Million Hearts® Cardiovascular Disease Risk Reduction Model

Briefing Presentation

Background & Rationale

- Heart attack and stroke (ASCVD) are leading causes of death and disability
- In the past
  - Risk reduction focused on specific process measure targets, i.e. LDL cholesterol level and blood pressure, with the same targets applied to all patients
  - Currently, risk factors are discussed as independent conditions rather than risk factors contributing to ASCVD
  - Patients have little idea of their actual risks of heart attack and stroke
- What the model will change
  - Uses data-driven, widely accepted predictive algorithm to give individualized 10-year risk score for ASCVD to each beneficiary
  - Providers get value-based payment depending on absolute risk drop across entire panel, necessitating population health management

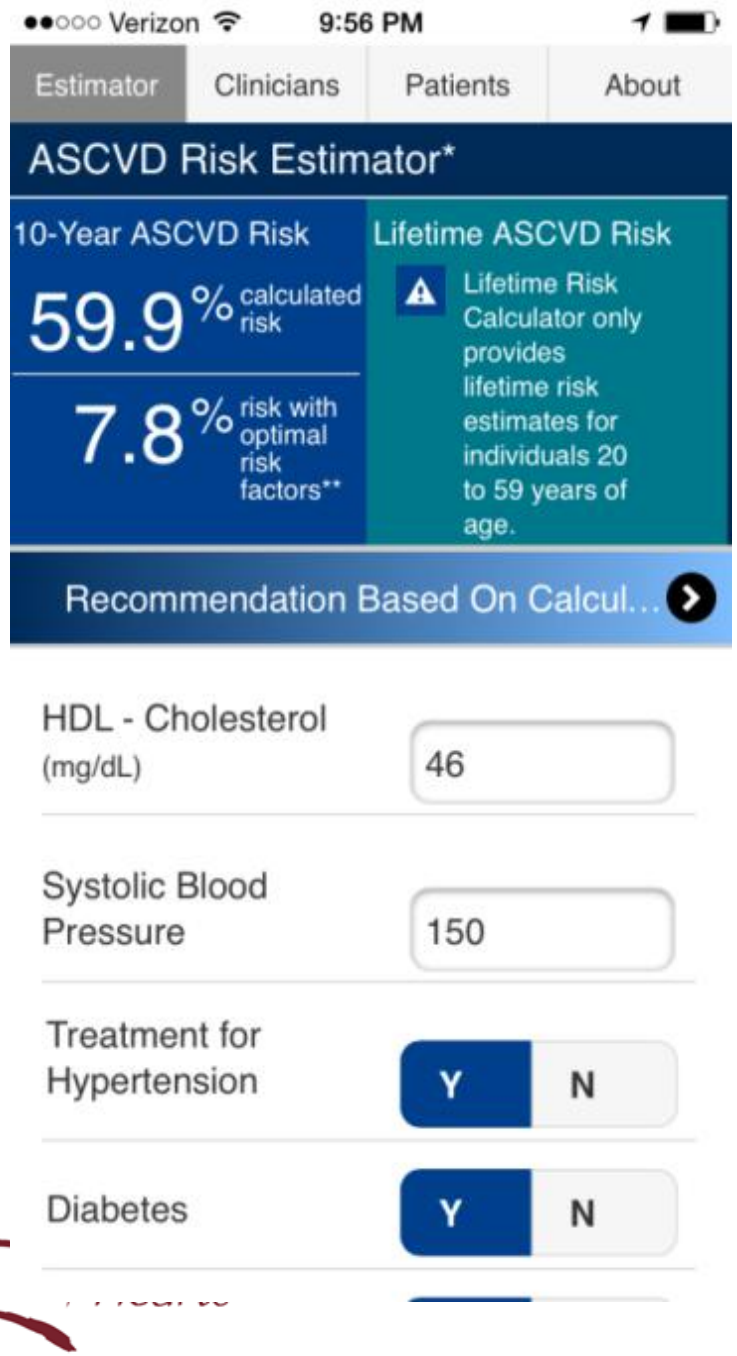
Better. Smarter. *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

Important Features of This Model

- First CMS model to incentivize reduction in a predicted future risk, paving way for future innovative approaches to value-based prevention (e.g. reduction in other preventable conditions)
- Focus on meaningful, patient-centered risk score
- Transparent, easily understood provider financial incentive
- Rigorous design, with clustering at practice level, at large scale (360 intervention and 360 control practices, enrolling almost 300,000 Medicare FFS beneficiaries)
- Path towards nationwide scaling if model test is successful

ACC/AHA Pooled Cohort
ASCVD Risk Estimator – Examples of Use



How Risk Calculators Enhance High Value Care:

For example, Joe Smith is a 65 year old African American man who smokes, has elevated cholesterol, and a borderline elevated blood pressure. His 10-year risk is 31.1% percent (high). Alan Jones is a 66 year old white man with mildly elevated blood pressure (e.g. SBP 135 mm Hg), but no other risk factors, so his 10-year-risk is 11% (low). Treating Joe Smith's blood pressure (though traditionally valued the same by current one-size-fits-all pay for performance approach) has a much larger impact on risk of ASCVD than treating Alan Jones's blood pressure—and the provider is rewarded more for intervention.

Model Overview

Aim

Offer provider incentives for risk stratification, shared decision-making and enhanced accountability across a provider's entire Medicare FFS patient panel—reduce predicted 10-year ASCVD risk, reduce the incidence of heart attacks & strokes, and add no net costs?

Practice Eligibility

- At least 1 practitioner: As defined by the PQRS definition
- Enrolled and eligible to bill for Medicare Part B
- Using an Office of the National Coordinator (ONC) certified Electronic Health Record
- Have met the criteria for the Medicare EHR Incentive Program in performance year 2015

Model Design Framework

- 5 year Model Test
- Randomized Evaluation Design
  - Planned 360 control and 360 intervention practices, with built in 20 percent attrition anticipated
  - Roughly 150,000 Medicare FFS benes in each arm
- Programmatic Elements
  - Risk Stratified Care
  - Population Health Management
  - Shared Decision Making
  - Individual Risk Modification Planning
  - Team-Based Care
  - Quality and Clinical Data Reporting

Target Population

- Initial risk stratification (intervention practices)
  - Performed on all Medicare FFS beneficiaries 18-79 years of age.
  - Exclusion criteria: prior heart attack and/or stroke, in hospice, 80 years or older, or Medicare Advantage or other health plan coverage as primary payer
- Ongoing Treatment of High Risk Beneficiaries
  - Model will follow claims based outcomes of all patients
  - Additionally, for high-risk (10-year ASCVD risk score greater than or equal to 30%; highest risk decile), provider will regularly reporting on longitudinal risk required over life of model

Beneficiary Attribution

- Prospective attribution with retrospective reconciliation.
  - Conducted annually
  - Reconciliation to ensure a match with primary risk stratification and risk score
- Beneficiaries will be attributed to practices utilizing TIN/NPI Combinations in addition to 1-year look back periods.

Evaluation Design

- Randomized Controlled Trial
  - Randomization 1:1 (Treatment : Control)
- Model powered to demonstrate improvements in quality, specifically, lower incidence in heart attacks & stroke
  - Primary Outcome – Reduction in heart attack and stroke, Absolute risk reduction
  - Secondary Outcome(s) – Reduction in total cost of care and improvement in mandatory PQRS measures from baseline

Control Group

- Model participants
- Annual attribution
- Submission of clinical indicators in years 1, 2, 3, and 5
  - Data submission on all aligned beneficiaries
- A one-time $20 per bene payment to offset the cost of preparing and transmitting data to CMS

Treatment Benefit Equations

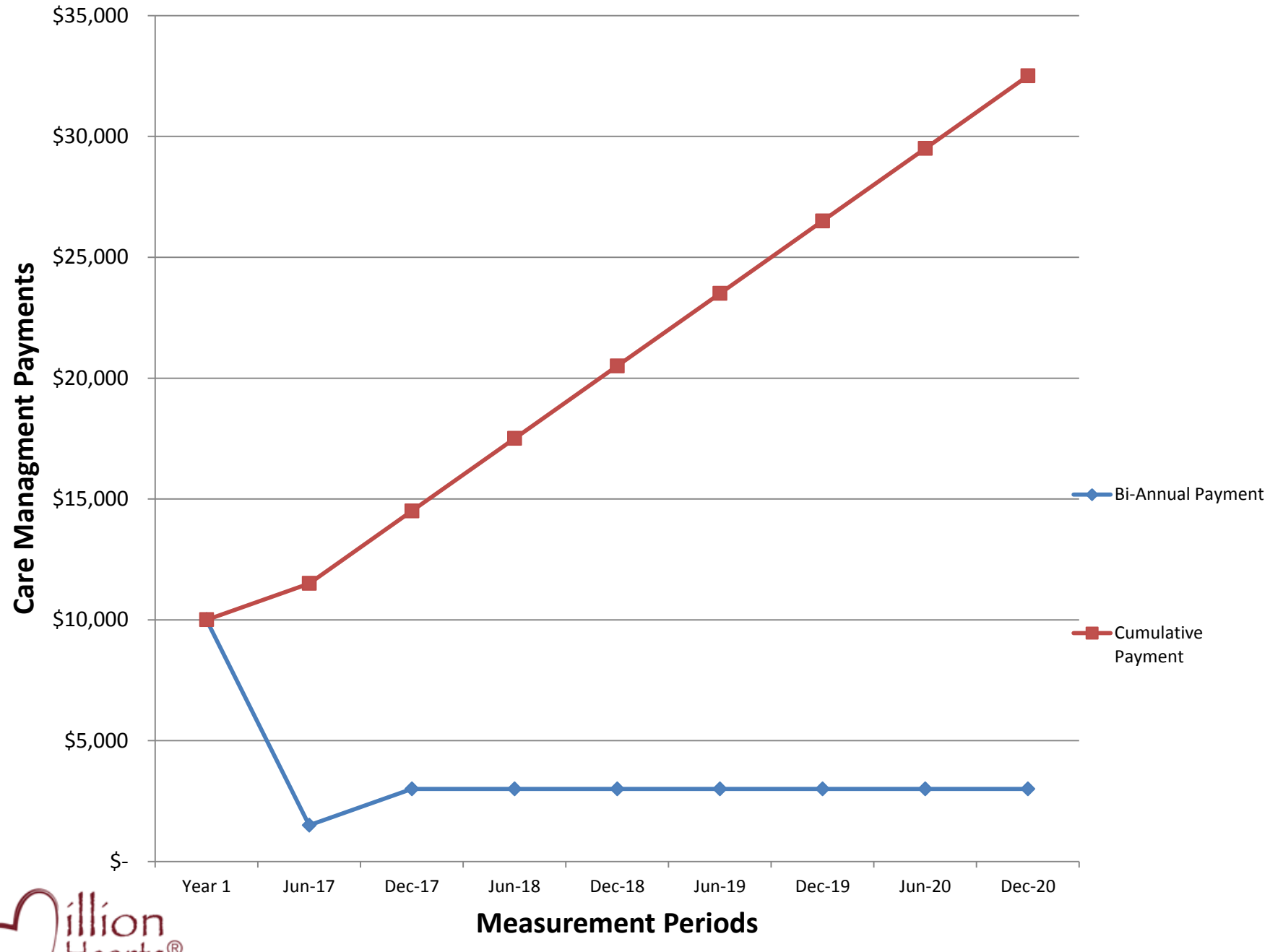
- Absolute risk reduction calculated using the Treatment Benefit Equation
  - Currently under development by national experts
  - Will re-calculate longitudinal risk based on treatments with aspirin, blood pressure control, statin therapy, tobacco cessation, and other interventions on fatal and non-fatal outcomes for primary prevention of ASCVD
  - Will allow estimate of ASCVD risk reduction from 1 or more therapies

Payment Model

- $10 per beneficiary one-time Cardiovascular Risk Assessment payment for: Population Level Risk Stratification, Shared Decision Making, and Enhanced Provider Accountability
- For high risk bene panel: Additional $10/bene/month cardiovascular care management fee, value-based, depending on high-risk PANEL WIDE risk reduction
  - Year 1: Reporting only
  - Year 2-5: Performance-based

Aggregate Absolute Risk Reduction	Fee Paid (per bene per month in panel)
<2 percentage points	$0
2-10 percentage points	$5
> 10 percentage points	$10

Payment Model: Average Practice Potential to Earn > $34,000 extra



Assumptions

- 4.4 providers per practice
- 400 Beneficiaries
- 50 High Risk Beneficiaries
- <10% Risk Reduction in Measurement Period 1: Jun 2017
- >10% Risk Reduction in subsequent Measurement Periods

Measurement Framework

- Data Registry
  - Provided to participating practices for free
  - Web-based tool that:
    - Allows providers to calculate risks
    - Provide shared decision making tools
    - Report results to CMS and PQRS program
    - Potential ability to integrate with practice's existing EHRs
- Reporting of clinical variables & PQRS measures
- Treatment Benefit Equation

Attestation of Services

- Bi-annual attestation of the provision of the following services for Risk Stratification:
  - Shared Decision Making
  - Individual Risk Modification Plan

Attestation of Services

- Bi-annual attestation of the provision of the following services for Cardiovascular Care Management Payment:
  - Minimum one re-assessment of the ACC/AHA ASCVD Pooled Cohort 10 year risk score utilizing the Treatment Benefit Equation
  - A minimum of two annual follow-up beneficiary encounters

Upcoming Milestones

Date	Activity
May 2015	Announcement
May – August 2015	LOI Period
July - August 2015	Application Period
August – November 2015	Application Review & Selection
November 2015	Awards
January 2016	Model Go Live

Thank You & Questions!

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