Clinical Services Subcommittee Federal Update

National Alzheimer's Project Act Advisory Council on Alzheimer's Research, Care, and Services

October 31, 2016

Health Resources & Services Administration Update

Medscape Article:

- *Bidirectional Impact of Alzheimer's Disease and Common Comorbid Conditions: Managing Patients*
- Published: September 7, 2017
- One month data: 3,281 participants

Goals 2, 4

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 beneficiaries' health, and spend health care dollars more wisely.

Care Transformation Functions

Access and continuity

Care management

Comprehensiveness and coordination

Person and caregiver engagement

Planned care and population health

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)

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

Comprehensive Primary Care Plus (continued)

- Enrolled beneficiaries with complex needs (e.g. cognitive impairment, chronic conditions, frailty) will be better able to achieve their goals and become engaged in care, have 24 hour access, and receive preventive services and care coordination
- To ensure beneficiaries with dementia are identified and flexibly care managed, CPC+ Track 2 practices are paid $100 PB-PM for patients with dementia diagnoses: https://innovation.cms.gov/Files/x/cpcplus-practiceslidepres.pdf
- CPC+ Care Delivery requirements 2.2 and 2.6 are especially relevant for people with dementia: https://innovation.cms.gov/files/x/cpcplus-practicecaredlvreqs.pdf

Information at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Comprehensive Primary Care (CPC) Initiative

- Earlier this month CMS announced the 2nd round of shared savings results with nearly all practices meeting quality of care requirements and four out of seven regions sharing in savings with CMS
- Results reflect the work of 481 practices serving 376,000 Medicare beneficiaries
- In addition to the Medicare savings of nearly $58M, CPC practices showed positive quality, with lower than expected hospital admission and readmission rates, and favorable performance on patient experience measures
- CPC practices' performance on electronic Clinical Quality Measures exceeded national benchmarks - particularly on preventive health
- 100 percent of practices that reported on screening for depression surpassed national benchmarks

(Strategy 2.E)
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Medicare Advantage Value-Based Insurance Design (VBID) Model Test

- Beginning in January 2018 - for Model Year 2 - CMS's Innovation Center will give some Medicare Advantage (MA) plans flexibility to target dementia (among other chronic conditions)
- VBID is structured cost-sharing and other design elements that encourage beneficiaries to use unique high-value services
- The VBID model gives flexibility to MA plans for a limited waiver of "uniformity" requirements, permitting MA organizations to tailor benefit designs
- The designs must fit into one or more category: reduced cost-sharing for high-value services; reduced cost-sharing when obtaining services at high-value providers; reduced cost-sharing for enrollees participating in disease management or related programs; and extra mandatory non-covered supplemental benefits
- General MA supplemental benefit guidance is at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf
- Stay tuned for release of a Request for Applications for the 2nd year!

(Strategy 2E)
Information at: http://innovation.cms.gov/initiatives/VBID

Independence At Home (IAH) Demonstration Performance Year 2 Results

- The IAH Demonstration provides chronically ill beneficiaries with a complete range of primary care services at home
- In August CMS announced the results of the second performance year
- IAH saved Medicare more than $10 million – an average of $1,010 per beneficiary – while delivering higher quality care in the beneficiary's home
- 15 practices served more than 10,000 Medicare beneficiaries and all improved quality from the first year in at least two of the Demonstration six quality measures, and four practices met all six

(Strategy 2E)
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-09.html

Medicaid Innovation Accelerator Project Beneficiaries with Complex Needs (BCN)

- Beginning this month CMS will hold a four-part national webinar series to share insights from the BCN initiative that states can use to design and implement activities related to Medicaid beneficiaries with complex needs and high costs:

- Identification and Stratification of Medicaid Beneficiaries with Complex Needs and High Costs – *(October 31, 2016 from 2:00 pm to 3:30 pm ET). Register here:* https://www.eventbrite.com/e/bcn-webinar-series-identification-and-stratification-of-medicaid-beneficiaries-with-complex-needs-tickets-28420861562

- The other three programs will be held in December, January, and February

(Strategy 2H)
Information at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html

Advance Care Planning

- In August CMS issued a new fact sheet on Medicare's Advance Care Planning benefit that describes beneficiary eligibility, provider/location eligibility, and diagnosis requirements
- This month CMS's Special Innovation Projects for the Quality Innovation Network-Quality Improvement Organizations announced twenty new two year projects including one to Mountain Pacific Quality Health Foundation that utilizes the Institute for Healthcare Improvement's Conversation Project Starter Kit and the Hawaii State Advance Care Planning and/or Physician Orders for Life Sustaining Treatment to improve advance care planning for Medicare beneficiaries in Hawaii

(Strategy 2C)

Fact sheet at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909289.html?DLPage=1&DLEntries=10&DLFilter=advance%20care%20plan& DLSortDir=ascending

QIO/QIN SIP Awards at: http://qioprogram.org/cms-awards-special-innovation-projects

"Addressing Neuropsychiatric Symptoms in Patients with Dementia"

- In June CMS sponsored a Medscape continuing education opportunity for professionals presented by Shari Ling and Laura Gitlin – both NAPA Advisory Council members - and Sharon Inouye and Constantine Lyketsos, also expert in ADRD
- The program provides a summary of treatment goals for comprehensive dementia care, addresses neuropsychiatric symptom management including a DICE (describe, investigate, create, evaluate) approach to difficult behaviors, provides for acute hospital management, and lists clinical and administrative resources
- The focus is on improving and maintaining quality of life of people with dementia, including support for families and caregivers across settings of care
- Continuing Medication Education Credit is valid through 06/09/2017

Over the past three months the program has been viewed nearly 9,000 times!!!!

http://www.medscape.org/viewarticle/863605?src=acdmpart_hhs_863605

Goals 2, 4

National Partnership to Improve Dementia Care in Nursing Homes

- The September 15th Medicare Learning Network (MLN) Connects® call on the National Partnership to Improve Dementia Care and Quality Assurance and Performance Improvement focused on effective care transitions between long-term and acute care settings, highlighting those that involve people with dementia
- The audio recording and transcript are at: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2016-09-15-Demetia-Care.html

(Strategy 3.D)

Improved Care in Long-Term Care Facilities

- In September CMS issued a final rule that made major changes to improve the care and safety of the nearly 1.5 million residents in 15,000 long-term care facilities (nursing homes) that participate in Medicare and Medicaid
- The policies in the final rule will reduce unnecessary hospital readmissions and infections, improve quality, and strengthen safety measures for residents
- Among other improvements, the final rule strengthens staffing provisions, requires person-centered care, includes specific requirement for dementia training, betters discharge planning, and updates infection prevention and control protocols

(Strategy 2G)
https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

National Quality Forum - Disparities

- NQF recently kicked off a new one year project to obtain multi-stakeholder guidance on how performance measurement can be used to address disparities for five target conditions, including mental illness
- NQF will examine disparities outcomes; review causes, effective interventions, and gaps; perform an environmental scan; develop a conceptual framework; and make recommendations for measure development
- The literature review will consider socioeconomic position, race, ethnicity, culture, residence and community, and disability

(Strategy 2.H)
Information at: http://www.qualityforum.org/Disparities_Project.aspx

QUESTIONS?

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