CMS has adopted a framework that categorizes payments to providers

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

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

**Medicare Fee-for-Service**

**GOAL 1:**
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. 30%

**GOAL 2:**
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. 85%

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

**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

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Care Organizations</strong></td>
<td></td>
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<tr>
<td></td>
<td>Medicare Shared Savings Program ACO*</td>
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<tr>
<td></td>
<td>Pioneer ACO*</td>
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<td></td>
<td>Comprehensive ESRD Care Model</td>
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<tr>
<td></td>
<td>Next Generation ACO</td>
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<td></td>
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<tr>
<td><strong>Bundled Payments</strong></td>
<td></td>
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<tr>
<td></td>
<td>Bundled Payment for Care Improvement*</td>
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<td></td>
<td>Comprehensive Care for Joint Replacement</td>
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<td></td>
<td>Oncology Care</td>
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<tr>
<td><strong>Advanced Primary Care</strong></td>
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<tr>
<td></td>
<td>Comprehensive Primary Care*</td>
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<tr>
<td></td>
<td>Multi-payer Advanced Primary Care Practice*</td>
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<tr>
<td><strong>Other Models</strong></td>
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<tr>
<td></td>
<td>Maryland All-Payer Hospital Payments*</td>
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<td></td>
<td>ESRD Prospective Payment System*</td>
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</tr>
</tbody>
</table>

* 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

CMS will continue to test new models and will identify opportunities to expand existing models
CMS will reach Goal 2 through more linkage of FFS payments to quality or value

Hospitals, % of FFS payment at risk (maximum downside)

<table>
<thead>
<tr>
<th>Program</th>
<th>Performance period 2014 (payment FY16)</th>
<th>Performance period 2015 (FY17)</th>
<th>Performance period 2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>6.55</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Physician, % of FFS payment at risk (maximum downside)

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment FY18)</th>
<th>2017 Performance period (payment FY19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VM (Value Modifier)</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

* Physician VM adjustment depends upon group size and can range from 2% to 4%
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 value over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in eligible alternative payment models (APMs)
Medicare Reporting Prior to MACRA

MACRA streamlines these programs into MIPS.

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

Merit-Based Incentive Payment System (MIPS)
MACRA affects Medicare Part B clinicians.

Affected clinicians are called “eligible professionals” (EPs) and will participate in MIPS. The types of Medicare Part B health care clinicians affected by MIPS may expand in the first 3 years of implementation.

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

Years 3+

Secretary may broaden EP group to include others such as:

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
Are there any exceptions to participation in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. FIRST year of Medicare Part B participation
2. Below low patient volume threshold
3. Certain participants in ELIGIBLE Alternative Payment Models

Note: MIPS does not apply to hospitals or facilities
MACRA changes how Medicare pays clinicians.

The system after MACRA:

* Or special lump sum bonuses through participation in eligible Alternative Payment Models
How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive +/- or neutral adjustments up to the percentages below.

+4%  +5%  +7%  +9%
-4%  -5%  -7%  -9%

Adjusted Medicare Part B payment to clinician

2019  2020  2021  2022 onward

Merit-Based Incentive Payment System (MIPS)

The potential maximum adjustment % will increase each year from 2019 to 2022
How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

![Diagram showing potential adjustments from 2019 to 2022 with a maximum adjustment of ±9% and an overall potential for a 3X adjustment.]

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Use of certified EHR technology

MIPS Composite Performance Score
RECALL: Exceptions to Participation in MIPS

There are 3 groups of clinicians who will NOT be subject to MIPS:

Certain participants in ELIGIBLE Alternative Payment Models
What is a Medicare Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by MACRA, **APMs include**:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by federal law
“Eligible” APMs are the most advanced APMs.

As defined by MACRA, eligible APMs must meet the following criteria:

- Base payment on quality measures comparable to those in MIPS
- Require use of certified EHR technology
- Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority
Note: MACRA does NOT change how any particular APM rewards value. Instead, it creates extra incentives for APM participation.
MACRA provides **additional** rewards for participating in APMs.
MACRA provides **additional rewards** for participating in APMs.

### Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>+</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>APM-specific rewards</td>
<td></td>
</tr>
</tbody>
</table>

APM participation = **favorable scoring** in certain MIPS categories
MACRA provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM
- MIPS adjustments

In APM
- MIPS adjustments
- APM-specific rewards

In eligible APM
- APM-specific rewards
  + 5% lump sum bonus

If you are a qualifying APM participant (QP)
How do I become a qualifying APM participant (QP)?

You must have a certain % of your patients or payments through an eligible APM.

QPs will:
- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

25% in 2019 and 2020
What about **private payer or Medicaid APMs?** Can they help me qualify to be a QP?

Yes, starting in 2021, participation in **some** of these APMs with other non-Medicare payers can **count toward** criteria to be a QP.

**IF the APMs meet criteria similar to those for eligible APMs run by CMS:**

- Certified EHR use
- Quality Measures
- Financial Risk

“Combination all-payer & Medicare threshold option”
Note: Most practitioners will be subject to MIPS.

Subject to MIPS

Not in APM

In non-eligible APM

In eligible APM, but not a QP

QP in eligible APM

Some people may be in eligible APMs and but not have enough payments or patients through the eligible APM to be a QP.

Note: Figure not to scale.
MIPS adjustments will begin in 2019.

*NOTE: Similar to prior quality programs, adjustments for MIPS will be based on performance in a prior year. The exact time (e.g. 1 yr. prior) will be determined in upcoming rule-making.*
Qualifying APM bonuses will also begin in 2019.

<table>
<thead>
<tr>
<th>Year</th>
<th>MIPS</th>
<th>Participation in Qualifying APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>+5%</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2021</td>
<td>+7%</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>+9%</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td></td>
<td></td>
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<tr>
<td>2024</td>
<td></td>
<td></td>
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<tr>
<td>2025</td>
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</tr>
</tbody>
</table>

*NOTE: Bonus payment for APM will be based on estimated aggregate payment for the prior year. E.g. bonus in 2019 will be based on payment for services in 2018.
**Fee schedule updates begin in 2016.**

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026 &amp; on</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>+0.5% each</td>
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<td></td>
<td></td>
<td>+0.25% or 0.75%</td>
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<tr>
<td></td>
<td>No change</td>
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</tbody>
</table>

*QPs will also get a +0.75% update to the fee schedule conversion factor each year.*

Everyone else will get a +0.25% update.
### Putting it all together:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>Participation in Qualifying APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each</td>
<td>4</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td>7</td>
<td></td>
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<tr>
<td>2019</td>
<td></td>
<td>9</td>
<td></td>
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<tr>
<td>2020</td>
<td></td>
<td>9</td>
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<td>2021</td>
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<td>2022</td>
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<tr>
<td>2025</td>
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<tr>
<td>2026 &amp; on</td>
<td></td>
<td>+0.25%</td>
<td>or 0.75%</td>
</tr>
</tbody>
</table>

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**Fee Schedule**
- 2016: +0.5% each
- 2017 to 2025: No change
- 2026 & on: +0.25% or 0.75%

**MIPS**
- Max Adjustment: 4, 5, 7, 9, 9, 9

**Participation in Qualifying APM**
- +5% bonus (excluded from MIPS)
Quality Can Be Measured and Improved at Multiple Levels

Community
- Population-based denominator
- Multiple ways to define denominator (e.g., county, HRR)
- Applicable to all providers

Practice setting
- Denominator based on practice setting (e.g., hospital, group practice)

Individual physician
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician’s total performance
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>
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<tr>
<td></td>
<td>- Advance Payment ACO Model</td>
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<td></td>
<td>- Comprehensive ERSD Care Initiative</td>
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<td>- Next Generation ACO</td>
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<td>Primary Care Transformation</td>
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<td>- Comprehensive Primary Care Initiative (CPC)</td>
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<td>- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<td></td>
<td>- Independence at Home Demonstration</td>
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<td>- Graduate Nurse Education Demonstration</td>
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<td>- Home Health Value Based Purchasing</td>
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<td>- Medicare Care Choices</td>
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<td></td>
<td>Bundled payment models</td>
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<tr>
<td></td>
<td>- Bundled Payment for Care Improvement Models 1-4</td>
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<td></td>
<td>- Oncology Care Model</td>
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<tr>
<td><strong>Deliver Care</strong></td>
<td><strong>Support providers and states to improve the delivery of care</strong></td>
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<td></td>
<td>Learning and Diffusion</td>
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<td>- Partnership for Patients</td>
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<tr>
<td></td>
<td>- Transforming Clinical Practice</td>
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<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><strong>Distribute Information</strong></td>
<td>Increase information available for effective informed decision-making by consumers and providers</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>
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<td></td>
<td>State Innovation Models Initiative</td>
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<td></td>
<td>- SIM Round 1</td>
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<td>- SIM Round 2</td>
</tr>
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<td></td>
<td>- Maryland All-Payer Model</td>
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<td>Million Hearts Cardiovascular Risk Reduction Model</td>
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<td>Initiatives Focused on the Medicaid</td>
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<td></td>
<td>- Medicaid Incentives for Prevention of Chronic Diseases</td>
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<td>- Strong Start Initiative</td>
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<td></td>
<td>- Medicaid Innovation Accelerator Program</td>
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<td>Dual Eligible (Medicare-Medicaid Enrollees)</td>
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<tr>
<td></td>
<td>- Financial Alignment Initiative</td>
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<td></td>
<td>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<tr>
<td></td>
<td>Medicare Advantage (Part C) and Part D</td>
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<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>
</tbody>
</table>

* Many CMMI programs test innovations across multiple focus areas
The Health Care Payment Learning and Action Network will accelerate the transition to alternative payment models

- Medicare alone cannot drive sustained progress towards alternative payment models (APM)

- Success depends upon a critical mass of partners adopting new models

- The network will
  - Convene payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  - Identify areas of agreement around movement to APMs
  - Collaborate to generate evidence, shared approaches, and remove barriers
  - Develop common approaches to core issues such as beneficiary attribution
  - Create implementation guides for payers and purchasers

### Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  - 30% in APM by 2016
  - 50% in APM by 2018

- Shift momentum from CMS to private payer/purchaser and state communities

- Align on core aspects of alternative payment design
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

* 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

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
Pioneer ACO: Actuarial Results to date

Pioneer ACO Savings / Loss Results by Year

2012
- 18 ACOS generated savings (14 received payment)
- 14 generated losses (1 owed CMS)

2013
- 14 ACOS generated savings (11 received payment)
- 9 generated losses (6 owed CMS)

2014
- 15 ACOS generated savings (11 received payment)
- 5 generated losses (3 owed CMS)

How to read this graph – in 2014, for example:
- Among 15 ACOs that generated savings, $82 M of the total savings was retained by CMS, while $62 was shared with 11 ACOs in the form of shared savings payments
- Among 5 ACOs that generated losses, $15 M of the total losses was absorbed by CMS, while $9 M was paid back to CMS by 3 ACOs
- Total program savings was $120 M

Total Pioneer ACO model savings has increased from $92 million in 2012 to $96 million in 2013 to $120 million in 2014 (average savings per ACO increased from $2.7 million to $4.2 million to $6.0 million)

1 Determination of whether an ACO with savings or loss will receive a payment from CMS or owe CMS is dependent on exceeding minimum financial threshold, risk track (some ACOs elected one-sided risk track offered only in PY1), quality score
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)

<table>
<thead>
<tr>
<th>Next Generation ACO</th>
<th>Pioneer ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 ACOs spread among 13 states</td>
<td>9 ACOs spread among 7 states</td>
</tr>
</tbody>
</table>

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
Medicare Shared Savings Program: Results to Date

- **Financial Results**
  - In 2014:
    - 92 ACOs (28%) held spending $806 million below their targets and earned performance payments of more than $341 million
  - In 2013¹:
    - 58 ACOs (26%) held spending $705 million below their targets and earned performance payments of more than $315 million

- **Quality Results**
  - ACOs that reported in both 2013 and 2014 improved average performance on 27 of 33 quality measures
  - Quality improvement was shown in such measures as patients’ ratings of clinicians’ communication, beneficiaries’ rating of their doctor, screening for tobacco use and cessation, and screening for high blood pressure

¹ 2013 figures include both 2012 and 2013 savings / loss generated for some ACOs that started mid-year in 2012 (these were the first ACOs in the program)
Summary of June 2015 Final Rule
Program Improvements

Addressing participation agreement renewals including allowing eligible ACOs to continue participation under the one-sided model (Track 1) for a second agreement period;

Increasing the emphasis on primary care services in the beneficiary assignment methodology;

Streamlining data sharing to provide improved access to data necessary for ACO health care operations such as quality improvement and care coordination, while maintaining beneficiary protections;

Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;

Providing ACOs choice of symmetric threshold for savings and losses under performance-based risk tracks;
ACO Eligibility Requirements: Major Provisions
Expanded requirements for the process the ACO has for coordinating care

Requires an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries. Such enabling technologies and services may include electronic health records and other health IT tools.

Requires the applicant to describe how the ACO intends to partner with long-term and post-acute care providers to improve care coordination for the ACO’s assigned beneficiaries.

ACOs will no longer send out letters that may confuse beneficiaries and beneficiaries will no longer have to sign and return forms to the ACO.

Expands the CPT codes that will be considered to be primary care services. We updated the definition of primary care services to include both TCM codes (CPT codes 99495 and 99496) and the CCM code (CPT code 99490) and will include these codes in our beneficiary assignment methodology.

Modifies the treatment of claims submitted by certain physician specialties, NP, PAs, and CNSs in the assignment algorithm.
Shared Savings Program Notice of Intent to Apply

• NOIA Memo Posted to CMS Website    April 1, 2016

• NOIA Submission Period May 2, 2016 – May 31, 2016 5:00 p.m. ET.

• Application Deadline (for initial, renewal and SNF 3-Day Waiver* applications)

• July 29, 2016, at 5:00 p.m. Eastern Time

• A NOIA submission does not bind an organization to submit an application. However, you must submit a NOIA to be eligible to submit an application for the January 1, 2017 program start date.

• We encourage all organizations that are considering applying or renewing to complete and submit a NOIA. CMS will not accept late submissions.
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
- 337 Awardees and 1237 Episode Initiators as of January 2016

- 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
The Case for Bundled Payments

- Large opportunity to reduce costs from waste and variation
- Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
- Improvements “spillover” to private payers
- Strategies learned in bundled payments lay the foundation for success in a value driven market
- Adoption of bundled payments is accelerating across both private and public payers
- Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives
### Bundled Payments for Care Improvement: Models Overview

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Bundled payment models for the acute inpatient hospital stay only (11 Awardees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2</td>
<td>Retrospective bundled payment model for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care (678 Awardees or Episode Initiators)</td>
</tr>
<tr>
<td>Model 3</td>
<td>Retrospective bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay (919 Awardees or Episode Initiators)</td>
</tr>
<tr>
<td>Model 4</td>
<td>Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only (10 Awardees)</td>
</tr>
</tbody>
</table>
# BPCI Provider Types

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>375</td>
<td>0</td>
<td>9</td>
<td>384</td>
</tr>
<tr>
<td>Physician Group Practice</td>
<td>234</td>
<td>49</td>
<td>0</td>
<td>283</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>0</td>
<td>99</td>
<td>0</td>
<td>99</td>
</tr>
<tr>
<td>Inpatient Rehab Facility</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Long Term Care Hospital</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>0</td>
<td>681</td>
<td>0</td>
<td>681</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>609</td>
<td>839</td>
<td>9</td>
<td>1457</td>
</tr>
<tr>
<td>Trigger Clinical Conditions</td>
<td>Condition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>Major bowel procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AICD generator or lead</td>
<td>Major cardiovascular procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td>Major joint replacement of the lower extremity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atherosclerosis</td>
<td>Major joint replacement of the upper extremity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back &amp; neck except spinal fusion</td>
<td>Medical non-infectious orthopedic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>Medical peripheral vascular disorders</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cardiac arrhythmia</td>
<td>Nutritional and metabolic disorders</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cardiac defibrillator</td>
<td>Other knee procedures</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cardiac valve</td>
<td>Other respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Other vascular surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cervical spinal fusion</td>
<td>Pacemaker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Pacemaker device replacement or revision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined anterior posterior spinal fusion</td>
<td>Percutaneous coronary intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex non-cervical spinal fusion</td>
<td>Red blood cell disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Removal of orthopedic devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>Renal failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Revision of the hip or knee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Double joint replacement of the lower extremity</td>
<td>Sepsis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>Simple pneumonia and respiratory infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fractures of the femur and hip or pelvis</td>
<td>Spinal fusion (non-cervical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal obstruction</td>
<td>Syncope &amp; collapse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>Transient ischemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>Urinary tract infection</td>
<td></td>
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</tr>
</tbody>
</table>
BPCI: Most Prevalent Clinical Episodes in Models 2-4

Of the 48 Clinical Episodes in the BPCI initiative, the five most prevalent are listed in the table below.

The most prevalent five Clinical Episodes make up 21.6% of the Clinical Episodes currently being tested in BPCI.

<table>
<thead>
<tr>
<th>Most Prevalent Clinical Episodes in Models 2-4</th>
<th>Number of Episodes</th>
<th>Percent of Total Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>916</td>
<td>6.4%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>595</td>
<td>4.2%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>559</td>
<td>4.0%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>516</td>
<td>3.7%</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>465</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total</td>
<td>3,051</td>
<td>21.6%</td>
</tr>
</tbody>
</table>
### History of BPCI Models 2-4 Transition to Phase 2

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Description of Entry Instructions and Cohort</th>
</tr>
</thead>
</table>
| Q4 2013       | • The first quarter of the period of performance (Phase 2).  
• Participants and their Episode Initiators could move clinical episodes into risk.  
• This first cohort was fairly small in number and reflective of early adopters. |
| Q1 2014       | • Additional Participants and their Episode Initiators began their period of performance through moving at least one clinical episode into risk (Phase 2).  
• Awardees, already in their period of performance, were also allowed to move additional clinical episodes into risk. |
| Q3 2015       | • Two open periods were offered, Q4 2013 and Q1 2014, resulting in tremendous growth in Participants entering Phase 1, the program preparatory period.  
• Program instructed all Awardees that all entities must enter the period of performance (Phase 2) in Q3 2015. |
| Q4 2015       | • All Awardees and Episode Initiators must move all clinical episodes into Phase 2 by Q4 2015 as Phase 1 of BPCI will come to an end. |
Within 90 days of discharge from the hospital, costly institutional Post-Acute Care was substituted by less costly home health care.

As a result, there were reductions in Medicare Part A payments to Skilled Nursing Facilities (SNF) and Inpatient Rehabilitation Facilities (IRF) accompanied by an increase of Part A payments to Home Health Agencies (HHA).

There were also reductions in the anchor inpatient length of stay and the 30-day readmission rate.

In the first quarter, BPCI awardees participated mostly with clinical episodes that fall into orthopedic surgery excluding the spine. Thus, Model 2 results were driven by patient episodes in this clinical episode group.
BPCI Model 3 Summary of Evaluation Results

Majority of Episode Initiators are Skilled Nursing Facilities (SNF), followed by Home Health Agencies (HHA); few Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals (LTCH)

Phase 2 SNFs likelier to be urban and not small compared to non-BPCI SNFs

Model 3 interviewees mentioned the same reasons as Model 2 Awardees for joining BPCI:

- Anticipate payment reform
- Opportunities for quality improvement
- See themselves as leaders and innovators

Preliminary results for orthopedic-surgical episodes in SNFs suggest:

- Institutional number of days lower across the baseline and intervention period than for comparison group
- No difference in the change in Part A payments between the intervention and comparison groups
Comprehensive Care for Joint Replacement (CJR)

- 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 in participating

67 selected Metropolitan Statistical Areas (MSAs) where 30% U.S. population resides

- Participant hospitals in these selected MSAs are all acute care hospitals paid under the IPPS that are not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes.

- The model will have 5 performance years, with the first beginning April 1, 2016
CJR Model: Description

The **CJR model begins April 1, 2016** and will last 5 performance years, through December 2020

CJR episodes include:

- Hospitalization for LEJIR procedure assigned **MS-DRG 469 or 470 and 90 days post-discharge**
- **All Part A and Part B services**, with the exception of certain excluded services that are clinically unrelated to the episode

- Providers and suppliers **continue to be paid via Medicare FFS**
CJR Model: Quality

Hospitals are assigned a composite quality score each year based on their performance and improvement on the **two quality measures:**

- Hospital Level Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (NQF #1550)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166)

*In addition, we are encouraging voluntary submission of THA/TKA patient-reported outcomes (PRO) and limited risk variable data*

- Performance and improvement on the PRO data elements are not taken into consideration as finalized in the rule
THA/TKA Complications Measure (NQF #1550)

**Definition** Hospital-level RSCR following elective THA/TKA (NQF #1550)
 Rate of complications occurring during index admission and up to a 90-day period following admission for THA/TKA

- Outcomes considered complications in this measure: Acute myocardial infarction, pneumonia, sepsis/septicemia within 7 days of admission
- Surgical site bleeding, pulmonary embolism, or death within 30 days of admission
- Mechanical complications, periprosthetic joint infection, or wound infection within 90 days of admission
CJR Model: Financial

Participant hospitals will receive prospective episode target prices that reflect expected spending for a LEJR episode. After a performance year, actual episode spending will be compared to the episode target prices:

- If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment, subject to quality performance.
- If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare beginning in Year 2.
CJR Model: Target Prices

Target prices will be set for episodes anchored by MS-DRG 469 vs. MS-DRG 470 and for episodes with hip fractures vs. without hip fractures.

Includes 3% discount to serve as Medicare’s savings.

Based on blend of hospital-specific and regional episode data (Census Division), transitioning to regional pricing.

### Target Price Hospital-Specific and Regional Blend

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital-Specific Portion</th>
<th>Regional Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2/3</td>
<td>1/3</td>
</tr>
<tr>
<td>Year 2</td>
<td>2/3</td>
<td>1/3</td>
</tr>
<tr>
<td>Year 3</td>
<td>1/3</td>
<td>2/3</td>
</tr>
<tr>
<td>Year 4</td>
<td>blank</td>
<td>100%</td>
</tr>
<tr>
<td>Year 5</td>
<td>blank</td>
<td>100%</td>
</tr>
</tbody>
</table>
Patient-Reported Outcomes (PRO)

Successful PRO collection factors into hospitals’ CJR composite quality score calculation

Composite quality score links payment to quality

Determined by performance and improvement in the Complications and HCAHPS Survey Scores

Hospitals with scores placing them in “Good” or “Excellent” quality will either receive a higher reconciliation payment or have less payment responsibility
Orthopedic and quality leaders support PROs

Align with CMS’s future direction of reporting patient-reported outcome performance measures (PRO-PMs)

Get head start on building your PRO collection infrastructure

Help inform development of a hospital-level, risk-adjusted PRO-PM for elective primary THA/TKA surgical procedures

PROs: Best Tool for Quality Improvement

Anticipate future federal measurement programs
Oncology Care Model: new emphasis on specialty care

- 1.6 million people annually diagnosed with cancer; majority are over 65 years
- Major opportunity to improve care and reduce cost with expected start July 2016
- Model Objective: Provide beneficiaries with higher intensity coordination to improve quality and decrease cost
- Key features
  - Implement 6 part practice transformation
  - Create two part financial incentive with $160 pbpm payment and performance based payment
  - Institute robust quality measurement
  - Engage multiple payers

Practice Transformation

1. Patient navigation
2. Care plan with 13 components based on IOM Care Management Plan
3. 24/7 access to clinician and real time access to medical records
4. Use of therapies consistent with national guidelines
5. Data driven continuous quality improvement
6. ONC certified electronic health record and stage 2 meaningful use by year 3
Medicare Care Choices Model (MCCM) provides new options for hospice patients

- MCCM allows Medicare beneficiaries who qualify for hospice to receive **palliative care services and curative care at the same time**. 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
  - Model will be phased in over 2 years with participants 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
State Innovation Model grants have been awarded in two rounds

CMS is testing the ability of state governments to utilize policy and regulatory levers to accelerate health care transformation

- Primary objectives include
  - Improving the quality of care delivered
  - Improving population health
  - Increasing cost efficiency and expand value-based payment

- 6 round 1 model test states
  (original performance period 2013-2016)

- 11 round 2 model test states
  (original performance period 2015-2019)

- 21 round 2 model design awardees
  (original performance period 2015-2016)
What are the steps in the state journey towards APMs?

1. Investing in primary care infrastructure, especially multipayor
   • PCMH (All)
   • Health homes (AR, MA, ME, MN, VT, CO, IA, MI)
   • Behavioral health and SUD integration (CO, CT, ME, MI, MN, NY, OH, OR, VT, WA)

2. Building in appropriate risk for providers
   • ACOs (ME, MA, MN, VT, CT, MI, WA)
   • Episodes (AR, VT, OH, TN)

3. Innovating pathways to address population health
   • Accountable communities for health (ME, MN, WA)
   • Community care teams including community health workers (CT, DE, ID, MI, NY, OR, RI)
   • Integrating social services and medical care (CO, CT, OR)
   • Developing financial accountability (In discussions in all payor states)

4. Investing in and using HIT/HIE and other data infrastructure
   • APCD (CO, CT, DE, ME, MN, NY, OR, RI, WA)
   • HIE interoperability (CO, CT, ID, ME, MI, NY, OR, RI, VT)
   • ADT feeds (IA, ME, NY, OR, VT)
   • Advanced analytics (ID, MI, MN, WA)

Success of SIM builds on successes of others

Source: SIM Initiative Evaluation Model Test Year Two Annual Report, July 2015
Round Two operational Plans
SIM must reach preponderance of care in state: Goals are aligned with LAN and MACRA

**Primary goal of SIM (2013)**
Over 80% of payments to providers from all payers in the state are in value-based purchasing and/or alternative payment models by end of performance period.

**Primary goal of LAN (2015)**
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs. In 2018, at least 50% of U.S. health care payments are so linked.

**Statutory language from MACRA relevant to all payor models (2015)**
- 2019-2020: 25% of Medicare revenues furnished as part of an eligible APM;
- 2021-2022: 50% of revenues furnished as part of an eligible APM (at least 25% Medicare);
- 2023: 75% of all payer revenues furnished as part of an eligible APM (at least 25% Medicare).

Alignment for entire nation on central parameters is important but challenging. States may be better forum to foster true alignment.
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
Financial goals for Maryland under the All-Payer Model

• In January of 2014, CMS, the State of Maryland, and Maryland hospitals agreed to the following financial goals over the 5 year model test period:

• Generate $330 million in Medicare savings over a five year performance period
  • Measured by comparing Maryland’s Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth.

• Limit annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita gross state product.
• Eliminate cost shifting among payers, equitably distributing the costs of uncompensated care and medical education.

• Shift virtually all of its hospital revenue over the five year performance period into global payment models.

If Maryland fails during the five-year performance period of the model, Maryland hospitals will transition over two years to the national Medicare payment systems (IPPS, OPPS).
Quality goals for Maryland under the All-Payer Model

CMS and the State of Maryland also agreed to the following quality goals over the 5 year model test period:

- **Readmissions**: Reduce the aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate in Maryland to the national Medicare 30-day unadjusted all-cause, all-site readmissions rate.

- **Hospital Acquired Conditions**: Maryland currently operates a program that measures 3M’s 65 Potentially Preventable Conditions. Under this model, Maryland must reduce the 65 PPCs by 30% **over five years**.

- **Population Health**: Maryland will submit an annual report demonstrating its performance along various population health measures, such as life expectancy, CVD, and asthma.

*If Maryland fails during any performance year of the model, Maryland hospitals will transition back to the national Medicare quality programs (HRRP, HACRP, etc).*
After only one year in the model (CY 2014), Maryland has made significant progress and achieved:

- **$116M in Medicare savings** (goal: $330M by year 5)
- **1.47% in the All-Payer total hospital per capita cost growth** (goal: 3.58% annually)
- Medicare FFS **30-day all-cause readmission rate reduced** from 1.2% to 1% above the national rate (goal: national rate by year 5)
- **26% reduction in the All-Payer aggregate Potentially Preventable Complication (PPC) rate** (goal: 30% by year 5)
- By July 1, 2014, hospitals had agreed to move more than **90% of the state’s aggregate hospital revenue into global budgets**.
  - The speed of that transition demonstrates hospitals’ commitment to the new model and to value-based care.
Need for Evolution of Maryland All-Payer Model

- While the All-Payer Model is achieving results, the nation is also evolving. Maryland needs to **continue care and payment transformation**. The Agreement with CMS commits the State to develop a total cost of care model to replace the All-Payer Model.
- **The Maryland All-Payer Model is limited** to hospitals. We must strengthen incentives to transform care across the spectrum, centered on patients, not provider sectors.
  - The model **does not necessarily align provider incentives with non-hospital providers**
    - Physicians and other providers in traditional fee for service (FFS) arrangements may have little incentive to align with hospitals
  - The model **does not include total cost of care for patients, only hospital costs**.
    - Before the start of the fourth year of the model, Maryland will develop a proposal for a new model that covers Medicare total per capita cost-of-care.
Clinical Transformation in Maryland

- Clinical transformation has already begun. Hospitals have published strategic transformation plans that reorient care towards population health and are in the process of developing partnerships with non-hospital providers.
  - Global budgets create incentives for hospitals, primary care physicians, and other providers to partner together to provide a better continuum of care for patients. But we can better reward systems that reorganize themselves around the needs of beneficiaries, not needs of institutions.
- The 2019 total cost of care model will need to link the financial incentives of hospitals and non-hospital providers in order to encourage further reform.
  - The current Agreement requires a total cost of care model. The State and providers will need to the write the vision for Maryland’s clinical transformation in a way that covers the Total Cost of Care.
  - A total cost of care vision is needed for hospitals to maintain their exemption from IPPS/OPPS
Conclusion—lessons from other SIM states and MACRA

- Steps other SIM states have taken
  - Investing in primary care infrastructure in a multi-payer fashion
  - Building in appropriate risk for all providers, to align provider incentives to true outcomes
  - Innovating pathways and accountability to improve the health of an entire population
  - Investing in data infrastructure
- Maryland providers are not automatically in an eligible APM under MACRA. We must work together if eligible APMs—and the 5% bonus payments—are a desired end state
Key Strategies:

**Increasing value-based payment for health care services.** PA will promote the transition from fee-for-service, volume-based health care to value-based payments that reward quality outcomes. The move will incentivize health care providers to focus on improving population health as well as health care delivery.

**Enhancing price and quality transparency.** PA will explore ways to inform health care consumers regarding the price and quality of health care services. Like other states, PA will examine consumer-friendly tools that provide consumers with data on price and quality in order to allow for informed health care decisions.

**Improving rural health care services.** PA will explore ways to improve health care for residents living in rural areas in a manner that is sustainable and better serves the health needs of local populations.
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Key Health Factors

Health Factor Examples

- Tobacco Use
- Nutrition and Exercise
- Substance Use
- Quality of Care
- Access to Care
- Preventive Care

Socioeconomic Factors

- Education
- Employment
- Income
- Family and Social Support
- Community Safety

Physical Environment

- Environmental Quality
- Built Environment

Health Behaviors

Health Care

New requirements under ACA. To retain tax exempt status, non-profit hospitals must:

- Conduct a “community health needs assessment” at least every three years
- Adopt implementation strategy to meet the community health needs identified through the assessment
- Penalty: $50,000 tax for each year that a tax-exempt hospital fails to satisfy requirement
Hospitals’ Role in Population Health: Community Building

IRS-approved activities:
Physical improvements and housing
Leadership development / training for community
Community health improvement advocacy
Coalition building
Economic development
Community support
Environmental improvement
Workforce development
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
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.