Materials from OneCare Vermont

In Support of Testimony at Vermont House Health Care Committee

January 28, 2016

Contents

1) OneCare written responses to questions identified by HHC Committee

2) CMS Background Source Materials – OneCare selected high level summary documents covering CMS-published perspective on some committee questions

   a) Better, Smarter, Healthier: Medicare transition from Volume to Value: Press release and fact sheet 1/26/15

   b) CMS Next Generation ACO Model Web Page (concise summary of Next Gen) plus Next Generation Scoring Matrix

   c) Medicare ACOs Provide Improved Care While Slowing cost Growth – Medicare ACO Performance 2014 Results Fact Sheet 8/25/15

   d) MACRA: MIPS & APMs - CMS web page on MACRA

3) *Via Separate PowerPoint Document*: Presentation by OneCare to address selected questions and provide additional context to discussions with committee on January 20, 2015 (Mr. Moore would like the opportunity to cover these slides in testimony; would need approximately 20 minutes)

Document #1

Follow-up questions from the House Health Care Committee regarding 1/20/2016 testimony about ACO's and the All-Payer Model

I. *Please map out: Who is participating, who is not? (Hospitals, providers, VNA, Home Health, mental health, etc.)*

Below is a summary of the current 2016 participation in the OneCare Vermont Accountable Care Organization (OCV) network. All are participating in at least the Medicare Shared Savings Program (MSSP), and most across all programs. We believe you received similar counts from the CHAC and Healthfirst ACOs in previous testimony documentation. Please note that some organizations may be counted by both OneCare and CHAC as both ACOs have contracts with certain organizations. The ACOs would need time to do an analysis of which providers in Vermont are not in any ACO, although OneCare is aware of at least some independent primary care practices who are not.

Hospitals:	
Critical Access Hospitals	4
PPS Hospitals (including Tertiary)	6
Psychiatric Hospital	1
Primary Care:	
Private Practice	10
FQHC	1 (multi-site)
RHC	1
Specialty Care:	
Private Practice	25
Mental Health/Substance Abuse:	
Designated Agencies	9
Private Mental Health Provider	1
Skilled Nursing Facilities:	24
Home Health & Hospice:	10

II. *Relation to Blueprint for Health?*

OneCare Vermont (OCV) and Blueprint for Health (BP) have tightly aligned over the years to set strategic priorities, align supportive resources, develop and measure improvement and support learning health systems that improve quality and increase patient satisfaction. Specific examples include:

1. **Aligning Incentives and Strategic Priorities:** OneCare and Blueprint have aligned practice and Health Services Area population reports to center around ACO measures in order to provide meaningful and actionable data to providers as well as to meet the measurement needs of ACOs. Blueprint incentive payments are now aligned to several ACO measures. Support for meeting those measures is provided jointly by the Blueprint and ACOs.

2. **Aligning Resources:** Community Collaboratives, OCV Regional Clinical Performance Committees, BP Unified Community Collaboratives and Field Team support:

a) **RCPC/ UCC:** Each health service area has established a Regional Clinical Performance Committee (RCPC), or Unified Community Collaboratives (UCC) that meets regularly to work on one or more priority areas that reflect individual community needs and ACO priorities. Community needs assessments, data from OCV and data from the Vermont Blueprint for Health have helped to inform the regions as they prioritize their community's areas of focus. Participants also receive training from subject matter experts (see Symposia and Learning Collaboratives) on best practices guidelines for how to implement tests of change. Participants received additional resource support from ACO and BP practice facilitators on how to carry out quality improvement initiatives for their priority areas (see field Team Unification).

b) **Field Team Unification:** BP practice facilitators, project managers and community health team leaders have met on a monthly basis since the fall with field team staff from OneCare Vermont, Health First and CHAC to organize around priorities that will impact primary care practices. We have had the opportunity to have presentations from subject matter experts on addiction (Vermont Department of Health) , quality improvement (Jeffords Center for Quality), quality measures selected by payer (ACOs), planning for priorities in community and regional meetings, and learning shared from RCPC teams across the state. This cross organizational communication has been invaluable for collaboration on priority areas and to understand how to best organize work to have the least amount of disruption to the delivery of primary care.

3. Learning Collaboratives and Symposia:

a) **Learning Collaboratives:** OneCare has been involved with the Health Care Innovation Project's (i.e. State Innovation Model) Integrated Communities Care Management Learning Collaborative that was highlighted in the "Opportunities to Improve Models of Care for People with Complex Needs" which was published by the Center for Health Care Strategies, Inc. OneCare has been a leader in those efforts, partnering with other Vermont ACOs, Vermont Health Care Innovation Project (VHCIP) staff, VT Blueprint for Health, and our provider network. This collaborative has identified best practice interventions and tools aimed at building high-performing, multidisciplinary care coordination systems that are able to care for complex, high-risk, high-cost patients. The combined leadership of the ACOs, Blueprint and VHCIP has provided experience with training regional teams on specific tools and skills for offering patients more intensive, cross-organizational care coordination.

b) **Symposia:** In the spring, OCV hosted a conference on reducing readmission to the hospital and on reducing ED utilization by high utilizers. It was very well attended with over 150 participants. Eight of the fourteen regional teams ultimately selected project work that involves improved services for Vermonters at end-of-life. To help jumpstart the quality improvement activities, OneCare Vermont, in collaboration with the Blueprint, conducted a fall conference devoted to learning from three communities who have worked to impact their utilization of hospice services. Subject matter experts in the field presented, and there was also some skill based training on having hard conversations. Using Institutes Of Medicine team measurement techniques, the regional teams will collect data on their team functioning. We will follow up by measuring the impacts of the teams.

III. From patient perspective: What do I know? Is my provider(s) participating? Am I "in" an ACO? What are my rights?

First to note is that current ACO Programs do not change the benefits and rights of covered individuals with their health plan or program

Individuals retain all the consumer rights, protections and processes under their Medicare, Medicaid, or Commercial plans. An ACO cannot declare a service non-covered or not medically necessary, nor can it declare it covered upon patient appeal if the plan does not cover that service. However, ACO providers are expected to innovate and more often augment care in ways which might have been limited or not incented under fee-for-service rules.

Required Website and Telephone Number

OneCare is required under its ACO programs to maintain a pubic website which can be easily found via internet search, and also a telephone number which is answered during business hours. These allows us to answer any patient questions or address concerns which pertain specifically to us as an ACO who facilitates a network of providers who are participating in ACO programs.

Consumer Notification of ACO Participation/Attribution

For Medicare Shared Savings Program, participants are required to display the approved CMS poster along with the *Notice to Patients* letter within their ACO facility/practice. The poster includes information about the Shared Savings Program. Beneficiaries may choose to decline sharing their health care information or reverse their decision by calling 1-800-MEDICARE. The *Notice to Patients* letter informs beneficiaries about what an ACO is and the benefits it can provide through data sharing. Additionally beneficiaries can be notified about their option to decline sharing their health care information via Advanced Notice through the Medicare & You Handbook.

For the Vermont Medicaid Shared Savings Program, participants are not obligated to notify beneficiaries of their participation within an ACO during an office visit. OneCare manages the beneficiary mailing notification process on a quarterly basis, which allows for beneficiaries to opt out of data sharing at the time of the mailing or any time during their attribution to OneCare via an active participant. Through this beneficiary mailing notification process, attributed beneficiaries are provided an *Opt-Out Form* and *Notice to Patients* letter providing them with the option to decline sharing their health care information. This letter outlines that their physician has joined OneCare Vermont Accountable Care Organization and explains the benefits an ACO can provide through data sharing.

For the Commercial Shared Savings Program, if a beneficiary purchases a BCBSVT Exchange plan and their participating provider is in an ACO, they are automatically attributed. Unless the beneficiary specifically asks, there is no communication between the beneficiaries and OneCare Vermont.

Consumer Representation on the OneCare Board of Managers

We are obligated to have the following representatives from each of the payer programs on our Board of Managers: one Medicare Beneficiary Representative, one Vermont Medicaid Beneficiary Representative and one Commercial Beneficiary Representative.

OneCare's Consumer-Engagement Committee

The Consumer Advisory Group brings together consumers from the communities served by OneCare to engage in discussions about their health care in an effort to improve their experiences and discuss how ACO policy might be designed to improve those experiences. Through consumer engagement, OneCare works to understand the issues and concerns of our population and to promote improvement in access, quality of care and beneficiary satisfaction. The Consumer Advisory Group consists of between 10 and 15 Vermont patients, family members or caregivers of patients, and OneCare staff. Members of OneCare management and the Board of Managers regularly attend meetings of the Consumer Advisory Group and report back to the OneCare Board of Managers following each meeting.

IV. From testimony last week:

a. Coordination with mental health, VNA, Home care?

The inclusion of Mental Health and Home Health & Hospice service in delivering effective population health management is not optional; it is critical to the success of the health care reform that we are all working toward. Like in all areas of health care, yesterday's revenue has become today's cost and we must work as a unified system to redesign the way we deliver care for our consumers. The focus needs to be on how to integrate these services appropriately and timely with other parts of the health care continuum. We can no longer think of mental health, home health and hospice services as "separate or add-on services." They must be considered as part of the "foundational building blocks" in a successful care delivery system. In the OneCare VT network, mental health and home health & hospice providers have been part of our network as an integral part since year two of our existence. OneCare has always had the philosophy that these services are critical to the overall success of our ACO. As such, these providers have been eligible for shared savings in the Medicare SSP and part of the Incentive Program in the Medicaid and Commercial SSPs.

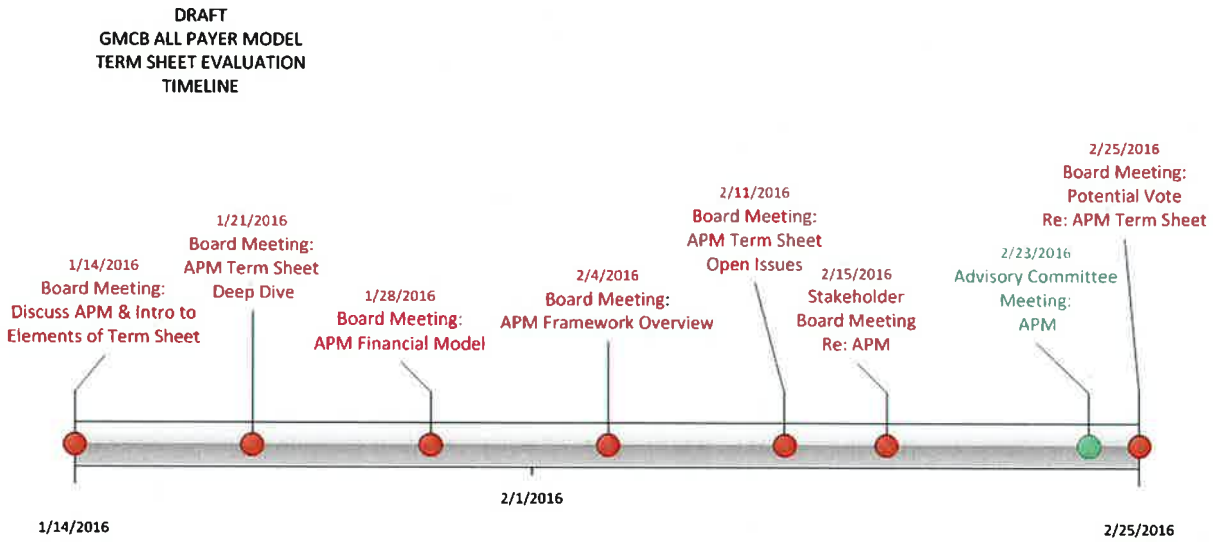
As we look at transforming the care that is delivered to VT consumers, we must address the three legs of this stool. These include transforming complex care needs by working with community based social services while paying close attention to the financial model. This collaboration is not only necessary, but critical if we are going to make any positive movement on improving the overall health of the population and improving the financial strain of the health care environment in VT. If we focus on any one of the three legs (clinical care, social services, financing) independently, the goal of providing the consumer with the most appropriate care in a cost effective manner is immediately compromised and at risk for failure. We cannot allow that to occur.

b. Too many performance measures? Conflicting sets of measures?

It is true that there are multiple competing measures that providers are responsible for reporting and acting upon. There was a lot of energy around aligning the Medicaid, Medicare, and Commercial measures, yet there is still opportunity to improve that measure set in order to more accurately measure outcomes and satisfaction and to narrow down the list in order for providers to put into place programs that move the needle on improvements. Another key intervention to cut down on provider burden is to move toward electronic monitoring of the ACO quality measures. Gap remediation is currently in progress and we hope to be able to realize the value of combining claims and clinical data within our data analytics infrastructure to perform ongoing reporting to participants.

V. What are timelines going forward?

From the GMCB's perspective, the timeline is below:



Attribution methodologies on ACOs?

Q: How are beneficiaries assigned to an ACO?

A: Medicare beneficiaries will be assigned to an ACO, in a two-step process after meeting the following criteria:

- Beneficiary must have at least one (1) month of Part A and Part B enrollment and cannot have any months of Part A only or Part B only enrollment.
- Beneficiary cannot have any months of Medicare Group (private) health plan enrollment.
- Beneficiaries will be assigned to only one Medicare Shared Savings initiative.
- Beneficiaries must live in the Unites States or its Territories and possessions.
- Beneficiary must have a primary care service with a physician at the ACO.
- Beneficiaries must have gotten the largest share of their primary care services from the participating ACO.

Two Step Process:

1) The first step assigns a beneficiary to an ACO if the beneficiary receives the plurality* of his or her primary care services from primary care physicians within the ACO. Primary care physicians are defined as those with one of four specialty designations: internal medicine, general practice, family practice, and geriatric medicine or for services furnished in a federally qualified health center (FQHC) or rural health clinic (RHC), a physician included in the attestation provided by the ACO as part of its application.

2) The second step only considers beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO. Under this second step, a beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO.

*A plurality means the ACO participants provided a greater proportion of primary care services, measured in terms of allowed charges, than the ACO participants in any other ACO or Medicare-enrolled provider TIN, but can be less than a majority of services.

The Next Generation ACO Model seeks to mitigate fluctuations in the aligned beneficiary population and to respect beneficiary preferences by supplementing claims-based alignment with voluntary alignment. Under voluntary alignment, Next Generation ACOs may offer beneficiaries the option to confirm or deny their care relationships with specific Next Generation Providers/Suppliers. This beneficiary input will be reflected in alignment for the subsequent year (e.g., during Performance Year 1, beneficiaries can confirm relationships that affect alignment for Performance Year 2, provided such beneficiaries meet other eligibility criteria). Confirmations of care relationships through voluntary alignment supersede claims-based attributions. For example, a beneficiary who indicates that a Next Generation Provider/Supplier is their main source of care may be aligned with the ACO, even if claims-based alignment would not result in alignment. This enables more alignment continuity across performance years. In addition, beneficiaries that seek care through their aligned ACO at a high rate could receive a coordinated care reward from CMS, providing an incentive to maintain their care relationship over the long term.

A: Medicaid Beneficiaries will be assigned to an ACO as follows:

Beneficiaries must fall within one of the following eligible populations for at least 10 months within the performance year.

- ABD Adult
- General Adult
- General Child

Beneficiaries are excluded from attribution if any of the following apply:

- Dually eligible
- Third Party Liability Coverage
- Eligible for VT Medicaid but have obtained coverage through Commercial insurers
- Those enrolled in VT Medicaid but receive a limited benefit package

Two Step Process:

1. The first step assigns the beneficiary to an ACO based on qualifying primary care services provided by attributing providers with one of the following specialty designations: Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, Pediatrics, or Naturopathic Medicine. In addition to physicians, the primary care provider may be a Nurse Practitioner, Physician Assistant, or a provider in a FQHC or RHC.
2. For eligible beneficiaries, not attributed in Step 1, beneficiaries are assigned to the Primary Care Provider that s/he selected or was auto assigned to in the performance year.

A: Commercial Beneficiaries will be assigned to an ACO as follows:

Beneficiaries must meet the following criteria:

- Employer must be situated in VT or the beneficiary must reside in VT. The Commercial Payer can select with of the above criteria they wish to apply.

- The insurer is the primary payer.

Two Step Process:

1. If the product requires the beneficiary to select a Primary Care Provider, the beneficiary is attributed to that Primary Care Provider.
2. The second step assigns the beneficiary to an ACO based on qualifying primary care services over the past 24 months which were provided by attributing provider with one of the following specialty designations: Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, Pediatrics, or Naturopathic Medicine. In addition to physicians, the primary care provider may be a Nurse Practitioner, Physician Assistant, or a provider in a FQHC or RHC.

VI. Unintentional disincentives?

The question as to whether or not the methodologies of MSSP and Next Generation (NG) could incent provider participants to somehow 'game' the system in order to improve their numbers comes up often. There are three primary scenarios. First, do the methodologies of MSSP or NG incent abuses of attribution? In this scenario, a provider would cull from their roster patients who are ill. This is highly unlikely for a couple of reasons: (1) in both MSSP and NG, patients choose their provider. Providers do not choose their patients; and (2) there is actually a positive aspect to having patients who are ill. CMS allows providers to offset a patient's degree of illness by way of the Hierarchical Condition Category (HCC), which adds to the baseline cost of care, against which savings are measured. As such, the adjustment that is made through the HCC to a provider's bottom line actually improves the provider's odds of hitting their numbers.

Second, do the methodologies of MSSP or NG incent providers to cut off patients whose illnesses are costly to treat? Again, the patient chooses the provider, not the other way around. Furthermore, shared savings are shared based on both cost measures and quality measures. Quality measures include the patients' view of how they are being treated by the provider. A provider that cuts off patients is not likely to get positive outcomes on their patient satisfaction measures. Furthermore, if the provider simply quit answering the phone, it could well trigger an investigation through professional regulation.

Third, do the methodologies of MSSP or NG incent providers to withhold expensive care? This would likely be a very short term practice, if it were to occur at all, because inexpensive care prevents expensive care, which in turn prevents more expensive care. Even in the current world of high deductibles, there are times when it is the patients who push back at the provider because they can't afford the deductible for a particular test or procedure. In that circumstance, if the care is necessary for the patient's clinical well-being, it is the provider who pushes back because it is in the patient's best interest.

In the end, success in this program is most likely when providers deliver high quality care efficiently (the right care at the right time). Better care is less expensive care. The goal is to keep the well, well and the sick from getting sicker.

The mechanics of incentives in MSSP involve saving enough money in the total cost of care (exceeding the minimum savings rate) to receive a check for half of those total savings after reconciliation against the quality measure results for the performance year that might diminish that shared savings amount.

There are really no disincentives in MSSP as patients retain total choice in where they decide to receive services, their deductibles and copayment out of pocket expenses are identical to regular Medicare, and providers of care are paid fee for service Medicare allowed amounts.

In Next Generation the provider incentives and disincentives (upside and downside risks) are spelled out in the model; if the total cost of care is less than the trended target amount the ACO is paid either 100% of that difference (after Medicare retains their discounted savings amount) or 80% of that amount depending on which risk model the ACO elected. There are really no unintentional disincentives.

VII. Need to hear from Agency of Admin. re GMCB/AoA developing proposal for parameters of a potential agreement.

The GMCB and the Administration announced the term sheet on Monday, January 25. The term sheet is available on the GMCB web site: http://gmcboard.vermont.gov/

VIII. What is the next generation model and how does it relate to All-Payer

The description below is from the CMMI web site:

The Next Generation Accountable Care Organization (NGACO) Model's Core Principles

- Protect Original Medicare beneficiaries' freedom to seek the services and providers of their choice;
- Engage beneficiaries in their care through benefit enhancements designed to improve the patient experience and reward seeking care from ACOs;
- Create a financial model with long-term sustainability;
- Utilize a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement and attainment of efficiency; and (3) ultimately transitions away from an ACO's recent expenditures when setting and updating the benchmark;
- Mitigate fluctuations in aligned beneficiary populations and respect beneficiary preferences by supplementing a prospective claims-based alignment process with a voluntary process; and
- Smooth ACO cash flow and support investment in care improvement capabilities through alternative payment mechanisms.

Medicare ACOs are comprised of groups of doctors, hospitals, and other health care providers and suppliers who come together voluntarily to provide coordinated, high-quality care at lower costs to their original Medicare patients. ACOs are patient-centered organizations where the patient and providers are true partners in care decisions. Participating patients will see no change in their original Medicare benefits and will keep their freedom to see any Medicare provider. Provider participation in ACOs is also voluntary. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

The goal of care coordination is to ensure that patients, especially those with chronic conditions, get the right care at the right time while avoiding medical errors and unnecessary duplication of services. Any patient who has multiple doctors has experienced the frustration of fragmented and disconnected care: lost or unavailable medical charts; duplicated medical procedures and tests; difficulty scheduling appointments; or having to share the same information repeatedly with different doctors. ACOs are designed to lift this burden from patients, while improving the partnership between patients and doctors in making health care decisions. Medicare beneficiaries will have better control over their health care, and providers will have better information about their patients' medical history and better

relationships with their patients' other providers. For providers, ACOs hold the promise of realigning the practice of medicine with the ideals of the profession—keeping the focus on patient health and the most appropriate care.

Medicare beneficiaries whose doctors participate in an ACO will still have freedom of choice among providers and can still choose to see providers outside of the ACO. Patients choosing to receive care from providers participating in ACOs will also have access to information about how well their doctors, hospitals, or other caregivers are meeting quality standards.

IX. What is the evidence that ACOs work?

The most agreed upon measure of success for the ACO programs is consistent improvement in quality scores year to year. In the third performance year, Pioneer ACOs showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures. OneCare has experienced a year over year 6% increase in all quality measures for Medicare. Shared Savings Program ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures.

While the actuary has not opined officially on cost savings in the Medicare Shared Savings Program, the program's financial results are in line with those that we expected. And early results show that ACOs with more experience in the program tend to perform better over time. Among ACOs that entered the Shared Savings Program in 2012, 37% generated shared savings, compared to 27% of those that entered in 2013, and 19% of those that entered in 2014. In addition, an independent evaluation report for CMS found that the Pioneer Model generated more than $384 million in savings over its first two years, while the CMS Office of the Actuary has certified that an expansion of the Pioneer Model would be expected to save the trust funds additional funds.

Counterbalancing these statements is the fact that the investments that the provider community has made in the infrastructure to participate effectively in ACO programs are not taken into account in calculating "savings." However, most provider groups would probably say that these investments in data analytic systems, care coordination, and effective communication channels among participant providers are critical for their future success in value based reimbursement models.

X. How does public health fit into this model?

Like our founders, we are collectively committed to moving from a "Sick Care" to a "Health Care" system by investing in solutions and partnerships that will promote health and well-being and make care more affordable for Vermonters. Collaborating with the Department of Health on clinical priorities, data sharing, promoting prevention activities, developing best practice tools and monitoring progress towards goals are all ways that we have worked to strengthen our public-private partnerships. Working to scale up activities that will address health inequalities, and moving away from fee-for-service payments are among the major strategies we will employ to deliver on our commitments. Specific activities have included:

1. Selected SBIRT as a clinical priority based on discussion with the Department of Health and our clinical champions. As a first step, in collaboration with the Department of Health, we are hosting a learning symposium on SBIRT which will support universal screening and prevention, behavioral health integration, and training on key interventions such as motivational interviews.
2. Develop best practice change kits on adolescent well care visit and developmental screening.

3. Aligned ACO immunization measure to match the measures supported by the Department of Health and secured necessary statutory and legal requirements to share data on immunization so to cut down on manual data abstraction.

4. Our largest providers have actively partnered with the Department of Health to work on the opiate crisis by opening up access to providers (UVMMC Day One Program) and by participating in behavioral health integration pilots.

XI. MACRA—more information, please.

On April 14, 2015, in a remarkably bipartisan vote (92-8), the Senate passed the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA does away with what many consider the failed Medicare Sustainable Growth Rate (SGR) and includes entitlement reforms, including higher Medicare Part B and D premiums for wealthier beneficiaries, and a $250 Medigap deductible (that liberals and AARP didn't like very much). Bob Doherty, Senior Vice President of the Division of Governmental Affairs and Public Policy of the American College of Physicians (ACP) wrote in the May 12 online edition of the *Annals of Internal Medicine*:

> "The MACRA," Doherty said, "is about more than SGR repeal: It's also about accelerating changes in Medicare payment policies to recognize value rather than volume. It offers physicians more stability and potentially more control over reimbursement in the following ways:
>
> - Payments are stabilized. The MACRA provides physicians with baseline annual Medicare payment updates of 0.5% from July 1 this year through December 31, 2018, allowing time for transition to 'value-based' payments.
> - Physicians have more choice and control over how they are paid. Beginning in 2019, annual updates on physician payments will be based on a physician's successful participation in a new quality reporting program called the Merit-Based Incentive Payment System (MIPS) or in an alternative payment model (APM). Physicians, or their practices, will decide annually in which they wish to participate."

From CMS.gov:

The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs): Delivery System Reform, Medicare Payment Reform, & the MACRA

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes include:

a. Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services.
b. Making a new framework for rewarding health care providers for giving better care not more just more care.
c. Combining our existing quality reporting programs into one new system.

How do the MACRA payment reforms work?

The MACRA will help us to move more quickly toward our goal of paying for value and better care. It also makes it easier for more health care providers to successfully take part in our quality programs in one of two streamlined ways:

a. Merit-Based Incentive Payment System (MIPS)
b. Alternative Payment Models (APMs)

MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.

What's the Merit-Based Incentive Payment System (MIPS)?

The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program based on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

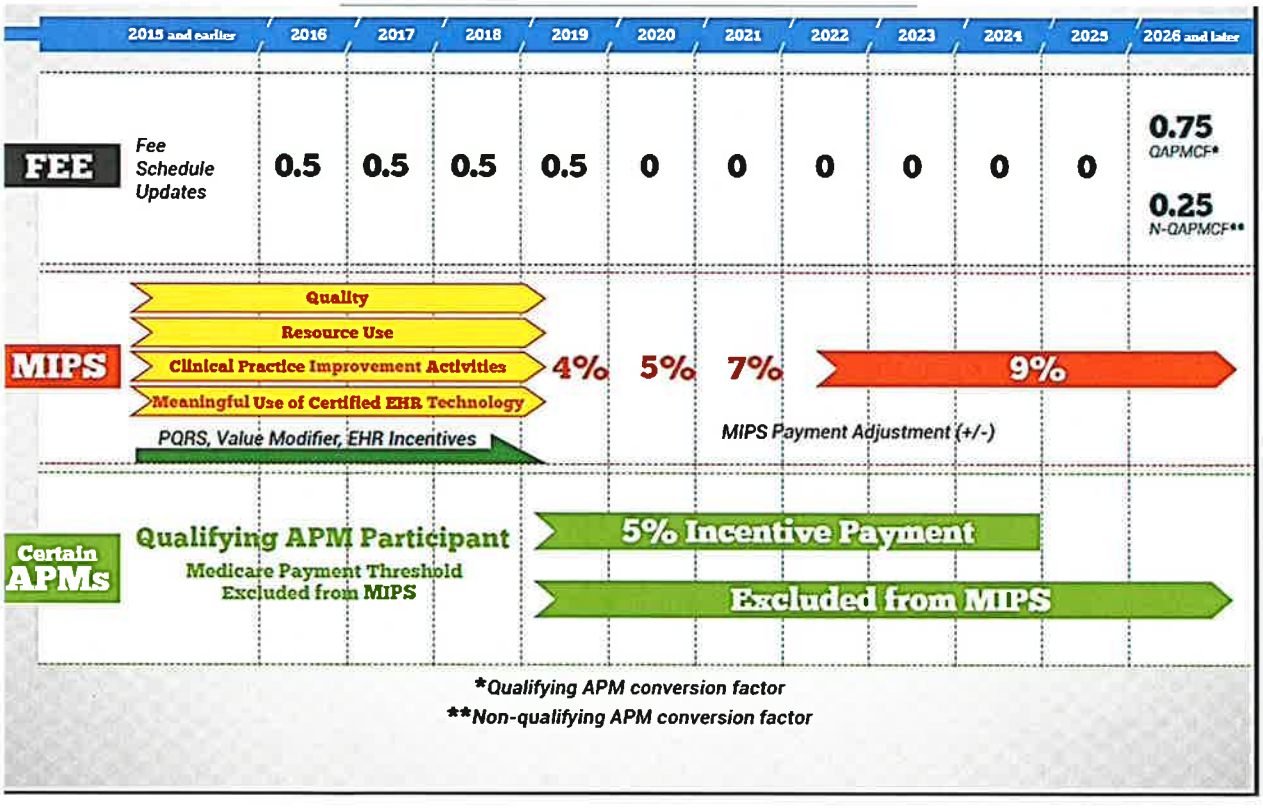
What are Alternative Payment Models (APMs)?

APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. For example:

- From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
- Increased transparency of physician-focused payment models.
- Starting in 2026, offers some participating health care providers higher annual payments.

Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and Bundled Payment Models are some examples of APMs.

Below, see table outlining CMS Timeline for the above payment structures:



Document #2 (a)

HHS.gov U.S. Department of Health & Human Services

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

"Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely," Secretary Burwell said. "We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement."

"We're all partners in this effort focused on a shared goal. Ultimately, this is about improving the health of each person by making the best use of our resources for patient good. We're on board, and we're committed to changing how we pay for and deliver care to achieve better health," Douglas E. Henley, M.D., executive vice president and chief executive officer of the American Academy of Family Physicians said.

"Advancing a patient-centered health system requires a fundamental transformation in how we pay for and deliver care. Today's announcement by Secretary Burwell is a major step forward in achieving that goal," AHIP President and CEO Karen Ignagni said. "Health plans have been on the forefront of implementing payment reforms in Medicare Advantage, Medicaid Managed Care, and in the commercial marketplace. We are excited to bring these experiences and innovations to this new collaboration."

"Employers are increasingly taking steps to support the transition from payment based on volume to models of delivery and payment that promote value," said Janet Marchibroda, Health Innovation Director and Executive Director of the CEO Council on Health and Innovation at the Bipartisan Policy Center. "There is considerable bipartisan support for moving away from fee for service toward alternative payment models that reward value, improve outcomes, and reduce costs. This transition requires action not only by the private sector, but also the public sector, which is why today's announcement is significant."

"Today's announcement will be remembered as a pivotal and transformative moment in making our health care system more patient- and family-centered," said Debra L. Ness, president of the National Partnership for Women & Families. "This kind of payment reform will drive fundamental changes in how care is delivered, making the health care system more responsive to those it serves and improving care coordination and communication among patients, families and providers. It will give patients and families the information, tools and supports they need to make better decisions, use their health care dollars wisely, and improve health outcomes."

The Affordable Care Act created a number of new payment models that move the needle even further toward rewarding quality. These models include ACOs, primary care medical homes, and new models of bundling payments for episodes of care. In these alternative payment models, health care providers are accountable for the quality and cost of the care they deliver to patients. Providers have a financial incentive to coordinate care for their patients – who are therefore less likely to have duplicative or unnecessary x-rays, screenings and tests. An ACO, for example, is a group of doctors, hospitals and health care providers that work together to provide higher-quality coordinated care to their patients, while helping to slow health care cost growth. In addition, through the widespread use of health information technology, the health care data needed to track these efforts is now available.

Many health care providers today receive a payment for each individual service, such as a physician visit, surgery, or blood test, and it does not matter whether these services help – or harm – the patient. In other words, providers are paid based on the volume of care, rather than the value of care provided to patients.

Today's announcement would continue the shift toward paying providers for what works – whether it is something as complex as preventing or treating disease, or something as straightforward as making sure a patient has time to ask questions.

In 2011, Medicare made almost no payments to providers through alternative payment models, but today such payments represent approximately 20 percent of Medicare payments. The goals announced today represent a 50 percent increase by 2016. To put this in perspective, in 2014, Medicare fee-for-service payments were $362 billion.

HHS has already seen promising results on cost savings with alternative payment models, with combined total program savings of $417 million to Medicare due to existing ACO programs – HHS expects these models to continue the unprecedented slowdown in health care spending. Moreover, initiatives like the Partnership for Patients, ACOs, Quality Improvement Organizations, and others have helped reduce hospital readmissions in Medicare by nearly eight percent– translating into 150,000 fewer readmissions between January 2012 and December 2013 – and quality improvements have resulted in saving 50,000 lives and $12 billion in health spending from 2010 to 2013, according to preliminary estimates.

To read a new Perspectives piece in the New England Journal of Medicine from Secretary Burwell: http://www.nejm.org/doi/full/10.1056/NEJMp1500445

To read more about why this matters: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-2.html

To read a fact sheet about the goals and Learning and Action Network: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

To learn more about Better Care, Smarter Spending, and Healthier People: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html

Participants in today's meeting include:

- Kevin Cammarata, Executive Director, Benefits, Verizon
- Christine Cassel, President and Chief Executive Officer, National Quality Forum
- Tony Clapsis, Vice President, Caesars Entertainment Corporation
- Jack Cochran, Executive Director, The Permanente Federation
- Justine Handelman, Vice President Legislative and Regulatory Policy, Blue Cross Blue Shield Association
- Pamela French, Vice President, Compensation and Benefits, The Boeing Company

- Richard J. Gilfillan, President and CEO, Trinity Health
- Douglas E. Henley, Executive Vice President and Chief Executive Officer, American Academy of Family Physicians
- Karen Ignagni, President and Chief Executive Officer, America's Health Insurance Plans
- Jo Ann Jenkins, Chief Executive Officer, AARP
- Mary Langowski, Executive Vice President for Strategy, Policy, & Market Development, CVS Health
- Stephen J. LeBlanc, Executive Vice President, Strategy and Network Relations, Dartmouth-Hitchcock
- Janet M. Marchibroda, Executive Director, CEO Council on Health and Innovation, Bipartisan Policy Center
- Patricia A. Maryland, President, Healthcare Operations and Chief Operating Officer, Ascension Health
- Richard Migliori, Executive Vice President, Medical Affairs and Chief Medical Officer, UnitedHealth Group
- Elizabeth Mitchell, President and Chief Executive Officer, Network for Regional Healthcare Improvement
- Debra L. Ness, President, National Partnership for Women & Families
- Samuel R. Nussbaum, Executive Vice President, Clinical Health Policy and Chief Medical Officer, Anthem, Inc.
- Stephen Ondra, Senior Vice President and Chief Medical Officer, Health Care Service Corporation
- Andrew D. Racine, Senior Vice President and Chief Medical Officer, Montefiore Medical Center
- Jaewon Ryu, Segment Vice President and President of Integrated Care Delivery, Humana Inc.
- Fran S. Soistman, Executive Vice President, Government Services, Aetna Inc.
- Maureen Swick, Representative, American Hospital Association
- Robert M. Wah, President, American Medical Association

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Note: All HHS press releases, fact sheets and other news materials are available at http://www.hhs.gov/news.

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Last revised: January 26, 2015

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Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume

Date: 2015-01-26
Title: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume
Contact: press@cms.hhs.gov

Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume

Rewarding Volume: Where We Are Now

Improving the quality and affordability of care for all Americans has always been a pillar of the Affordable Care Act, alongside expanding access to such care. The law gives us the opportunity to shape the way health care is delivered to patients and to improve the quality of care system-wide while helping to reduce the growth of health care costs.

When it comes to improving the way providers are paid, we want to reward value and care coordination – rather than volume and care duplication. In partnership with the private sector, the Department of Health and Human Services (HHS) is testing and expanding new health care payment models that can improve health care quality and reduce its cost.

HHS has adopted a framework that categorizes health care payment according to how providers receive payment to provide care.[1]

- category 1—fee-for-service with no link of payment to quality
- category 2—fee-for-service with a link of payment to quality
- category 3—alternative payment models built on fee-for-service architecture
- category 4—population-based payment

*for more detail and examples, see "Payment Taxonomy Framework"

Value-based purchasing includes payments made in categories 2 through 4. Moving from category 1 to category 4 involves two shifts: (1) increasing accountability for both quality and total cost of care and (2) a greater focus on population health management as opposed to payment for specific services.

Prior to 2011, many Medicare payments to providers were tied only to volume, rewarding providers based on how many tests they ran, how many patients they saw, or how many procedures they did, for example, regardless of whether these services helped (or harmed) the patient. But thanks to reforms under the Affordable Care Act and other changes, by 2014, an estimated 20 percent of Medicare reimbursements had shifted to categories 3 and 4, directly linking provider reimbursement to the health and well-being of their patients.

Rewarding Value: Where We Are Going

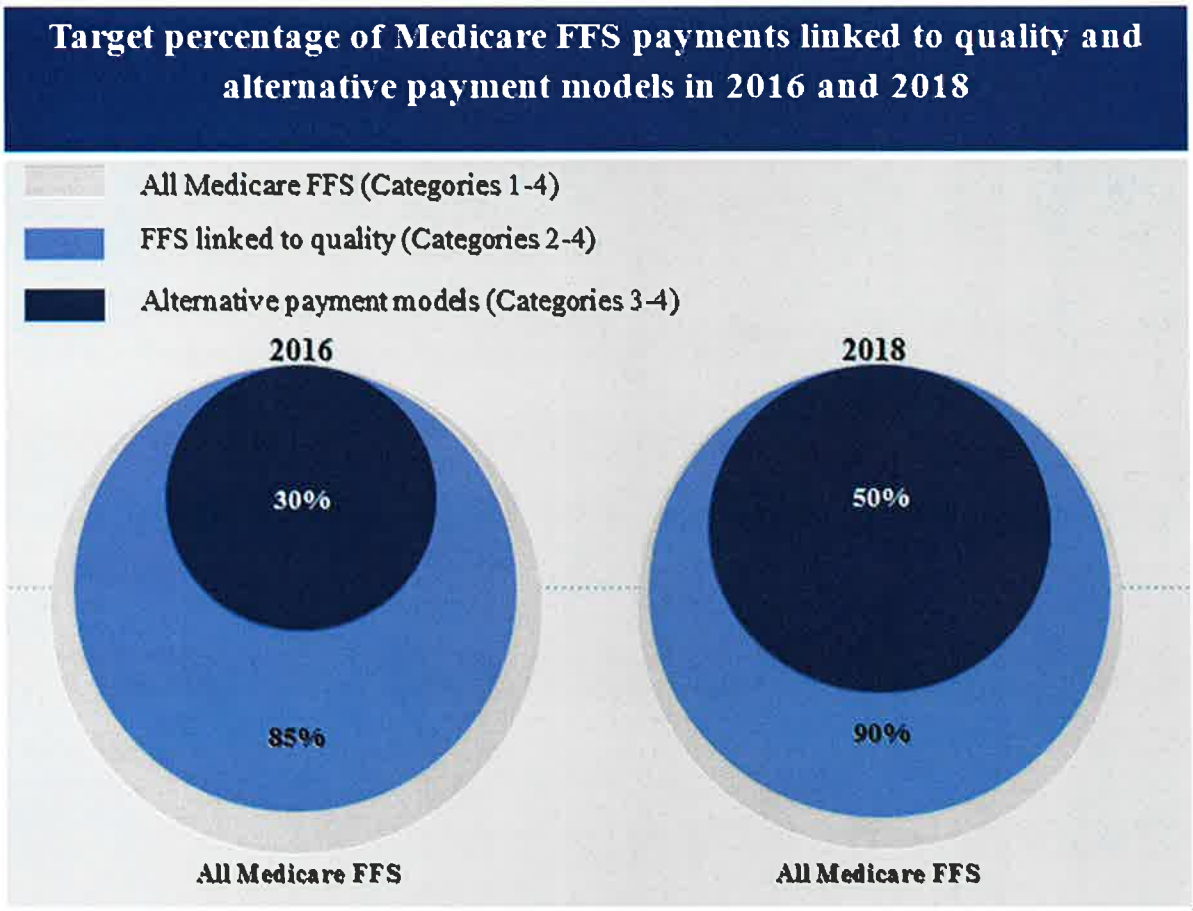
To help drive the health care system towards greater value-based purchasing – rather than continuing to reward volume regardless of quality of care delivered – HHS has set a goal to have 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016 and 50 percent in categories 3 and 4 by the end of 2018. This will be achieved through investment in alternative payment models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees. Overall, HHS seeks to have 85 percent of

Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018.

Three years ago, Medicare had limited payments in alternative payment models, but at the end of 2014 these value-based payments represented approximately 20 percent of Medicare fee-for-service payments to providers. This increase was driven by the Medicare Shared Savings Program (MSSP) and Pioneer ACOs, the Bundled Payment for Care Improvement Initiative, and the Comprehensive Primary Care Initiative, among other programs. HHS is working with private payers, including health plans in the Health Insurance Marketplace and Medicare Advantage plans, as well as state Medicaid programs to move in the same direction toward alternative payment models and value-based payment to providers and to meet or exceed the goals outlined above wherever possible.

Payment Taxonomy Framework

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



How We Get There: Health Care Payment Learning and Action Network

At HHS, we have a responsibility to help align the way providers are paid as a key step toward better care, smarter spending, and healthier people. We also know that we cannot do it alone. Working in concert with our partners in the private, public and non-profit sectors, we are announcing the establishment of the Health Care Payment Learning and Action Network to help align the important work being done across sectors.

All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success: providers must make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care. Making operational changes will be attractive only if the new alternative payment models and payment reforms are broadly adopted by a critical mass of payers. When providers encounter new payment strategies for one payer, but not others, the incentives to fundamentally change are weak. In fact, a provider that alters its system to prevent admissions and succeed in an alternative payment environment may lose revenue from payers that continue fee-for-service payments.

The Learning and Action Network will accelerate the transition to more advanced payment models by fostering collaboration between HHS, private payers, large employers, providers, consumers, and state and federal partners. Working together, Learning and Action Network partners will:

- Serve as a convening body to facilitate joint implementation and expansion of new models of payment and care delivery
- Identify areas of agreement around movement toward alternative payment models and define how best to report on these new payment models
- Collaborate to generate evidence, share approaches, and remove barriers
- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, and risk adjustment
- Create implementation guides for payers and purchasers

Alignment between HHS, private sector payers, employers, providers, and consumers will help health care payments transition more quickly from pure fee-for-service to alternative payment models – a critical step toward better care, smarter spending, and healthier people.

[1]Rajkumar R, Conway PH, Tavenner M. CMS--engaging multiple payers in payment reform. JAMA. 2014 May 21;311(19):1967-8.

Document #2 (b)

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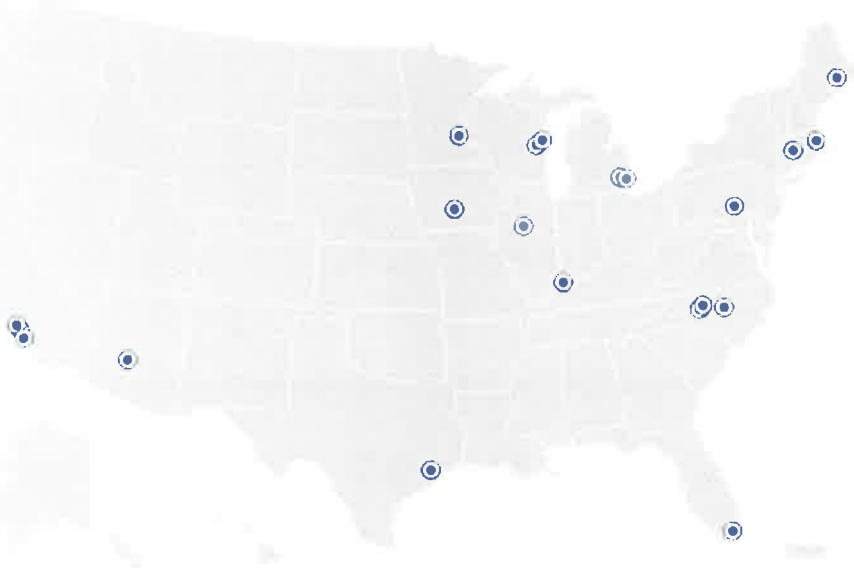
Next Generation ACO Model

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program (Shared Savings Program), the Next Generation ACO Model offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.

Select anywhere on the map below to view the interactive version



Source: Centers for Medicare & Medicaid Services

There are 21 ACOs participating in the Next Generation ACO Model. (List)

To view an interactive map of this Model, visit the Where Innovation is Happening page. *expand Right Caret* Read more about

Background

Medicare ACOs are comprised of groups of doctors, hospitals, and other health care providers and suppliers who come together voluntarily to provide coordinated, high-quality care at lower costs to their Original Medicare patients. ACOs are patient-centered organizations where the patient and providers are true partners in care decisions. Medicare beneficiaries will have better control over their health care, and providers will have better information about their patients' medical history and better relationships with patients' other providers. Provider participation in ACOs is purely voluntary, and participating patients will see no change in their Original Medicare benefits and will keep their freedom to see any Medicare provider. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Initiative Details

The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program (MSSP). The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.

Included in the Next Generation ACO Model are strong patient protections to ensure that patients have access to and receive high-quality care. Like other Medicare ACO initiatives, this Model will be evaluated on its ability to deliver better care for individuals, better health for populations, and lower growth in expenditures. This is in accordance with the Department of Health and Human Services' "Better, Smarter, Healthier" approach to improving our nation's health care and setting clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality rather than the quantity of care they provide to patients. In addition, CMS will publicly report the performance of the Next Generation Pioneer ACOs on quality metrics, including patient experience ratings, on its website.

The Model will consist of three initial performance years and two optional one-year extensions. Specific eligibility criteria are outlined in the Request for Applications (PDF).

How To Apply

Letters of Intent (LOI) and applications will be made available in spring 2016 to ACOs interested in participating in the Next Generation ACO Model in 2017.

Questions regarding the Next Generation ACO Model can be directed to NextGenerationACOModel@cms.hhs.gov.

I'm a Medicare Beneficiary, so what does this mean for me?

- I received a Voluntary Alignment form. What is this? (PDF)
- What is the 3-day Skilled Nursing Facility Rule Waiver? (PDF)
- What is the Telehealth Waiver (PDF)? (PDF)
- What is the Post-Discharge Home Visit Waiver? (PDF)

Additional Information

- Fact Sheet
- Press Release
- Voluntary Alignment Frequently Asked Questions (PDF)
- Frequently Asked Questions (PDF)
- Financial & Alignment Frequently Asked Questions
- Next Generation ACO & Pioneer ACO Comparison Table (PDF)
- Request for Applications (PDF)

Benefit Enhancements

Benefit enhancements are waivers of certain Medicare service rules (i.e., telehealth, post-discharge home visits, and the three-day skilled nursing facility rule), and initiatives intended to assist Next Generation Accountable Care Organizations in improving care for and engagement of their beneficiaries.

- Telehealth Expansion Waiver (PDF)
- Post-Discharge Home Visit Waiver (PDF)
- Three-Day Skilled Nursing Facility Waiver (PDF)

Open Door Forums

- First Open Door Forum | Slides (PDF) | Audio (ZIP - 106MB)
- Second Open Door Forum | Slides (PDF) | Audio (WMV - 113MB)
- Third Open Door Forum | Slides (PDF) | Audio (WMV - 74.8MB)
- Fourth Open Door Forum | Slides (PDF) | Audio (WMV - 104MB)
- Fifth Open Door Forum | Slides (PDF) | Audio (WMV - 121MB)

Model Summary

Stage: *Announced*
Number of Participants: *21*
Category: *Accountable Care*
Authority: *Section 3021 of the Affordable Care Act*

Milestones & Updates

Jan 11, 2016
Announced: 21 ACO participants

Apr 30, 2015
Announced: Pioneer and Next Generation ACO comparison fact sheet posted

Apr 16, 2015
Updated: Fifth open door forum slides and audio posted

Apr 09, 2015
Updated: Fourth open door forum slides and audio posted

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7500 Security Boulevard, Baltimore, MD 21244

Medicare Next Genration ACO Program - CMMI Scoring Criteria

Selection Domain	Applicant Selection Criteria	Points
Organizational Structure		**10**
	Demonstrate a history of collaboration between Providers/Suppliers and/or a credible plan for how the Providers/Suppliers will work together in the model;	
	Have an organizational structure that promotes patient-centered care and the goals of the model. The applicant ACO is made up of a diverse set of Providers/Suppliers that demonstrates a clear commitment to providing high quality, coordinated care to beneficiaries.	
Leadership and Management		**10**
	Have a governance structure that is clearly defined and demonstrates commitment to providing high quality care to beneficiaries consistent with the three-part aim of better health, better care, and lower costs;	
	Have a multi-stakeholder board comprised of well-qualified individuals that adequately and collectively represent the interests of patients and providers;	
	Demonstrate an effective governance structure plan, including a governing body and/or organizational mechanisms to make decisions, distribute payments, and obtain resources necessary to achieve the three-part aim;	
	Have identified, or demonstrated plans to identify, executives and lead staff throughout the organization with responsibility for clinical, financial, management, HIT, and quality improvement functions;	
	If applicable, demonstrate good conduct in prior CMS programs and/or demonstrations.	
Financial Plan and Risk-Sharing Experience		**30**
	Demonstrate at least 3 years of experience with outcomes-based arrangements (that meet stated outcomes-based contracting definition);	
	If applicable, demonstrate good performance in past CMS programs, demonstrations, or both;	
	Demonstrate past experience with outcomes-based contracts for a minimum of 10,000 lives;	
	Document significant degrees of financial risk and revenue derived from outcomes-based contracts;	

	Document reductions in medical expenditures achieved through previous outcomes-based contracts;	
	Demonstrate a credible plan for converting the preponderance of revenue to outcomes-based contracts;	
	Have an ACO funding approach (including any savings/losses distribution, if applicable) that demonstrates: (1) a strong commitment to the three-part aim of better health, better care, and lower costs; and (2) a credible plan for ensuring repayment to Medicare of its share of losses relative to the benchmark.	
Patient Centeredness		**20**
	Demonstrate the ability to engage beneficiaries and their caregivers in shared decision making, taking into account patient preferences and choices;	
	Have a feasible plan to establish mechanisms to conduct patient outreach and education on the benefits of care coordination;	
	Demonstrate the ability to effectively involve beneficiaries in care transitions to improve the continuity and quality of care across settings;	
	Demonstrate the ability to engage and activate beneficiaries at home to improve self management	
	Have mechanisms to evaluate patient satisfaction with access and quality of care, including choice of providers and choice in care settings.	
Clinical Process Improvement, Care Coordination, and Data Capacity		**30**
	Clinical Process Improvement (10 points)	
	• Present a strong, credible, coordinated, and feasible plan to realize the three-part aims of better health, better care, and lower costs;	
	• Provide credible plan for incorporating medication management into the care coordination approach;	
	• Demonstrate past experience designing, implementing, and assessing the effectiveness of specific care improvement interventions.	
	Care Coordination (10 points)	
	• Demonstrate existing capacity or plans to expand capacity to coordinate care through an interdisciplinary team structure that includes practitioners with the necessary areas of expertise and appropriate staffing to meet the needs of complex patients;	

	• Demonstrate a history of collaboration among major stakeholders in the community being served, including incorporation of relevant social services in care plans and management;	
	• Demonstrate a compelling plan to succeed in the areas of quality improvement and care coordination.	
	Data Capacity (10 points)	
	• Provide a clear and detailed plan for a majority of eligible professionals in the organization to meet EHR meaningful use criteria and requirements;	
	• Have population health management tools and functions or concrete plans to develop and invest in such tools and functions;	
	• Have the ability, or credible plans to develop the ability, to electronically exchange patient records across Providers/Suppliers and other providers in the community to ensure continuity of care;	
	• Have the ability to, or credible plan to gain the ability to, share performance feedback on a timely basis with participating providers.	
Total Points		**100**

Document #2 (c)

Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014

Date: 2015-08-25

Title: Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014

Contact: go.cms.gov/media

The Centers for Medicare & Medicaid Services today issued 2014 quality and financial performance results showing that Medicare Accountable Care Organizations (ACOs) continue to improve the quality of care for Medicare beneficiaries, while generating financial savings. As the number of Medicare beneficiaries served by ACOs continues to grow, these results suggest that ACOs are delivering higher quality care to more and more Medicare beneficiaries each year.

According to the results, the 20 ACOs in the Pioneer ACO Model and 333 Medicare Shared Shavings Program ACOs generated more than $411 million in total savings in 2014, which includes all ACOs' savings and losses. At the same time, 97 ACOs qualified for shared savings payments of more than $422 million by meeting quality standards and their savings threshold. The results also show that ACOs with more experience in the program tend to perform better over time.

SUMMARY OF RESULTS:

Pioneer Performance Year 3 Results

Pioneer ACOs are early adopters of coordinated care and tend to be more experienced, have an established care coordination infrastructure, and assume greater performance-based financial risk. The 20 Pioneer ACOs participating in 2014 (Performance Year 3) were accountable for 622,265 beneficiaries, a 2% increase from 607,945 beneficiaries in 2013 (Performance Year 2). These ACOs showed continued strong performance and improvement across financial, quality of care, and patient experience measures.

Financial:

- During the third performance year, Pioneer ACOs generated total model savings of $120 million, an increase of 24% from Performance Year 2 ($96 million), which was itself an increase from Performance Year 1 ($88 million).
- Of 15 Pioneer ACOs who generated savings, 11 generated savings outside a minimum savings rate and earned shared savings. These 11 ACOs qualify for shared savings payments of $82 million. Of 5 Pioneer ACOs who generated losses, three generated losses outside a minimum loss rate and owed shared losses. These ACOs are paying CMS $9 million in shared losses.
- Total model savings per ACO increased from $2.7 million per ACO in Performance Year 1 to $4.2 million per ACO in Performance Year 2 to $6.0 million per ACO in Performance Year 3.

Quality of Care and Patient Experience:

- The mean quality score among Pioneer ACOs increased to 87.2 percent in Performance Year 3 from 85.2 percent in Performance Year 2, which was itself an improvement from 71.8 percent in Performance Year 1.
- The organizations showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6% across all quality measures compared to Performance Year 2. Particularly strong improvement was seen in medication reconciliation (70% to 84%), screening for clinical depression and follow-up plan (50% to 60%), and qualification for an electronic health record incentive payment (77% to 86%).
- Pioneer ACOs improved the average performance score for patient and caregiver experience in 5 out of 7 measures compared to Performance Year 2, suggesting that Medicare beneficiaries who obtain care from a provider participating in a Pioneer ACO continue to report a positive experience.

Medicare Shared Savings Program Performance Year 2014 Results

Ninety-two Shared Savings Program ACOs held spending $806 million below their targets and earned performance payments of more than $341 million as their share of program savings. No Track 2 ACOs owed CMS losses. Total net savings to the Medicare Trust Funds was $465 million. These numbers represent an increase from 2013, when 58 ACOs held spending $705 million below their targets and earned performance payments of more than $315 million. Total net savings to the Medicare Trust Funds was $383 million.

- An additional 89 ACOs reduced health care costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.

- ACOs with more experience in the program were more likely to generate shared savings. Among ACOs that entered the program in 2012, 37 percent generated shared savings, compared to 27 percent of those that entered in 2013, and 19 percent of those that entered in 2014.
- Shared Savings Program ACOs that reported in both 2013 and 2014 improved 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, screening for high blood pressure, and Electronic Health Record use.
- Shared Savings Program ACOs achieved higher average performance rates on 18 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare FFS providers reporting through this system.
- Eligible professionals participating in ACOs also qualify for their Physician Quality Reporting System (PQRS) incentive payments for reporting their quality of care through the ACO. These providers will also avoid the PQRS payment adjustment in 2016 because their ACO satisfactorily reported quality measures on their behalf for the 2014 reporting year.
- The Shared Savings Program continues to receive strong interest from both new applicants seeking to join the program as well as from existing ACOs seeking to continue in the program for a second agreement period starting in 2016. New and renewing ACOs will be announced around the end of 2015.

Document #2 (d)

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MACRA: MIPS & APMs

The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs):

Delivery System Reform, Medicare Payment Reform, & the MACRA

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes include:

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services.
- Making a new framework for rewarding health care providers for giving better care not more just more care.
- Combining our existing quality reporting programs into one new system.

How do the MACRA payment reforms work?

The MACRA will help us to move more quickly toward our goal of paying for value and better care. It also makes it easier for more health care providers to successfully take part in our quality programs in one of two streamlined ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.

What's the Merit-Based Incentive Payment System (MIPS)?

The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program based on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

What are Alternative Payment Models (APMs)?

APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. For example:

- From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
- Increased transparency of physician-focused payment models.
- Starting in 2026, offers some participating health care providers higher annual payments.

Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and bundled payment models are some examples of APMs.

Where can I find more information about the MACRA?

- Get more in-depth information on the MACRA.
- Read or find answers to many questions about the MACRA Request for Information (RFI).
- View the MLN Connects® National Provider Call presentation of the 2016 Medicare Physician Fee Schedule (PFS) Proposed Rule including an overview of MACRA.
- View the MACRA timeline.
- See more about the MACRA and our "Path to Value."
- See how we decide whether to test a model.
- Learn more about Physician Focused Payment Models (PFPMs) Technical Committee.

Other Important links:

- CMS Quality Initiatives – General Information
- CMS Quality Strategy

CMS' Value-Based Programs

Document #3

(Via Separate PowerPoint)