CENTERS FOR MEDICARE & MEDICAID SERVICES

VALUE BASED CARE

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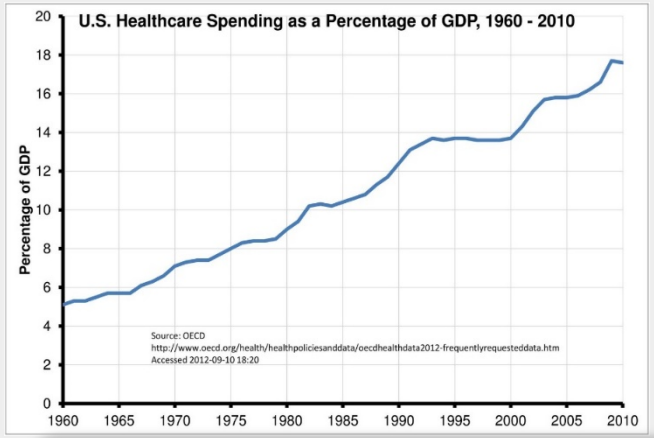
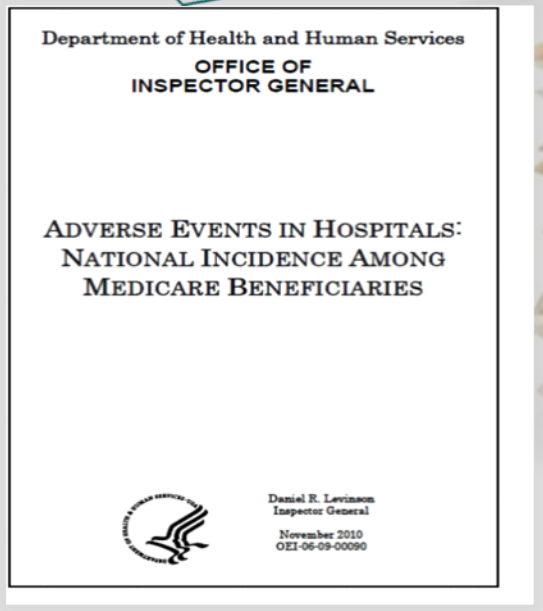
CMS Strategic Goals

- **Empower patients and clinicians to make decision about their health care**
- **Usher in a new era of state flexibility and local leadership**
- **Support innovative approaches to improve quality, accessibility, and affordability**
- **Improve the CMS customer experience**

Not too long ago - 1 in 7



about 1 in 7 experienced an adverse event



The Journey to Value Based Care

"We must shift away from a fee-for-service system that reimburses only on volume and move toward a system that holds providers accountable for outcomes and allows them to innovate. Providers need the freedom to design and offer new approaches to delivering care."

Seema Verma,
September 19, 2017

"What does value-based mean to CMS? How do we determine value? How do we empower patients, inspire competition, and encourage innovation? Value is determined by patients, not policy makers. This means we will need to empower patients by encouraging innovation and choice in where they get care. Making health care more about health and less about bureacracy."

Seema Verma,
July 10, 2018

What is Value Based Care

CMS currently defines **value-based care** as *paying for health care services in a manner that directly links performance on **cost**, **quality** and the **patient's experience of care**.*

Source: CMS VBP Affinity Group

What is Value-Based Purchasing?

- Foundational principles of CMS VBP:
  - **Alignment** - VBP programs must be streamlined and aligned with one another
  - **Accountability & Engagement** - All stakeholders must be in this together; how we hold stakeholders responsible
  - **Full Clinical Picture** - Measures and weighting of measures must reflect full clinical picture of a patient, not just by setting; scoring methodology
  - **Patient-Centered Framework** - VBP programs must be developed within a patient centered framework
  - **Health Information Technology and Interoperability** – Health Information Technology must be nimble, aligned, focused on agreed upon goals and interoperable; accurate, high-quality data must the priority for any quality improvement work
  - **Population Based Approach** - A population based approach must be taken incorporated, not just an individual patient/procedure approach
  - **Value/Efficiency** - Quality and cost must be linked
  - **Data Accessibility** - Providers should have real-time access to data and feedback on their performance.
  - **Adaptability to Evolving Payment Models** - IT systems, processes and internal operations must evolve and be able to support the evolving payment models.
  - **Provider Incentives/Timeliness** - Improve incentives to encourage providers to submit claims in a timely manner, align timelines across programs, and give timely feedback.

Currently Acknowledged Categories of Value Based Care

- Movement to value includes the progression from from fee-for-service payments to integrated payment models such as Medicare Advantage or Alternative Payment Models. Currently accepted progression pathways from Medicare and Commercial Payers are listed below. MIPS is a Category 2 program with the potential of improving care and serving as a gateway to category 3 and 4.

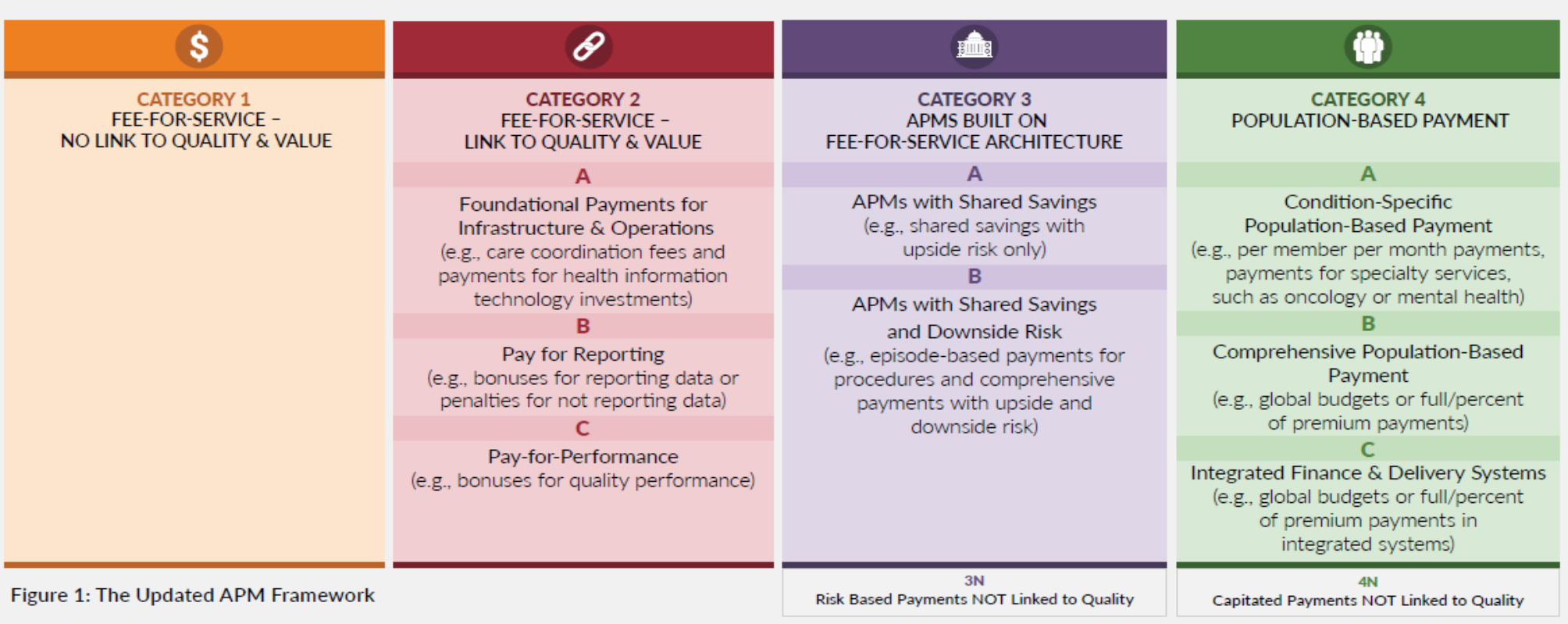


Figure 1: The Updated APM Framework

The Health Care Payment Learning & Action Network (LAN) , Alternative Payment Model (APM) Framework, Updated July 2017

Value-Based Purchasing at CMS

VBP Programs & Models

CMS VBP Programs

1. End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)
2. Hospital-Acquired Condition (HAC) Reduction Program (HACRP)
3. Hospital Readmissions Reduction Program (HRRP)
4. Hospital Value-Based Purchasing (VBP) Program
5. Marketplace Quality Initiatives: Quality Improvement Strategy (QIS)
6. Marketplace Quality Initiatives: Quality Rating System (QRS)
7. Medicaid 1115 Demonstrations
8. Medicare Shared Savings Program
9. Quality Payment Program (QPP)
10. Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program
11. Value Modifier Program

Center for Medicare and Medicaid Innovation (CMMI) VBP Models

12. Accountable Care Organization (ACO) Investment Model (AIM)
13. Accountable Health Communities (AHC) Model
14. Bundled Payments for Care Improvement (BPCI) Advanced
15. Comprehensive Care for Joint Replacement (CJR) Model
16. Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model
17. Comprehensive Primary Care Plus (CPC+)
18. Episode Payment Models (EPMs)
19. Medicare-Medicaid Financial Alignment Initiative
20. Health Care Innovation Awards Round Two
21. Home Health Value-Based Purchasing (HHVBP) Model
22. Independence at Home Model
23. Maryland All-Payer Model [Non-QPP APM]
24. Medicaid Innovation Accelerator Program (IAP)
25. Medicare Accountable Care Organization (ACO) Track 1+ Model
26. Medicare Advantage Value-Based Insurance Design (VBID) Model
27. Medicare Care Choices Model
28. Million Hearts® Cardiovascular Disease Risk Reduction Model
29. Multi-Payer Advanced Primary Care Program
30. Next Generation Accountable Care Organization (NGACO) Model
31. Oncology Care Model (OCM)
32. Part D Enhanced Medication Therapy Management Model
33. Pennsylvania Rural Health Model
34. State Innovation Models Initiative
35. Strong Start for Mothers & Newborns Initiative: Enhanced Prenatal Care Models
36. Transforming Clinical Practice Initiative (TCPI)
37. Vermont All-Payer Accountable Care Organization (ACO) Model

Meaningful Measures Initiative

Launched in 2017, the purpose of the Meaningful Measures initiative is to:

- Improve outcomes for patients
- Reduce data reporting burden and costs on clinicians and other health care providers
- Focus CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients

Meaningful Measures Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity to help identify measures that:

Address high-impact measure areas that safeguard public health

Are patient-centered and meaningful to patients, clinicians and providers

Are outcome-based where possible

Fulfill requirements in programs' statutes

Minimize level of burden for providers

Identify significant opportunity for improvement

Address measure needs for population based payment through alternative payment models

Align across programs and/or with other payers

Meaningful Measures

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:

- Equity of Care
- Community Engagement

Make Care Affordable

Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:

- Healthcare-associated Infections
- Preventable Healthcare Harm

Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

Meaningful Measures

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Meaningful Measures Area: Interoperability

- Lack of interoperability has posed significant challenges to the use of health IT for data exchange and care coordination

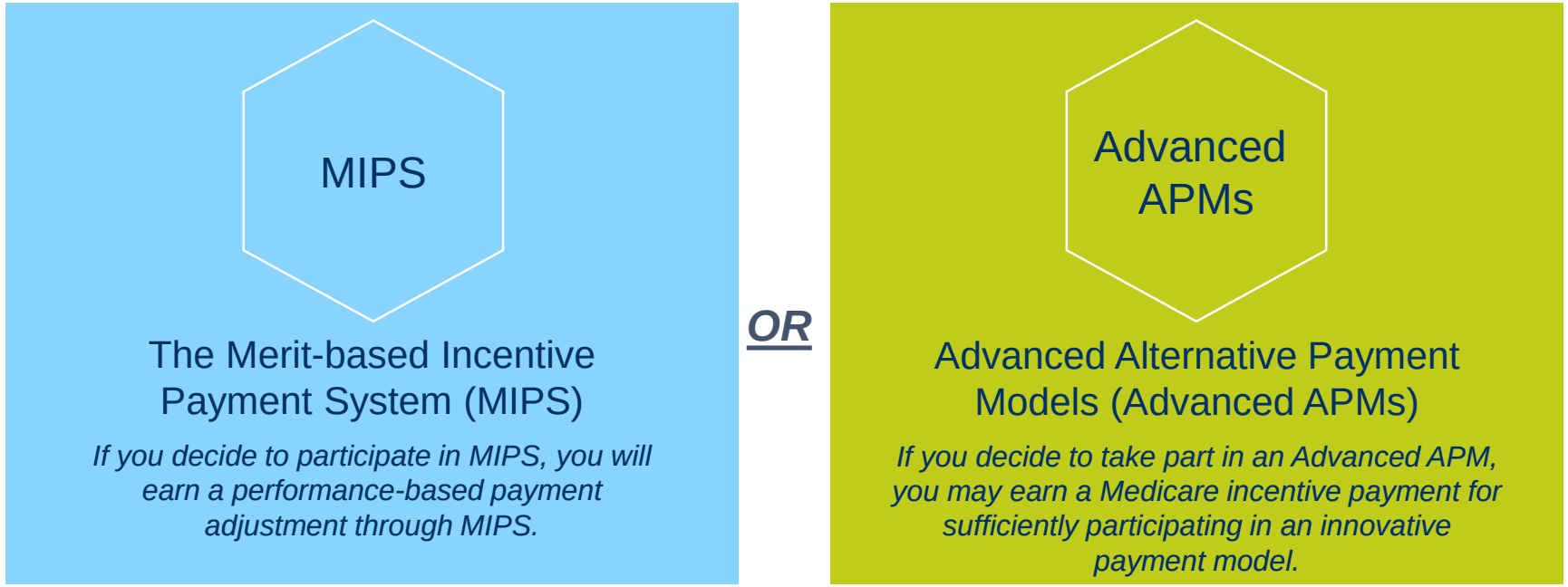
- HHS has explicit authority to advance interoperability as described in the *21st Century Cures Act*.

- CMS is committed to advancing health information technology to:
  - Mature technology
  - Mature standards governed by HHS, and
  - Less regulatory obstacles to interoperability.

Quality Payment Program

MIPS and Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:



Quality Payment Program Objectives

- Improve beneficiary outcomes and engage and empower consumers by providing healthcare information useful for driving value and making healthcare decisions.
- Enhance clinician experience and support their efforts to achieve better patient outcomes through flexible and transparent program design and interactions with easy-to-use program tools.
- Increase the availability of Advanced APMs, as well as the opportunities for clinicians to transition from MIPS to Advanced APMs.
- Increase program understanding through customized communication, education, outreach, and support that meet the needs of the diversity of clinicians and stakeholders, especially the unique needs of small practices.
- Improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
- Promote a Quality Payment Program system that embodies human-centered design principles and continuous improvement.
- Ensure operational excellence in program implementation and ongoing development to make sure the program works for all stakeholders, including smaller independent and rural practices.

MIPS Year 3 (2019) Proposed

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists

Year 3 (2019) Proposed

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers

MIPS Year 3 (2019) Proposed

Low-Volume Threshold Determination

Proposed low-volume threshold includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule **AND** furnishing covered professional services to more than 200 Medicare beneficiaries a year **AND** providing more than 200 covered professional services under the PFS. To be included, a clinician must exceed all three criterion.

Note: For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

MIPS Year 3 (2019) Proposed

Performance Periods

Year 2 (2018) Final

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 3 (2019)– *No Change*

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

MIPS Year 2 (2018)

Timeline for Year 2

2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

Advanced APMs

Advanced APM Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices 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.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- 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.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- 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

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

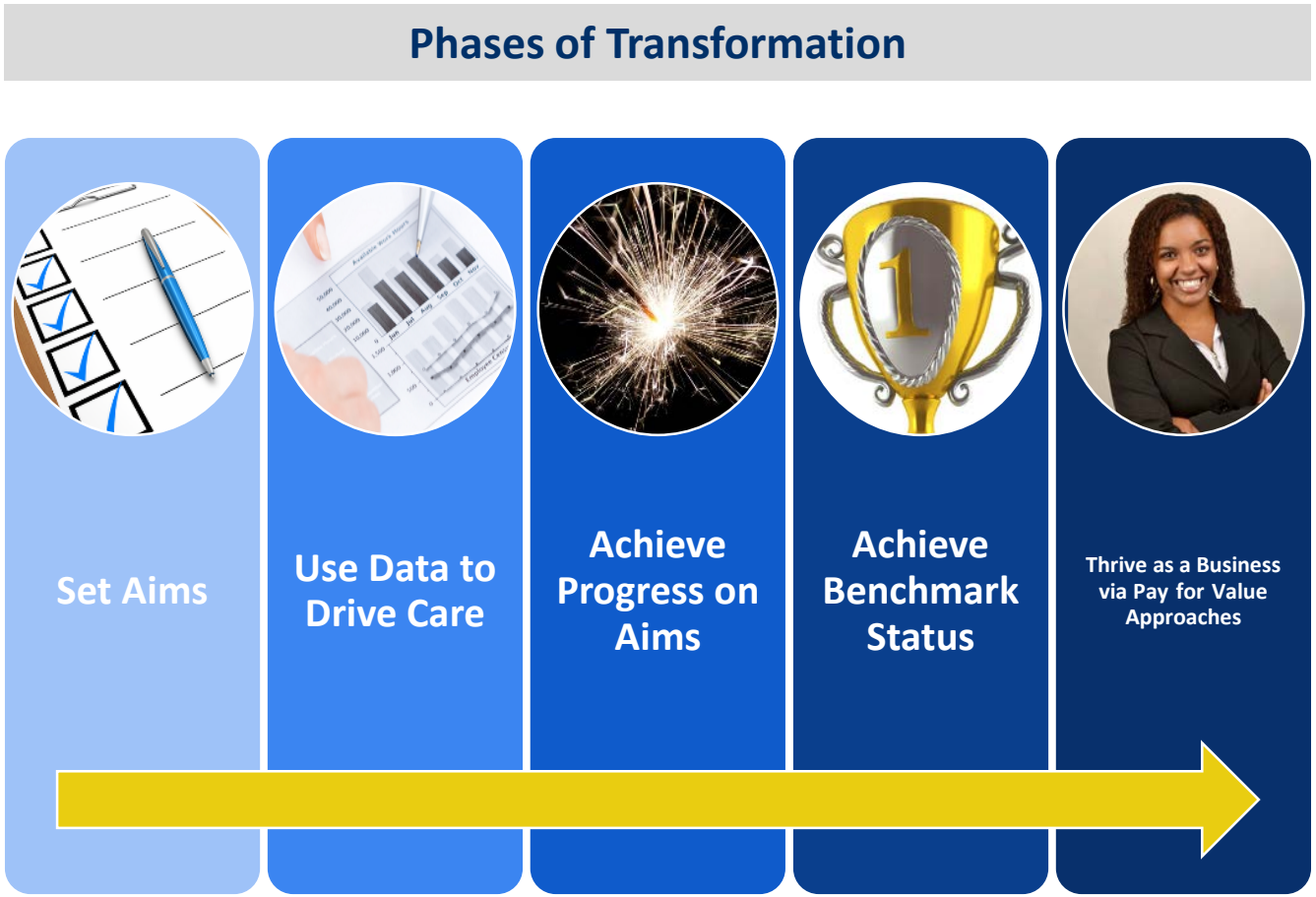
Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation



- Two network systems have been 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

Strengthen Patients and Families as Partners in their Care

- CMS Patient and Family Engagement (PFE) Strategy
  - **Vision**: A transformed healthcare system that **proactively engages patients and caregivers** in the definition, design, and delivery of their care.
  - **Mission**: To create an inclusive, collaborative and aligned national PFE framework that is guided by patient-centered values and **drives genuine transformation in attitudes, behavior, and practice**.
  - **Values**:
    - Patient-centered
    - Health Literacy
    - Accountability
    - Respect

CMS VBP Program Impacts

CMS's VBP Programs have made meaningful impacts on improving quality and cost of care. Examples of program successes include:

30 quality measures improved on by 430 CMS Accountable Care Organizations (Medicare Shared Savings Program)

2.1 million fewer incidents of harm and $28 billion saved (Hospital-Acquired Conditions Reduction Program)

22% improvement in dialysis adequacy and 17% decrease in readmissions for dialysis patients (ESRD Quality Incentive Program)

$319 million net savings to Medicare total cost of care through avoidance of preventable readmissions and ER visits (Maryland All-Payer Model)

150,000 fewer all-cause readmissions with rate decline to 17.5% (Hospital Readmissions Reduction Program)

Questions?

Disclaimers

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