Learning Our Way into a Better System: The Impact of Quality Improvement and Innovation on the Medicare Program

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November 8, 2019
AGENDA

• Describe the main ways that Medicare has changed over the past few years & CMS priorities
• Describe the main quality improvement programs in Medicare
• Describe the principal impacts of innovation on the Medicare Program over the next 5 years
MEDICARE: WHERE WE’VE BEEN

- Medicare legislation enacted in 1965
- Initially, all FFS
- 1982: TEFRA law created Medicare Managed Care (Tax Equity and Fiscal Responsibility Act)
- 1983: introduction of hospital PPS (DRG)
- At that time, rest of system was all “cost-based reimbursement”
- 1997: BBA (Balanced Budget Act)
  - Extended PPS to SNF, HHA, IRF, HOP
  - Formalized “Medicare+Choice”, “Medicare Advantage”, Medicare Part C
MEDICARE: WHERE WE’VE BEEN

• 2003: Medicare Modernization Act (MMA) established “Medicare Part D” for prescription drug coverage
• 2011: CMS Innovation Center established (CMMI)
• 2015: MACRA law passed
  • Ended the “Sustainable Growth Rate” (SGR) payment methodology for physicians
  • Implemented the new payment methodology:
    • Quality Payment Program (QPP)-Merit Based Incentive Payment System (MIPS)
# Medicare: Where We’ve Been, By the Numbers

<table>
<thead>
<tr>
<th>Year</th>
<th>#benes (Total)</th>
<th>#benes (FFS)</th>
<th>#benes (MA&amp;other Health Plans)</th>
<th>$(outlays)</th>
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<tbody>
<tr>
<td>1967</td>
<td>19.1M</td>
<td>19.1M</td>
<td>0</td>
<td>$3.2B</td>
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<td>1997</td>
<td>33.6M</td>
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<td>5.9M (15.9%) 332 “risk contracts”</td>
<td>$200B</td>
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<tr>
<td>1998</td>
<td></td>
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<tr>
<td>2017</td>
<td>58.5M</td>
<td>38.7M (66%)</td>
<td>19.8M (34%)</td>
<td>$705.9B</td>
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<tr>
<td>2018</td>
<td>60M</td>
<td>39M (65%)</td>
<td>21M (35%)</td>
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MEDICARE: WHERE WE ARE GOING
THE CMS INNOVATION CENTER (CMMI)

• 2010: ACOs (Medicare Shared Savings Programs, MSSP)
  • 518 Programs in 2019
• 2012-2016: Pioneer ACOs
• 2016: “NextGen” ACOs
  • 41 Programs in 2019
• Episode-Based Payment Initiatives (Bundled Payment Programs):
  • 2013: BPCI (Bundled Payment for Care Improvement), Model 1
  • 2019: BPCI Advanced
  • 2016: Comprehensive Care for Joint Replacement Model (CJR Model)
MEDICARE: WHERE WE ARE GOING
THE CMS INNOVATION CENTER (CMMI)

• Specialty Models:
  • 2016: Oncology Care Model (OCM)
  • 2019: ESRD Treatment Model (ETC Model)

• Primary Care Models:
  • 2012: Comprehensive Primary Care Model (CPC)
  • 2017: CPC+
  • 2019: Direct Contracting Model
  • 2019: Primary Care First
  • 2015-2019: Transforming Clinical Practice Initiative (TCPI)
MEDICARE: WHERE WE ARE GOING
THE CMS INNOVATION CENTER (CMMI)

• LTC, chronic disease, hospice:
  • 2015: Initiative to Reduce Avoidable Hospitalization Among SNF Residents: Phase 2
  • 2016: Home Health Value Based Purchasing Model
  • 2016: Medicare Care Choices Model (MCCM)

• Models to Accelerate New Innovations:
  • 2016: Accountable Health Communities Model
  • 2019: Emergency Triage, Treat, and Transport Model (ET3)
  • 2019: Artificial Intelligence Health Outcomes Challenge

• Initiatives to Speed the Adoption of Best Practices:
  • 2015: Health Care Payment-Learning and Action Network HCP-LAN
The 2019 CMS strategy is built on one main goal:

PUT PATIENTS FIRST
CMS STRATEGIC PRIORITIES FOR 2019
MAIN QUALITY RELATED STRATEGIC PRIORITIES

• Empowering Patients
• Price Transparency
• My Health EData
• eMedicare
• Patients over Paperwork
• Modernize CMS
• Unleash Innovation
MyMedicare.gov Help

Electronic Mail Setting
If you want to receive Medicare-related information via email, you will need to provide a current email address. You may have already provided your email address during Registration.

If you did not provide an email address at that time but would like to add one now, or if your email address has changed, you can update your information by clicking the edit link in the Current Email Address section. You will be able to update your information in the pop-up window that is displayed. When you are finished, click Submit to continue. As long as your new email address is valid, it will be changed and an Email Confirmation page will be shown.

You will be able to update your information in the pop-up window that is displayed. When you are finished, click Submit to continue.

As long as your new email address is valid, it will be changed and an Email Confirmation page will be shown.

If you decide not to change your email address, click "Cancel" and you will return to the My Account page.
New Online Tool Displays Cost Differences for Certain Surgical Procedures

Press release

Ne27, 2018 | eHealth, Initiatives, Leadership

New Online Tool Displays Cost Differences for Certain Surgical Procedures

Procedure Price Lookup will help patients with Medicare consider potential cost differences when choosing among safe and clinically appropriate settings.

Today, the Centers for Medicare & Medicaid Services (CMS) launched a new online tool that allows consumers to compare Medicare payments and copayments for certain procedures that are performed in both hospital outpatient departments and ambulatory surgical centers. The Procedure Price Lookup tool displays national averages for the amount Medicare pays the hospital or ambulatory surgical center and the national average copayment amount a beneficiary with no Medicare supplemental insurance would pay the provider.

"Price transparency in health care is a priority for the Trump Administration. Working with their clinicians, the Procedure Price Lookup will help patients with Medicare consider potential cost differences when choosing where to have a medical procedure that best meets their needs," said CMS Administrator Seema Verma.

The Procedure Price Lookup tool is launching as required by Congress in the 21st Century Cures Act. Medicare's statutes require that CMS maintain separate payment systems for different types of healthcare providers, meaning both CMS and patients may pay different amounts for the same service, depending on the site of care.

TRY THE “WHAT’S COVERED APP”

https://www.youtube.com/watch?v=G759n0EUV70&feature=youtu.be
Blue Button 2.0

A developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to the applications, services and research programs they trust.

Overview

Blue Button 2.0 from CMS contains four years of Medicare Part A, B and D data for 53 million Medicare beneficiaries.

This data reveals a variety of information about a beneficiary’s health, including type of Medicare coverage, drug prescriptions, primary care treatment and cost. Beneficiaries also have full control over how their data can be used and by whom, with identity and authorization controlled by MyMedicare.gov.
PATIENTS OVER PAPERWORK: RESULTS AT 2 YEARS

Saved an estimated $6.6 billion

Reduced 42 million clinician hours of burden through 2021

#PoPForward2019
CMS HAS ADOPTED A FRAMEWORK THAT CATEGORIZES PAYMENT TO PROVIDERS

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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CMS QUALITY PRIORITIES FOR 2019

- “Meaningful Measures” (related to clinician burden reduction)
- Fighting the Opioid Epidemic
- Improving Behavioral Health
- Improving Patient Safety (reducing harm caused to patients by the health care system)
- Improving Care and Quality for Patients with Chronic Diseases
  - Diabetes
  - Cardiovascular Disease
  - CKD and ESRD (renewed focus since 10 July 2019)
- Continuing to improve the Quality of Care Transitions
- Improving Quality of care in Long Term Care, including reducing abuse of patients in Nursing Homes
WEAKNESSES OF FEE FOR SERVICE PAYMENT

- Excessive use of low-value services
- Insufficient incentives to improve quality of care
- Poor coordination of care
CLEAR DIRECTION

“We are moving away from fee-for-service.”

-- Administrator Seema Verma

CMS Quality Conference, 2018
QUALITY IMPROVEMENT PROGRAMS AND PRINCIPAL IMPACTS OF INNOVATION OVER THE NEXT 5 YEARS

- National Quality Improvement and Innovation Contractors (NQIIC): 12th SOW
- Quality Payment Program: MIPS Value Pathway
- Alternative Payment Models (APMs) & Advanced APMs (AAPMs)
  - Recently Released CMMI Model Tests
- Health Care Payment Learning & Action Network (HCP LAN)
What is a Network of Quality Improvement and Innovation Contractor (NQIIC)?

• NQIICs are the 59 contractors that successfully competed to become part of the new 10-year IDIQ umbrella contract for implementation of the Quality Improvement Program.

• NQIICs awardees have large scale quality improvement expertise, extensive experience with Health Information Technology, a track record of enrolling and supporting healthcare provider organizations in achieving quantitative results, and deep experience with the healthcare needs of nursing homes, clinical practices, hospitals and communities.
What is a Quality Innovation Network–Quality Improvement Organization (QIN-QIO)?

- QIN-QIOs will be a subset of NQIIC contractors: 1) those who successfully competed to be part of the contractor pool to implement the Quality Improvement Organization Program, and 2) who also meet the specific statutory criteria as defined in the CMS Code of Federal Regulations (CFR) 475.101(a), CFR 475.103 and CFR 475.105.

- QIN-QIOs for the 12th Scope are those who meet the criteria outlined above, and who also successfully compete to receive a Task Order 1 Award, which will establish who the QIN-QIOs are throughout the 5-year period.
## 12th SOW: 5 Aims

### Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse
- Engage 414 communities and 6.8 million Medicare beneficiaries to improve access to behavioral care and improve behavioral health outcomes.
- Decrease opioid related adverse events, including deaths, by 7% with a focus on Medicare beneficiaries using opioids.

### Increase Patient Safety
- Reduce all cause harm in hospitals, community-based facilities, and long-term care settings by 2024.
- Reduce by 10% or more all cause harm in hospitals and reducing adverse drug events across all of these settings.

### Prevention and Management of Chronic Diseases
- Supporting the Million Hearts Initiative to prevent 1 million cardiovascular events by improving aspirin use, blood pressure control, cholesterol management, smoking cessation and cardiac rehabilitation.
- Supporting 69,000 Medicare beneficiaries to quit smoking.
- Preventing 25,171 Medicare beneficiaries from developing diabetes.
- Screen for, diagnose and manage 238,464 individuals with CKD to prevent progression of Chronic Kidney Disease (CKD) or progressing to ESRD; and
- Improving diabetes management in at least 238,464 Medicare beneficiaries.

### Increase Quality of Care Transitions
- Improve community-based care transitions to reduce hospital admissions by 4.1% nationally, and
- Reduce hospital readmissions by 5.4% nationally.

### Improve Quality and Patient Safety in Long-Term Care Settings
- Improve by 11% the mean total quality score for all nursing homes,
- Reduce by 41% the percentage of nursing homes with a total quality score less than 890 (2 star nursing homes).
QUALITY PAYMENT PROGRAM

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 two participation tracks:

- **MIPS**
  - Merit-based Incentive Payment System

  If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

- **Advanced APMs**
  - Advanced Alternative Payment Models

  If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
QUALITY PAYMENT PROGRAM
Considerations

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov
MIPS VALUE PATHWAYS

Request for Information (RFI)

While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS’ goal to develop a meaningful program for every clinician, regardless of practice size or specialty.

CMS is proposing MIPS Value Pathways (MVPs) to create a new participation framework beginning with the 2021 performance year. This new framework would:

• Unite and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS

• Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities

• Streamline MIPS reporting by limiting the number of required specialty or condition specific measures

CMS encouraged the health care community to review the MIPS Value Pathways Request for Information (RFI) and our illustrative diagram and submit formal comments. We look forward to working with you to establish this new framework.

OPENED: 29 July    CLOSED: 27 September
MIPS VALUE PATHWAYS: “ILLUSTRATIVE DIAGRAM”

**Current Structure of MIPS (In 2020)**
- Many Choices
- Not Meaningfully-Aligned
- Higher Reporting Burden

**New MIPS Value Pathways Framework (In Next 1-2 Years)**
- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician’s Practice/Specialty or Public Health Priority

**Future State of MIPS (In Next 3-5 Years)**
- Simplified
- Increased Voice of the Patient
- Increased CMS Provided Data
- Facilitates Movement to Alternative Payment Models (APMs)

Building Pathways Framework

**MIPS Value Pathways**
Clinicians report on fewer measures and activities based on specialty and/or outcome within a MIPS Value Pathway.

Moving to Value

- **Value**
  - Cost
  - Quality and IA aligned

- **Foundation**
  - Promoting Interoperability
  - Population Health Measures

- **Enhanced Performance Feedback**
  - Patient-Reported Outcomes

- **Population Health Measures**: A set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

- **Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.**

**Pathways:**
What should be the structure and focus of the Pathways? What criteria should we use to select measures and activities?

**Participation:**
What policies are needed for small practices and multi-specialty practices? Should there be a choice of measures and activities within Pathways?

**Public Reporting:**
How should information be reported to patients? Should we move toward reporting at the individual clinician level?
INNOVATION CONTINUES: CMMI RECENT MODELS

The CMS Innovation Center

The Center for Medicare & Medicaid Innovation (the Innovation Center) with CMS supports the development and testing of innovative health care payment and service delivery models.

Learn More >

Our Innovation Models

The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

Learn More >
THE HEALTH CARE PAYMENT LEARNING & ACTION NETWORK (HCP LAN): LEARN CONSTANTLY—BE PART OF THE COMMUNITY

What is the Health Care Payment Learning & Action Network?

Launched in 2015 by the U.S. Department of Health and Human Services (HHS), the Health Care Payment Learning & Action Network (LAN) is a public-private partnership whose mission is to accelerate the health care system's transition to alternative payment models (APMs) by aligning the innovation, power, and reach of the private and public sectors. The LAN's purpose is to facilitate the shift from the fee-for-service (FFS) payment model to a model that pays providers for quality care, improved health, and lower costs. The LAN is led by a Guiding Committee that provides executive leadership and strategic direction to accelerate achieving the goals described below. The LAN offers stakeholders a broad portfolio of resources to facilitate that transition, including the APM Framework, primary care and maternity care APM resource books, and white papers on a wide range of topics related to designing episode-based and population-based APMs.

GOALS

The goals of the LAN include:

- Linking 50% of all health care payment in the U.S. to quality and value through APMs by 2018
- Increasing the alignment of APM components, such as quality measures, risk adjustment, and data sharing, within and across the public and private sectors
- Diffusing cutting-edge knowledge and promising practices on operationalizing APMs to accelerate the design, testing, and implementation of APMs