Healthcare Transformation: Moving Towards Integrated Healthcare

Patricia A. Meier, M.D.
Chief Medical Officer
CMS Kansas City Regional Office
Agenda Items

• Healthcare Transformation and MACRA legislation

• Quality Payment Program
  - Measure and activities related to opioid initiative
  - Activities related to behavioral health

• Selected CMMI Initiatives
  - CPC plus
  - Accountable Communities Model
  - Transforming Clinical Practice Initiative
What is “MACRA”?  


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 **quality of services over quantity**
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in *advanced* alternative payment models (APMs)
Quality Payment Program Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV
The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

- **MIPS**
  - The Merit-based Incentive Payment System (MIPS)
  - *If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

- **Advanced APMs**
  - Advanced Alternate Payment Models (APMs)
  - *If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
What are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

Note: These are defaults weights; the weights can be adjusted in certain circumstances
MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - “So what?”—Provides for an easier transition due to familiarity

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

60% of final score

Different requirements for groups reporting CMS Web Interface or those in MIPS-APMs

May also select specialty-specific set of measures
CMS’s Approach

- Awareness
- Education
- Technical Assistance
- Data as a Tool
- Policy
- Diversion Awareness

OUD: Opioid Use Disorder
Policy: Quality Payment Program
Merit-Based Incentive Payment System (MIPS)

- Links clinician payments to quality and value
- Performance Year starts Jan 1, 2017
- Includes opioid-related quality measures and clinical improvement activities related to prescription drug monitoring programs (PDMP)

Annual registration in the Prescription Drug Monitoring Program

Consultation of the Prescription Drug Monitoring Program

www.qpp.cms.gov
Quality Measures

Showing 3 Measures

- **Documentation of Signed Opioid Treatment Agreement**
  - ADD

- **Evaluation or Interview for Risk of Opioid Misuse**
  - ADD

- **Opioid Therapy Follow-up Evaluation**
  - ADD
MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

*Keep in mind:*

- Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)
- Only the scoring is different
MIPS Performance Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- Clinicians choose from 90+ activities under 9 subcategories:

  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response
Improvement Activities: Behavior & Mental Health

- Depression screening
- Diabetes screening
- Electronic Health Record Enhancements for BH data capture
- Implementation of co-location PCP and MH services
- Implementation of integrated PCBH model
- MDD prevention and treatment interventions
- Tobacco use
- Unhealthy alcohol use
Improvement Activities

Showing 2 Activities

- Annual registration in the Prescription Drug Monitoring Program
  - ADD

- Consultation of the Prescription Drug Monitoring program
  - ADD
MIPS Performance Category: Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
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.

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.
CMMI Innovation Model Sites

Screenshot CMMI website, Jan 2017
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>
</thead>
<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>
</tr>
<tr>
<td></td>
<td>‒  Pioneer ACO Model</td>
</tr>
<tr>
<td></td>
<td>‒  Medicare Shared Savings Program (housed in Center for Medicare)</td>
</tr>
<tr>
<td></td>
<td>‒  Advance Payment ACO Model</td>
</tr>
<tr>
<td></td>
<td>‒  Comprehensive ERSD Care Initiative</td>
</tr>
<tr>
<td></td>
<td>‒  Next Generation ACO</td>
</tr>
<tr>
<td></td>
<td>▪  Primary Care Transformation</td>
</tr>
<tr>
<td></td>
<td>‒  Comprehensive Primary Care Initiative (CPC)</td>
</tr>
<tr>
<td></td>
<td>‒  Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
</tr>
<tr>
<td></td>
<td>‒  Independence at Home Demonstration</td>
</tr>
<tr>
<td></td>
<td>‒  Graduate Nurse Education Demonstration</td>
</tr>
<tr>
<td></td>
<td>‒  Home Health Value Based Purchasing</td>
</tr>
<tr>
<td></td>
<td>‒  Medicare Care Choices</td>
</tr>
<tr>
<td></td>
<td>▪  Bundled payment models</td>
</tr>
<tr>
<td></td>
<td>‒  Bundled Payment for Care Improvement Models 1-4</td>
</tr>
<tr>
<td></td>
<td>‒  Oncology Care Model</td>
</tr>
<tr>
<td></td>
<td>‒  Comprehensive Care for Joint Replacement</td>
</tr>
<tr>
<td></td>
<td>▪  Initiatives Focused on the Medicaid</td>
</tr>
<tr>
<td></td>
<td>‒  Medicaid Incentives for Prevention of Chronic Diseases</td>
</tr>
<tr>
<td></td>
<td>‒  Strong Start Initiative</td>
</tr>
<tr>
<td></td>
<td>‒  Medicaid Innovation Accelerator Program</td>
</tr>
<tr>
<td></td>
<td>▪  Dual Eligible (Medicare-Medicaid Enrollees)</td>
</tr>
<tr>
<td></td>
<td>‒  Financial Alignment Initiative</td>
</tr>
<tr>
<td></td>
<td>‒  Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
</tr>
<tr>
<td></td>
<td>▪  Medicare Advantage (Part C) and Part D</td>
</tr>
<tr>
<td></td>
<td>‒  Medicare Advantage Value-Based Insurance Design model</td>
</tr>
<tr>
<td></td>
<td>‒  Part D Enhanced Medication Therapy Management</td>
</tr>
<tr>
<td><strong>Deliver Care</strong></td>
<td><strong>Support providers and states to improve the delivery of care</strong></td>
</tr>
<tr>
<td></td>
<td>▪  Learning and Diffusion</td>
</tr>
<tr>
<td></td>
<td>‒  Partnership for Patients</td>
</tr>
<tr>
<td></td>
<td>‒  Transforming Clinical Practice</td>
</tr>
<tr>
<td></td>
<td>‒  Community-Based Care Transitions</td>
</tr>
<tr>
<td></td>
<td>▪  Health Care Innovation Awards</td>
</tr>
<tr>
<td></td>
<td>▪  Accountable Health Communities</td>
</tr>
<tr>
<td></td>
<td>▪  State Innovation Models Initiative</td>
</tr>
<tr>
<td></td>
<td>‒  SIM Round 1</td>
</tr>
<tr>
<td></td>
<td>‒  SIM Round 2</td>
</tr>
<tr>
<td></td>
<td>‒  Maryland All-Payer Model</td>
</tr>
<tr>
<td></td>
<td>▪  Million Hearts Cardiovascular Risk Reduction Model</td>
</tr>
<tr>
<td><strong>Distribute Information</strong></td>
<td><strong>Increase information available for effective informed decision-making by consumers and providers</strong></td>
</tr>
<tr>
<td></td>
<td>▪  Health Care Payment Learning and Action Network</td>
</tr>
<tr>
<td></td>
<td>▪  Information to providers in CMMI models</td>
</tr>
<tr>
<td></td>
<td>▪  Shared decision-making required by many models</td>
</tr>
</tbody>
</table>

* Many CMMI programs test innovations across multiple focus areas
CPC+ a New Advanced Primary Care Medical Home Model

CPC+ By the Numbers

<table>
<thead>
<tr>
<th>5 Years</th>
<th>14 Regions</th>
<th>2 Program Tracks</th>
<th>Up to 2,500 Practices Per Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning January 2017, progress monitored quarterly</td>
<td>Only practices in selected states/counties may apply</td>
<td>Based on practices’ readiness for transformation</td>
<td>Dependent upon interest and eligibility; applications due 9/15</td>
</tr>
</tbody>
</table>

Online Resource: CPC+ In Brief
CPC+ Offered in Fourteen Regions

Only Practices in Selected States/Counties May Apply

Online Resource: CPC+ Payer and Region List
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

### Requirements for

**Track 1**

- **Access and Continuity**
  - Empanelment
  - 24/7 patient access
  - Assigned care teams

- **Care Management**
  - Risk stratified patient population
  - Short-term and targeted, proactive, relationship-based care management
  - ED visit and hospital follow-up

**Track 2**

- Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
- Two-step risk stratification process for all empanelled patients
- Care plans for high-risk chronic disease patients

**Online Resources:** Care Delivery Transformation Brief, Video, and Practice Requirements
CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Requirements for

**Track 1**

**Comprehensiveness and Coordination**
- Identification of high volume/cost specialists
- Improved timeliness of notification and information transfer from EDs and hospitals

**Patient and Caregiver Engagement**
- At least annual Patient and Family Advisory Council
- Assessment of practice capabilities to support patient self-management

**Planned Care and Population Health**
- At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy

Requirements for

**Track 2**

**Comprehensiveness and Coordination**
- Behavioral health integration
- Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs
- Collaborative care agreements
- Development of practice capability to meet needs of high-risk populations

**Patient and Caregiver Engagement**
- At least biannual Patient and Family Advisory Council
- Patient self-management support for at least three high-risk conditions

**Planned Care and Population Health**
- At least weekly care team review of all population health data
### Three Payment Innovations Support CPC+ Practice Transformation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Medicare FFS)</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

**Online Resources:** Payment Innovations Brief and Video
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.
Initiative Goals

- Model aims to identify and address beneficiaries’ health related social needs in at least the following core areas:
  - Housing instability and quality
  - Food insecurity
  - Utility needs
  - Interpersonal violence
  - Transportation needs
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
Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

**PRIMARY CARE & SPECIALIST PHYSICIANS**

*Transforming Clinical Practice Initiative*

- Supports physicians and other clinicians through active, collaborative and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANS) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

*Locate the PTN(s) and SAN(s) in your state*

---

**SMALL & SOLO PRACTICES**

*Small, Underserved Rural Support Technical Assistance*

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

---

**LARGE PRACTICES**

*Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support*

- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

*Locate the QIN-QIO that serves your state*

---

**TECHNICAL SUPPORT**

*All Eligible Clinicians Are Supported By:*

- **Quality Payment Program Portal**
  
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  
  Assists with all Quality Payment Program questions including program basics and tips for getting started.

- **Advanced Alternative Payment Model (APM) Learning Networks**
  
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.
Contact Info

Patricia A. Meier, M.D.
Chief Medical Officer
CMS Kansas City Regional Office
patricia.meier@cms.hhs.gov