Welcome to HHS

Arnold Epstein, MD
Deputy Assistant Secretary
Office of Health Policy
Payment Model Proposal Submission and Review Process

Clara Filice, MD, MPH, MHS
Medical Officer
HHS ASPE Office of Health Policy
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(2) Criteria and process for submission and review of physician-focused payment models.–
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(2) Criteria and process for submission and review of physician-focused payment models.—

(A) Criteria for assessing physician-focused payment models.—

(i) <<NOTE: Deadline.>> Rulemaking.—Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

(ii) MedPAC submission of comments.—During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iii) Updating.—The Secretary may update the criteria established under this subparagraph through rulemaking.
```
``(2) Criteria and process for submission and review of physician-focused payment models.---
``(A) Criteria for assessing physician-focused payment models.---
``(B) Stakeholder submission of physician-focused payment models.---On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).
(2) Criteria and process for submission and review of physician-focused payment models.–

(A) Criteria for assessing physician-focused payment models.--

(B) Stakeholder submission of physician-focused payment models.--On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

(C) Committee review of models submitted.--The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.
PROPOSAL REVIEW PROCESS: ISSUES FOR COMMITTEE CONSIDERATION
Goals for today

• To raise some of the issues Committee will need to consider in developing a process for proposal submission and review
• Provide the Committee with the opportunity to share initial thoughts
• To invite public comment
Committee’s guiding principles for process?

- What principles should guide development of the Committee’s process for submitting and reviewing proposals?
  - Efficiency?
  - Comprehensiveness?
  - Analytic rigor?
  - Productivity?
  - Easy accessibility?
  - Other?
Basic steps

1. Stakeholder Submission
2. Preparation for Review
3. Committee Review & Recommendations
4. Secretarial Review
1. Stakeholder Submission

- Request for proposals?
- Letter of Intent?
- Proposal template?
- Electronic submission?
1. Stakeholder Submission

- What information should be required for submission?
  - Enough information to meet Committee’s charge will be necessary
  - Whether and what additional information is required of submitters not specified in the law
    - Impact on quality and volume of proposals
2. Preparation for Review

- Extent of preparatory activities/technical assistance?
- Initial review? Or straight to full Committee?
  - Time frame for initial review?
  - Order of initial review?
  - Content of initial review?
- Public comment?
3. Committee Review & Recommendations

- Who presents a proposal?
- What role should the submitter(s) play?
- How will proposals be evaluated/scored?
- What are potential outcomes for proposals?
- Timing and content of comment & recommendations?
- How should Committee agree on comments and recommendations?
• The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.
Discussion and Public Comment

• What principles should guide the Committee’s development of a process for proposal submission and review?
• What elements of the process are most important?
Discussion and Public Comment

• What principles should guide the Committee’s development of a process for proposal submission and review?
• What elements of the process are most important?
Public Comment #1

• Please limit your remarks to no more than 3 **minutes** during today’s session.

• We will have a timekeeper and the video monitor will turn yellow when you have one minute left.
  – When you see the monitor turn yellow, please wrap up your comments
  – When you see the monitor turn red, please stop commenting.

• If your comments are more extensive, submit them to us in writing so they can be carefully considered.
Procedures

• We will alternate taking comments from those in the audience and on the phone until we are out of time.

• We will start with those who registered to comment and were given a number at check-in. Please line up according to the number.

• Today is just the first of many opportunities to share your thoughts with us.
Instructions for Public Comment

- **In-Person Participants in 505A**
  - Participants will come up to the podium to speak. Each person received a number when they checked-in and will be called in that order.

- **Overflow Room Participants in 405A**
  - During the Public Comment period, a member of the ASPE staff will escort anyone that signed up and will be brought over to the main room 505A.

- **Conference Call Participants on Phone**
  - During the Public Comment period, conference call participants that signed up to give a public comment will be queued when his/her turn comes up by the operator.
GO

3:00 Minutes
Wrap Up Now
1:00 Minute
Stop
Next person
CMS Innovation and Health Care Delivery System Reform

Amy Bassano
Mai Pham
Center for Medicare and Medicaid Innovation
January 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

Historical state

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

Systems and Policies
- Fee-For-Service Payment Systems

Evolving future state

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.

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

<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>
</tr>
<tr>
<td>Description</td>
<td>Limitation in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Accountable Care Organizations</td>
<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
</tr>
<tr>
<td>Medicare Fee-for-Service examples</td>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
<td>Medical homes</td>
<td>Maryland hospitals</td>
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<td></td>
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<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
<td>Bundled payments</td>
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<td>Comprehensive Primary Care initiative</td>
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<td>Comprehensive ESRD</td>
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<td></td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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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

**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

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical Performance</th>
<th>Goals</th>
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<tbody>
<tr>
<td>2011</td>
<td>~70%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>~20%</td>
<td>80%</td>
</tr>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
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<tr>
<td>2018</td>
<td>50%</td>
<td>90%</td>
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Alternative payment models (Categories 3-4)
FFS linked to quality (Categories 2-4)
All Medicare FFS (Categories 1-4)
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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</thead>
<tbody>
<tr>
<td><strong>Accountable Care Organizations</strong></td>
<td>Medicare Shared Savings Program ACO*</td>
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<td></td>
<td>Pioneer ACO*</td>
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<td></td>
<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>
<td>Bundled Payment for Care Improvement*</td>
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<td></td>
<td>Comprehensive Care for Joint Replacement</td>
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<td></td>
<td>Oncology Care</td>
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<tr>
<td><strong>Advanced Primary Care</strong></td>
<td>Comprehensive Primary Care*</td>
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<td></td>
<td>Multi-payer Advanced Primary Care Practice*</td>
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<tr>
<td><strong>Other Models</strong></td>
<td>Maryland All-Payer Hospital Payments*</td>
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<td></td>
<td>ESRD Prospective Payment System*</td>
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</table>

* Model completion or expansion

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
CMS 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 (payment FY16)</th>
<th>2015 (FY17)</th>
<th>2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>6.55</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Readmissions Reduction Program</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Physician, % of FFS payment at risk (maximum downside)

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment 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>
</tr>
<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%*
CMS is aligning with private sector and states to drive delivery system reform

CMS Strategies for Aligning with Private Sector and states

- Convening Stakeholders
- Incentivizing Providers
- Partnering with States
Delivery System Reform and Our Goals

Early Results

CMS Innovation Center
Medicare growth has fallen below GDP growth and national health expenditure growth since 2010 due, in part, to CMS policy changes and new models of care.

**Average growth rate (2010–2014)**
- Medicare/beneficiary: 1.3%
- GDP / capita: 3.3%
- National Health Expenditure/capita: 3.7%

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

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* January 2016

** Last updated April 2015
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
Independence at Home (IAH) Demonstration saved more than $3,000 per beneficiary

- IAH tests a service delivery and shared savings model using home-based primary care to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions.
- In year 1, demo produced more than $25 million in savings, an average of $3,070 per participating beneficiary per year.
- CMS awarded incentive payments of $11.7 million to nine practices that produced savings and met the designated quality measures for the first year.
- All 17 participating practices improved quality in at least three of the six quality measures.

- There are 14 total practices, including 1 consortium, participating in the model.
- Approximately 8,400 patients enrolled in the first year.
- Duration of initial model test: 2012 - 2015.
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)
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)
  - $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...

17% ↓ Hospital Acquired Conditions → 87,000 LIVES SAVED → 2.1 million PATIENT HARM EVENTS AVOIDED → $20 billion IN SAVINGS

Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>2010-2013 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>62.4% ↓</td>
</tr>
<tr>
<td>Early Elective Delivery</td>
<td>70.4% ↓</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infections</td>
<td>12.3% ↓</td>
</tr>
<tr>
<td>Venous thromboembolic complications</td>
<td>14.2% ↓</td>
</tr>
<tr>
<td>Re-admissions</td>
<td>7.3% ↓</td>
</tr>
</tbody>
</table>
Delivery System Reform and Our Goals

Early Results

CMS Innovation Center
The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

“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”

Section 3021 of Affordable Care Act

Three scenarios for success
1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking
# The Innovation Center portfolio aligns with delivery system reform focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
</tr>
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<tbody>
<tr>
<td><strong>Pay Providers</strong></td>
<td><strong>Test and expand alternative payment models</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Accountable Care</td>
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<tr>
<td></td>
<td>▪ Pioneer ACO Model</td>
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<tr>
<td></td>
<td>▪ Medicare Shared Savings Program (housed in Center for Medicare)</td>
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<td></td>
<td>▪ Advance Payment ACO Model</td>
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<td></td>
<td>▪ Comprehensive ERSD Care Initiative</td>
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<td>▪ Next Generation ACO</td>
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<td>▪ <strong>Primary Care Transformation</strong></td>
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<td></td>
<td>▪ Comprehensive Primary Care Initiative (CPC)</td>
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<td></td>
<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><strong>Deliver Care</strong></td>
<td><strong>Bundled payment models</strong></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>▪ <strong>Initiatives Focused on the Medicaid</strong></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>▪ <strong>Dual Eligible (Medicare-Medicaid Enrollees)</strong></td>
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<td>▪ Financial Alignment Initiative</td>
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<td></td>
<td>▪ Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td></td>
<td>▪ <strong>Medicare Advantage (Part C) and Part D</strong></td>
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<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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<tr>
<td><strong>Distribute Information</strong></td>
<td><strong>Support providers and states to improve the delivery of care</strong></td>
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<td>▪ <strong>Learning and Diffusion</strong></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>▪ <strong>Health Care Innovation Awards</strong></td>
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<td>▪ <strong>Accountable Health Communities</strong></td>
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<tr>
<td><strong>Distribute Information</strong></td>
<td><strong>Increase information available for effective informed decision-making by consumers and providers</strong></td>
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<td>▪ <strong>State Innovation Models Initiative</strong></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>▪ <strong>Million Hearts Cardiovascular Risk Reduction Model</strong></td>
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<tr>
<td></td>
<td>▪ <strong>Shared decision-making required by many models</strong></td>
</tr>
</tbody>
</table>

* Many CMMI programs test innovations across multiple focus areas
CMS has engaged the health care delivery system and invested in innovation across the country

Source: CMS Innovation Center website, December 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>
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<tbody>
<tr>
<td>21 ACOs spread among 13 states</td>
<td>9 ACOs spread among 7 states</td>
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</table>
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

- 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
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
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
Comprehensive ESRD Care will improve patient centered coordination of care

CEC model will improve care coordination through the creation of ESRD Seamless Care Organizations (ESCO) that will include dialysis providers, nephrologist, and other medical providers

- CEC Model launched on 10/1/2015 with 13 ESCOs serving 15,000+ beneficiaries nationwide, including 12 LDOs and 1 non-LDO
- Goal is to test an ACO model centered solely around ESRD patients
- ESRD patients = 1.1% of Medicare beneficiaries
- Dialysis costs account for approximately 33% of total cost of care for ESRD patients
  - Opportunity exist to improve patient centered care that coordinates dialysis care with care outside of dialysis

Dialysis costs account for approximately 5.6% of payments beneficiaries

Care Model
- Improve care coordination
  - Clinical and support services
  - Data driven, population care management
- Enhance communication between providers
  - Whole-patient care management
  - EHR information exchange among providers
- Increase access to care
  - After hours call-in line; extended business hours
  - Enhanced convenience through on-site ‘rounding’
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

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

*Uses American College of Cardiology/American Heart Association (ACA/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator
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
Health Care Innovation Awards: delivery system innovations

<table>
<thead>
<tr>
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<th>Round 1</th>
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Results and Metrics

- Approximately 760,000 Medicare, Medicaid, and CHIP beneficiaries served in Round One
- Projects funded in all 50 states, the District of Columbia and Puerto Rico

The projects from HCIA Awards are:

- **generating ideas** for additional tests,
- providing promising ideas that are also being **integrated into future models**, and
- projects are spurring ideas to be adopted by the **private sector**.

* Darker colors on map represent more HCIA projects in that state
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

![Phases of Transformation](image)
Selected Examples of Current CMMI Model Design Factors

1. The strength of the evidence base.
2. Potential for cost savings.
4. Evaluative feasibility.
5. Scalability.
6. Demographic, clinical and geographic diversity.

Model Life Cycle Framework

1. Idea/Concept
   - Idea added to CMMI Tracker
   - Identify Concept Paper
     - Group/Team
   - Develop Concept Paper
   - PMC Review
   - Concept Paper sent to Clearance
   - Identify Full Support team
   - Team Kick-Off Meeting

2. Planning & Design
   - ICIP/FOA
     - Gather Full Evidence & Research (Clinical Design)
   - High Level Business Processes & Requirements
   - Other Plans (Learning, Evaluation, Procurements, Budget, Project Management etc.)
   - Detailed Business Processes & Requirements
   - ICIP Review by PMC
   - Clearances (Incl. Policy Clearance)
   - Obtain Apportionment ($$$)
   - Make Announcement/Post Solicitation

3. Solicit & Build
   - Receive apps, review apps, make selections
   - (Other) FAR Solicitations & Selection
   - Implementation of Design
     - Receive POA application – Make Selection
       - Provider/Bene Alignment
       - Enrollment
       - IT Systems Build
       - Learning Systems Build
       - Other Build
   - PMC Design Review
   - PMC Go Live Decision
   - Go Live!

4. Run/Evaluate/Scale
   - Evaluate
     - Quality Reporting
   - Data Submission/Exchange, Analytics (Other)
   - Program Evaluation
   - Run
     - Participant Payments & Reimbursements
     - Learning & Collaboration Systems
     - Participant Oversight
     - FAR Contracts Oversight
     - Program Management
     - Financial Oversight/Management
   - Scaling Steps (TBD)
   - PMC Next Steps (TBD)

5. Closing (TBD)
   - Final Participant Invoicing
   - Final Contractor Invoicing
   - Close Contract
   - Close Cooperative Agreement
   - Close Data Archive
   - Model Closed

NOTE: STEPS WITHIN PHASES ARE NOT NECESSARILY CHRONOLOGICAL AND WILL OVERLAP AND ITERATE
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)**
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**
  - All Medicare fee-for-service (FFS) payments (Categories 1-4): 30%
  - Medicare FFS payments linked to quality and value (Categories 2-4): 85%
  - Medicare payments linked to quality and value via APMs (Categories 3-4): 50%

- **2018**
  - All Medicare fee-for-service (FFS) payments (Categories 1-4): 50%
  - Medicare FFS payments linked to quality and value (Categories 2-4): 90%

- Medicare payments linked to quality and value via APMs (Categories 3-4)
- Medicare payments to QPs in eligible APMs under MACRA
Alternative Payment Models (APMs)

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

According to MACRA law, 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

- MACRA **does not change how any particular APM rewards value.**
- APM participants who are not “QPs” will receive **favorable scoring under MIPS.**
- Only **some** of these APMs will be **eligible** APMs.
How does MACRA provide additional rewards for participation in APMs?

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive **favorable scoring** under the MIPS clinical practice improvement activities performance category.

Those who participate in **the most advanced** APMs may be determined to be **qualifying APM participants ("QPs")**. As a result, 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
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
APPROXIMATE TIMELINE FOR RULEMAKING ON CRITERIA FOR PHYSICIAN-FOCUSED PAYMENT MODELS

DEC – MAR
Review public comment and prepare NPRM.

APR – AUG
Review public comments and prepare Final Rule.

SEP – NOV
Issue Final Rule on Criteria for physician-focused payment models.

APPROXIMATE TIMELINE FOR RULEMAKING ON CRITERIA FOR PHYSICIAN-FOCUSED PAYMENT MODELS

Dec   Jan   Feb   Mar   Apr   May   Jun   Jul   Aug   Sep   Oct   Nov

Approx April, 2016
Issue Notice of Proposed Rule Making (NPRM) on physician-focused payment models.

November, 2016
Statutory deadline to issue Secretary’s criteria on physician-focused payment models via Final Rule.
Innovation Center – 2016 Looking Forward

We are focused on:

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio
Public Comment #2

• Please limit your remarks to no more than 3 minutes during today’s session.

• We will have a timekeeper and the video monitor will turn yellow when you have one minute left.
  – When you see the monitor turn yellow, please wrap up your comments
  – When you see the monitor turn red, please stop commenting.

• If your comments are more extensive, submit them to us in writing so they can be carefully considered.
Procedures

• We will alternate taking comments from those in the audience and on the phone until we are out of time.

• We will start with those who registered to comment and were given a number at check-in. Please line up according to the number.

• Today is just the first of many opportunities to share your thoughts with us.
Instructions for Public Comment

• **In-Person Participants in 505A**
  – Participants will come up to the podium to speak. Each person received a number when they checked-in and will be called in that order.

• **Overflow Room Participants in 405A**
  – During the Public Comment period, a member of the ASPE staff will escort anyone that signed up and will be brought over to the main room 505A.

• **Conference Call Participants on Phone**
  – During the Public Comment period, conference call participants that signed up to give a public comment will be queued when his/her turn comes up by the operator.
GO
3:00 Minutes
Wrap Up Now
1:00 Minute
Stop

Next person
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