Health System Transformation: A review of CMS goals and Priority Initiatives for Post-Acute Care

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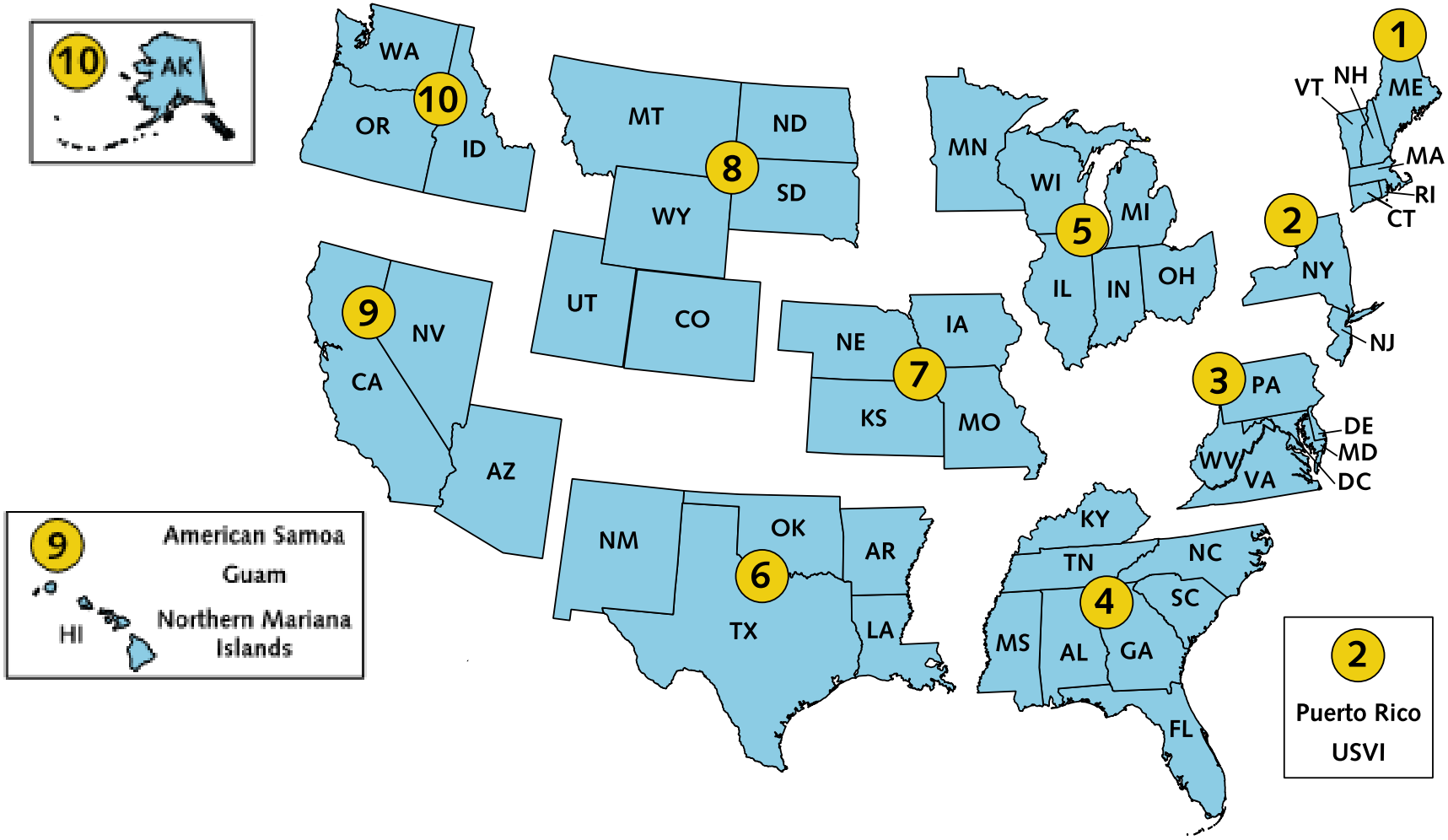
Objectives

- Overview of CMS priorities
  - Continuous quality improvement to improve patient safety
  - Focus on payment and delivery system transformation
  - Shifting from Volume to Value-Based payments
- CMS Innovation Center update
  - Review of select programs
  - New models focused on the post-acute population
- Next steps in health system reform
  - Calendar Year (CY) 2017 final rule
  - The Medicare Access and CHIP Reauthorization Act (MACRA)
  - Transforming Clinical Practice Initiative (TCPI)

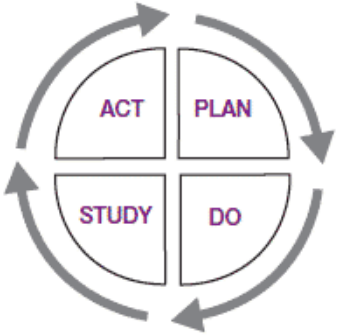
CMS OFFICES

10 Regions and 4 Territories



Complications

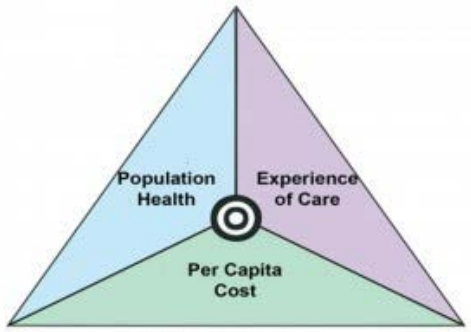
[A Surgeon's Notes on an Imperfect Science]



The 'Must Do' List: Certain Patient Safety Rules Should Not Be Elective

Robert Wachter

August 20, 2015



IHI Triple Aim

HA Blog, August 20, 2015. http://healthaffairs.org/blog

Better. **Smarter.** *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

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.

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models 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 (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

Hospital Readmission Reduction

- What's the problem?

- **High re-admission rates could indicate breakdowns in care delivery systems.**
  - Payment systems incentivized fragmentation.
  - More complicated cases = more "hands in the pot."
  - Expectation of patients to self-manage is great

- **Medicare patients said they were more dissatisfied with their preparation for discharge than any other patient satisfaction measure.**
  - 80% received discharge information.
  - 59% received medication information.

What's all of this costing us?

- Re-admissions cost Medicare $17.4 billion in 2004.[1]
  - 30-day re-admission rate: 19.6%.
  - Of them, 50.2% didn't see a doctor before re-hospitalization
  - Re-hospitalized patients stayed 0.6 days longer on average.

- We could have saved $12 billion if we prevented 30-day "potentially preventable" readmissions in 2005.[2]
  - "Potentially preventable" per MedPAC estimates.
  - 13.3% of all hospitalizations or 3 out of 4 ***re-admissions***!

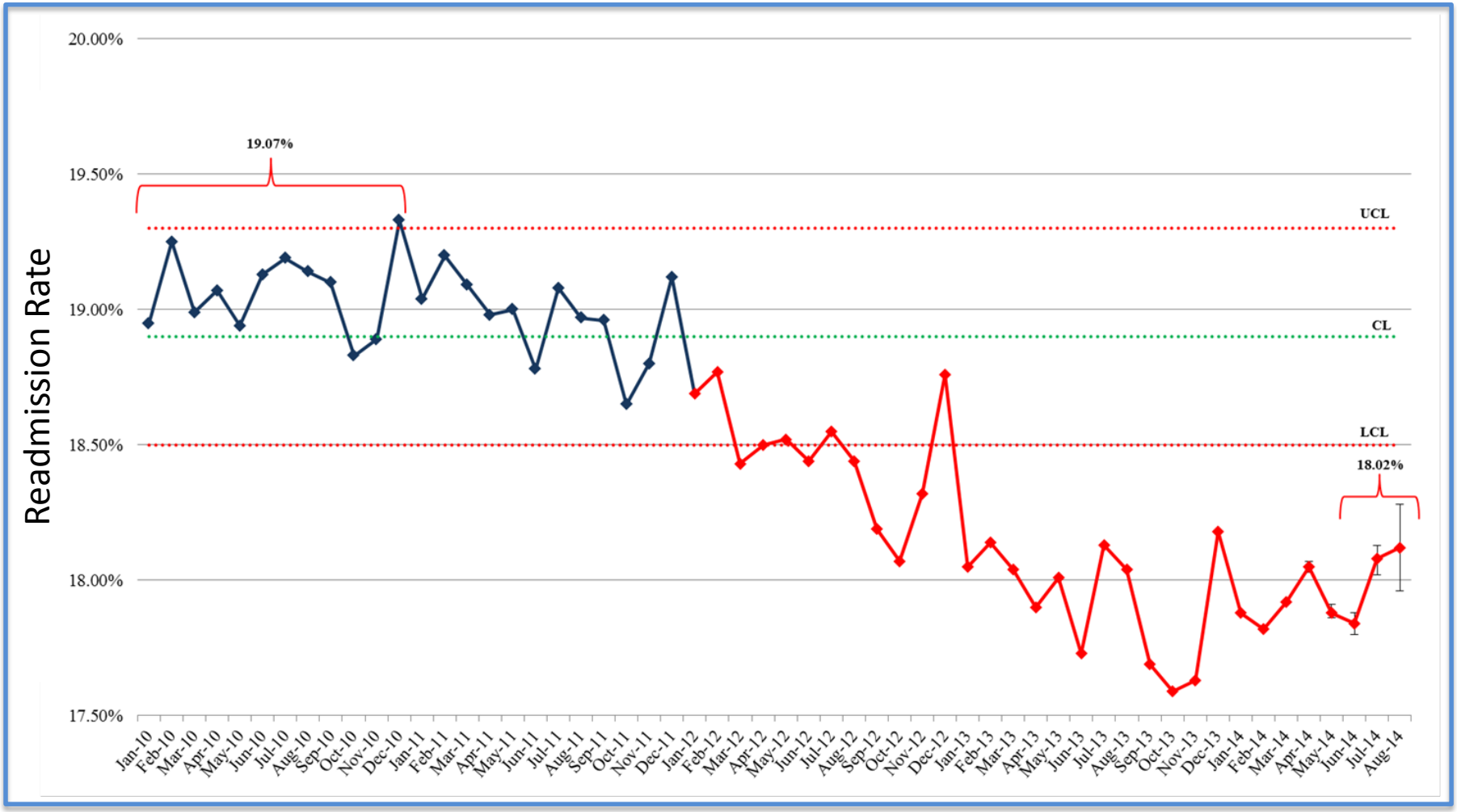
- First NEJM article published November 1984.[3]
  - Rate was 22% after 60 days.
  - Re-admissions comprised 25¢ of every inpatient claim dollar.

Goals for the CMS Hospital Readmission Reduction Program

Promote broadest possible efforts to lower readmission rates:

- Assume all patients are at risk of readmission and their risk can be lowered
- Opportunity to focus efforts on patients most at risk of readmission
- CMS is targeting funding support to hospitals and communities with greatest need for improvement
- Goal is not zero readmissions, but to lower readmission rates overall

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

Why are patients readmitted?

Provider-Patient interface

Unmanaged condition worsening

Use of suboptimal medication regimens

Return to an emergency department/lack of primary care

Unreliable system support

Lack of standard and known processes between providers

Unreliable information transfer

Unsupported patient & family engagement during transfers

No Community infrastructure for achieving common goals

CMS Quality Strategy Goals

"Working to Achieve Health Equity"

CMS Health Equity Plan for Medicare

Priority 1: Expand the Collection, Reporting, and Analysis of **Standardized Data**

Priority 2: Evaluate **Disparities Impacts** and Integrate Equity Solutions Across CMS Programs

Priority 3: Develop and Disseminate **Promising Approaches** to Reduce Health Disparities

Priority 4: Increase the Ability of the **Health Care Workforce** to Meet the Needs of Vulnerable Populations

Priority 5: Improve **Communication & Language Access** for Individuals with LEP & Persons with Disabilities

Priority 6: Increase **Physical Accessibility** of Health Care Facilities

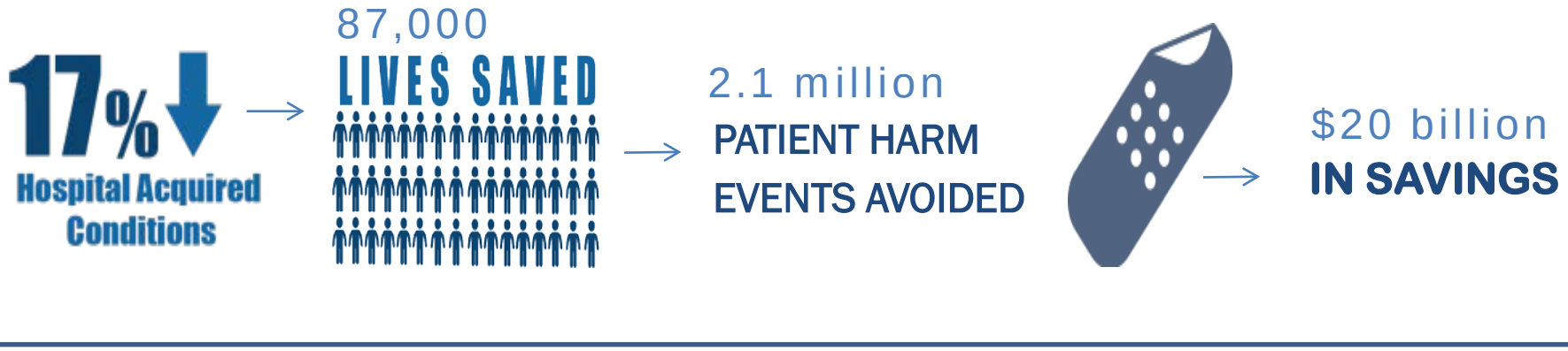
The Innovation Center portfolio aligns with delivery system reform focus areas

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

Partnership for Patients contributes to quality improvements

Data shows from 2010 to 2014…



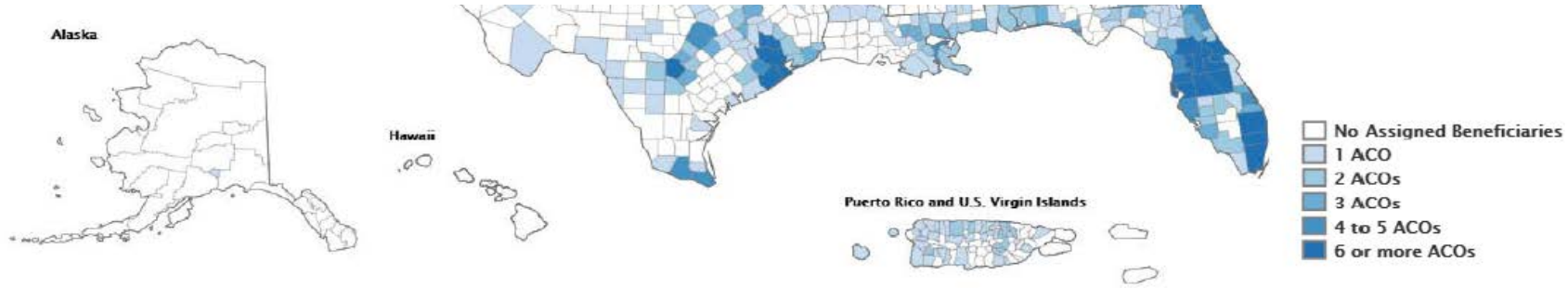
Leading Indicators, change from 2010 to 2013

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% ↓

ACO Participation

ACO-Assigned Beneficiaries by County

Accountable Care	Accountable Care	Accountable Care	Accountable Care
Accountable Care Organizations (ACOs): General Information	**ACO Investment Model**	**Advance Payment ACO Model**	**Comprehensive ESRD Care Model**
ACOs are groups of clinicians, hospitals, and other health-care providers that choose to come together to deliver coordinated, high-quality care to the Medicare patients they serve.	The ACO Investment Model is testing new pre-payment approaches meant to support Medicare Shared Savings Program ACOs.	The Advance Payment ACO Model is providing upfront and monthly payments to 35 ACOs participating in the Medicare Shared Savings Program.	The Comprehensive ESRD Care Model is designed to improve care for beneficiaries with ESRD while lowering Medicare costs.



Recent CMS Innovation Center Models

- **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

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.

5
Years

Beginning 2017, progress monitored quarterly

Payer Solicitation Period:

April 15 – June 1

Practice Application Period:

August 1 – September 15

Up to 20
Regions

Selection based on payer interest and coverage

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

Comprehensive Primary Care Plus (CPC+)

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

Goals

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

Participants and Partners

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

Care Transformation Functions


Access and continuity


Care management


Comprehensiveness and coordination


Patient and caregiver engagement


Planned care and population health

Payment Redesign Components


PBPM risk-adjusted care management fees


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


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

Why Post-Acute Care?

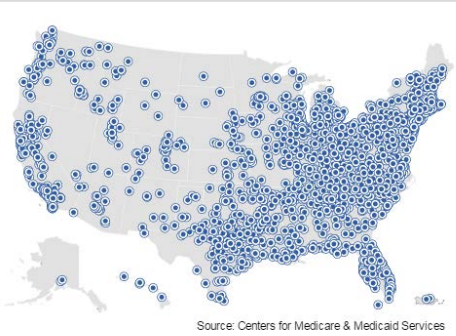
- Important part of the health system
- 42% of Medicare fee for service beneficiaries discharged from hospitals go to PAC
  - Sicker and quicker discharges
- Large numbers of Medicare enrollees served in these settings (over 5.5 million beneficiaries)
- Recovery, support and rehabilitation
  - Transition to lowest safe level of care

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 1237 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

https://innovation.cms.gov/initiatives/bundled-payments/

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**

~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**

Overview of the CJR Model

- **Episode of care begins** with an admission to a participant hospital of a beneficiary who is ultimately discharged under one of two MS-DRGs:
  - MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities), **or**
  - MS-DRG 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities)

- **Episode of care ends** 90 days post-discharge in order to cover the complete period of recovery for beneficiaries

- The **episode includes** all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with a few exclusions/exceptions.

Logistics of the CJR Model

- Beneficiaries retain their freedom of choice to choose services and providers.
- Participation in the CJR model is at the **hospital level**
  - Individual physicians or other practitioners have not been selected to participate in the model
  - The hospital may need to work with physicians and medical groups to ensure appropriate workflow and coordination
- Hospitals participating as episode initiators in Model 1 or Models 2 or 4 of the BPCI initiative for the LEJR clinical episode are excluded from participation in the CJR model.
  - The model will allow participant hospitals to enter into financial arrangements with providers and suppliers who furnish services to Medicare beneficiaries during a CJR episode

https://innovation.cms.gov/initiatives/cjr

Transitional Care Management Service Requirements

- Services are required during the beneficiary's transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
- The health care professional takes responsibility for the beneficiary's care; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.
- The 30-day **TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days**.

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

Changes the Medicare Home Health Prospective Payment System for 2016

- **IMPACT Act** (2014) implementation
  - CMS finalizing one standard cross-setting measure for reporting, focused on skin integrity

- Also finalizing a proposal to launch a new initiative: **the Home Health Value Based Purchasing (HHVBP) Model**
  - Authorized under the Innovation Center, leverages successes and lessons learned from other value-based purchasing programs and demonstrations including:
    - Hospital Value-Based Purchasing Program
    - Home Health Pay-for-Performance
    - Nursing Home Value-Based Purchasing
  - Nine states will participate including **ARIZONA** in Region 9

Proposed Hospital Outpatient Prospective Payment System Changes

- **Addressing Physicians' Concerns Regarding Pain Management**
  - Proposal to remove the pain management dimension from the Hospital Value-Based Purchasing program
- **Focusing Payments on Patients Rather than Setting**
  - Proposal to implement section 603 of the Bipartisan Budget Act of 2015
  - Certain items and services provided by hospital off-campus outpatient departments would no longer be paid under the OPPS
- **Streamline requirements**
  - Proposal for clinicians, hospitals, and critical access hospitals to use a 90-day EHR reporting period in 2016

2017 Medicare Physician Fee Schedule Proposed Rule

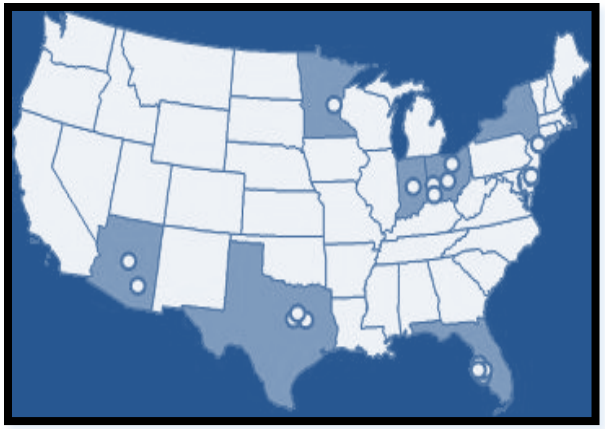
- Expand the Diabetes Prevention Program model starting January 1, 2018
- Proposing modifications to the Medicare Shared Savings Program to update the quality measures set and align with the proposals for the Quality Payment Program
- Requiring health care providers and suppliers to be screened and enrolled in Medicare in order to contract with Medicare Advantage health plans to provide Medicare-covered items and services to beneficiaries enrolled in Medicare Advantage
- Increasing transparency of Medicare Advantage pricing data and medical loss ratio (MLR) data from Medicare health and drug plans
- Revalue certain CPT codes to make separate payments for non face-to-face evaluation and management services
- Adding services to the list of those eligible to be furnished via telehealth

Diabetes Prevention Program (DPP) meets criteria for expansion

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

Timeline:

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



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

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

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

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

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

- 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

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**

What is "MACRA"?

MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

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 ***advanced* alternative payment models (APMs)**

Medicare Reporting under MACRA

MACRA streamlines these programs into
The **Quality Payment Program.**

Physician Quality Reporting Program (PQRS)

Value-Based Payment Modifier

Medicare Electronic Health Records (EHR) Incentive Program

Quality Payment Program

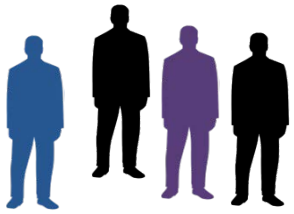
The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

MACRA affects Medicare Part B clinicians.

Affected clinicians are called **"eligible clinicians"**. The types of **Medicare Part B** health care clinicians affected by these changes may expand in the first 3 years of implementation.

Years 1 and 2	Years 3+
	*Secretary may broaden EP group to include others such as* 
Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists	**Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals**

Take note:

- Changes under MACRA related to the Quality Payment Program do not affect the Medicaid EHR Incentive program

- Clinicians attesting under Medicaid EHR Incentive program should continue to do so based on that program time frame and schedule

Proposed Rule released April 27, 2016

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

Quality Payment Program

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

- Major Provisions of MIPS
- 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**

MACRA changes how Medicare pays clinicians.

The system after **MACRA**:

One Path to Quality:

The Merit-based Incentive Payment System (MIPS)

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.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

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

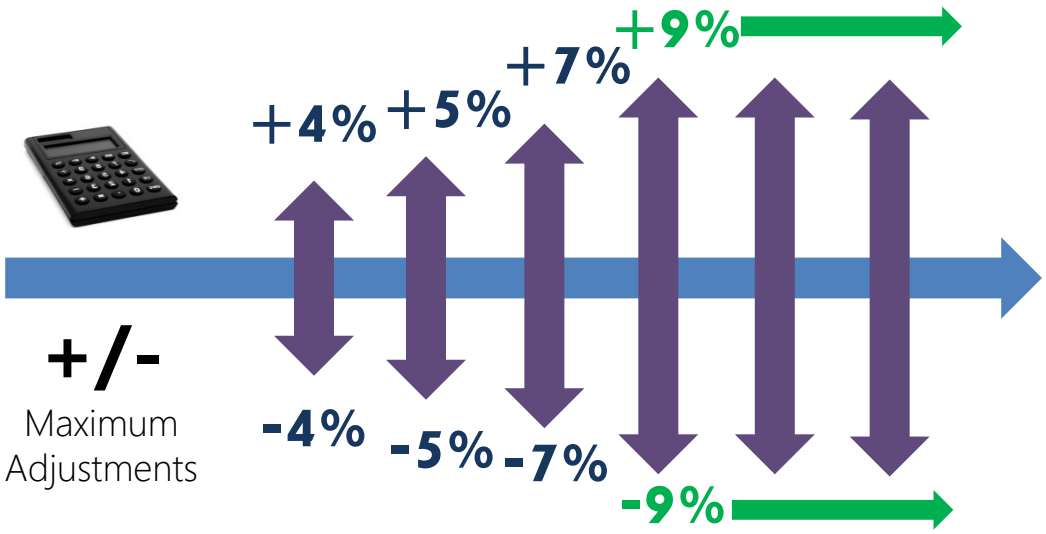
What will be involved in MIPS?

The MIPS composite performance **score** has **4 weighted categories**:

Clinicians will be reimbursed under Medicare Part B based on this Performance Score

How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

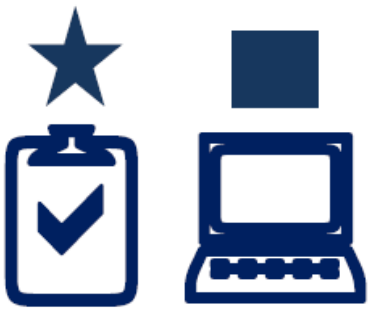
2019 2020 2021 2022 onward

Merit-Based Incentive Payment System **(MIPS)**

*The potential **maximum** adjustment % will **increase** each year from **2019 to 2022***

PROPOSED RULE

MIPS Performance Period



MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
Performance Period		Payment Year						

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

↓

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

Another Path to Quality:

Advanced Alternative Payment Models (APMs)

What is a Medicare Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

As defined by MACRA, **APMs include:**

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

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)

PROPOSED RULE
Medical Home Models

Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medical Home Model is an APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

To Review….
The Proposed Quality Payment Program for Medicare Part B

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

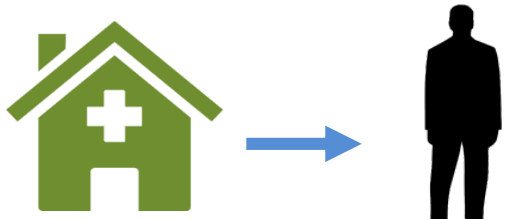
REVIEW:
Participation in the Quality Payment Program

Potential financial rewards

Not in APM	In APM	In advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **qualifying APM participant (QP)**

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



Advanced APM → QP

25% in 2019 and 2020

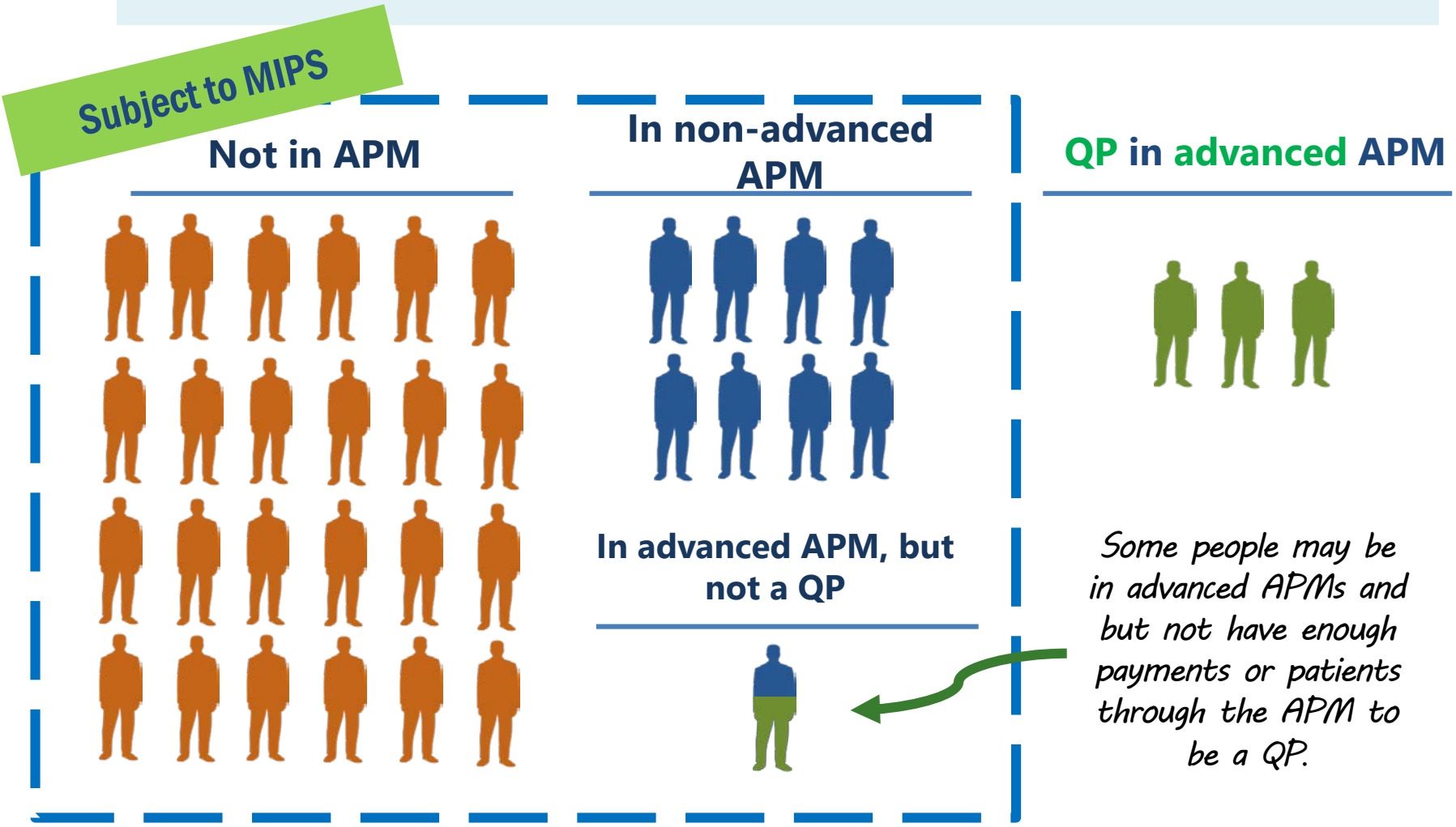
You must have a **certain %** of your patients or payments through an **advanced APM**.

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

Note: Most practitioners will be subject to MIPS.



Note: Figure not to scale.

TAKE-AWAY POINTS

1) MACRA **changes the way Medicare pays clinicians** and offers financial **incentives** for providing high **value** care.

2) The **Quality Payment Program** includes two pathways to value: participation in **MIPS**, or in an advanced **APM**.

3) Medicare **Part B clinicians** will participate in **MIPS**, unless they are in their first year of Part B participation, have a low volume of patients, or participate in an Advanced APM.

4) **Payment adjustments** and bonuses under the program will begin in **2019**

What should I do to prepare for MACRA?

- Look for future educational activities
- Review fact sheets and the proposed rule on these changes released April 27th
- http://go.cms.gov/QualityPaymentProgram
- Final rule targeted for fall 2016
- Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.

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

References & Further Reading

The Proposed Quality Payment Program
http://go.cms.gov/QualityPaymentProgram

Health Care Payment Learning and Action Network
http://innovationgov.force.com/hcplan

IMPACT Act
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

CMS Health Equity Plan
https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

Questions?

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