NATIONAL QUALITY FORUM

Quality Policy Member Network – Payment Reform and the Evolving Role of Quality Measurement

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November 15, 2016

WELCOME! NQF Members collaborating to improve quality policy

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NQF Member Networks

An NQF-wide commitment to enriching the Member experience

By opting in to a NQF Member Network, participants can expect to:

1. expand knowledge of quality measurement, measure endorsement and related policy and payment issues
2. build relationships with other Members and with NQF staff
3. Take advantage of exclusive programming designed to serve your interests

Introduction to our Speakers

Ann Greiner
Vice President, Public Affairs

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMS Innovation and Health Care Delivery System Reform

Hoangmai Pham, MD
Chief Innovation Officer,
Center for Medicare and Medicaid Innovation
November 15, 2016

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***.

CMS has adopted a framework that categorizes payments to providers

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

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

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

As of **January 01, 2016**, the **30% goal was achieved one year ahead of schedule.**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

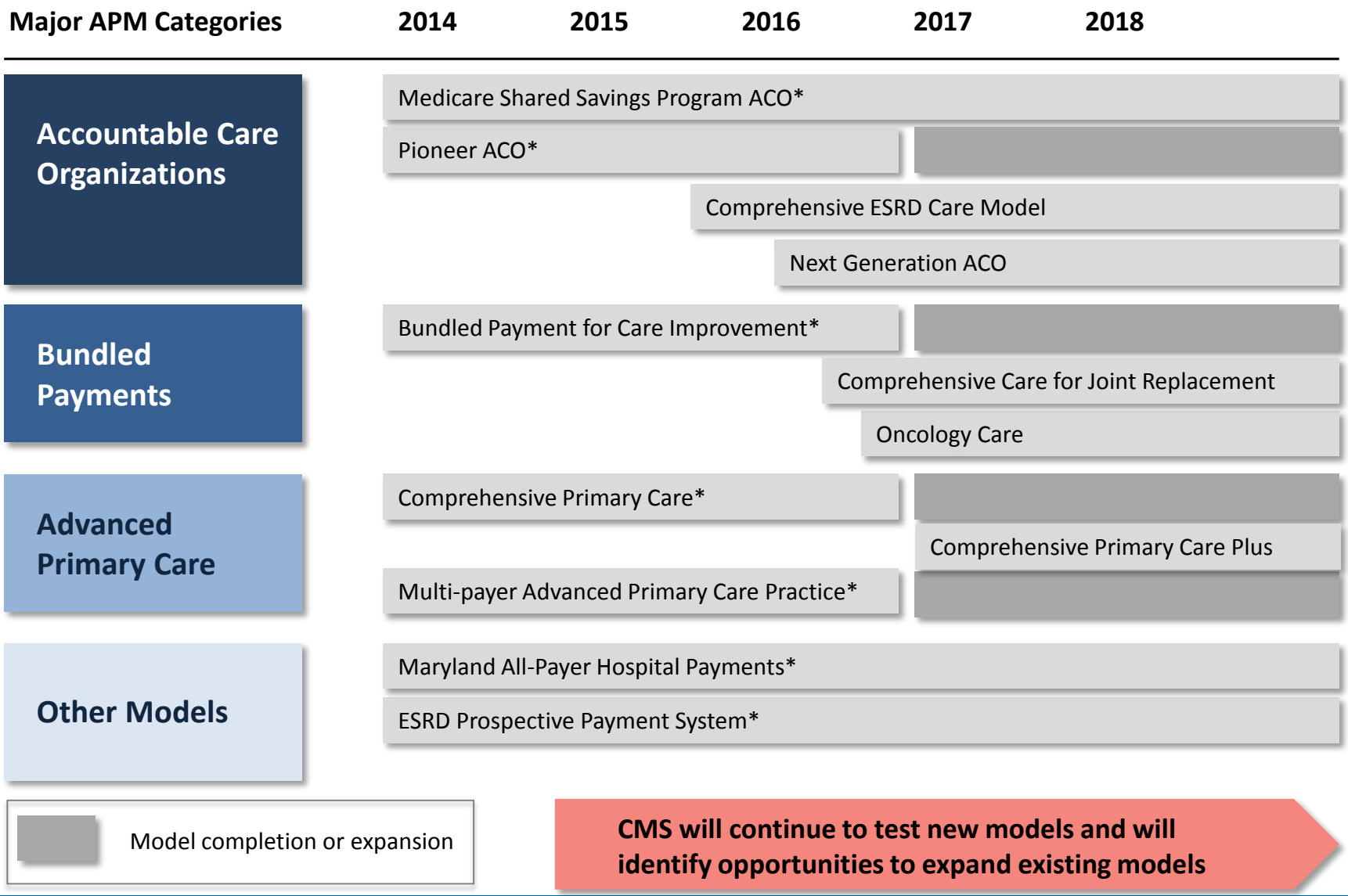
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality



* 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

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)**

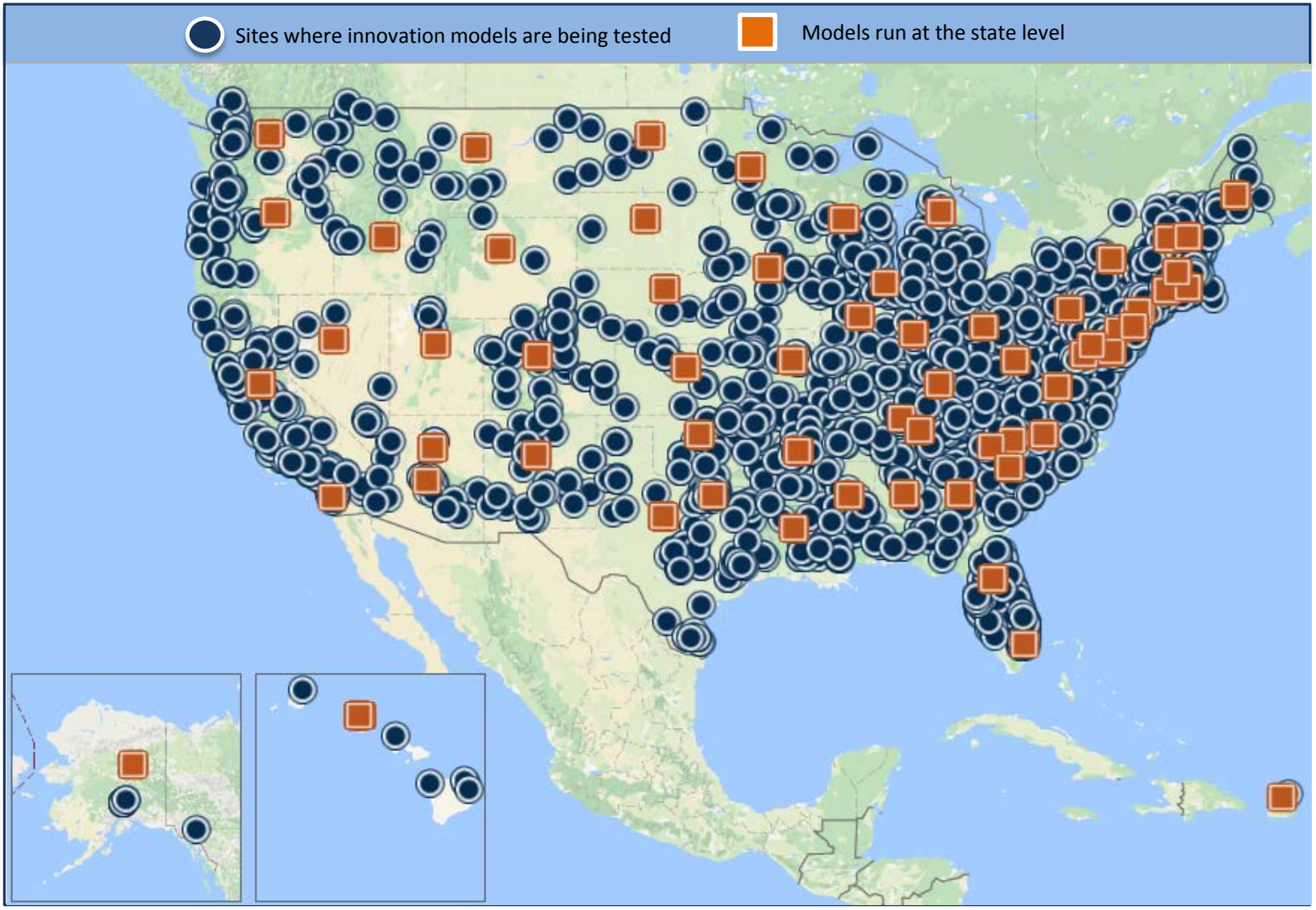
If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Innovation Center portfolio aligns with delivery system reform focus areas

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) & 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 – Frontier Community Health Integration Project ▪ **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 – Integrated ACO ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management ▪ **Medicare Part B Drug Payment Model**
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 – Vermont All-Payer ACO 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

CMS has engaged the health care delivery system and invested in innovation across the country

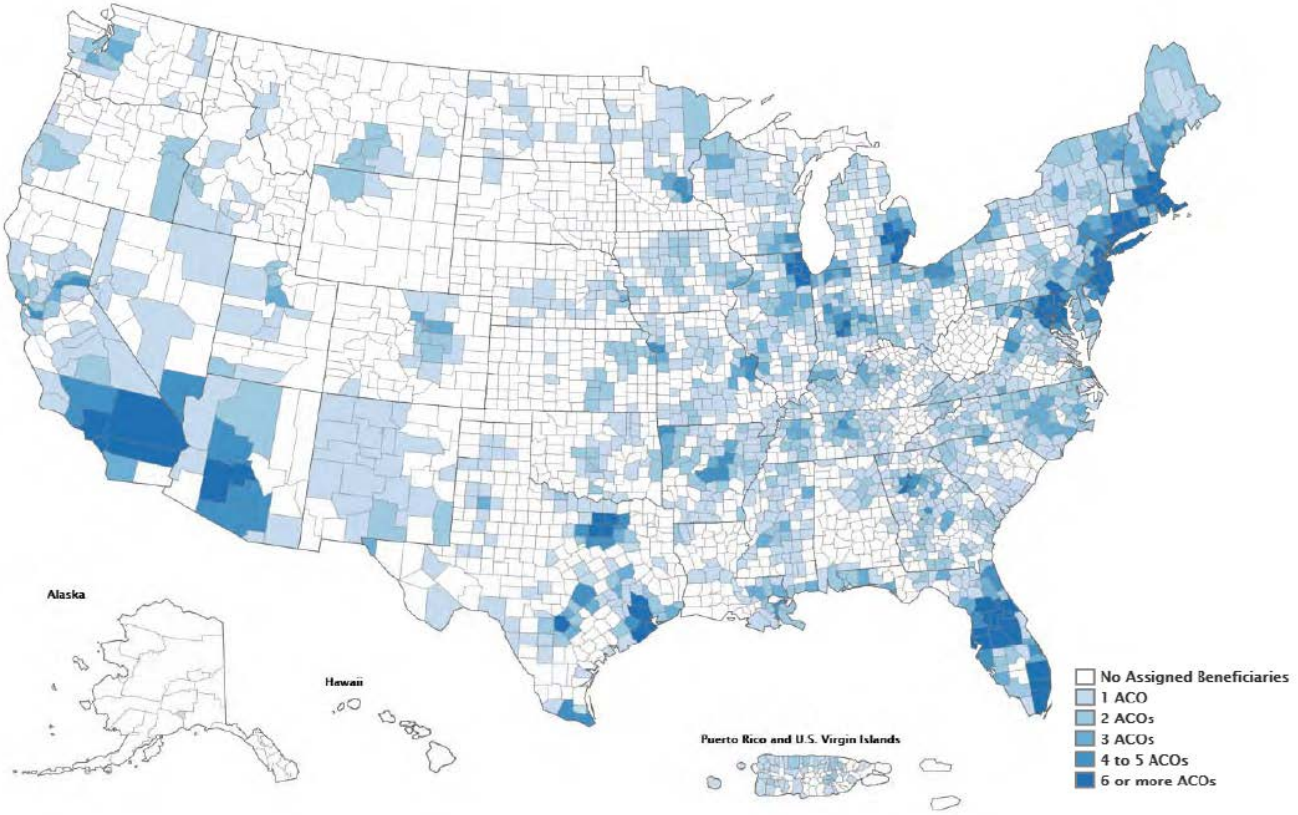


Source: CMS Innovation Center website, September 2016

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **477 ACOs** have been established in the MSSP, Pioneer ACO, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **121 new ACOS** in 2016 **(of which 64 are risk-bearing)** covering **8.9 million assigned beneficiaries** across 49 states & Washington, DC

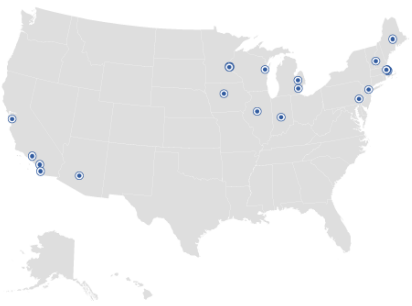
ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

Pioneer ACOs meet requirement for expansion after two years and continued to generate savings in performance year 3

- Pioneer ACOs were designed for **organizations with experience in coordinated care** and ACO-like contracts
- Pioneer ACOs **generated savings for three years in a row**
  - **Total savings** of $92 million in PY1, $96 million in PY2, and $120 million in PY3‡
  - **Average savings per ACO increased** from $2.7 million in PY1 to $4.2 million in PY2 to $6.0 million in PY3‡
- Pioneer ACOs showed **improved quality outcomes**
  - **Mean quality score increased** from 72% to 85% to 87% from 2012–2014
  - Average performance score **improved in 28 of 33 (85%) quality measures** in PY3
- Elements of the Pioneer ACO have been **incorporated into track 3 of the MSSP ACO**



Source: Centers for Medicare & Medicaid Services

- 19 ACOs operating in 12 states (AZ, CA, IA, IL, MA, ME, MI, MN, NH, NY, VT, WI) reaching over 600,000 Medicare fee-for-service beneficiaries
- Duration of model test: January 2012 – December 2014; 19 ACOs extended for 2 additional years

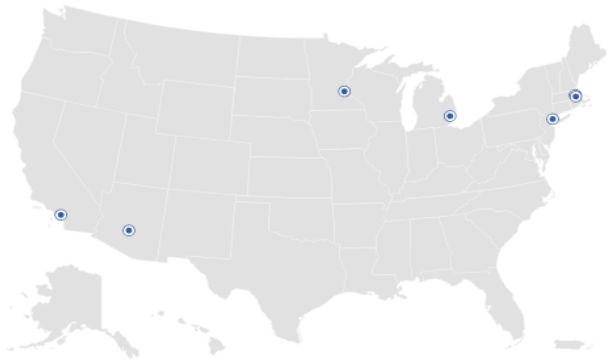
‡ Results from actuarial analysis

Next Generation ACO Model builds upon successes from Pioneer and MSSP ACOs

Designed for **ACOs experienced** coordinating care for patient populations

- **21** ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- Model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth & skilled nursing facilities)

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



Model Principles

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

Vermont All-Payer ACO Model - joint effort to transform health and healthcare throughout the State

First alternative payment model that aligns incentives for nearly **all providers delivering care across an entire state** in order to improve health, health care quality, and value for its residents beginning January 1, 2017

- Aligning the incentives across Vermont will create **a strong business case for the healthcare system to improve health outcomes and population health** and place Vermont healthcare cost growth on a more financially sustainable trajectory

Key Features:

- **Statewide Targets** - ACO scale targets, financial targets, and population health/health outcomes targets that bridge the traditional care delivery system with public health agencies and community health programs
- **Vermont Medicare ACO Initiative** - Medicare Fee-for-Service ACO initiative tailored to Vermont
- **Start-up Funding for Care Coordination** - $9.5 million of start-up funding made available in 2017 to support care coordination and bolster collaboration between practices and community-based providers

Statewide Targets

ACO scale targets
At least **70% of all Vermont residents** across payers, including **90% of Vermont Medicare beneficiaries**, attributed to an ACO

Population health and health outcomes targets
- Substance use disorder
- Suicide
- Chronic conditions
- Access to care

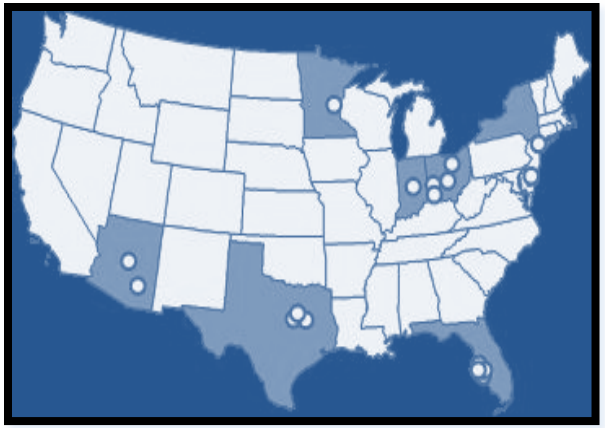
Financial targets
- **Reduce per capita healthcare expenditure growth** across all payers to at most 3.5%
- **Reduce per capita Medicare healthcare expenditure growth** to 0.1%-0.2% points below projected national Medicare growth

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.

Medicare Diabetes Prevention Program Expansion

The Medicare Diabetes Prevention Program expanded model is a structured behavioral change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes.

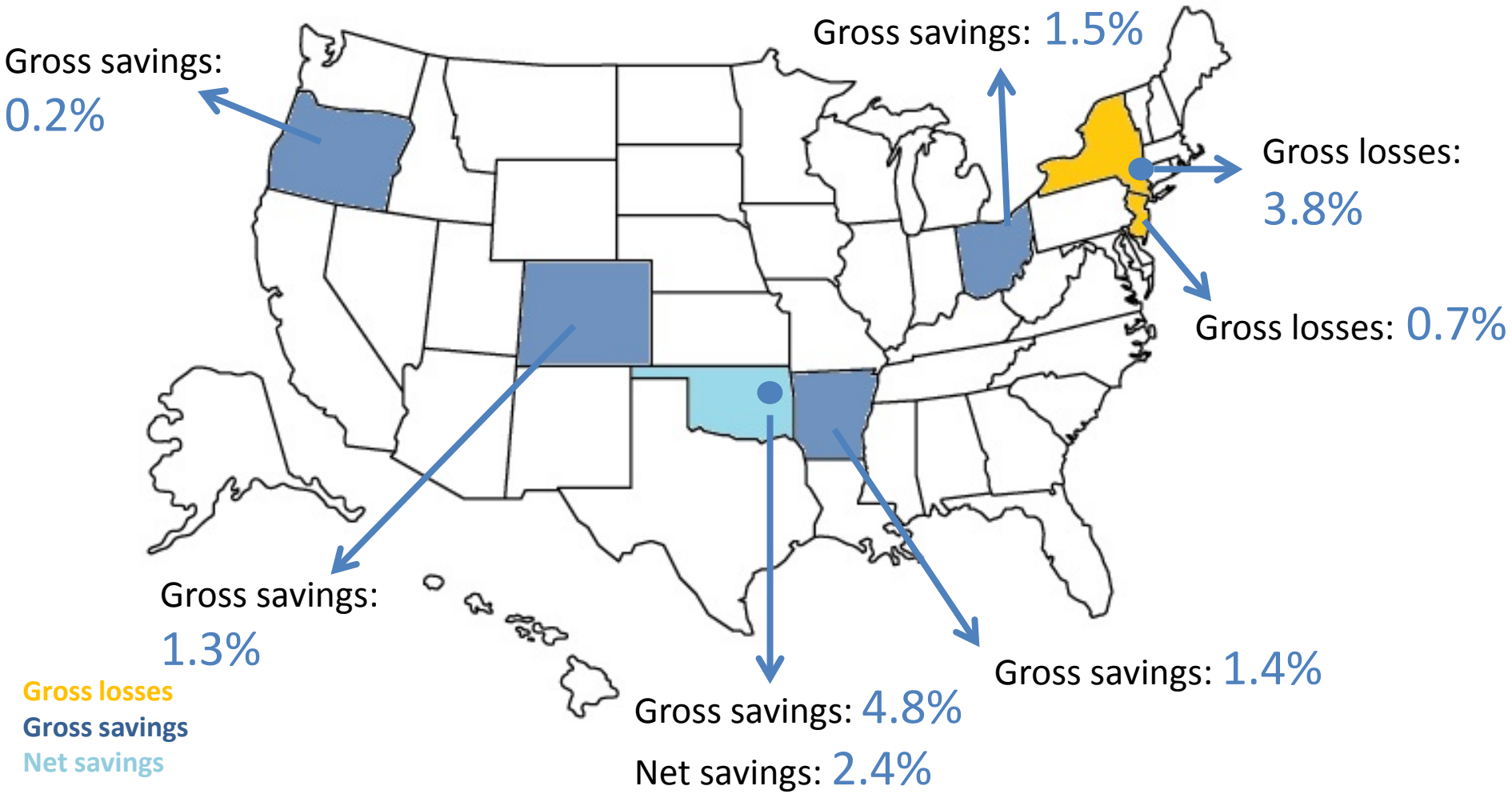
Overview of Medicare Diabetes Prevention expanded model

- **Benefit Description** - Additional preventive service with no cost-sharing under Medicare. The core benefit is a 12-month intervention, with ongoing maintenance sessions available if weight loss of 5 percent is achieved and maintained
- **Beneficiary Eligibility -** Medicare beneficiaries with pre-diabetes (blood tests & BMI)
- **Supplier Eligibility -** organizations must be recognized by the CDC
- **Enrollment** – organizations recognized by CDC will enroll in Medicare as suppliers to deliver the service. Additional rulemaking is required to finalize supplier enrollment.

Timing: Supplier enrollment will begin in 2017, billing and coverage of the benefit begins January 1, 2018

CPC shared savings results for 2014 (performance year 2*) varied

Results based on actuarial benchmarking methodology



*2014 CPC Shared Savings & Quality Results

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

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 **high-risk Medicare beneficiaries**
- In year 2, demo produced more than **$10 million in savings**, an average of $1,010 per participating beneficiary per year
- CMS awarded **incentive payments of $5.7 million to seven practices** that produced savings and met the designated quality measures for the second year
- All 15 participating practices **improved quality in at least two of the six** quality measures

- There are 14 total practices, including 1 consortium, participating in the model
- Approximately 10,400 patients enrolled in the first two years with duration of initial model test: 2012 - 2017

Medicare Care Choices Model (MCCM) provides new options for hospice patients

MCCM allows Medicare beneficiaries who qualify for hospice to receive **supportive care services while receiving care for their terminal condition.** Evidence from private market that 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, phased in over 2 years with **130+ participating hospices** randomly assigned to phase 1 or 2

Services

The following services are available 24 hours a day, 7 days a week:

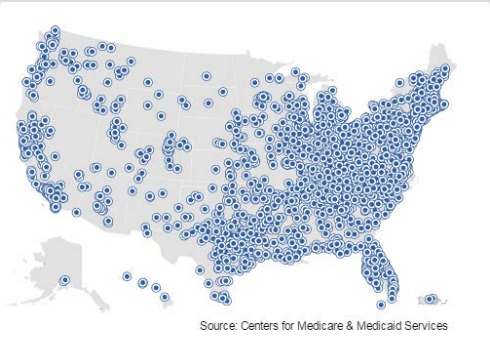
- Nursing
- Social work
- Hospice aide
- Hospice homemaker
- Volunteer services
- Chaplain services
- Bereavement services
- Nutritional support
- Respite care

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

- 305 Awardees and 1143 Episode Initiators as of July 2016



Source: Centers for Medicare & Medicaid Services

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

Comprehensive Care for Joint Replacement (CJR) will test a bundled payment model across a broad cross-section of hospitals

- The model tests bundled payment of **lower extremity joint replacement (LEJR) episodes** 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**

Oncology Care Model: new emphasis on specialty care

1.6 million people annually diagnosed with cancer; a significant proportion are over 65 years

- Major opportunity to improve care & reduce cost starting July 1, 2016, through June 30, 2021

  196 participating practices
  3,200+ oncologists
  17 participating payers
  155,000+ Medicare FFS beneficiaries/year, estimated **$6 billion** in care included in 6-month episodes

- Model Objective: Provide beneficiaries with **improved care coordination to improve quality and decrease cost**
  - Implement six practice redesign activities
  - Create two-part **financial incentive** with $160 pbpm payment and potential for performance-based payment
  - Institute robust **quality** measurement
  - Engage **multiple payers**

Practice Redesign Activities

1) Patient navigation

2) Care plan with 13 components based on IOM Care Management Plan

3) 24/7 access to clinician with real-time access to medical records

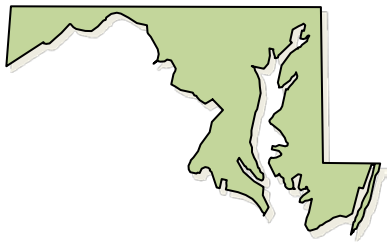
4) Use of therapies consistent with national guidelines

5) Data-driven continuous quality improvement

6) Use of certified EHR technology

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**

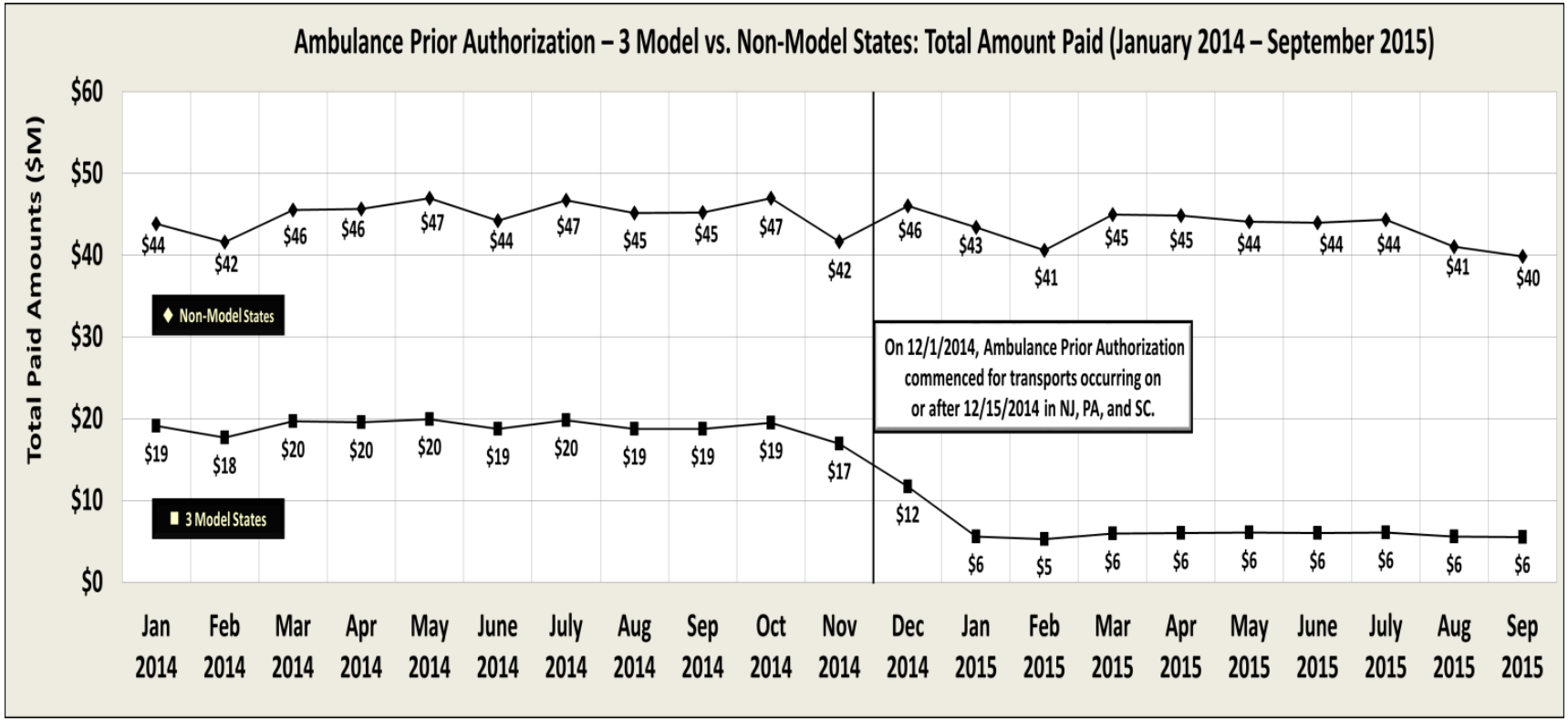


- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013

Ambulance Prior Authorization Model

- Geographic model in Pennsylvania, New Jersey, South Carolina
- Providers request prior authorization for exemption from post-hoc claims reviews
- 18,367 requests received in first year



Innovation Center – 2016 Looking Forward

We are focused on:

- Implementation of Models and MACRA
  - Advanced APM opportunities – ACO 1+, re-openings of NGACO and CPC+, new models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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NATIONAL QUALITY FORUM

Payment Reform and the Evolving Role of Quality Measurement

Helen Burstin, MD, MPH, FACP
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QPN Member Network

November 15, 2016

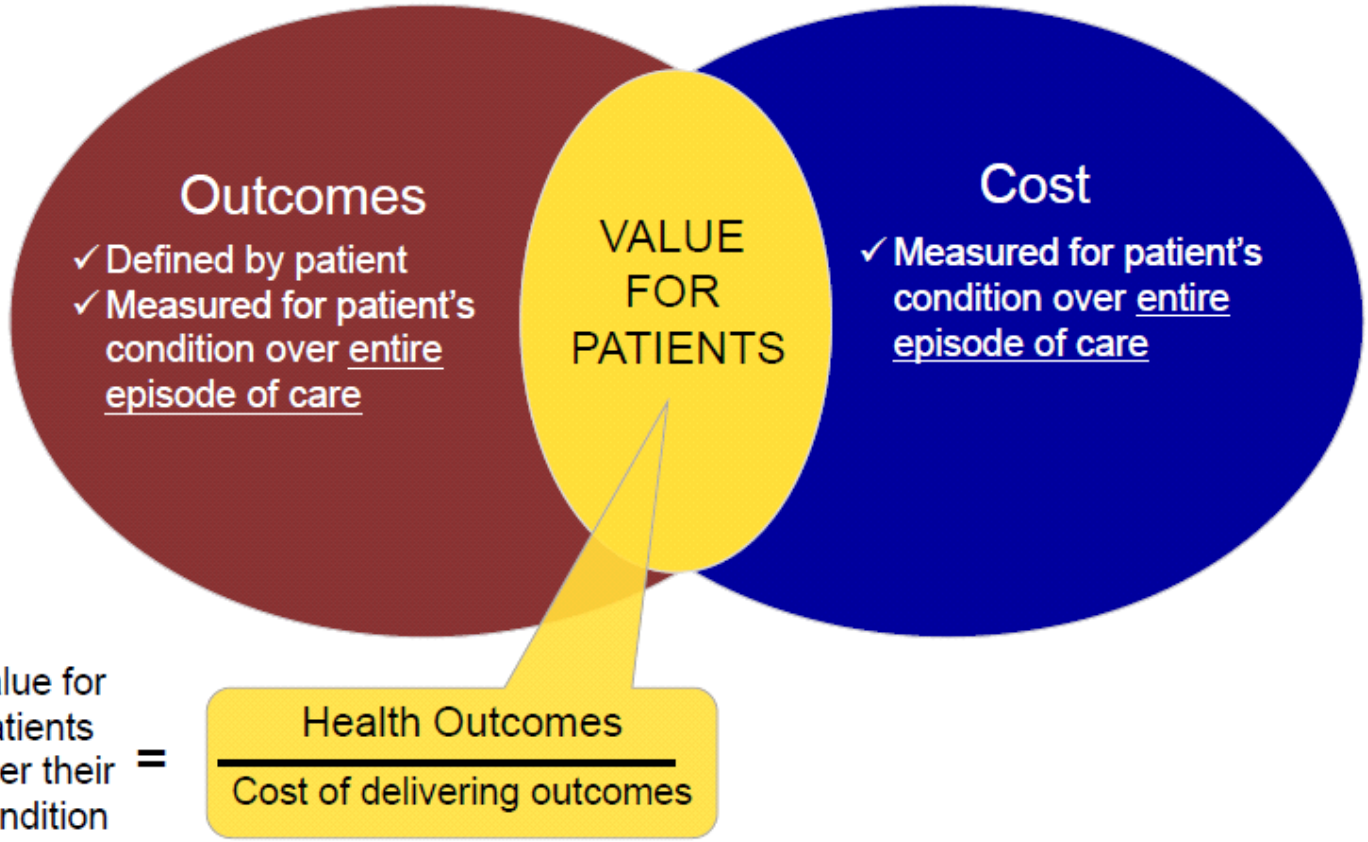
National Quality Strategy

Better Care

Healthier People, Healthier Communities

Smarter Spending

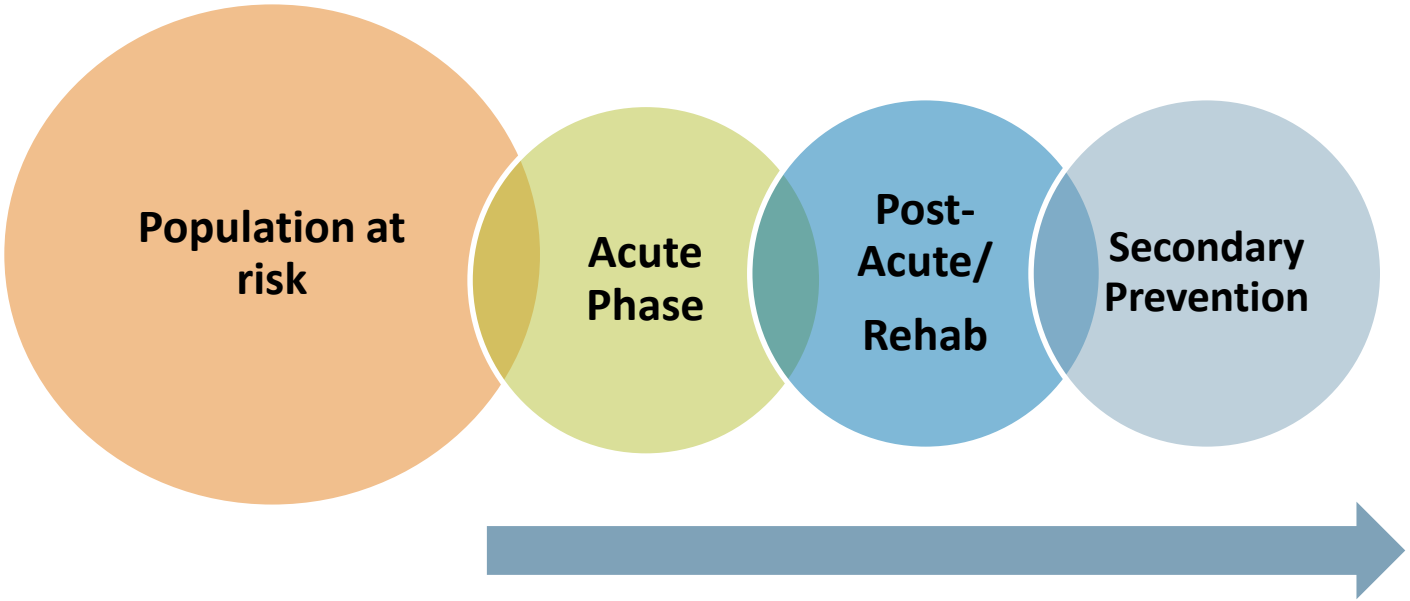
Scope of Future Measurement



Measurement in Evolution

- Reduce unnecessary measurement
  - Measure when and where it is most appropriate
  - Remove measures that don't add value
  - Assess burden and benefits of measurement
- Drive toward patient-centered outcome measures
- Measurement science issues (e.g., risk adjustment)
- Fill prioritized measurement gaps
- Address disparities in all we do

Patient Focused Episodes



- Functional Status
- Quality of Life
- Shared decision-making
- Clinical outcomes & PROs
- Costs

RWJF Project: Amplifying the Patient Voice

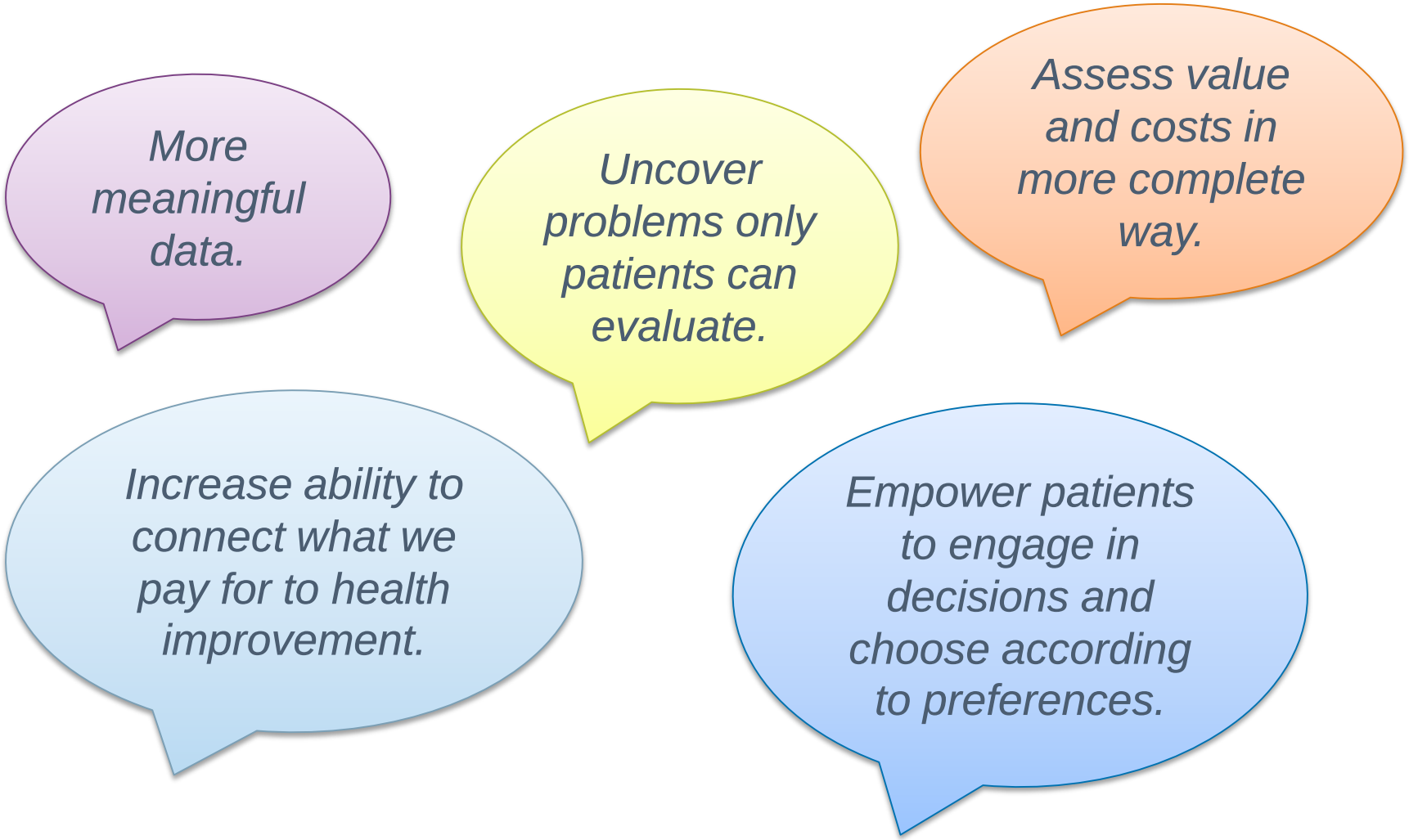
NATIONAL QUALITY FORUM

Establish successful model to develop performance measures driven by the outcomes that are meaningful and relevant to patients.

patientslikeme®

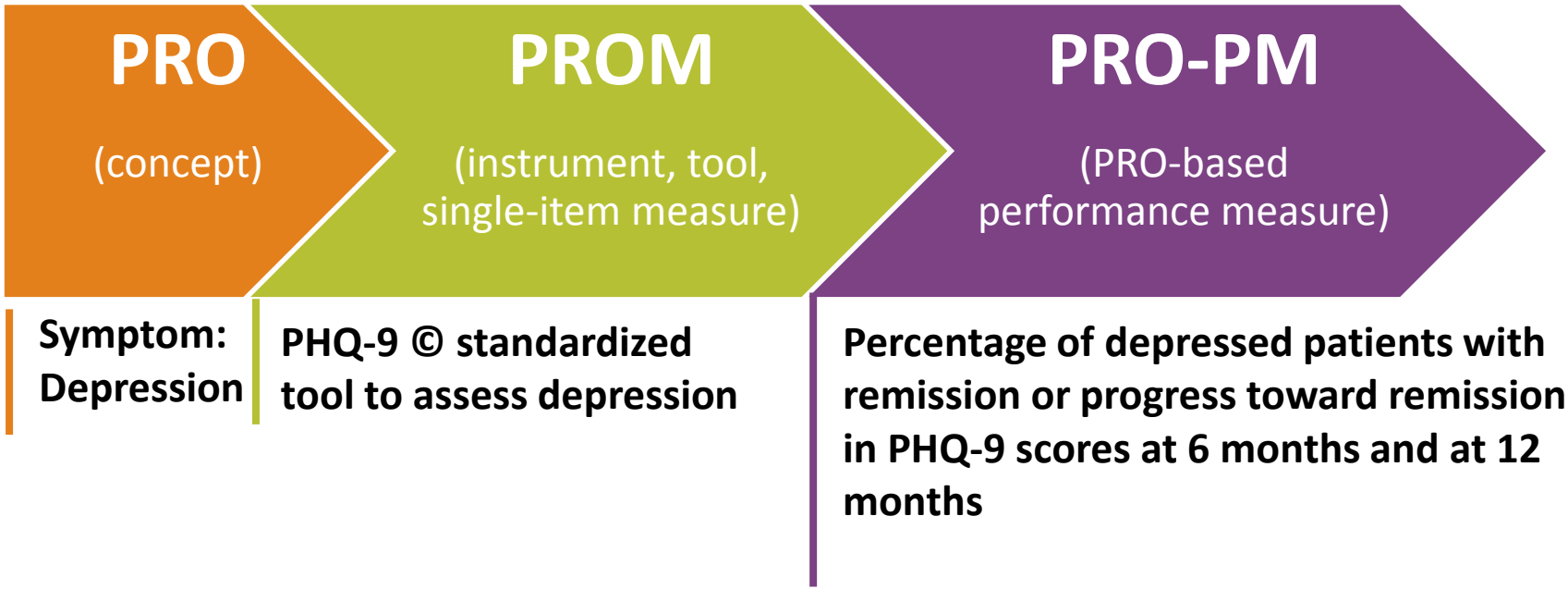
Live better, together.™

PLM/NQF Stakeholder PRO-PM Listening Sessions with Stakeholders



Next Generation Measurement: Collaboration and Action

PRO-PM Example: Depression Remission



Shared Decision Making

"The process of **interacting** with patients who **wish** to be involved in arriving at an **informed, values-based** choice among two or more medically reasonable alternatives"[1]

Informed
The choices
The options
The benefits and harms of the options

Values-Based
What's important to the patient

[1]A.M. O'Connor et al, "Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids" *Health Affairs,* 7 October, 2004

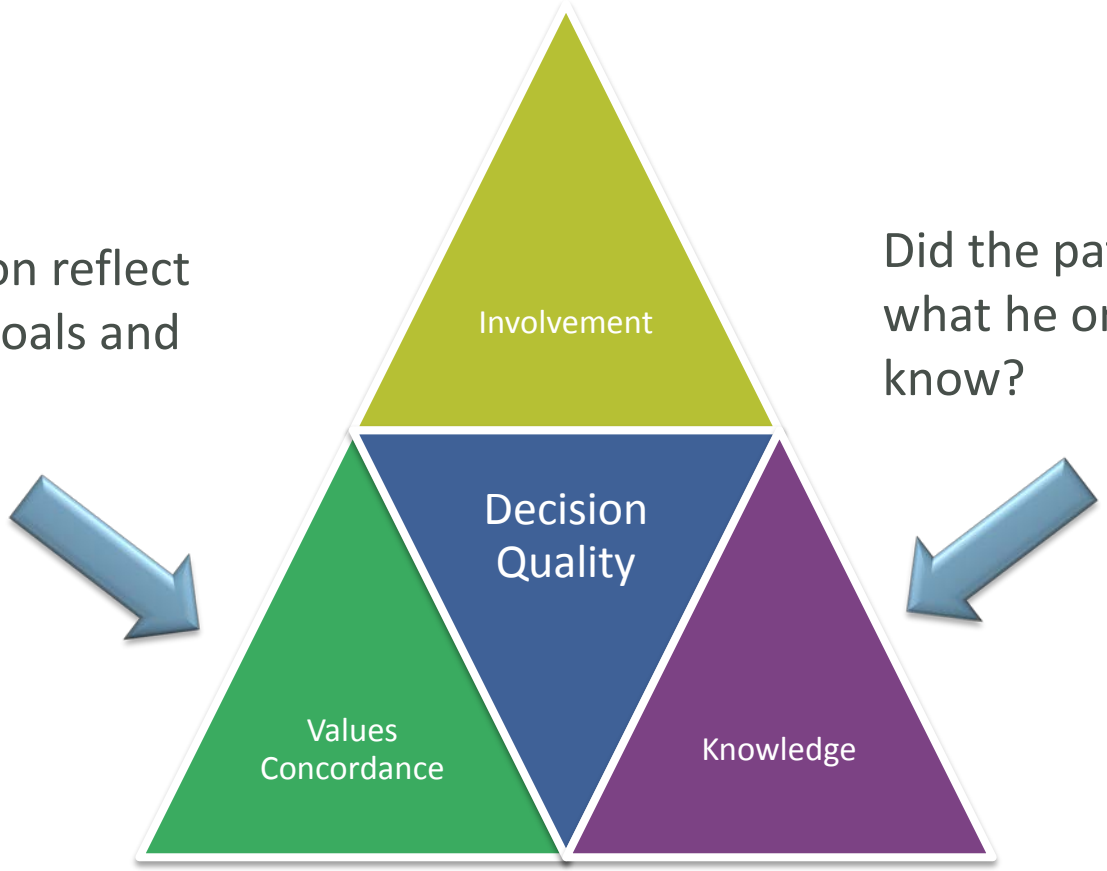
Measurement of Decision Quality

Did the patient know a decision was being made?

Did the patient know the pros and cons of the treatment options?

Did the provider elicit the patient's preferences?

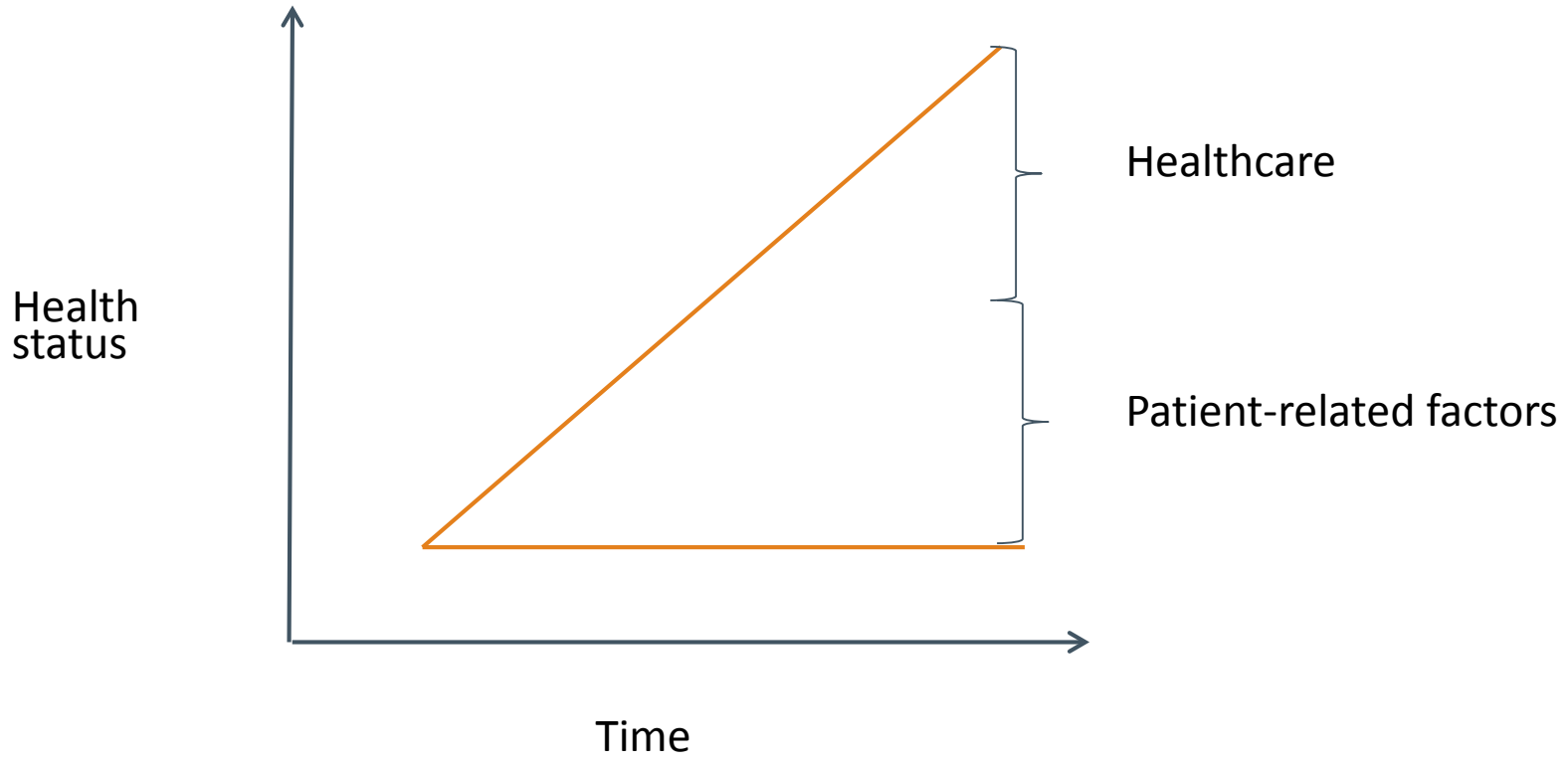
Did the decision reflect the patient's goals and concerns?



Did the patient know what he or she needed to know?

Influence of Healthcare and Risk Factors

Outcome due to healthcare and patient-related risk factors



Summary of Data Availability for Social Risk Factor Indicators

SOCIAL RISK FACTOR	DATA AVAILABILITY			
Indicator	**1**	**2**	**3**	**4**
SEP				
Income		■		
Education		■		
Dual Eligibility	■			
Wealth			■	
Race, Ethnicity, and Cultural Context				
Race and Ethnicity		■		
Language		■		
Nativity	■			
Acculturation				■
Gender				
Gender identity				■
Sexual orientation				■
Social Relationships				
Marital/partnership status		■		
Living alone			■	
Social Support			■	
Residential and Community context				
Neighborhood deprivation		■		
Urbanicity/Rurality	■			
Housing		■		
Other environmental measures				■

1. Available for use now

2. Available for use now for some outcomes, but research needed for improved, future use

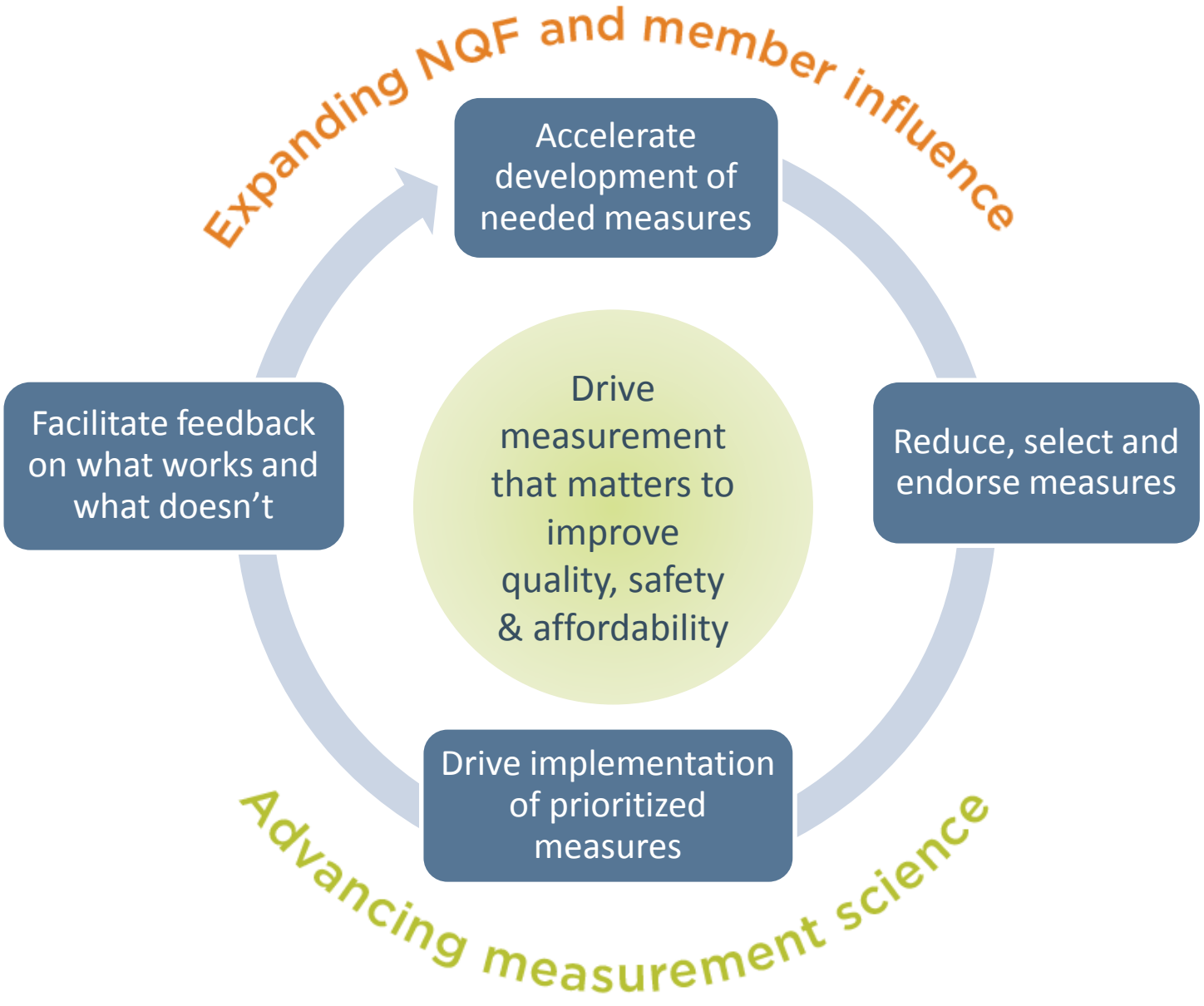
3. Not sufficiently available now; research needed for improved, future use

4. Research needed to better understand relationship with health care outcomes and on how to best collect data

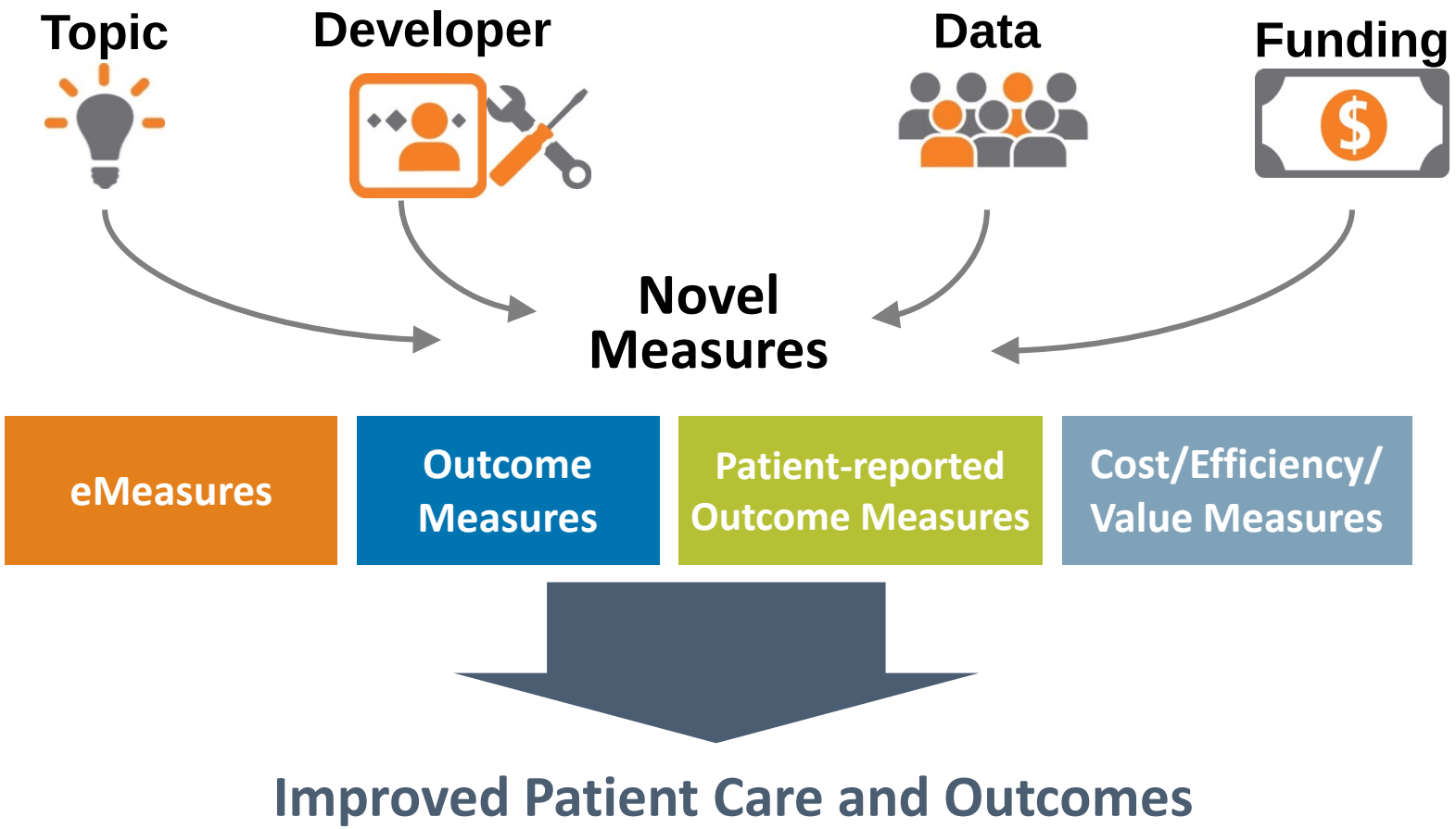
Risk Adjustment/Stratification

- Move beyond reliance on claims-based risk assessment
- Better account for unmeasured clinical complexity:
  - Patient frailty
  - Risk-based grouping of multiple chronic conditions
  - Risk differences within clinical conditions
  - Patient complexity: frailty, disability, poor functional status, and multiple chronic conditions

NQF: Lead. Prioritize. Collaborate.

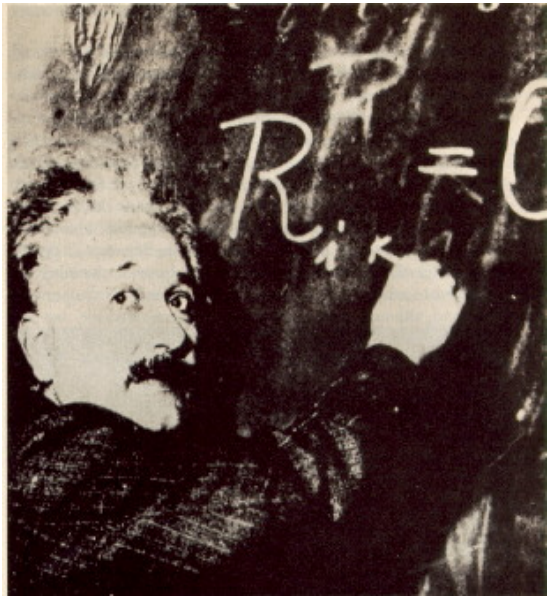


NQF Measure Incubator:
Getting to quality measures that matter



The Quality Imperative

Not everything that counts can be counted, and not everything that can be counted counts



~William Bruce Cameron

Helen Burstin, MD, MPH, FACP

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Questions and Answers

Join us at the next NQF Member Meet-Up!

December 5, 2016 5:00 pm – 7:00 pm

Helen Darling, National Quality Forum

Dean Rosen, Mehlman Castagnetti Rosen & Thomas

Neleen Rubin, Rubin Health Policy Consulting

RSVP today!


THANK YOU