# CMS Priorities in 2016: The Million Hearts Initiative and Transformation to Value-based Payment

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*Centers for Medicare and Medicaid Services*

Presentation to the Medical Directors
Best Practices and GPRA Measures Continuing Medical Education Conference
May 9th, 2016

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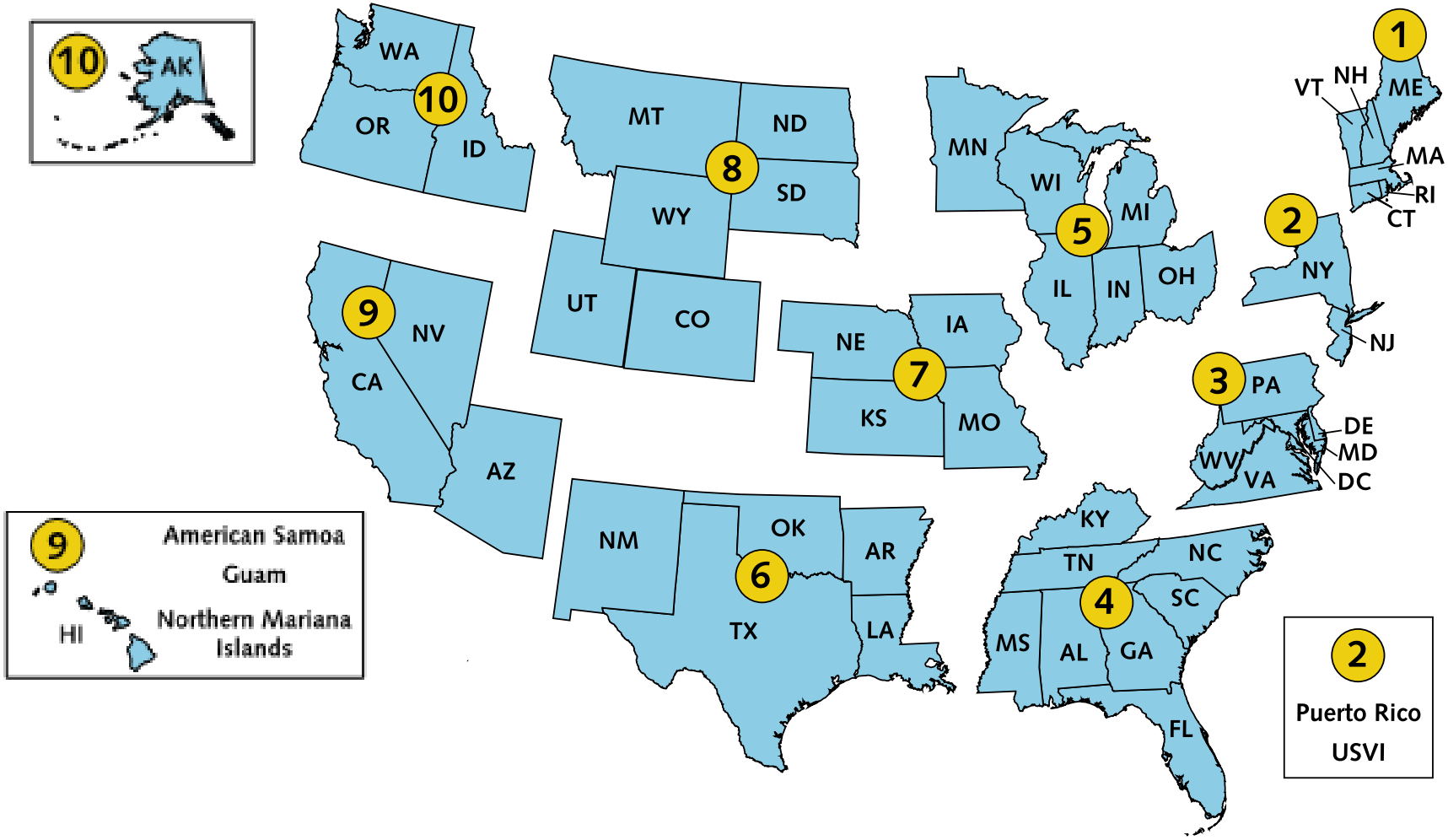
# Objectives

- Provide an overview of the Million Hearts Initiative
  - Goals of the Initiative
  - Current status
  - Review resources to achieve the goals of Million Hearts
  - Discuss measurement, and new models to incentivize population health management
- Next steps for Million Hearts Campaign
- A (brief) review of the Medicare Access and CHIP Reauthorization Act (MACRA)

# CMS OFFICES

## 10 Regions and 4 Territories



# Key CMS Priorities in health system transformation

3 goals for our health care system:

**BETTER care**
**SMARTER spending**
**HEALTHIER people**

Via a focus on 3 areas

**Incentives**

**Care Delivery**

**Information Sharing**

**Affordable Care Act** → **MACRA**

Historical state

Evolving future state

**Public and Private sectors**

## Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

## Systems and Policies

- Fee-For-Service Payment Systems

## Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

## Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

# How do we get there?

- Partnership for Patients
- New Models of Care & Payment to Support Medicare-Medicaid Enrollees
  - Accountable Care Organizations (ACOs)
  - Bundled Payments for Care Improvement
  - Comprehensive Primary Care Initiative & Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Health Care Innovation Challenge & Innovation Center Grants
- The Million Hearts Initiative
- Value Based Purchasing

# Million Hearts®

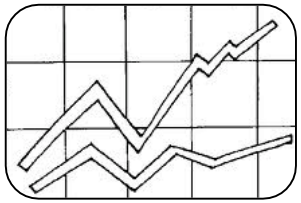
**Goal: Prevent 1 million heart attacks and strokes by 2017**

- National initiative co-led by CDC and CMS
- In partnership with federal, state, and private organizations innovating and implementing
- To address the causes of 1.5M events and 800K deaths a year, $312.6 B in annual health care costs and lost productivity and major disparities in outcomes

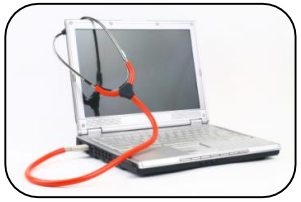
# Key Components of Million Hearts®

## Excelling in the ABCS
*Optimizing care*

Prioritizing the ABCS



Health tools and technology



Innovations in care delivery

## Keeping Us Healthy
*Changing the context*



Million Hearts®

Health Disparities

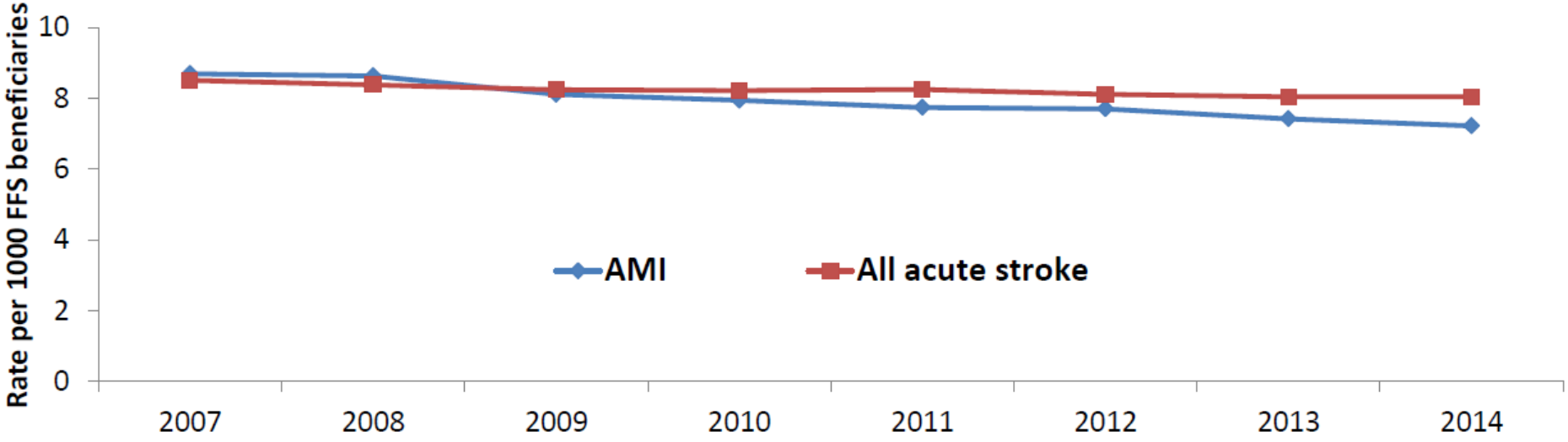
# First Quarter 2016 Highlights

## *Key Strategies with Major Milestones*

1. Recognize and Reward High Performers
2. Drive Use of Evidence-based Strategies
3. Reduce Disparities in CV Outcomes
4. Improve Collection, Reporting, Awareness of ABCS
5. Increase Adoption of Healthy Fed Food Guidelines
6. Encourage Food and Restaurant Industry to Reduce Sodium Content and Offer Consumers More Choices
7. Tell the Story of Impact

Million Hearts®

# Monitoring Progress: Long-term Outcomes




*Rates are among those beneficiaries aged ≥65 years with Medicare Part A and B coverage and were adjusted to appropriately represent the number of full-time equivalent beneficiaries enrolled during the period and the 2010 Medicare population age distribution

- CMS claims data are available quarterly and annually
- ABCS, sodium, trans-fat, smoking prevalence must improve to impact CV event rates

| Performance Indicators | Data Source | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| Medicare FFS acute MI & stroke hospitalization rates per 1000 beneficiaries* | CMS Dashboard | AMI: 7.74 **Stroke: 8.25** | AMI: 7.70 **Stroke: 8.11** | AMI: 7.42 **Stroke: 8.04** | AMI: 7.22 **Stroke: 8.04** |
| Overall Event Rate per 100,000 adults* | NIS, NEDS, NVSS | 1249.6 | 1201.0† | Winter 2015 | Winter 2016 |

*Standardized by age to the 2010 US Census population; †Amounts to 20,000 to 80,000 events prevented

# Million Hearts® Participation

**66,780**
likes on Facebook


**45,787**
subscribers to the Million Hearts® e-Update


**40M+**
reached with hypertension protocol tools

**96**
public- and private-sector partners

**1M+** visits to the Million Hearts® website


Million Hearts®

# Million Hearts® Accomplishments to Date*

## Changing the Environment

**Reduce Smoking**

Almost 4 million fewer cigarette smokers†

**Reduce Sodium Intake**

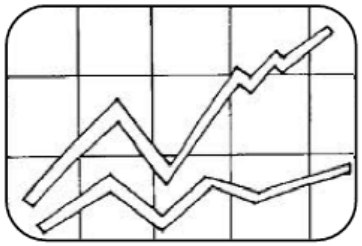

More than 2 billion meals/year will have reduced sodium‡

**Eliminate Trans Fat Intake**


**Accomplished:** FDA issued the final determination on artificial trans fat§

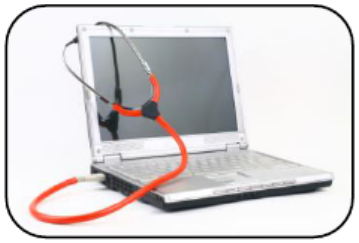
## Optimizing Care in the Clinical Setting

### Focus on the ABCS



Millions of Americans are covered by health care systems that are recognizing or rewarding performance in the ABCS**

### Health Tools and Technology



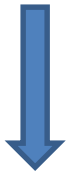
Over half a million patients have been identified as potentially having hypertension using health IT tools††

### Innovations in Care Delivery

Millions of dollars in public and private funds have been leveraged to focus on improving the ABCS‡‡

# What Will It Take to Prevent a Million?

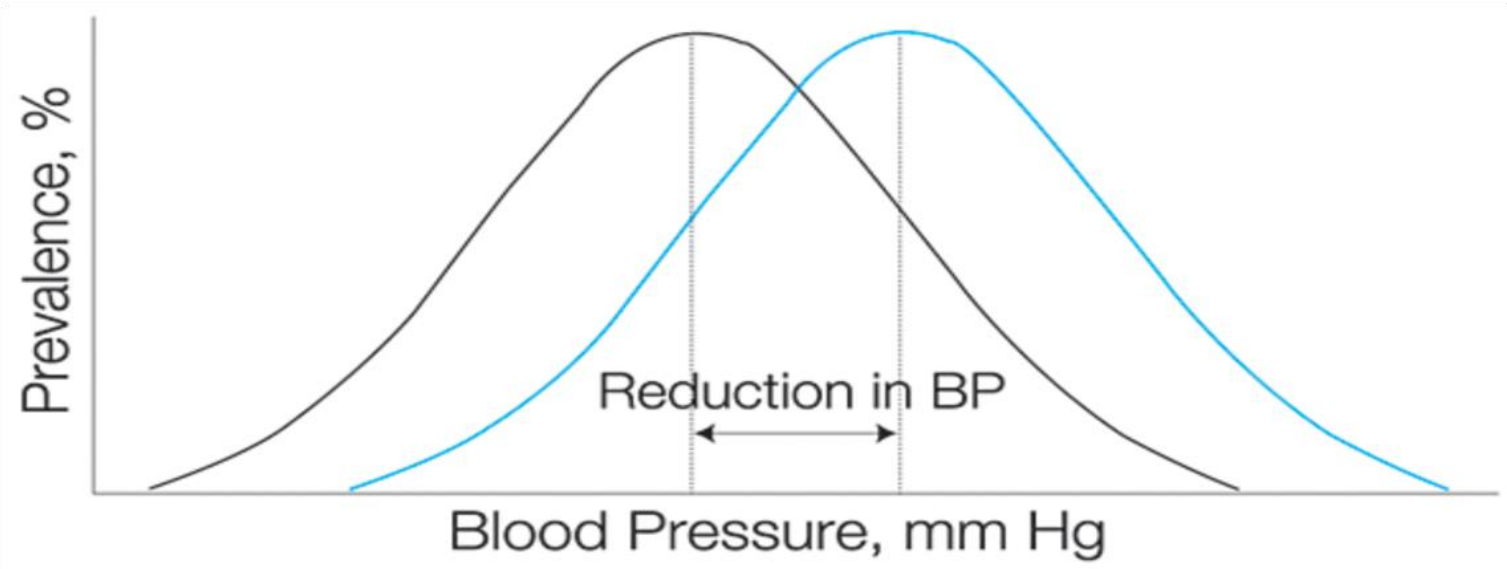
- 6.3 million smokers need to quit
- 10 million need to achieve consistent blood pressure control
- Reduce the intake of salt by 20% each day



- Knowledge Translation and Diffusion
- Create Incentives and  Alignment
- Stakeholders in Action
- Measuring and Reporting Systematically
- Innovating and Implementing for Population Health
- Research: Understanding What Works and Why

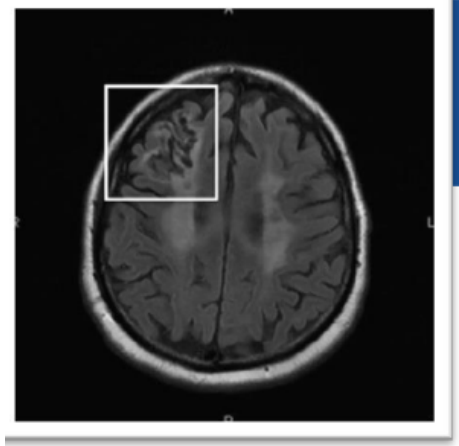
# It Doesn't Take Much to Have a BIG Impact

## Small Reductions in Systolic BP Can Save Many Lives




| Reduction in BP, mm Hg | % Reduction in Mortality | | |
|---|---|---|---|
| | Stroke | CHD | Total |
| 2 | −6 | −4 | −3 |
| 3 | −8 | −5 | −4 |
| 5 | −14 | −9 | −7 |

Whelton, PK, et al. JAMA. 2002;288:1882; Stamler R, et al, Hypertension. 1991:17:I–16.



# Public Health Burden of Stroke

***Stroke is the Fifth Leading Cause of Death in the U.S.***

- **6.8 million Americans** have had a known stroke; almost **800,000 new strokes** eac year (~23% are recurrent strokes).
- The aging of the US population is on course to lead to a **21.9% increase in prevalence of stroke by 2030.**
- **Hypertension and atherosclerosis** are the most common **treatable risk factors fo stroke, cognitive decline and dementia.**
- **"Silent strokes"** can be seen in 6% - 28% of older people, and are associated with cognitive decline and dementia.
- **White matter disease** can be seen in 40-80% of older people, and are associated with hypertension and risk of cognitive decline and dementia.
- Nearly half of people ≥65 years old have **cognitive deficits** 6 months after an ischemic stroke

# Review of Evidence Linking Hypertension and Cognitive Decline/Dementia

ARIC

Original Investigation | October 2014

**Midlife Hypertension and 20-Year Cognitive Change**
**The Atherosclerosis Risk in Communities Neurocognitive Study**

Rebecca F. Gottesman, MD, PhD[1,2]; Andrea L. C. Schneider, MD, PhD[3]; Marilyn Albert, PhD[1]; Alvaro Alonso, MD, PhD[4]; Karen Bandeen-Roche, PhD[4]; Laura Coker, PhD[4]; Josef Coresh, MD, PhD[3]; David Knopman, MD[5]; Melinda C. Power, ScD[3]; Andreea Rawlings, MS[3]; A. Richey Sharrett, MD, DrPH[3]; Lisa M. Wruck, PhD[3]; Thomas H. Mosley, PhD[6]

Cardiovascular Health through Young Adulthood and Cognitive Functioning in Midlife

Jared P. Reis, PhD,[1] Catherine M. Loria, PhD,[1] Lenore J. Launer, PhD,[2] Stephen Sidney, MD, MPH,[3] Kiang Liu, PhD,[4] David R. Jacobs Jr, PhD,[5,6] Na Zhu, MD, PhD,[5] Donald M. Lloyd-Jones, MD, ScM,[4] Ka He, MD, ScD,[7] and Kristine Yaffe, MD[8]

REGARDS

**Vascular risk factors and cognitive impairment in a stroke-free cohort**

F.W. Unverzagt, PhD,[a] L.A. McClure, PhD, V.G. Wadley, PhD, N.S. Jenny, PhD, R.C. Go, PhD, M. Cushman, MD, B.M. Kissela, MD, B.J. Kelley, MD, R. Kennedy, MD, C.S. Moy, PhD, V. Howard, PhD, and G. Howard, PhD

CARDIA

**Early Adult to Midlife Cardiovascular Risk Factors and Cognitive Function**

**Kristine Yaffe, MD; Eric Vittinghoff, PhD; Mark J. Pletcher, MD, MPH; Tina D. Hoang, MSPH; Lenore J. Launer, PhD; Rachel A. Whitmer, PhD; Laura H. Coker, PhD; Stephen Sidney, MD**

Articles

Framingham Offspring

**Midlife vascular risk factor exposure accelerates structural brain aging and cognitive decline**

**S. Debette, MD, PhD, S. Seshadri, MD, A. Beiser, PhD, R. Au, PhD, J.J. Himali, MS, C. Palumbo, PhD, P.A. Wolf, MD and C. DeCarli, MD**

The Association Between Midlife Blood Pressure Levels and Late-Life Cognitive Function

HAAS

The Honolulu-Asia Aging Study

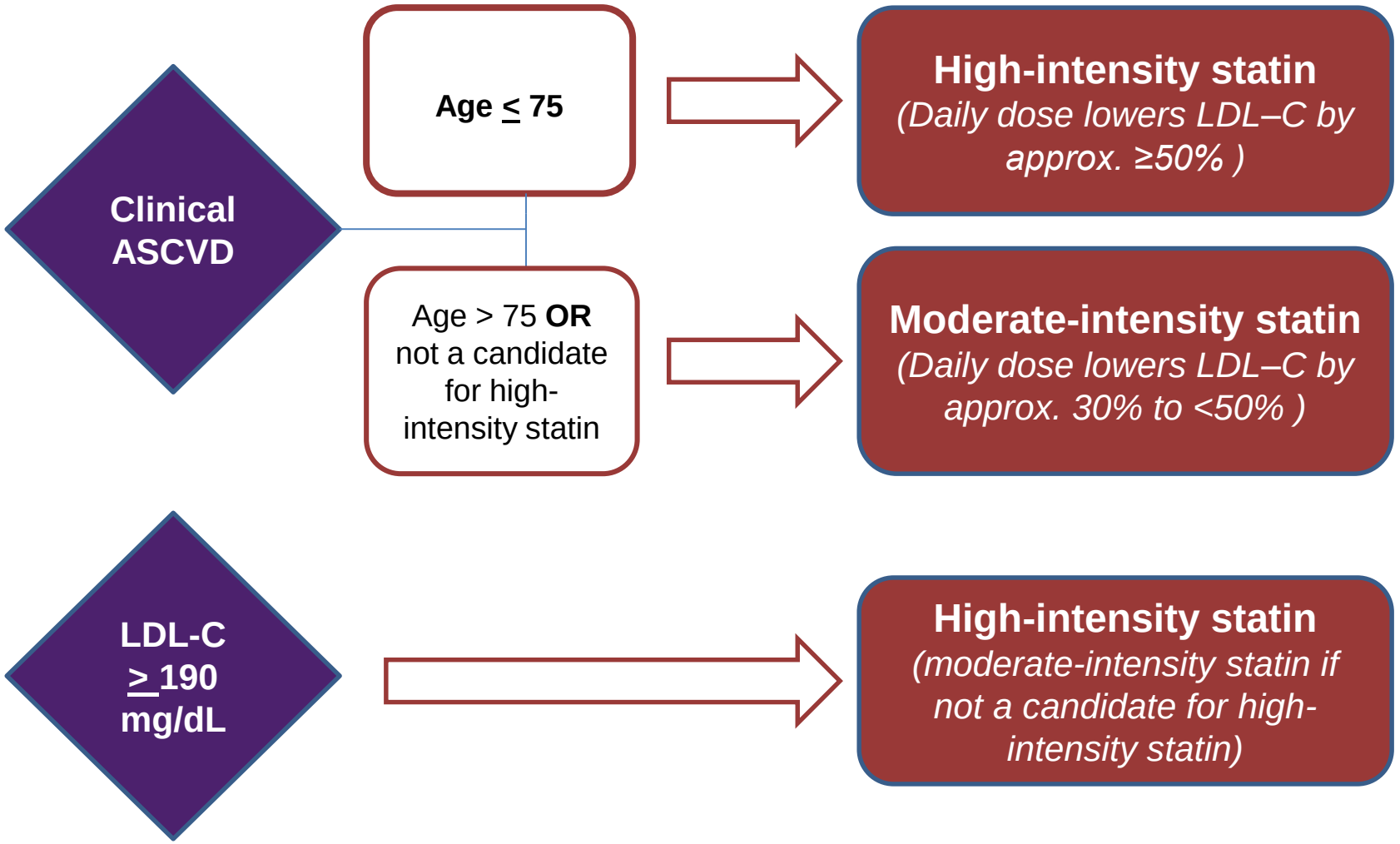
Lenore J. Launer, PhD; Kamal Masaki, MD; Helen Petrovitch, MD; Daniel Foley, MS; Richard J. Havlik, MD

*+ countless reviews…*

An important take-home message:

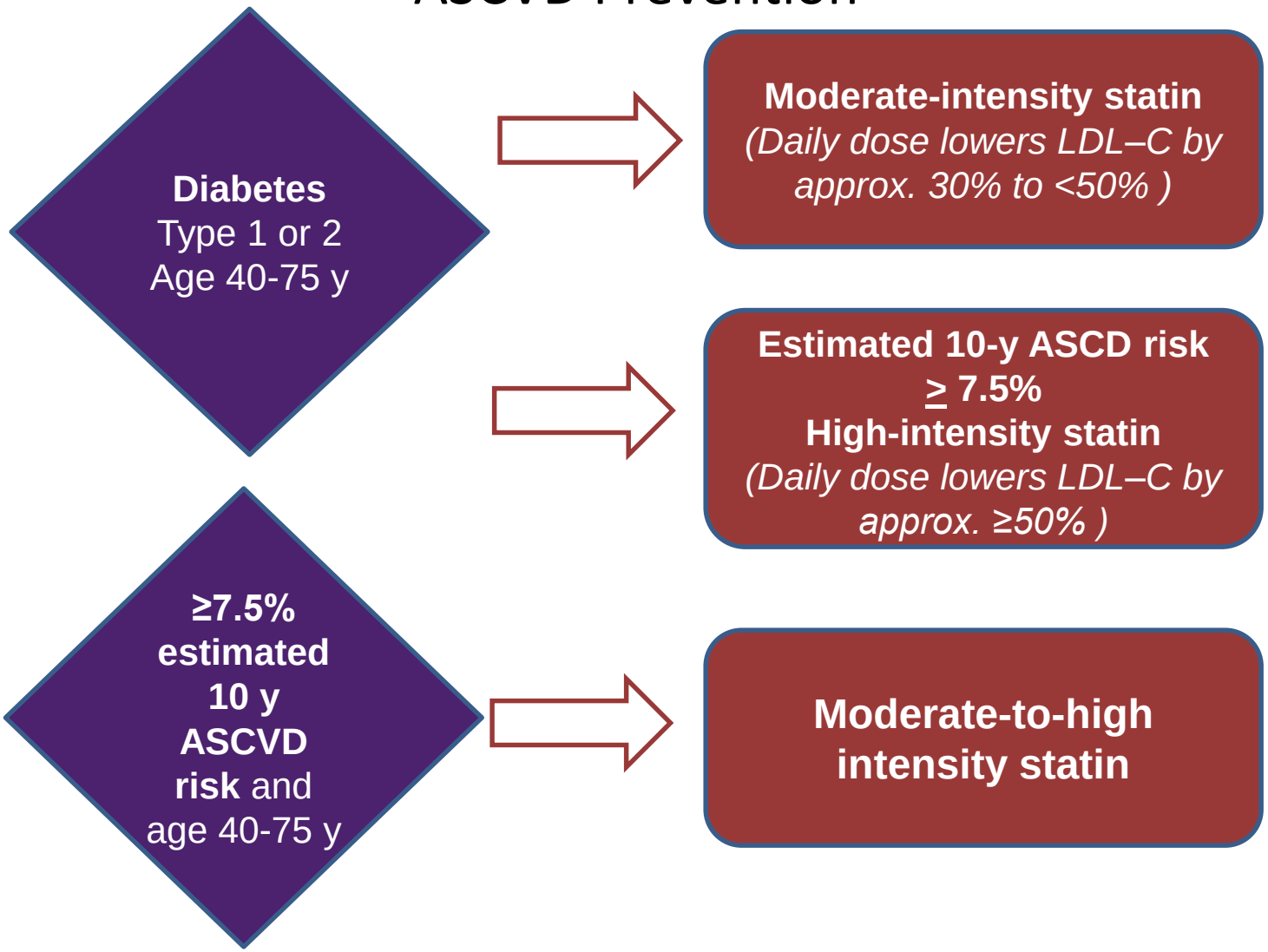
- Observational studies suggest a link between hypertension in mid-life and later cognitive decline.

# Recommendations for Statin Therapy in ASCVD Prevention




Adapted from the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. E-Published on November 12, 2013, available at [http://content.onlinejacc.org/article.aspx?doi=10.1016/j.jacc.2013.11.002]

# Recommendations for Statin Therapy in ASCVD Prevention




Adapted from the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. E-Published on November 12, 2013, available at [http://content.onlinejacc.org/article.aspx?doi=10.1016/j.jacc.2013.11.002]

# Comparison of Treatment Goals

| | JNC 7 | 2014 Hypertension Guidelines |
|---|---|---|
| Adults (<60 years) | <140 / 90 mmHg | <140 / 90 mmHg |
| Adults (≥60 years) | <140 / 90 mmHg | <150 / 90 mmHg |
| Diabetes / Chronic Kidney Disease | <130 / 90 mmHg | <140 / 90 mmHg |
| | | |

- Current national performance measures use <140/90
- Some guidelines and reports include a treatment goal of <150/90 mmHg for those ≥80 years of age

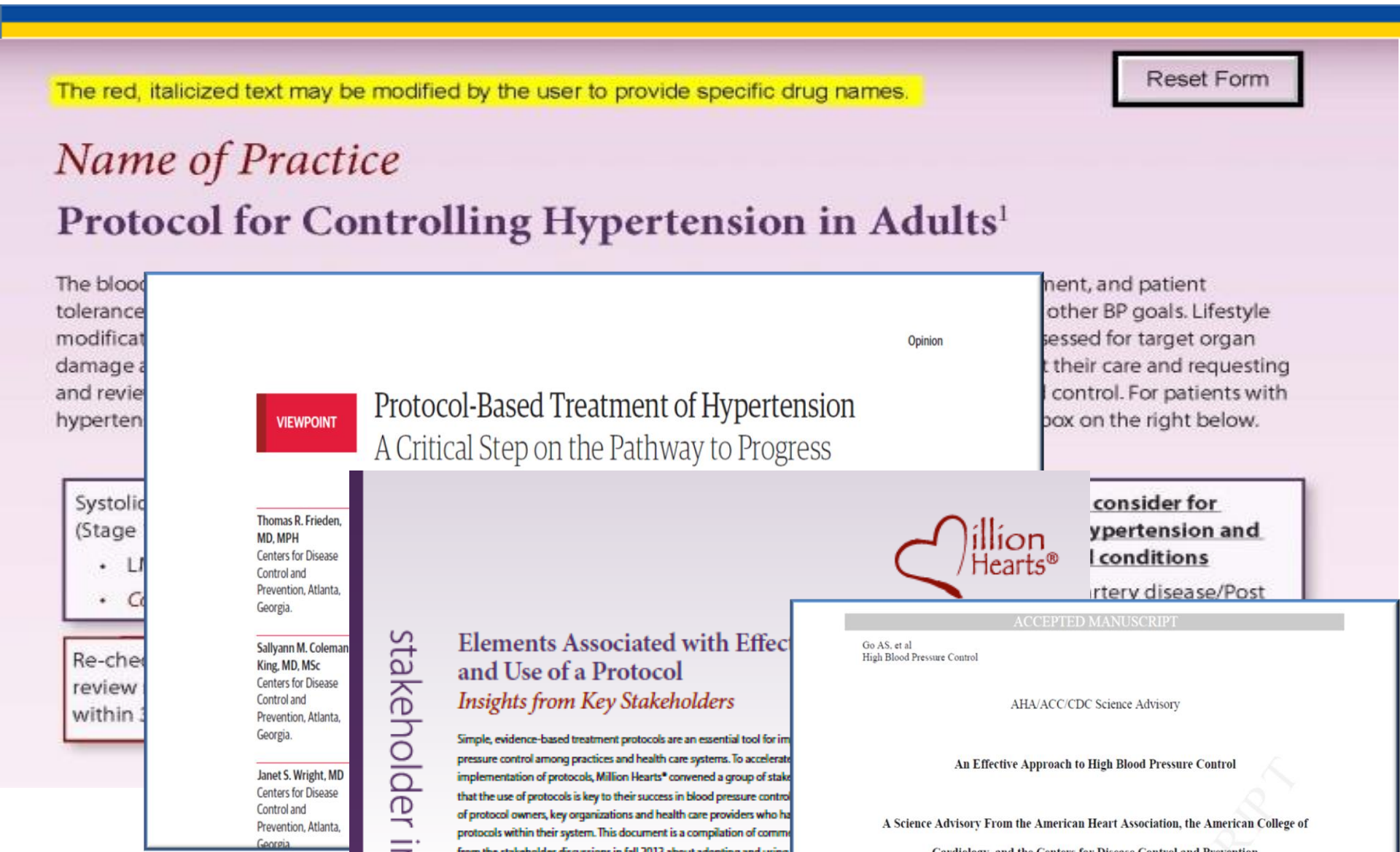
# AHA/ASA Recommendations Regarding Blood Pressure Lowering and Cognition

1. In patients with stroke, lowering blood pressure is effective for reducing the risk of post-stroke dementia (Class I, Level of Evidence: B).
2. There is reasonable evidence that, in middle-aged and young-elderly, lowering blood pressure can be useful for the prevention of late-life dementia (Class IIa, Level of Evidence: B).
3. The usefulness of lowering blood pressure in individuals age 80+ is not well-established (Class IIb, Level of Evidence: B)

## Endorsements from other organizations:

- **American Society for Hypertension, Alzheimer's Association, AAN**
- **CDC** – Improving Population Blood Pressure Control for Brain and Heart Health (Public Health Reports)
- **WHO and Alzheimer's Disease International**– World Alzheimer's Report highlights vascular risk factors as important prevention targets for dementia

# Protocol as the Team Playbook



# U.S. Age-Standardized Death Rates from Stroke by Race/Ethnicity 2000-2013

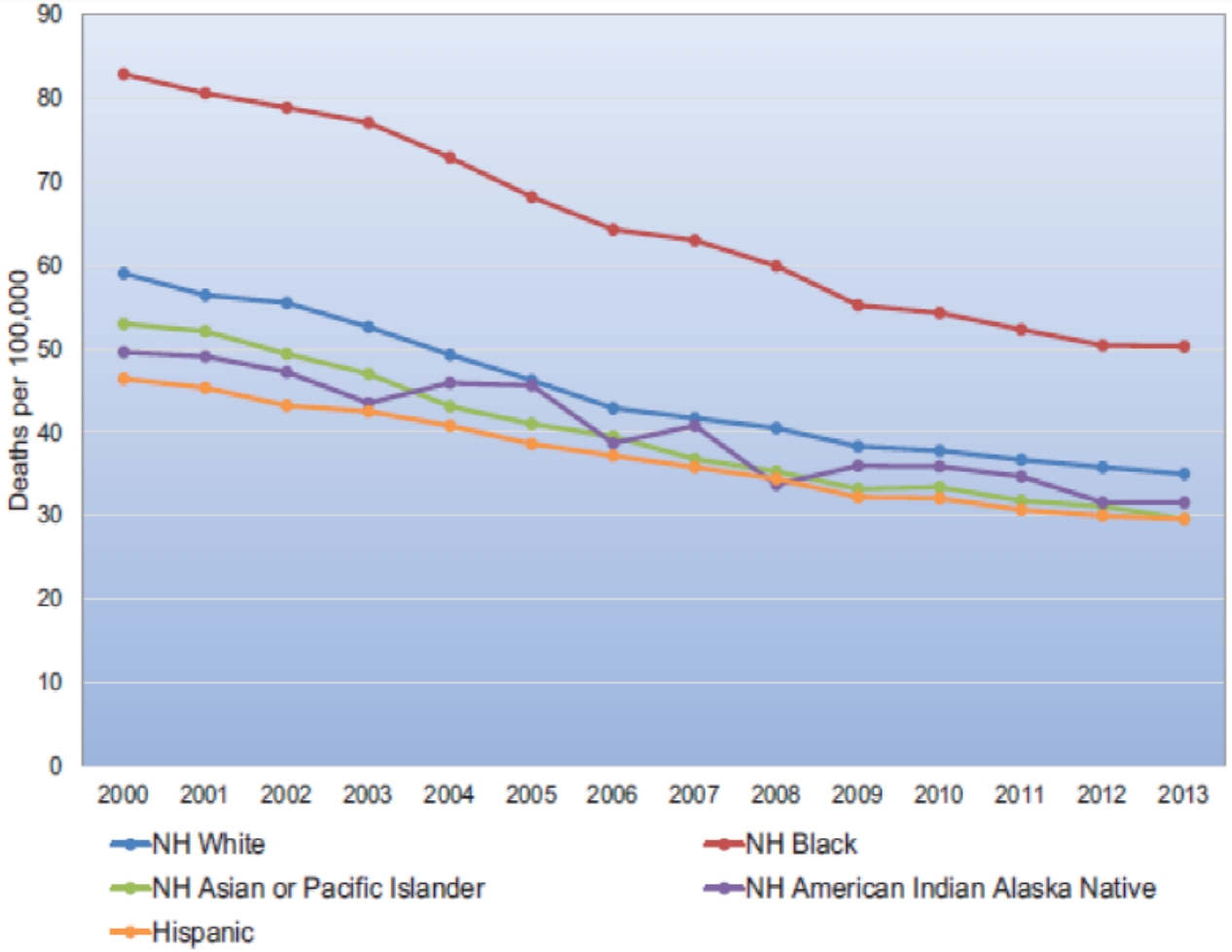



**Chart 2-16.** US age-standardized death rates* attributable to stroke by race/ethnicity, 2000 to 2013. NH indicates non-Hispanic. *Directly standardized to the age distribution of the 2000 US standard population. Stroke (all cerebrovascular disease): *International Classification of Diseases, 10th Revision* I60 to I69. Source: Centers for Disease Control and Prevention, National Center for Health Statistics.[25]

*Circulation.* 2015; 133:e39-e360

# CMS Health Equity Plan for Medicare

**Priority 1:** Expand the Collection, Reporting, and Analysis of **Standardized Data**

**Priority 2**: Evaluate **Disparities Impacts** and Integrate Equity Solutions Across CMS Programs

**Priority 3**: Develop and Disseminate **Promising Approaches** to Reduce Health Disparities

**Priority 4**: Increase the Ability of the **Health Care Workforce** to Meet the Needs of Vulnerable Populations


**Priority 5**: Improve **Communication & Language Access** for Individuals with LEP & Persons with Disabilities

**Priority 6**: Increase **Physical Accessibility** of Health Care Facilities

# Million Hearts Cardiovascular Disease Risk Reduction Model will reward population-level risk management

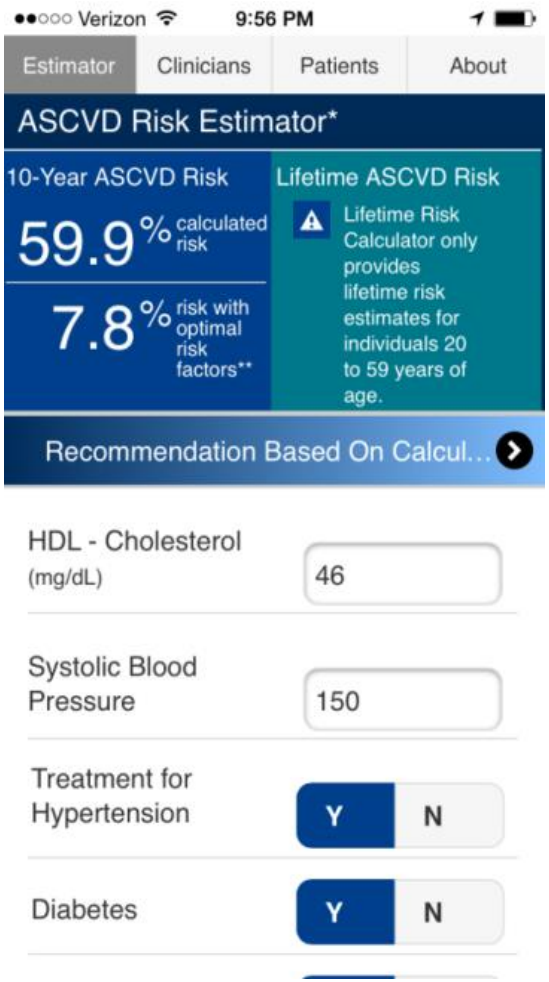
- Heart attacks and strokes are **a leading cause of death and disability** in the United States
  - Prevention of cardiovascular disease can significantly reduce both CVD-related and all-cause mortality
- Participant responsibilities
  - Systematic beneficiary **risk calculation* and stratification**
  - **Shared decision making** and evidence-based **risk modification**
  - **Population health management** strategies
  - **Reporting of risk score** through certified data registry
- Eligible applicants
  - General/family practice, internal medicine, geriatric medicine, multi-specialty care, nephrology, cardiology
  - Private practices, community health centers, hospital-owned practices, hospital/physician organizations

## Payment Model

- Pay-for-outcomes approach
- Disease risk assessment payment
  - One time payment to risk stratify eligible beneficiary
  - $10 per beneficiary
- Care management payment
  - Monthly payment to support management, monitoring, and care of beneficiaries identified as high-risk
  - Amount varies based upon population-level risk reduction

*Uses American College of Cardiology/American Heart Association (ACA/AUA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

# ACC/AHA Pooled Cohort ASCVD Risk Estimator – Examples




**How Risk Calculators Enhance High Value Care:**

Joe Smith is a 65 year old African American man who smokes, has elevated cholesterol, and a borderline elevated blood pressure. His 10-year risk is 31.1% percent (high).

Alan Jones is a 66 year old white man with mildly elevated blood pressure (e.g. SBP 135 mm Hg), but no other risk factors, so his 10-year-risk is 11% (low).

Treating Joe Smith's blood pressure (traditionally valued the same by current one-size-fits-all measure) has a much larger impact on risk of ASCVD than treating Alan Jones's blood pressure

# Model Design Framework

- 5 year Model Test
- Randomized Evaluation Design
  - Planned 360 control and 360 intervention practices, with built in 20 percent attrition anticipated
  - Roughly 150,000 Medicare FFS beneficiaries in each arm

- Programmatic Elements
  - Risk Stratified Care
  - Population Health Management
  - Shared Decision Making
  - Individual Risk Modification Planning
  - Team-Based Care
  - Quality and Clinical Data Reporting

# Important Dates

http://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/

Call for applications renewed!

**Registration is now open until April 15, 2016 at 6:00 pm EDT. Interested applicants must submit a non-binding letter of intent (LOI) between April 4, 2016 and April 15, 2016** 6:00 pm EDT.

Letters of intent will be used for CMS planning purposes only. The letter is not binding but must be submitted in order to access the application.

# Looking Ahead: June, September, December

## *2016 Focused Actions*

- Hypertension control
  - Increase use of self-measured BP monitoring and treatment protocols
  - Support processes to find those at risk, either undiagnosed or uncontrolled
- Smoking cessation
  - Facilitate use of tobacco cessation protocols and cessation action guide
- Sodium reduction
  - Advance adoption of procurement guidelines and disseminate healthy eating resources
- Cholesterol management
  - Post protocols and tools
  - Encourage implementation of statin measure across federal settings
- Cardiac rehab
  - Facilitate collective actions to increase referral, participation and completion
- Recognize high performers and disseminate their best practices
- Assist your efforts to tell the story of your impact and to ***finish strong***

What does it mean for you?

# THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# What is "MACRA"?

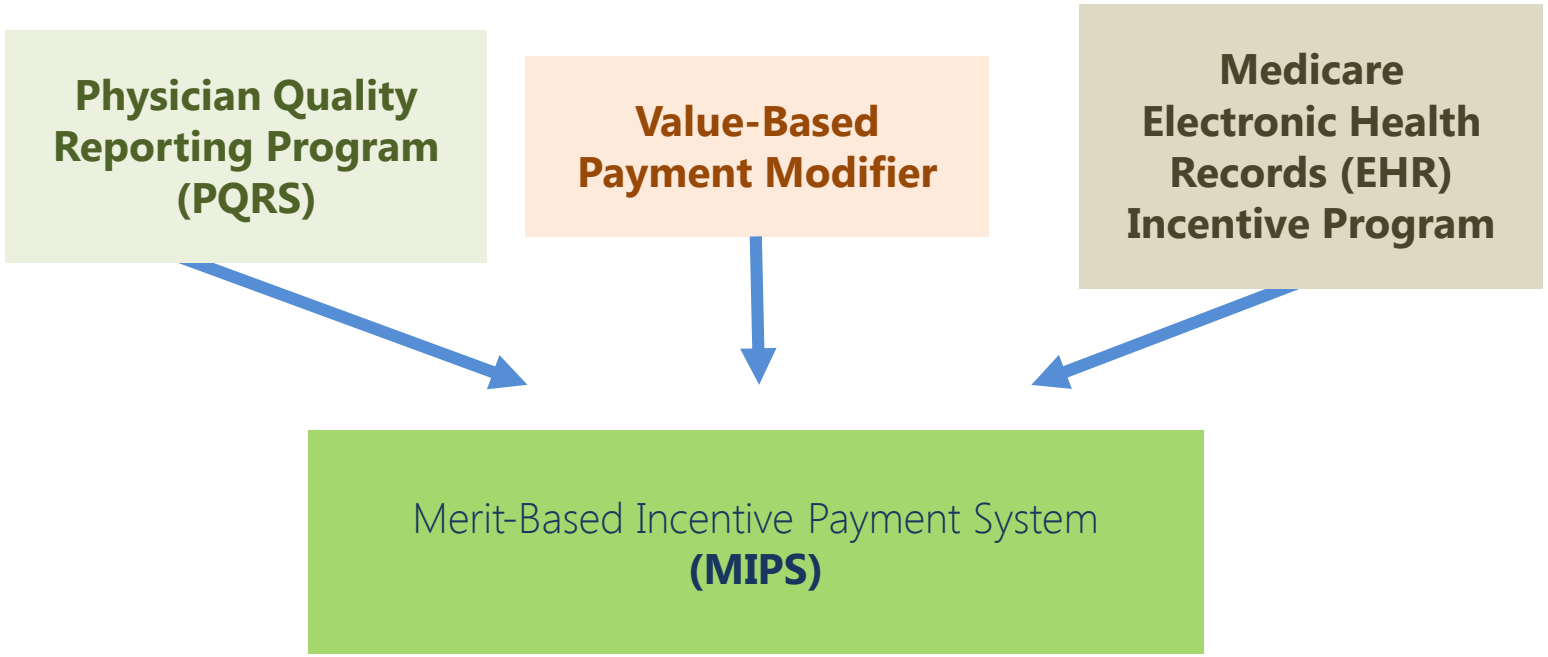
MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

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.**



# MACRA changes how Medicare pays clinicians who participate in Medicare Part B

The system after **MACRA**:

Services provided

Medicare **Fee Schedule**

Adjustments

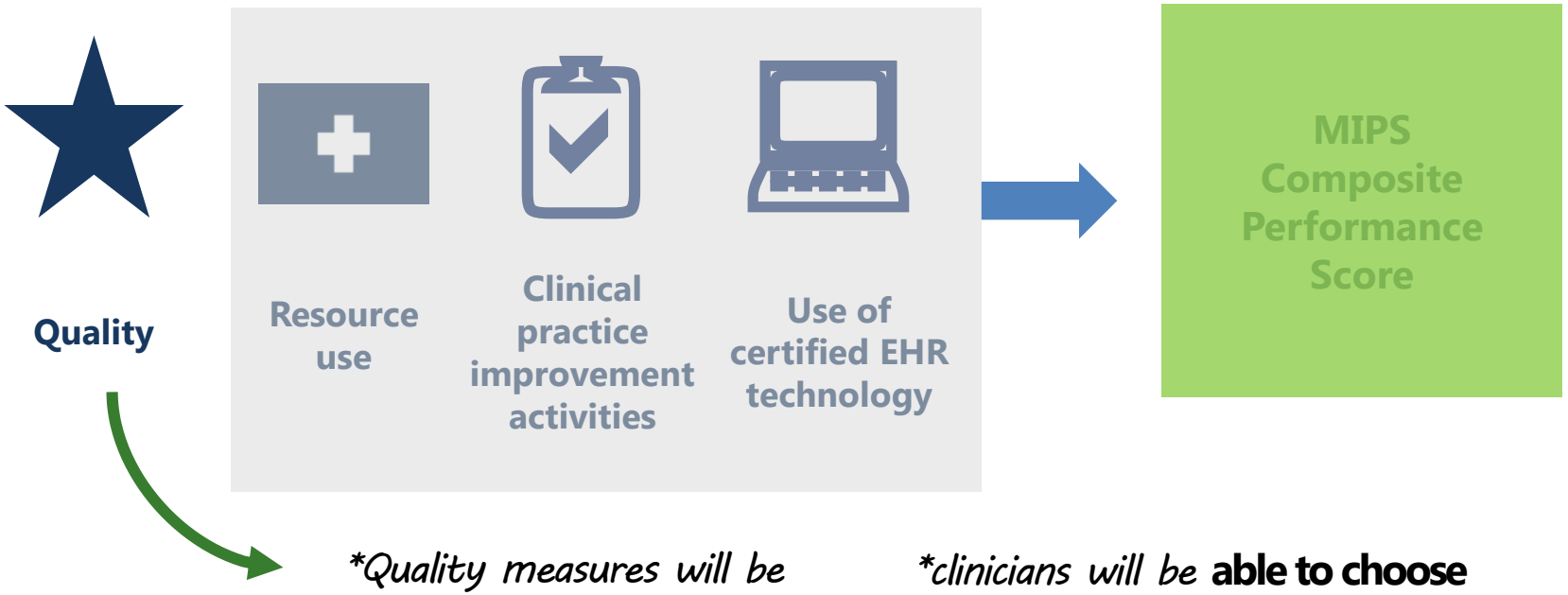
**Final payment** to clinician

Merit-Based Incentive Payment System **(MIPS)**

**Or special lump sum bonuses through participation in eligible Alternative Payment Models*

# What will determine my MIPS score?

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




*Quality measures will be published in an **annual list**

*clinicians will be **able to choose** the measures on which they'll be evaluated

# 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**

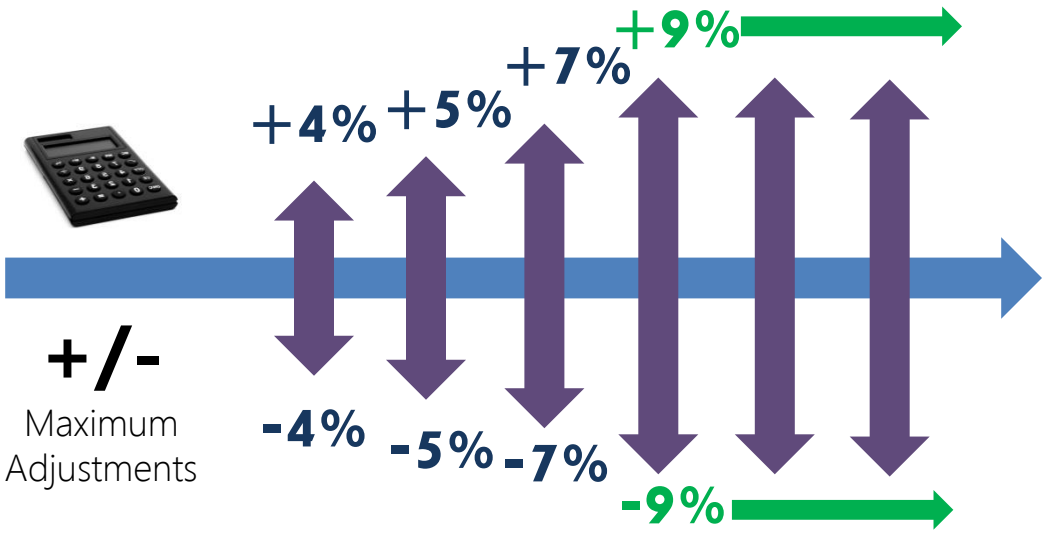
**MIPS Composite Performance Score**

| | Quality | Resource use | Clinical practice improvement activities | Use of certified EHR technology |
|---|---|---|---|---|
| 2019 | 50% | 10% | 15% | 25% |
| 2020 | 45% | 15% | 15% | 25% |
| 2021 | 30% | 30% | 15% | 25% |

*% weights for quality and resource use are scheduled to adjust each year until 2021*

# How much can MIPS adjust payments?

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




**Adjusted** Medicare Part B **payment** to clinician

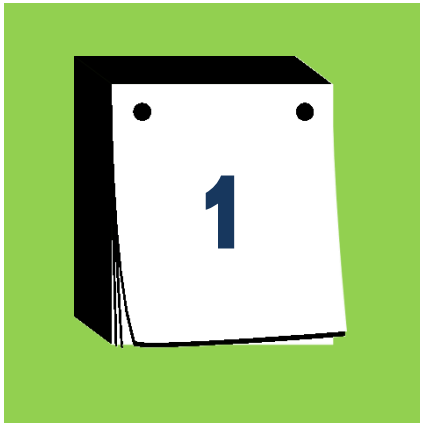
2019 2020 2021 2022 onward

Merit-Based Incentive Payment System **(MIPS)**

*The potential **maximum** adjustment % will **increase** each year from **2019 to 2022***

# Are there any exceptions to participation in MIPS?

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




**FIRST year of Medicare Part B participation**

**Below low patient volume threshold**

**Certain participants in ELIGIBLE Alternative Payment Models**

Note: MIPS **does not** apply to hospitals or facilities

# 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

# TAKE-AWAY POINTS

1) MACRA **changes the way Medicare pays clinicians** and offers financial **incentives** for providing high **value** care.

2) Medicare **Part B clinicians** will participate in the **MIPS** program, unless they are in their 1st year of Part B participation, meet criteria for participation in certain **APMs**, or have a low volume of patients.

3) Payment adjustments and bonuses will begin in **2019**.

4) A **proposed rule** is targeted for spring 2016, with the **final rule** targeted for **fall 2016**.

# What should I do to prepare for MACRA?

- Look for future educational activities
- Look for a proposed rule in spring 2016 and provide comments on the proposals.
- Final rule targeted for early fall 2016
- Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.

# Transforming Clinical Practice Initiative

- Support more than 140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing and procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled

Contact information for the Transforming Clinical Practice Initiative
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx

# Practice Transformation Networks (PTNs) In Region 9

- Arizona Health-e Connection
- Children's Hospital of Orange County
- Local Initiative Health Authority of Los Angeles County
- National Rural Accountable Care Consortium
- Pacific Business Group on Health
- VHA/UHC Alliance Newco, Inc.

# 6 Key Benefits to Participating Clinicians

1. Optimize health outcomes for your patients
2. Promote connectedness of care for your patients
3. Learn from high performers how to effectively engage patients and families in care planning
4. More time spent caring for your patients
5. Stronger alignment with new and emerging federal policies
6. Opportunity to be a part of the national leadership in practice transformation efforts

http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx

# Measure Alignment Efforts

- CMS Draft Quality Measure Development Plan
  - Highlight known measurement gaps and develop strategy to address these
  - Promote harmonization and alignment across programs, care settings, and payers
  - Assist in prioritizing development and refinement of measures
  - Public Comment period closed March 1st, final report to be published in May

- Core Measures Sets released February 16th
  - ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

- CMS is already using measures from the each of the core sets
- Commercial health plans are rolling out the core measures as part of their contract cycle

# References & Further Reading

Health Care Payment Learning and Action Network
http://innovationgov.force.com/hcplan

CMS Innovation Center
https://innovation.cms.gov/

CMS Draft Quality Measures Development Plan
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-CMS-Quality-Measure-Development-Plan-MDP.pdf

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

CMS Health Equity Plan
https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

Contact information for the Transforming Clinical Practice Initiative
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx

# Questions?

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