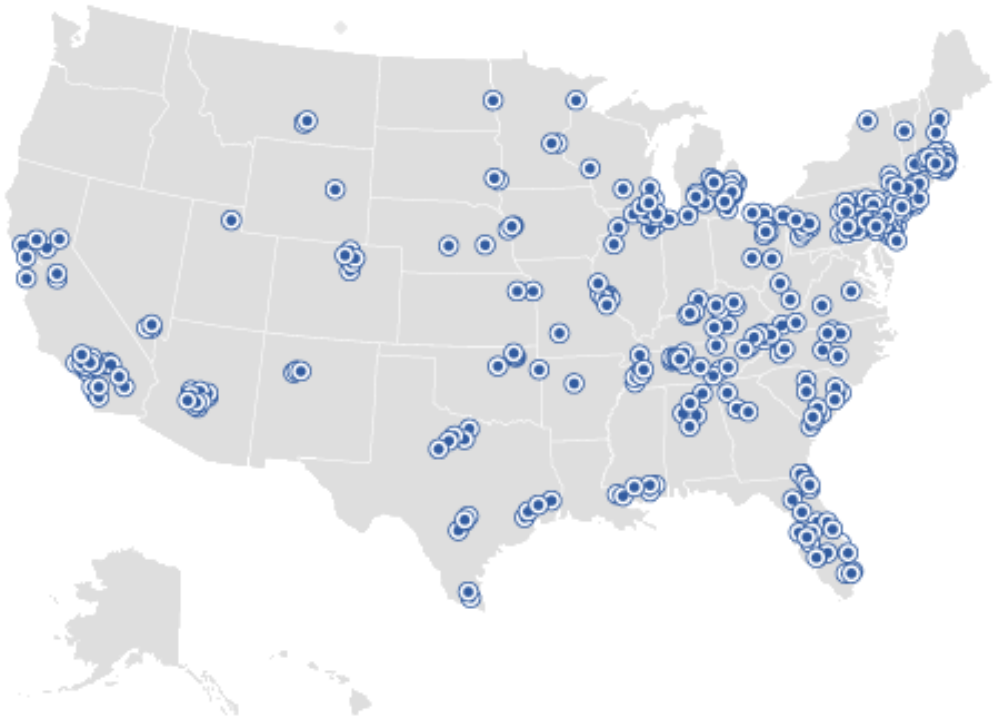
IAH tests a service delivery and shared savings model using home-based primary medical care to improve health outcomes and reduce expenditures for high-risk Medicare beneficiaries.

First year results – good quality results and over $3000 per beneficiary per year savings



Bundled Payment Models

Bundled Payments for Care Improvement is also growing rapidly



Source: Centers for Medicare & Medicaid Services

- 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: Acute care hospital stay only
- 102 Awardees and 167 episode initiators in phase 2 as of January 2015
- 85 new awardees and 373 new episode initiators entered phase 2 in April 2015
- 187 new awardees and 1,575 new episode initiators entered Phase 2 on July 1, 2015

* Current as of January 2015

What is the Comprehensive Care Joint Replacement model?

- The model would **test bundled payments for lower extremity joint replacement (LEJR)** across a broad cross-section of hospitals.

- The payment model would **apply to most Medicare LEJR procedures within select geographic areas** with few exceptions.

- The payment model would be **implemented through rule making, and the performance period proposed to begin on January 1, 2016.**

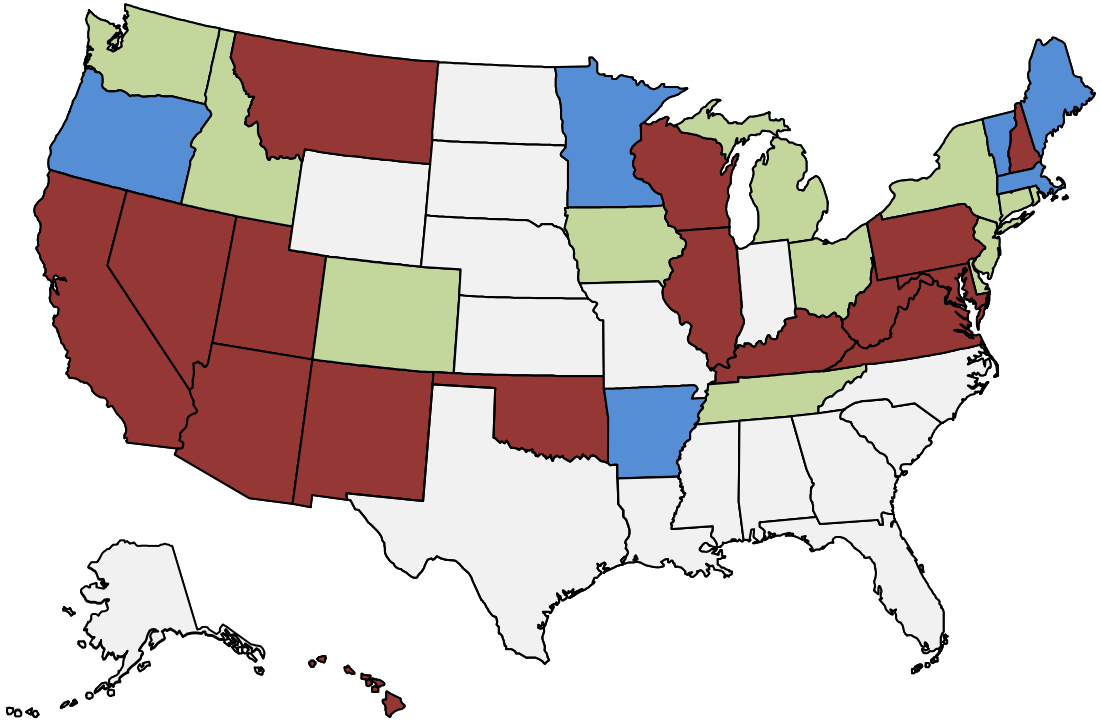
CCJR Participants

- Participants include **Inpatient Prospective Payment System (IPPS) Hospitals in select Metropolitan Statistical Areas (MSA)** not participating in phase II of the Bundled Payment for Care Improvement (BPCI) model for the lower extremity joint replacement clinical episode.
  - BPCI Model 2 and Model 3 LEJR episodes **initiated by participating physician group practices or post-acute care facilities** would take precedence over Comprehensive Care Joint Replacement model episodes.

- **75 MSAs** were selected in a **two-step randomization** process.
  - MSA were placed into **five groups** based on their historic LEJR episode payment and their population size.
  - **Fifteen MSAs were then randomly selected within each group.**

State Based Models

State Innovation Model grants have been awarded in two rounds: 38 States and Territories

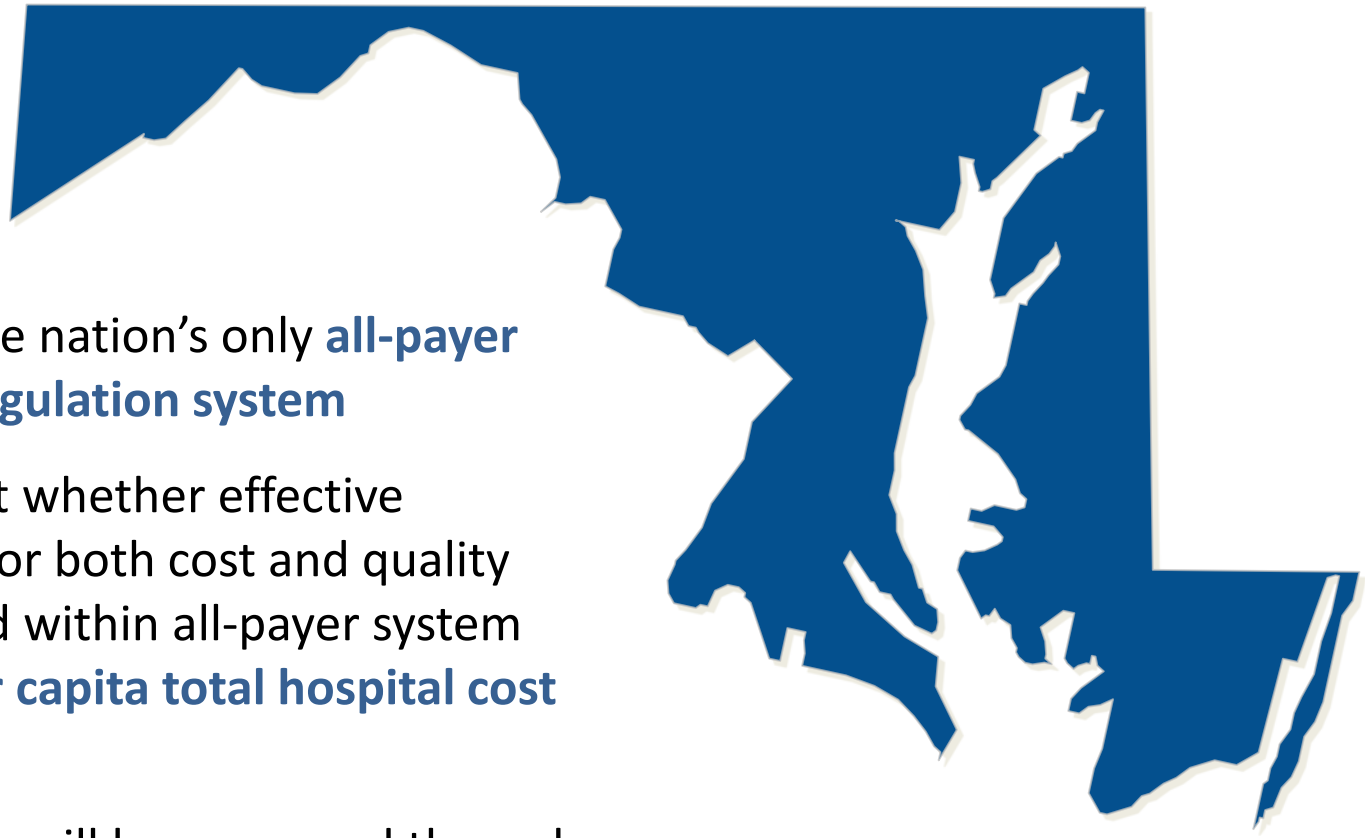


- Six round 1 model **test states**
- Eleven round 2 model **test states**
- Twenty one round 2 model **design states**

Primary objectives include

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

Maryland is testing an innovative All-Payer Payment Model



- 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**
- **Quality of care** will be measured through
  - Readmissions
  - Hospital Acquired Conditions
  - Population Health

* US census bureau estimate for 2013

Additional Models and Initiatives

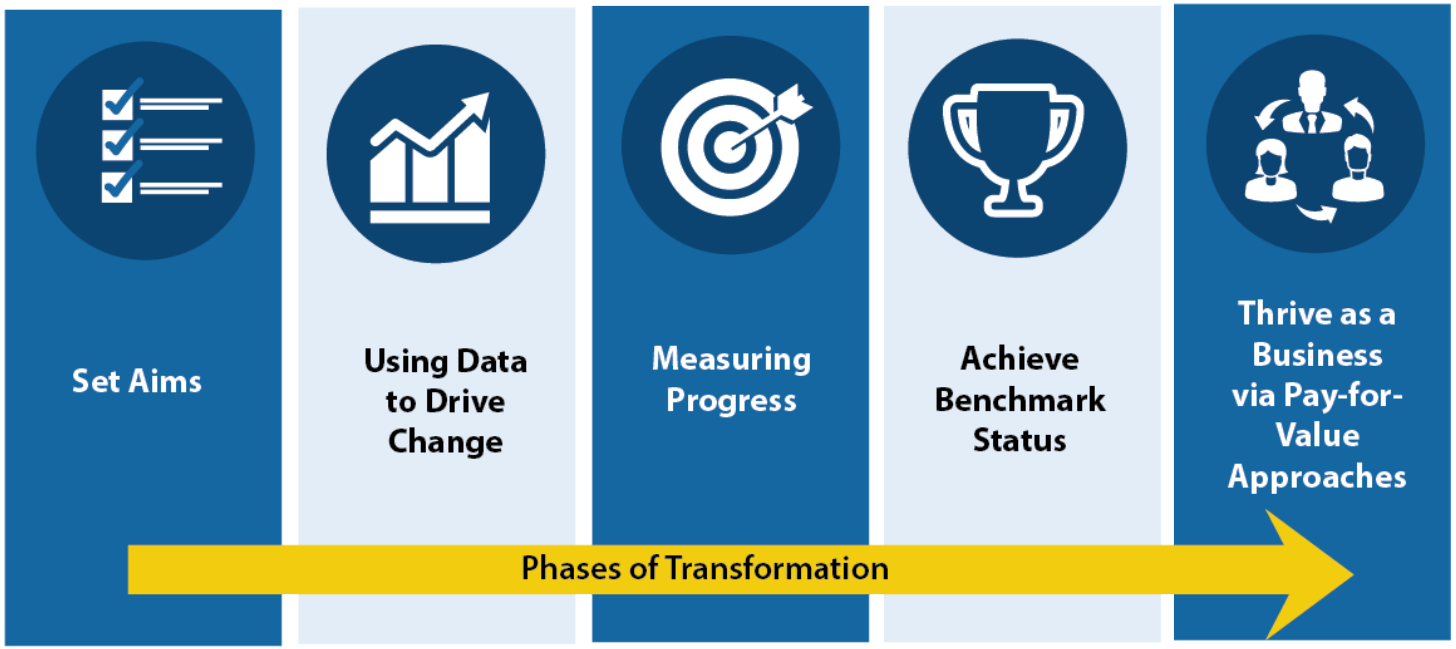
Medicare Care Choices

- **Proposed in rule making**
- **Concurrent hospice and palliative care services along with curative care**
- **These services must be available 24/7, 365 calendar days per year.**
- **CMS will pay a $400 per beneficiary per month fee to the Medicare Care Choices Model participating hospices.**

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

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



On the Horizon

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?

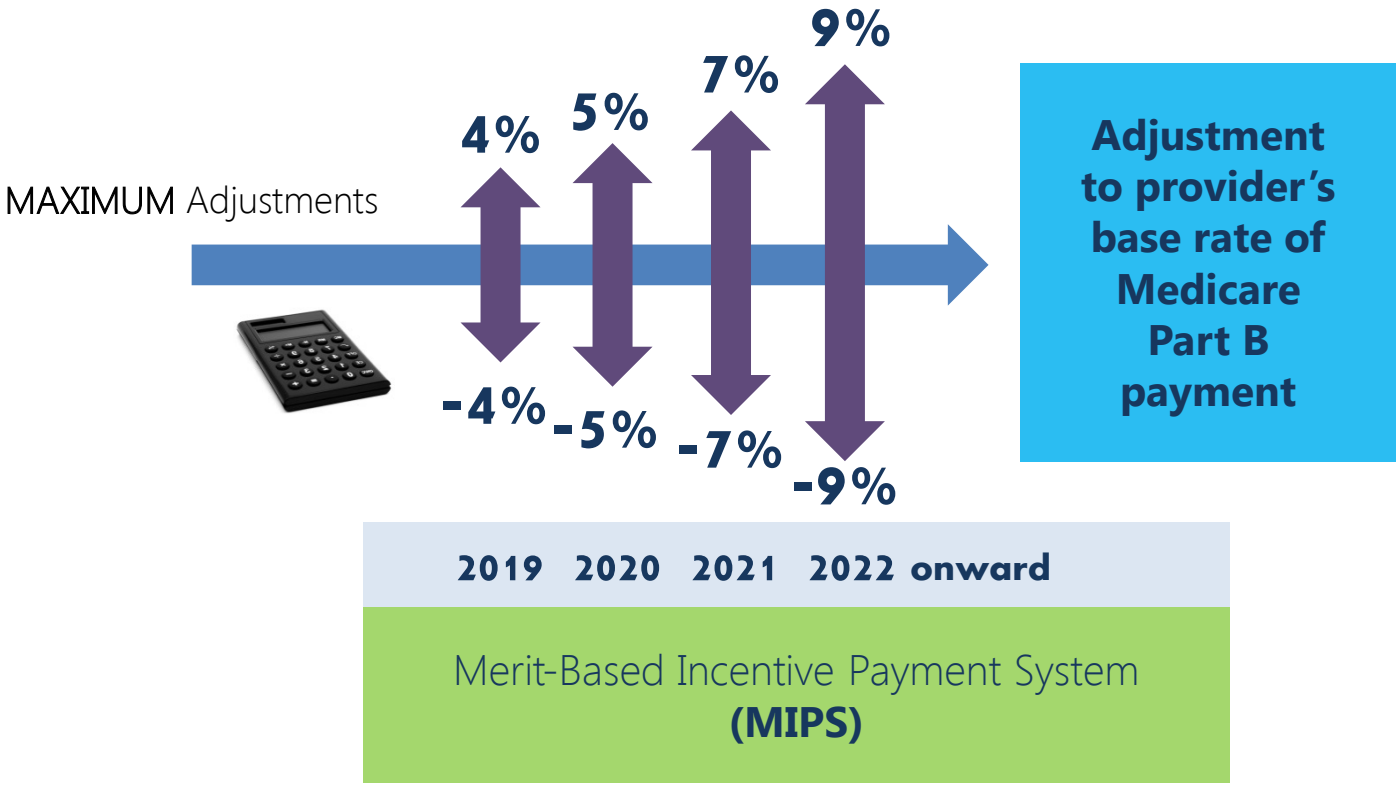
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible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

How will physicians and practitioners be scored under MIPS?

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

How much can MIPS adjust payments?

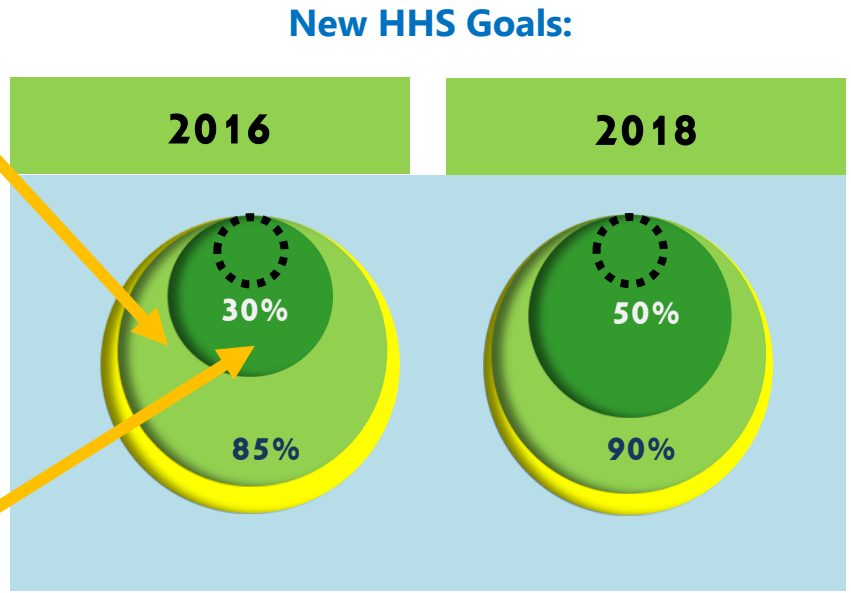
- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



Recall: How MACRA get 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.



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

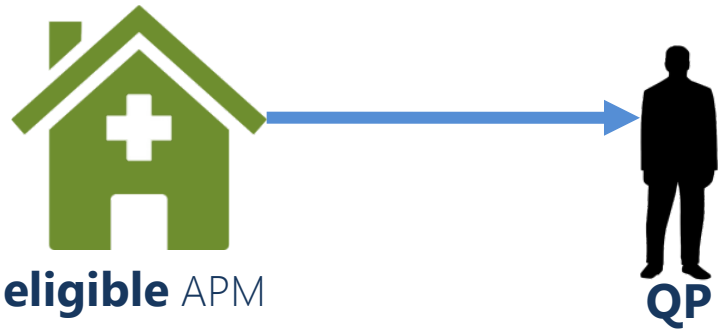
Medicare payments to QPs in eligible APMs under MACRA

What is an eligible APM?

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

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

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



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

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

QPs:

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

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

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

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