How Technology Can Assist Brazil in its Health Care Challenges

Panel 1: Health Technology: Greater Efficiency, Lower Cost, Better Care

Transforming the US health care system.

3 goals for the US health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on **3 areas**

Incentives

Care Delivery

Information Sharing

Reforming the Health Care Delivery System will result in better care, smarter spending, and healthier people

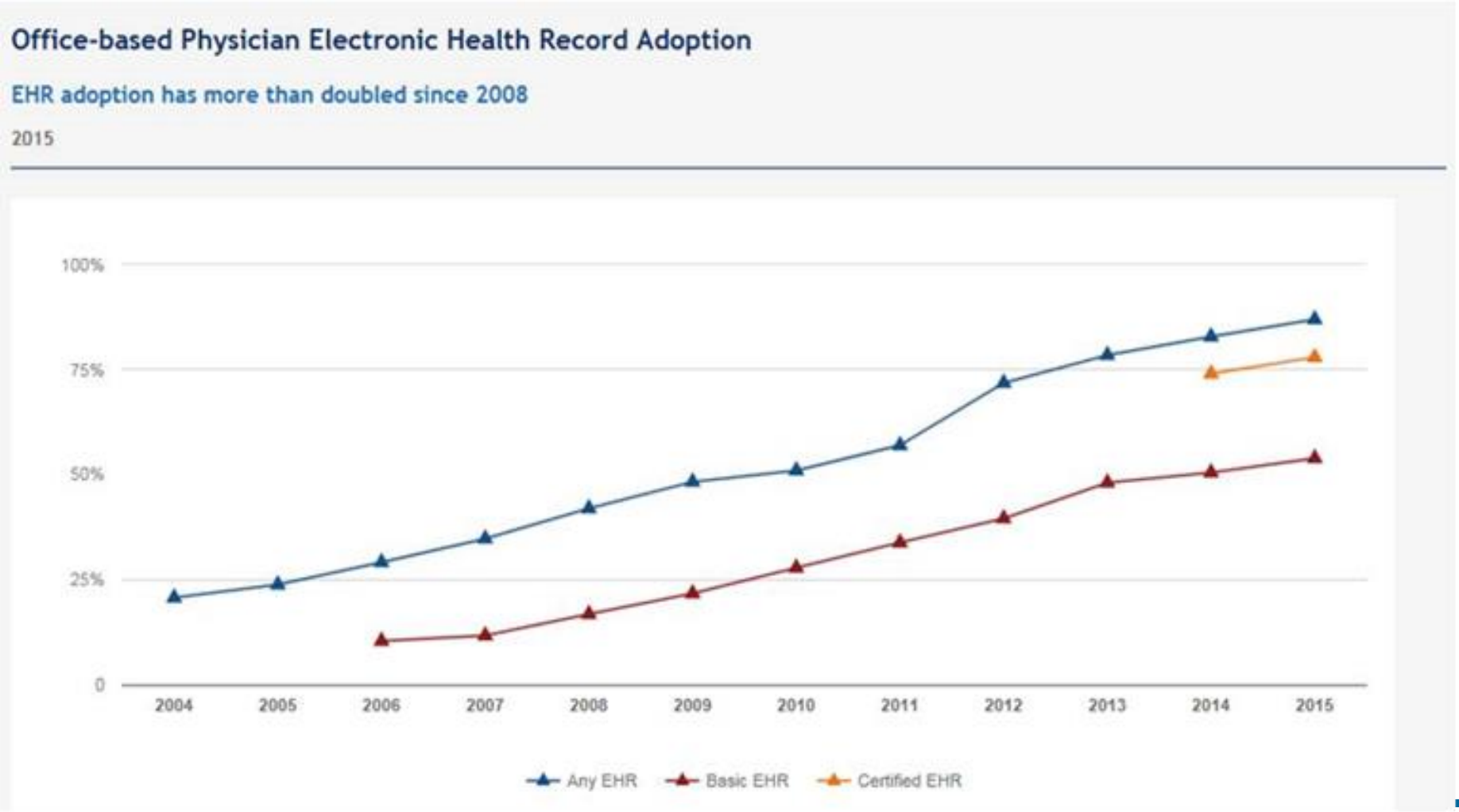
Key characteristics

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

Key characteristics

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

Electronic Health Record Adoption Among US Physicians



DIGITAL HEALTH FUNDING

2011 - 2016

ROCK HEALTH

Source: Rock Health Funding Database

Note: Only includes U.S. deals >$2M; data through December 31, 2016

What is a Culture of Innovation?

- An accepted attitude or mindset of an organization that recognizes innovation as a novel and discontinuously different product, service, process, organizational structure, or business model that adds substantive value and its origin is based in a different way of seeing, understanding and thinking about something in the world.

Data and Financial Incentives Are Key Innovation Drivers for Value-Based Care

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

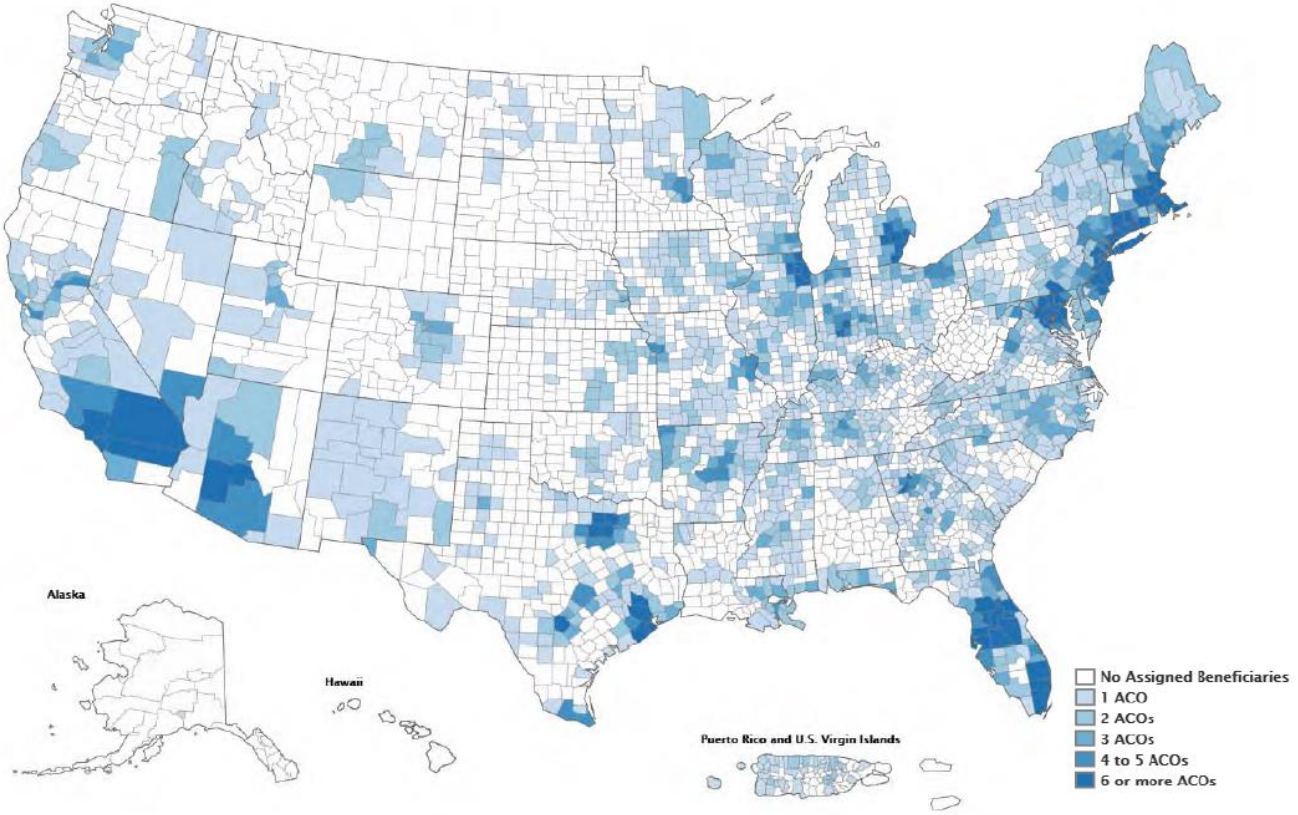
1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **561 ACOs (of which 120 are risk-bearing)** have been established in the MSSP, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **85 more ACOS** in 2017 than in 2016.
- These ACOs together **cover 12.3 million assigned beneficiaries.**

ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

Spotlight: Pioneer ACO Model, Monarch HealthCare

Monarch is Orange County, California's largest association of private physicians with approximately **20,000 beneficiaries**.

Disease Management Program

- Developed COPD, heart failure, diabetes, chronic kidney disease and chronic pain programs for beneficiaries at all levels of acuity
- Educated beneficiaries and caregivers about warning signs and needed action to prevent hospital admissions

Outcomes Success

Improved outcomes and experiences for beneficiaries, earned impressive quality score of **85.70 out of 100** in 2014

Generated **3.96% in gross savings** in 2014 and is one of the highest financial performers among Pioneer ACOs

Monarch HealthCare ACO

Comprehensive Primary Care Initiative: 2012-2016

Four-year multi-payer model designed to strengthen primary care

BACKGROUND

474 practices in **7 regions** supported by **38 public and private payers**

Practices **enhanced care delivery** by providing care management, coordinated care, and engaging patients

Diverse supports: PBPM care management fees, shared savings opportunity, learning and data feedback

KEY FINDINGS

Reductions in Part A and B expenditures, driven by reduced hospital inpatient and SNF spending

Favorable effects on **patient experience** and **provider satisfaction**

Practices underwent **significant transformation** in the delivery of primary care

Comprehensive Primary Care Plus (CPC+) builds on the lessons learned in CPC

Comprehensive Primary Care Plus (CPC+)

CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

Goals

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality of care, improve patients' health, and spend health care dollars more wisely.

Participants and Partners

- Up to 5,500 practices across two rounds:
  - Round 1: 2,893 practices in 14 regions
  - Round 2: Up to 2,607 practices in 10 regions
- Two tracks to accommodate diversity of practices
- 54 public and private payers in CPC+ regions
- Health IT vendors partner with CMS and Track 2 practices
- 5 year model: 2017-2021; 2018-2022

Care Transformation Functions


Access and continuity


Care management


Comprehensiveness and coordination


Patient and caregiver engagement


Planned care and population health

Payment Redesign Components


PBPM risk-adjusted care management fees


Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care


For Track 2, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to offer flexibility in delivering care outside traditional office visits

The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Comprehensive ESRD Care Initiative – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project – Medicare Diabetes Prevention Program ▪ **Bundled payment models** – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ **Initiatives Focused on the Medicaid** – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ **Dual Eligible (Medicare-Medicaid Enrollees)** – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Integrated ACO ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design Model – Part D Enhanced Medication Therapy Management
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice ▪ **Health Care Innovation Awards** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health Model – Vermont All-Payer ACO Model ▪ **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ **Information to providers in CMMI models** ▪ **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas

Oncology Care Model: New Emphasis on Specialty Cancer Care

1.6 million people annually diagnosed with cancer; a significant proportion are over 65 years

- Major opportunity to improve care & reduce cost starting July 1, 2016, through June 30, 2021

  196 participating practices
  3,200+ oncologists
  17 participating payers
  155,000+ Medicare FFS beneficiaries/year, estimated **$6 billion** in care included in 6-month episodes

- Model Objective: Provide beneficiaries with **improved care coordination to improve quality and decrease cost**
  - Implement six practice redesign activities
  - Create two-part **financial incentive** with $160 pbpm payment and potential for performance-based payment
  - Institute robust **quality** measurement
  - Engage **multiple payers**

Practice Redesign Activities

1) Patient navigation

2) Care plan with 13 components based on IOM Care Management Plan

3) 24/7 access to clinician with real-time access to medical records

4) Use of therapies consistent with national guidelines

5) Data-driven continuous quality improvement

6) Use of certified EHR technology

What can health care providers do to help transform the health care system?

- **Eliminate** patient harm
- **Focus** on better care, smarter spending, and healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Help us** develop specialty physician payment and service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

What is “MACRA”?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

MACRA Goals

Through MACRA, HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician's or practitioner's status with respect to MIPS and/or APMs.
- Support **multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.

Looking Forward

Focused on:

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across Medicare and Medicaid
- Portfolio analysis and launch new models to round out portfolio