@NJHCQI #InnovativePaymentModels

Spring Annual Meeting & Conference
May 4, 2016

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New Jersey Health Care Quality Institute

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May 4, 2016

Overview

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

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

Public and Private sectors

Key characteristics

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

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

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

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

> *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.*

FOCUS AREAS

- Pay Providers
- Deliver Care
- Distribute Information

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

CMS has adopted a framework that categorizes payments to providers

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

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

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 (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

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

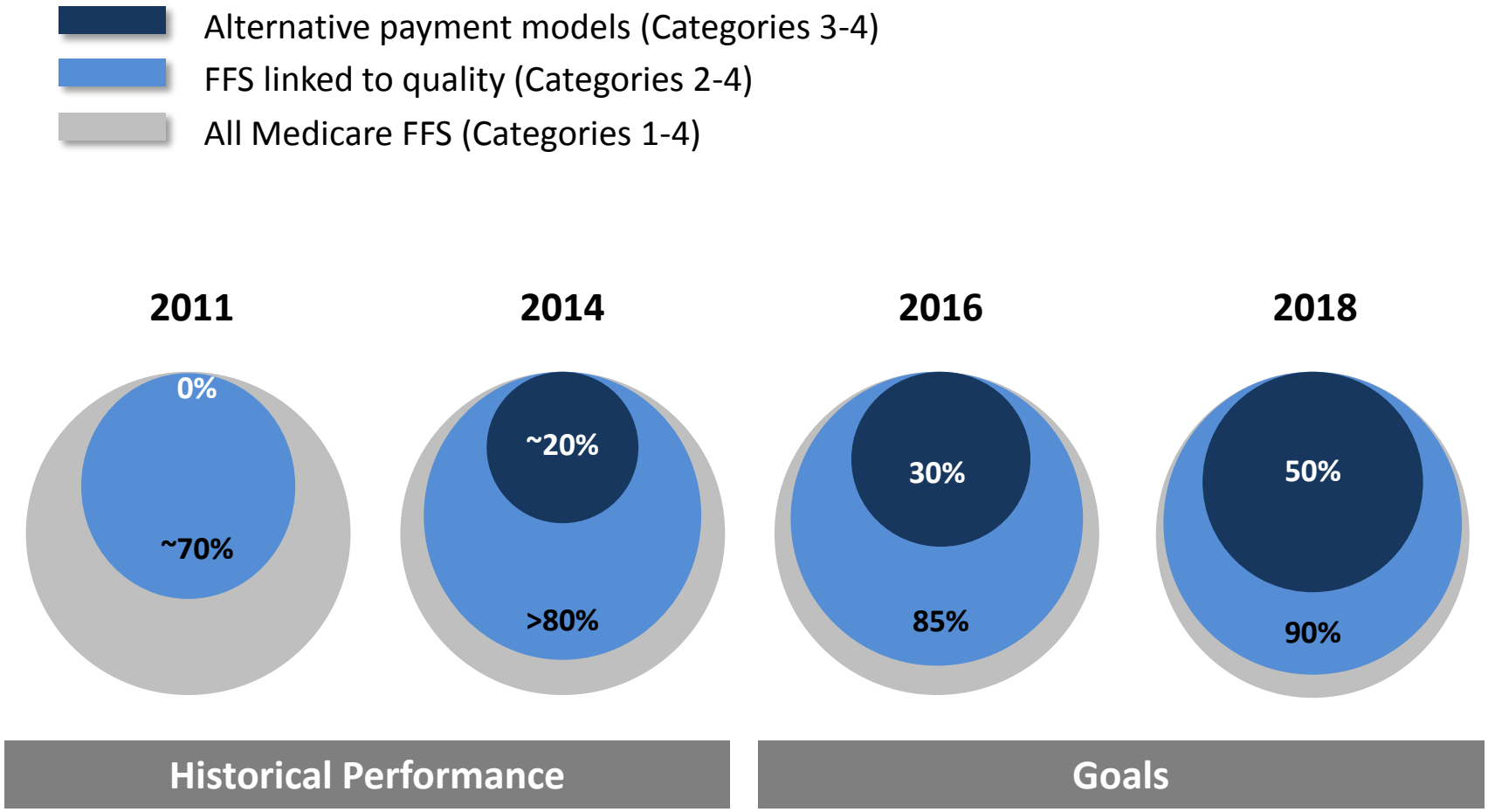
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

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 for payers

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



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

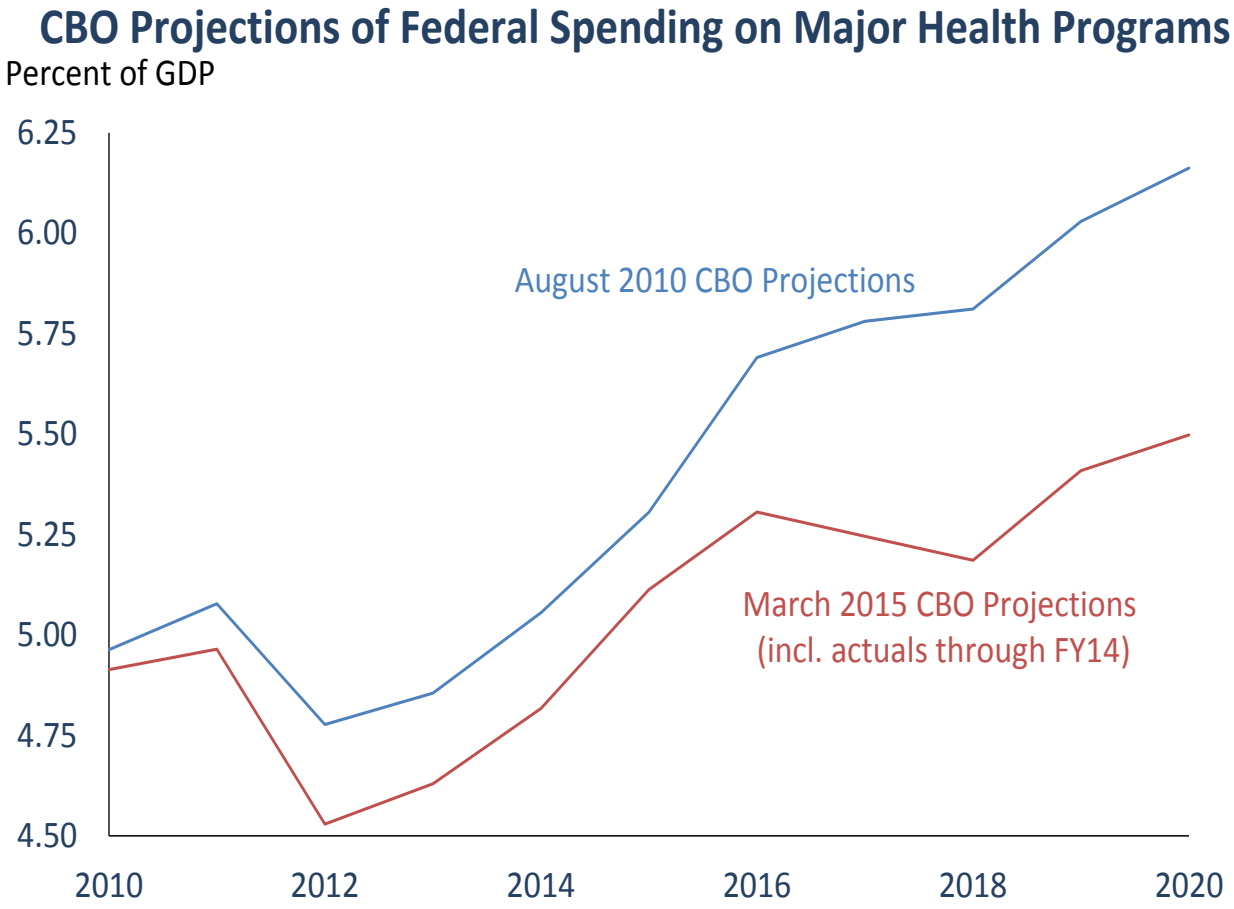
- Match or exceed Medicare alternative payment model goals across the US health system
  - -30% in APM by 2016
  - -50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Results: Higher Value, Lower Costs



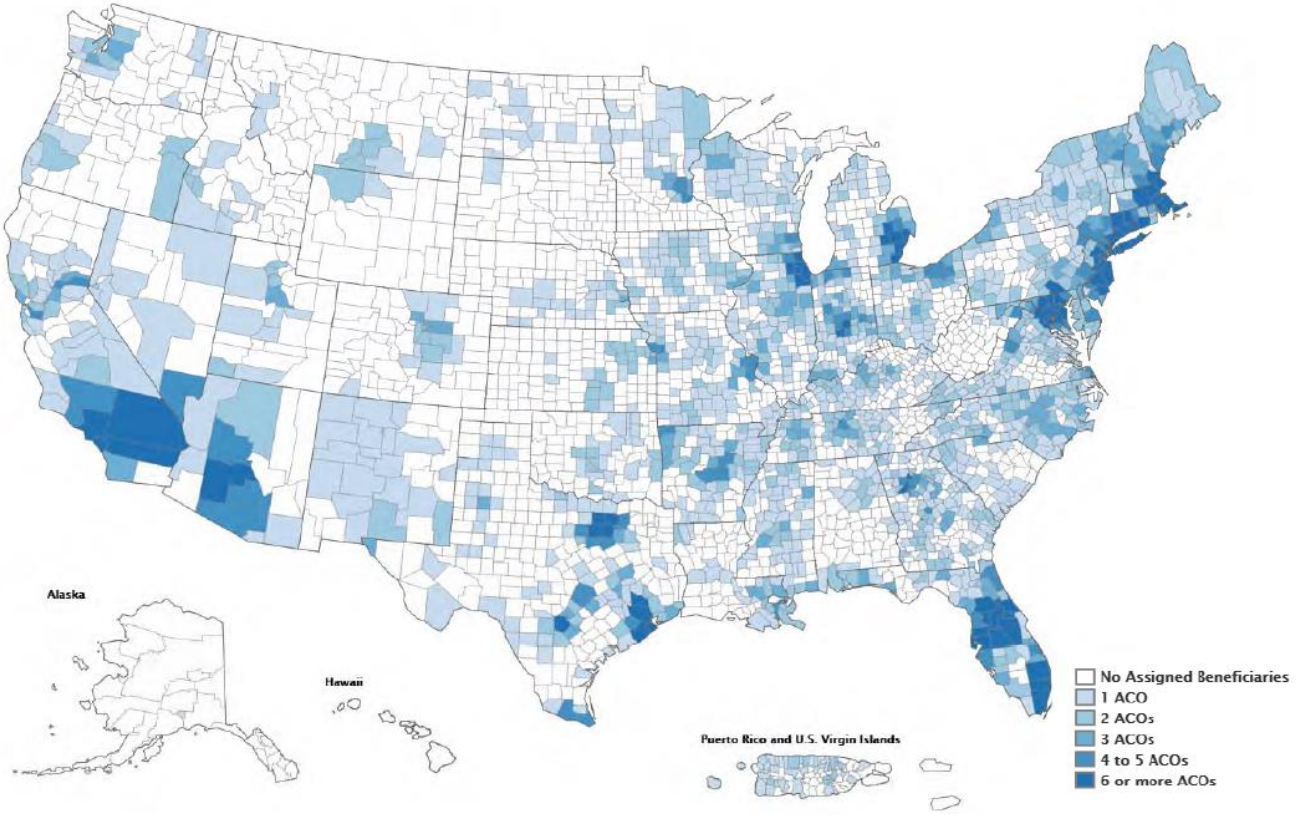
Source: Congressional Budget Office; CEA calculations.
Note: The August 2010 GDP estimates have been adjusted for major NIPA revisions in the summer of 2013. Without these revisions, the decline since August 2010 would be larger.

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

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

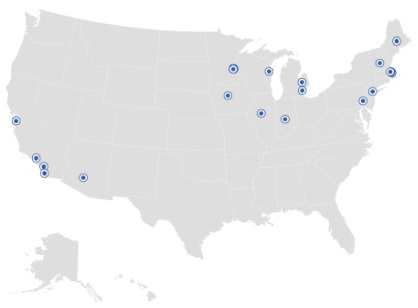
ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

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
- **Met criteria for expansion, including Actuary certification (improved quality and lower costs).** 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

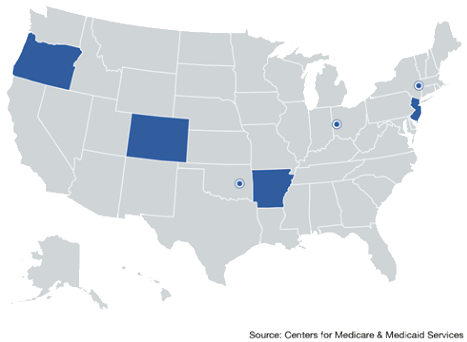
‡ Results from actuarial analysis

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

- **$14 or 2%* reduction part A and B expenditure** in year 1 among all 7 CPC regions and similar results year 2
- Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions



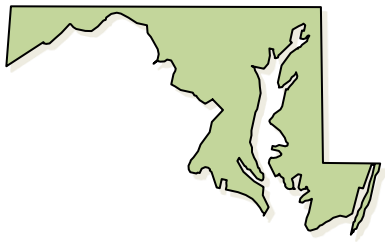
Source: Centers for Medicare & Medicaid Services

- 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)

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**

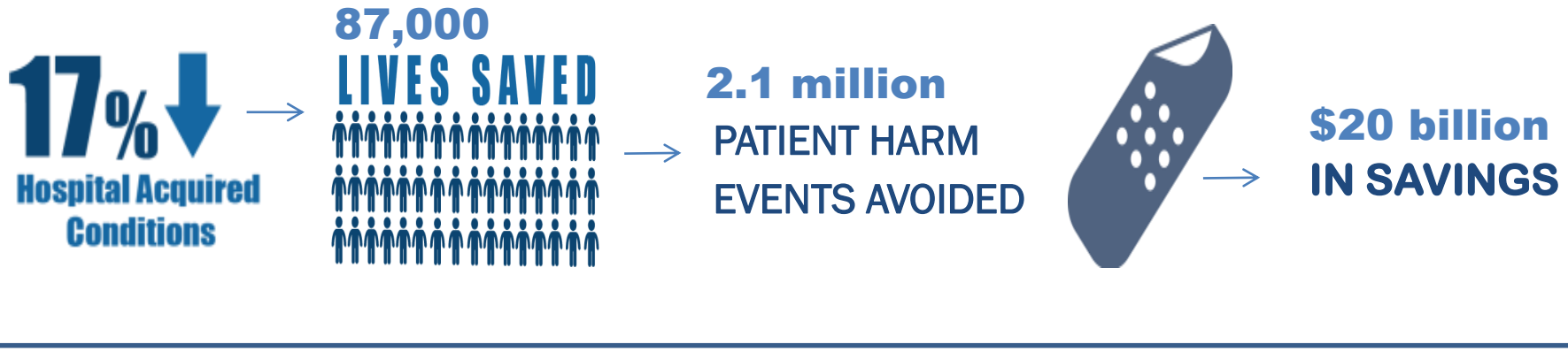


- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013

Partnership for Patients contributes to quality improvements

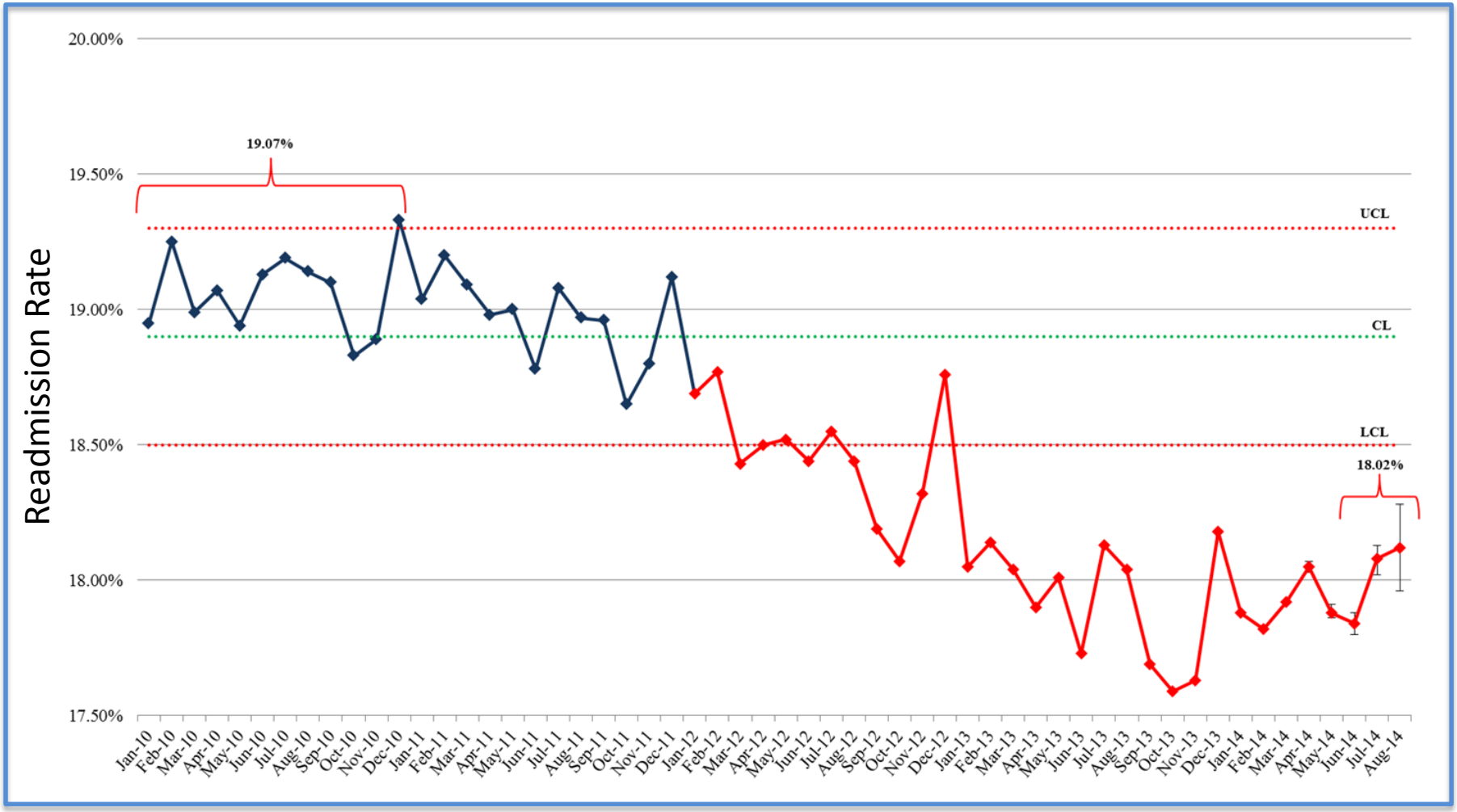
Data shows from 2010 to 2014…



Leading Indicators, change from 2010 to 2013

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

Medicare all-cause, 30-day hospital readmission rate is declining

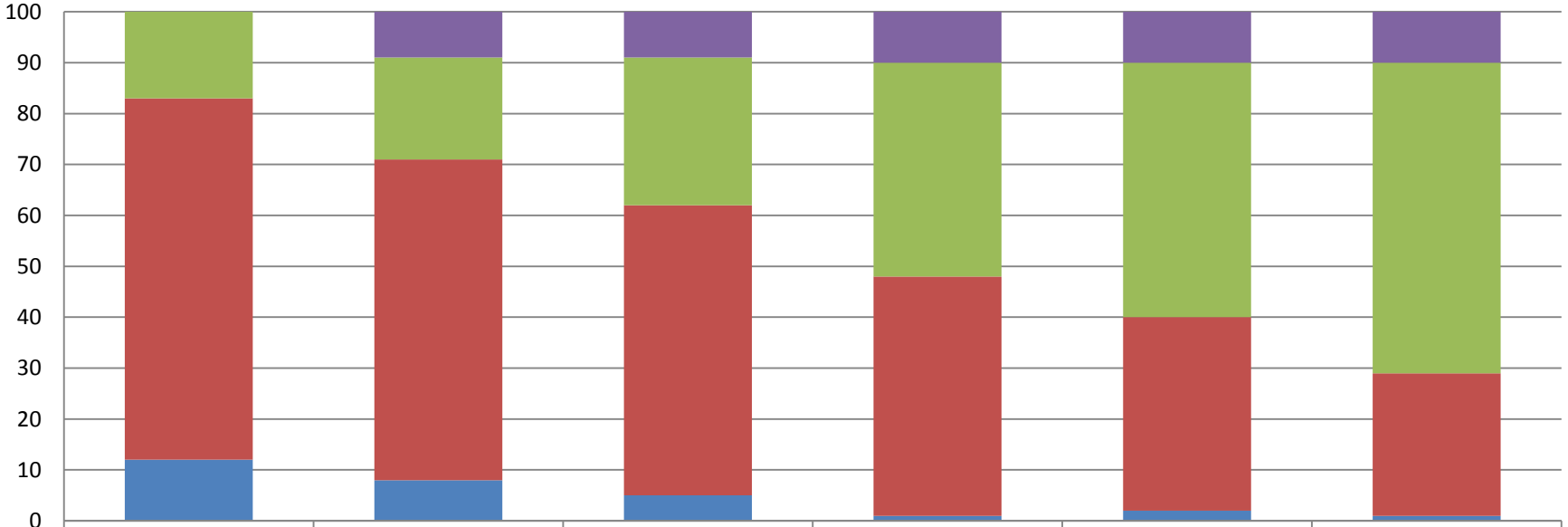


Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

Legend: CL: control limit; UCL: upper control limit; LCL: lower control limit

Beneficiaries move to MA plans with high quality scores

Medicare Advantage Enrollment Rating Distribution



	2009 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	2016(%)
5	0	9	9	10	10	10
4	17	20	29	42	50	61
3	71	63	57	47	38	28
2	12	8	5	1	2	1

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

The Innovation Center portfolio aligns with delivery system reform focus areas

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

* Many CMMI programs test innovations across multiple focus areas

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)

Next Generation ACO	Pioneer ACO
21 ACOs spread among 13 states	9 ACOs spread among 7 states

Model Principles

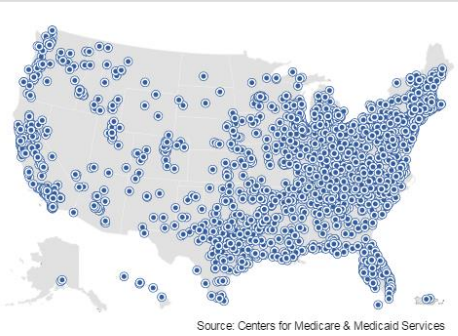
- Prospective attribution
- Financial model for long-term stability (smooth cash flow, improved investment capability)
- Reward quality
- Benefit enhancements that improve patient experience & protect freedom of choice
- Allow beneficiaries to choose alignment

Bundled Payments for Care Improvement is also growing rapidly

The bundled payment model targets 48 conditions with a single payment for an episode of care

- Incentivizes providers to take **accountability for both cost and quality** of care
- **Four Models**
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care
  - Model 3: Retrospective post-acute care only
  - Model 4: Prospective acute care hospital stay only

- 337 Awardees and 1254 Episode Initiators as of January 2016



Source: Centers for Medicare & Medicaid Services

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

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,** including approximately **20% of all Medicare LEJR procedures**

800 Inpatient Prospective Payment System Hospitals participating in **67** **selected Metropolitan Statistical Areas (MSAs)** where 30% U.S. population resides

- 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

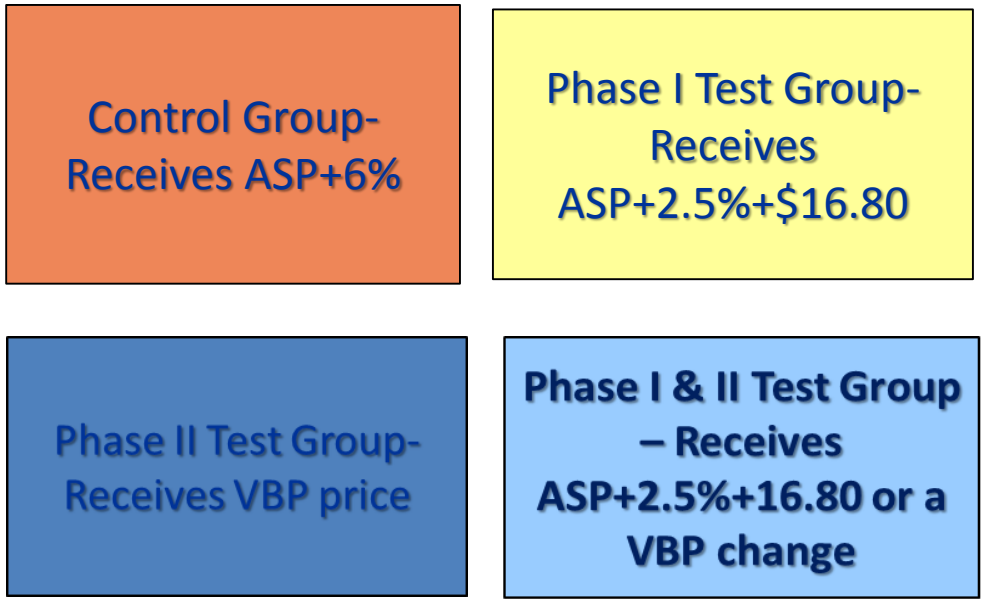
- 1.6 million people annually diagnosed with cancer; majority are over 65 years
- Major opportunity to improve care and reduce cost with expected start July 2016
- Model Objective: Provide beneficiaries with **higher intensity coordination to improve quality and decrease cost**
- Key features
  - Implement 6 part **practice transformation**
  - Create two part **financial incentive** with $160 pbpm, payment and performance based payment based on episode-of-care
  - 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

The Part B Drug Payment Model Addresses Medication Value

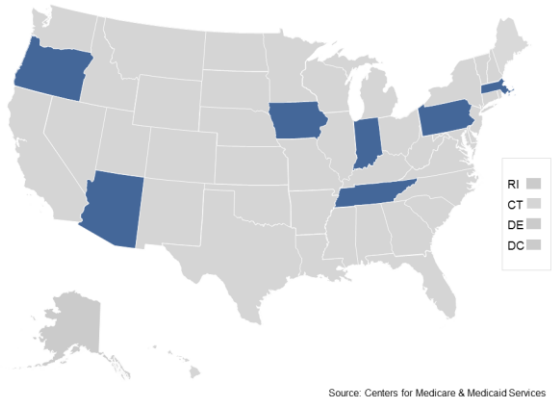
- Proposed to test whether alternative drug payment designs will lead to better value for drugs and biologicals paid under Part B, improved patient care, and reduced expenditures
- Proposed model arms and payment:



- Timeline
  - Phase I: begin in late 2016 (no earlier than 60 days after the rule is finalized).
  - Phase II: begin no sooner than January 1, 2017.
    - Implementation of the VBP tools could take time.
  - 5 year duration.
    - Goal is to have both phases of the model in full operation during the last 3 years.
  - Comment period closes May 9 at 5pm

Medicare Advantage Value Based Insurance Design Model offers more flexibility to Medicare Advantage Plans

- Allows MA plans to **structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use clinical services that have the greatest potential to positively impact on enrollee health**
- Will **begin on January 1, 2017 and run for 5 years**
- Plans in **7 states** will be eligible to participate
  - Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee



Source: Centers for Medicare & Medicaid Services

- Eligible Medicare Advantage plans in these states, upon approval from CMS, **can offer varied plan benefit design for enrollees who fall into certain clinical categories** identified and defined by CMS
- Changes to benefit design made through this model may **reduce cost-sharing and/or offer additional services to targeted enrollees**

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 addressing health-related social needs

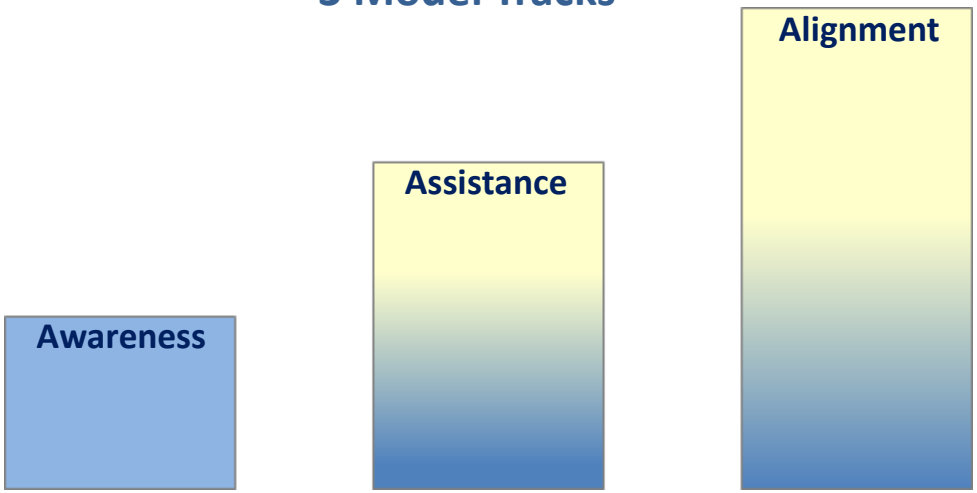
Key Innovations

- **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

44 Anticipated Award Sites

3 Model Tracks



Track 1 **Awareness –** Increase beneficiary ***awareness*** of available community services through information dissemination and referral

Track 2 **Assistance –** Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services

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

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

MACRA: What is it?

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)**

Thank You!

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Spring Annual Meeting & Conference
May 4, 2016

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