CMS Medical Officer Update: Health System Transformation resources and new CMMI Model

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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.

Section 3021 of Affordable Care Act
Focus on Social Determinants of Health: Addressing Social Needs

- Hospital Readmission Reduction...what’s the problem?
  - High re-admission rates could indicate breakdowns in care delivery systems
    - Payment systems incentivized fragmentation
    - More complicated cases = more “hands in the pot”
    - Expectation of patients to self-manage is great

Clinician-patient interaction
- Episodic treatment
- Unmanaged condition worsening
- Use of suboptimal medication regimens
- Lack of primary care or social support
- Return to ER

No community infrastructure to achieve common care goals
- Lack of standard communication
- Unreliable information transfer
- Unsupported patient/family engagement during transfers
- Lack of follow-up to address prevention
Accountable Health Communities Model addresses 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

### 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

### Total Investment

$157 million

### Anticipated Award Sites

44

[https://innovation.cms.gov/initiatives/ahcm](https://innovation.cms.gov/initiatives/ahcm)
CMS Health Equity Plan for Medicare

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

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

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

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

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

**Priority 6:** Increase Physical Accessibility of Health Care Facilities
Key CMS Priorities in health system transformation

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on 3 areas:

- Incentives
- Care Delivery
- Information Sharing

Affordable Care Act → MACRA
MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

**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 exceed HHS goals
MIPS changes how Medicare links performance to payment

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into MIPS:

Merit-Based Incentive Payment System (MIPS)
What should I do to prepare for MACRA?

- Look for future educational activities
- Look for a proposed rule in spring 2016 and provide comments on the proposals.
- Final rule targeted for early fall 2016
- Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.
Transforming Clinical Practice Initiative

- Support more than 140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing and procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled
Practice Transformation Networks (PTNs) In Region 9

- Arizona Health-e Connection
- Children's Hospital of Orange County
- Local Initiative Health Authority of Los Angeles County
- National Rural Accountable Care Consortium
- Pacific Business Group on Health
- VHA/UHC Alliance Newco, Inc.
Support and Alignment Networks (SANs)

- American College of Emergency Physicians
- American College of Physicians
- HCD International, Inc.
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium
6 Key Benefits to Participating Clinicians

1. Optimize health outcomes for your patients
2. Promote connectedness of care for your patients
3. Learn from high performers how to effectively engage patients and families in care planning
4. More time spent caring for your patients
5. Stronger alignment with new and emerging federal policies
6. Opportunity to be a part of the national leadership in practice transformation efforts

http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx
Measure Alignment Efforts

• CMS Draft Quality Measure Development Plan
  – Highlight known measurement gaps and develop strategy to address these
  – Promote harmonization and alignment across programs, care settings, and payers
  – Assist in prioritizing development and refinement of measures
  – Public Comment period closed March 1st, final report to be published in May

• Core Measures Sets released February 16th
  – ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  – Cardiology
  – Gastroenterology
  – HIV and Hepatitis C
  – Medical Oncology
  – Obstetrics and Gynecology
  – Orthopedics

• CMS is already using measures from the each of the core sets
• Commercial health plans are rolling out the core measures as part of their contract cycle

References & Further Reading

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

CMS Innovation Center
https://innovation.cms.gov/

CMS Draft Quality Measures Development Plan

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

CMS Health Equity Plan

Contact information for the Transforming Clinical Practice Initiative
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx
Questions?

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