
CMS Priorities: Health System Transformation, Health Information Technology and Data Analytics



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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

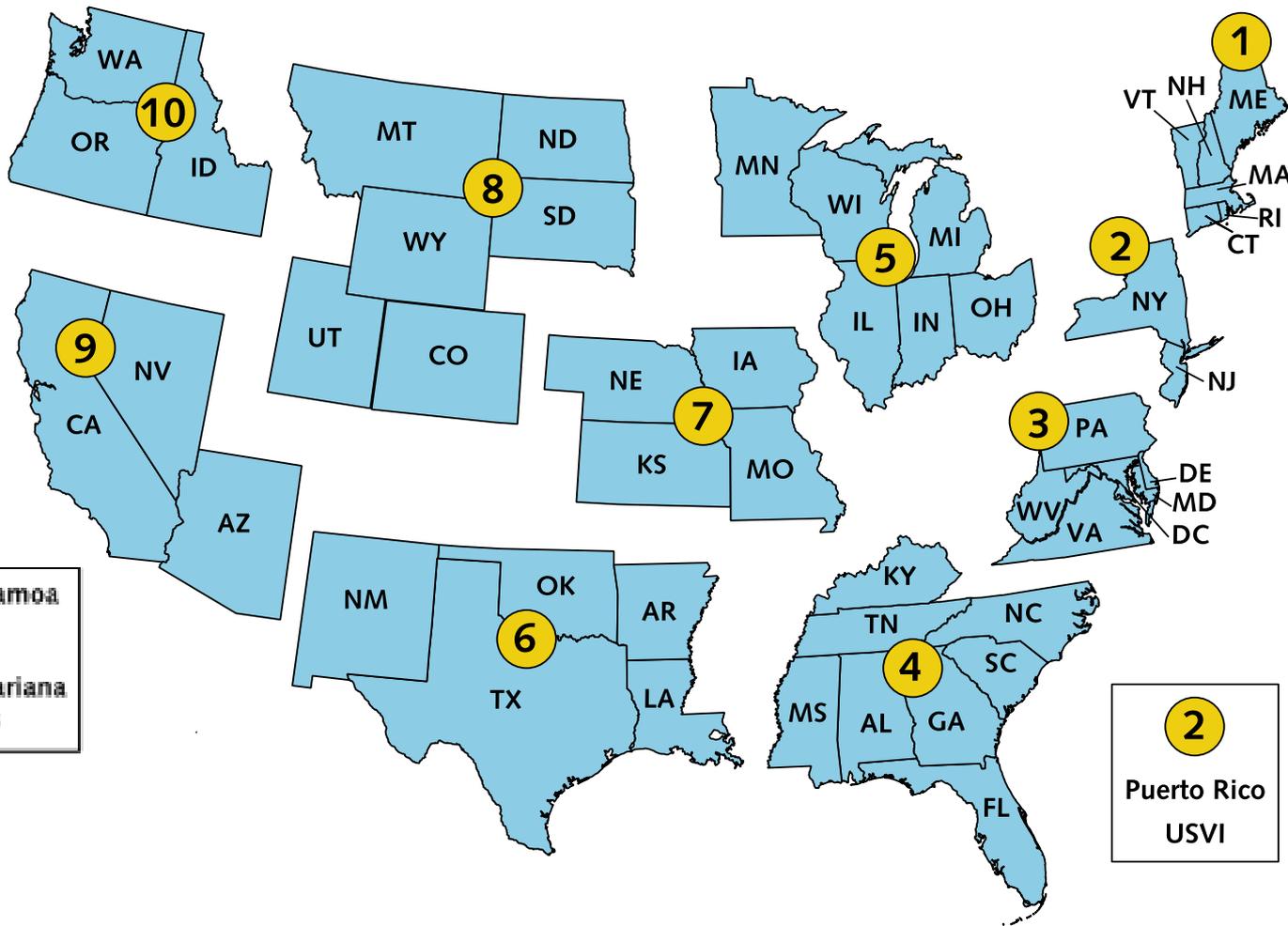
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Objectives

- Brief Overview of CMS Priorities
 - Quality of care: transparency and accountability
 - Shifting from Volume- to Value-Based Payments
 - Implementation of MACRA
- Efforts to gather and analyze data
 - Availability of data sets
 - Health equity
- Measure alignment & next steps

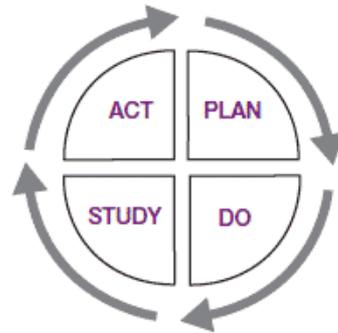
CMS OFFICES

10 REGIONS AND 4 TERRITORIES



Complications

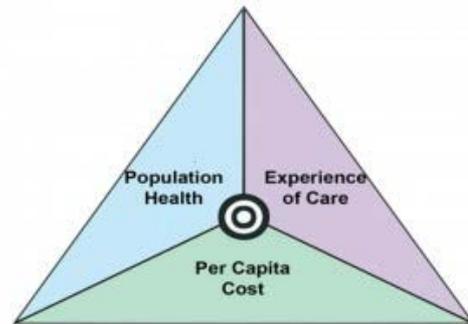
[A SURGEON'S NOTES ON
AN IMPERFECT SCIENCE]



The 'Must Do' List: Certain Patient Safety Rules Should Not Be Elective

Robert Wachter

August 20, 2015



IHI Triple Aim

HA Blog, August 20, 2015. <http://healthaffairs.org/blog>



Better. Smarter. *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: *better care, smarter spending, and healthier people.*



Better Care, Smarter Spending, Healthier People

Focus Areas

Description

Incentives

- Promote value-based payment systems
 - Test new alternative payment models
 - Increase linkage of Medicaid, Medicare FFS, and other payments to value
 - Bring proven payment models to scale
-

Care Delivery

- Encourage the integration and coordination of services
 - Improve population health
 - Promote patient engagement through shared decision making
-

Information

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

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

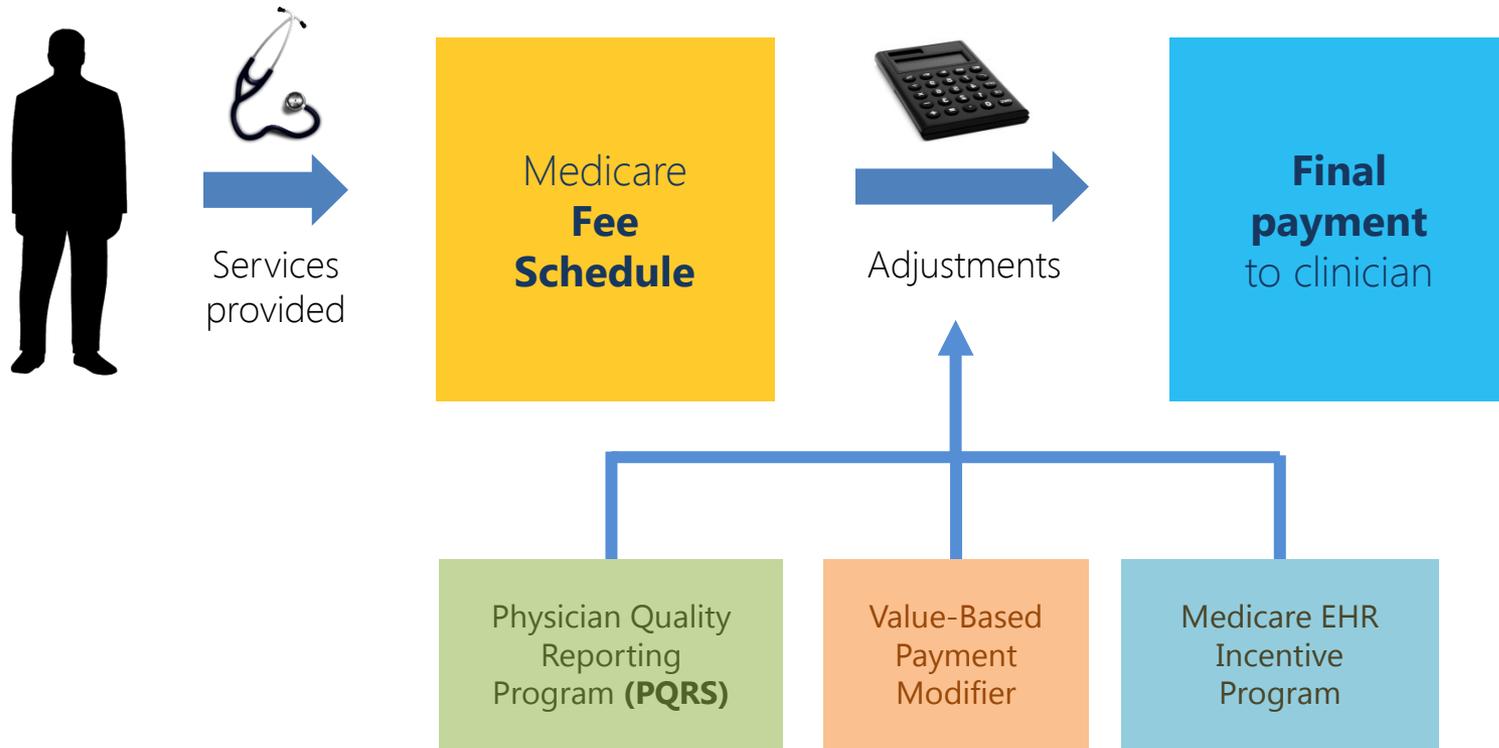
Affordable Care Act



MACRA

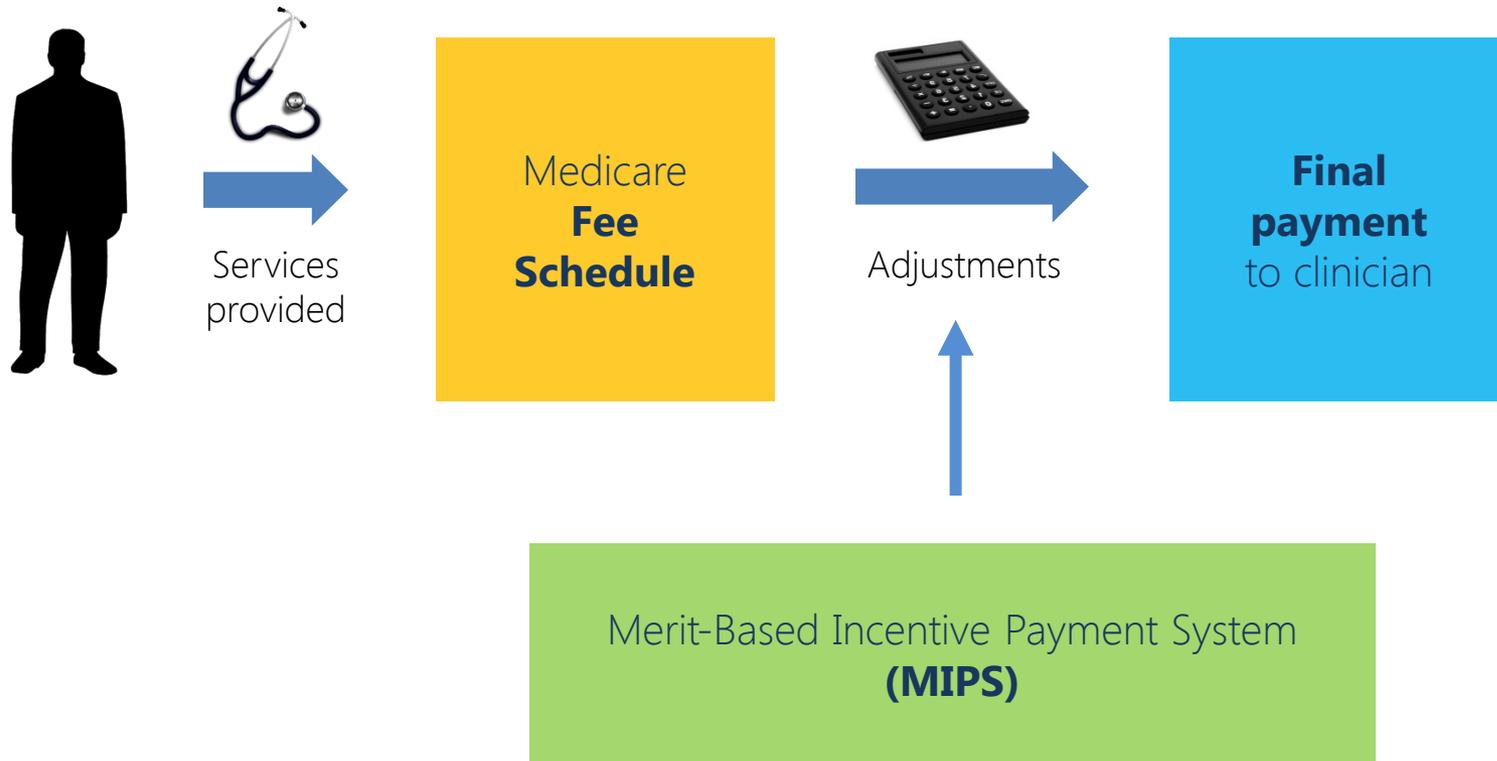
MACRA changes how Medicare pays clinicians.

The **current** system:



MACRA changes how Medicare pays clinicians.

The system after **MACRA**:



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

MACRA changes how Medicare pays clinicians.

In 2019, a composite performance **score will determine reimbursement under Medicare Part B** by evaluating performance in **4 weighted categories**:





Guiding Themes during Transition

- Move away from rewarding use of technology and focus instead on outcomes
- Allow physicians to customize goals around their practices (so user-centered tech can be developed)
- Level the tech playing field to allow apps, analytic tools, plug ins & reduce EHR lock
- Interoperability standards that build on use cases coming from physicians and patients



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



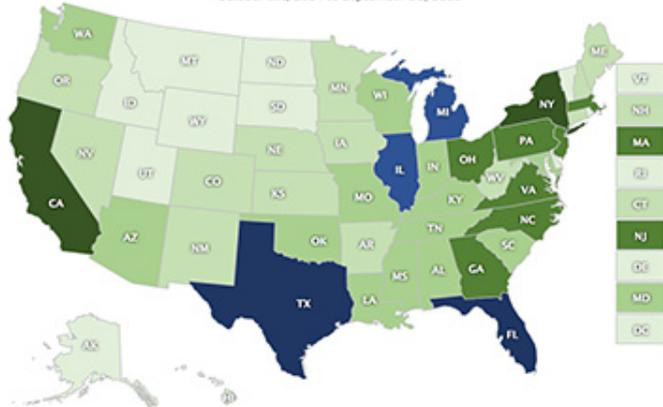
Data Transparency: New Data Sets

(1) Availability and use of services provided to Medicare beneficiaries by ambulance and home health agencies

(2) List of all approved providers and suppliers in Medicare's fee-for-service operations

- Available at <https://data.cms.gov>
- Ongoing focus on fraud, waste, and abuse
- Temporary enrollment moratoria for the first time (2013, 2014)
 - Halted the enrollment of new home health agencies (HHAs) and ground ambulance suppliers in certain geographic areas
 - Opportunity to analyze and monitor existing provider and supplier base,
 - Development of fraud prevention and detection tools in these areas

Moratoria Map: Home Health – Number of Fee-for-Service Beneficiaries
October 1st, 2014 to September 30, 2015



Moratoria Provider Services and Utilization Data Tool

[The Moratoria Provider Services and Utilization Data Tool](#) includes interactive maps and a dataset that shows national, state and county level provider services and utilization data for selected health service areas. The data provide information on the number of Medicare providers servicing a geographic region, with Moratoria regions at the state and county level clearly indicated, and the number of Medicare beneficiaries who use a health service area. Provider services and utilization data by geographic regions are easily compared using the interactive map.



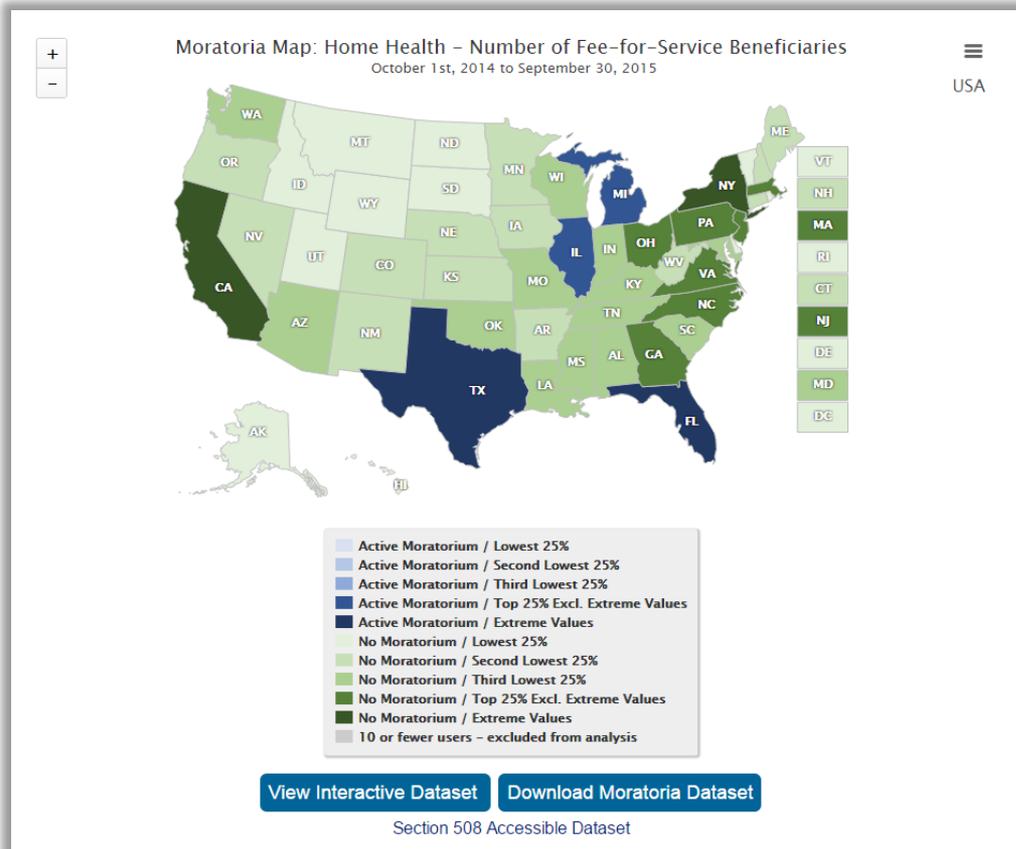
Public Provider Enrollment

[The Public Provider Enrollment data files](#) have key non-sensitive Medicare Provider Enrollment information for providers who are approved to bill Medicare. Data elements include NPI, Enrollment ID, Enrollment Type and State, Gender, Provider Specialty, Reassignment Relationships and Limited Practice Location Information.



Data Tool 1:

Moratoria Provider & Supplier Services Utilization Tool



- Ambulance and HHA paid claims data
- Medicare fee-for-service beneficiaries
 - No individually identifiable information
 - about Medicare beneficiaries or their providers
 - Covers the period from October 1, 2014 to September 30, 2015, and are updated quarterly

Data Tool 2:

Public Provider Enrollment

Medicare Fee-For-Service Public Provider Enrollment Data: 2016, Release 1

The Public Provider Enrollment data for Medicare fee-for-service includes providers who are actively approved to bill Medicare or have completed the 855O at the time the data was pulled from the Provider Enrollment and Chain Ownership System (PECOS). The release of this provider enrollment data is not related to other provider information releases such as Physician Compare or Data Transparency.

These files are populated from PECOS and contain basic enrollment and provider information, reassignment of benefits information and practice location city, state and zip. These files are not intended to be used as real time reporting as the data changes from day to day and the files are updated only on a quarterly basis. If any information on these files needs to be updated, the provider needs to contact their respective Medicare Administrative Contractor (MAC) to have that information updated. To find your respective MAC, go to <https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontractors.html>.

This data does not include information on opt-out providers. Information is redacted where necessary to protect Medicare provider privacy.

To review more information about the Public Provider Enrollment data, please refer to the [Data Dictionary](#) and [Data Guidance](#) document.

 [Download Factsheet for Public Provider Enrollment Files](#)

Public Provider Enrollment Files

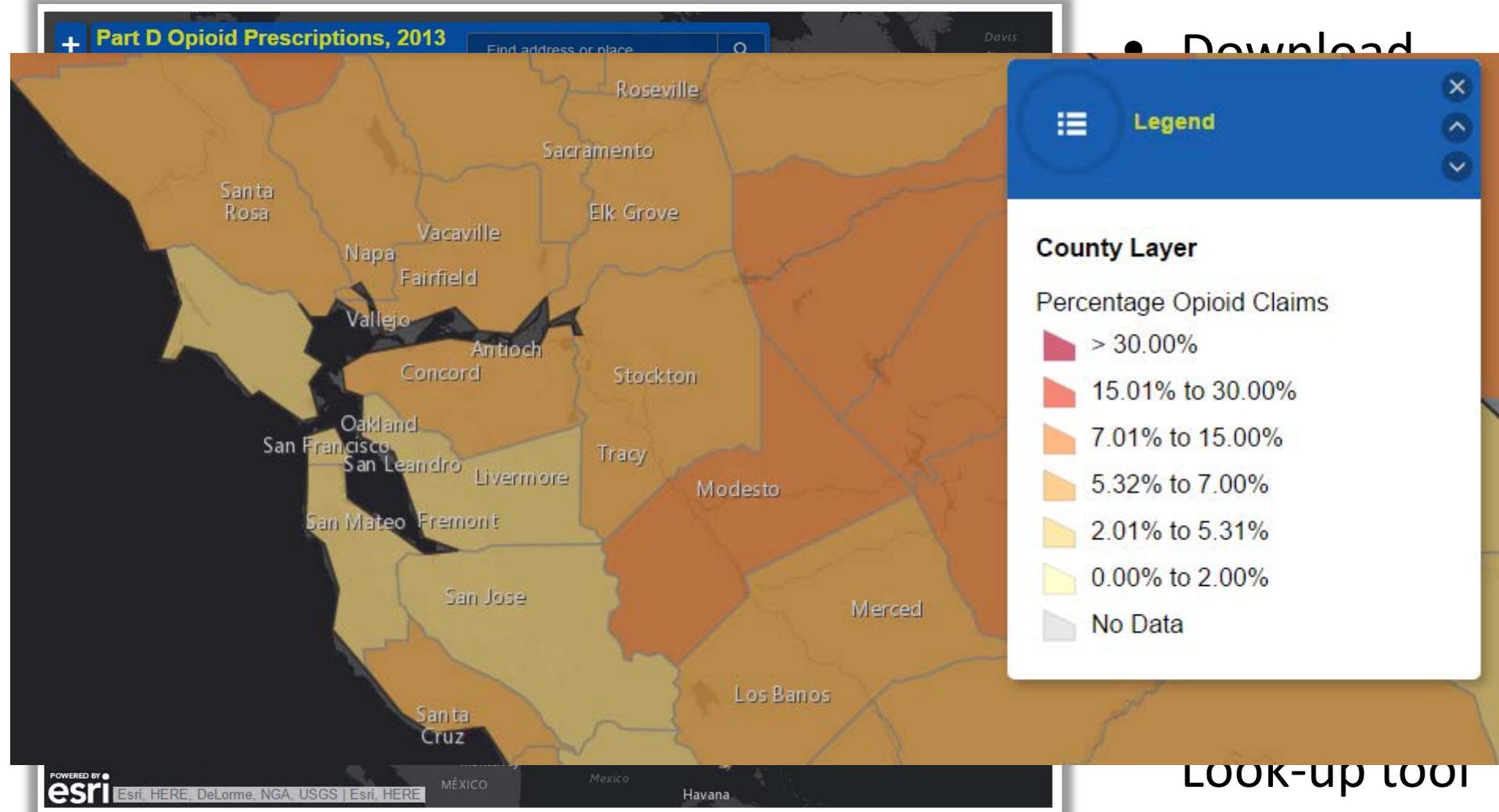
 [Base Provider Enrollment File](#)

 [Reassignment Sub-File](#)

 [Address Sub-File](#)

- Subset of Provider Enrollment, Chain, and Ownership System (PECOS) data
- Long-term goal is to continue to expand data elements
- Eventually consolidate other existing public lists
 - Ordering & Referring File
 - Part D Prescribing File
 - Revalidation Lists

Data Tool 3: Medicare Part D Opioid Drug Mapping Tool



• Download

Look-up tool

<http://www.resdac.org>



CMS Data Access to Promote Health Equity Research

CMS Office of Minority Health (OMH) is supporting five (5) "seats" in the CMS Virtual Research Data Center (VRDC) for a period of 36 months each to assist researchers in gaining access to and understanding of CMS restricted access data for the conduct of health services research in health equity.

[1](#) [2](#) [3](#) [4](#) [5](#) [6](#)

Contact Us

[SUBMIT A QUESTION](#)

GETTING STARTED

New to [CMS](#) data? Check out this guide to Getting Started. You'll find resources on:

- CMS data strengths and limitations
- choosing the right files
- preparing a data request
- data analysis tips

Mapping Medicare Disparities

Mapping Medicare Disparities

The Mapping Medicare Disparities (MMD) Tool contains health outcome measures for disease prevalence, costs, and hospitalization for 18 specific chronic conditions, emergency department utilization, readmissions rates, mortality and preventable hospitalizations. The MMD Tool provides a user friendly way to explore and better understand disparities in chronic diseases, and allows users to explore health outcome measures by age, race and ethnicity, gender; 3) compare national average; and 4) compare differences between two racial and ethnic groups.

Helpful links: [Quick Start Guide](#) | [FAQs](#) | [MMD Tool Technical Documentation](#)

Year: 2012

Geography: County

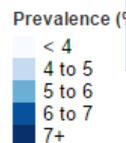
Measure: Prevalence

Adjustment: Actual

Analysis: Base Measure

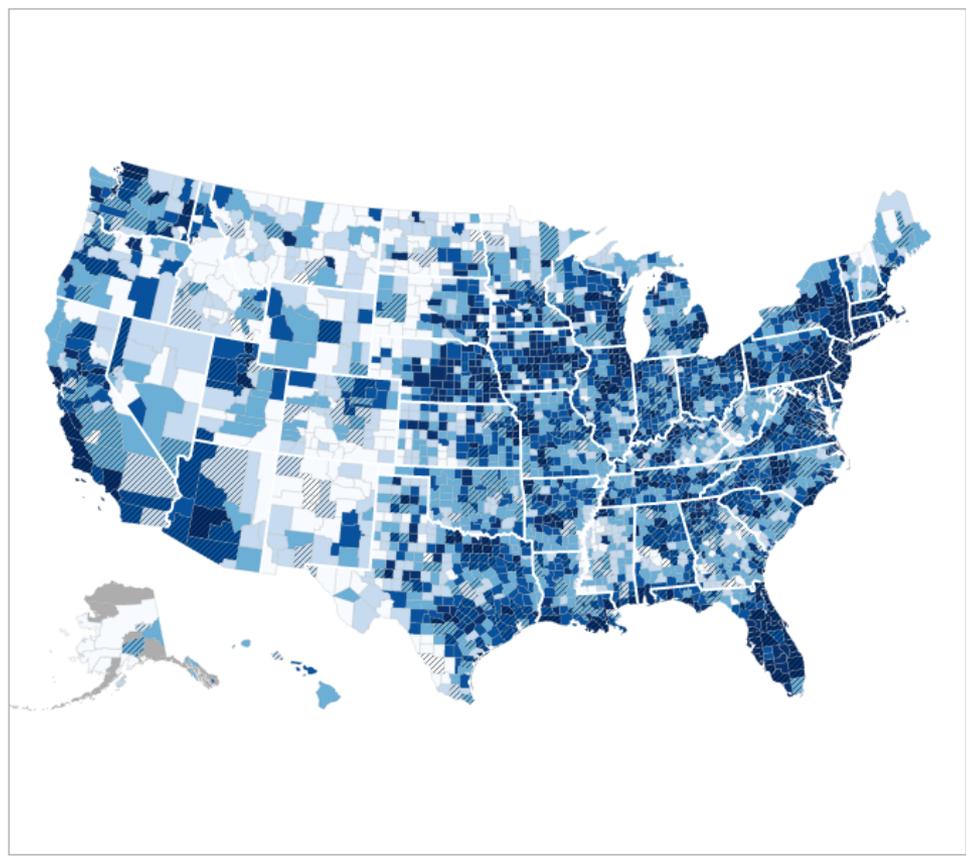
Condition: Acute Myocardial Infarct

- Sex: Acute Myocardial Infarction
- Age: Alzheimer's Disease
- Dual Eligible: Asthma
- Race and Ethnicity: Arthritis
- Comparison: Atrial Fibrillation
- Race and Ethnicity: Cancers
- Comparison: Chronic Kidney Disease
- Race and Ethnicity: Chronic Obstructive Pulmonary Disease
- Comparison: Depression
- Race and Ethnicity: Diabetes
- Comparison: Disability (Reason for Medicare Eligibility)
- Race and Ethnicity: End-Stage Renal Disease (Reason for Medicare Eligibility)
- Comparison: Heart Failure
- Race and Ethnicity: Hyperlipidemia
- Comparison: Hypertension
- Race and Ethnicity: Ischemic Heart Disease
- Comparison: **Obesity**
- Race and Ethnicity: Osteoporosis
- Comparison: Schizophrenia
- Race and Ethnicity: Stroke



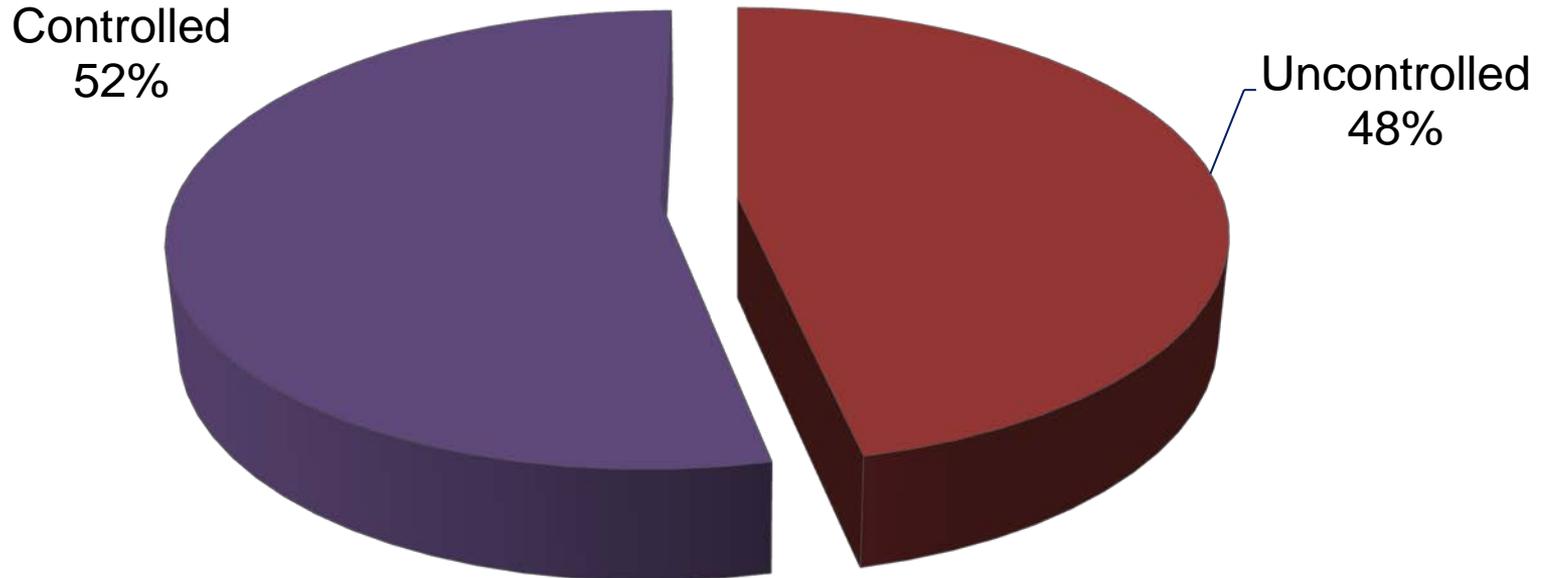
Disparities (MMD) Tool contains health outcome measures for disease prevalence, costs, and hospitalization for 18 specific chronic conditions, emergency department utilization, readmissions rates, mortality and preventable hospitalizations. The MMD Tool provides a user friendly way to explore and better understand disparities in chronic diseases, and allows users to: 1) visualize health outcome measures at a national, state, or county level; 2) explore health outcome measures by age, race and ethnicity, gender; 3) compare differences between two geographic locations (e.g., benchmark against the national average); and 4) compare differences between two racial and ethnic groups within the same geographic area.

[Quick Start Guide](#) | [FAQs](#) | [MMD Tool Technical Documentation](#) | [Office of Minority Health MMD Tool homepage](#)

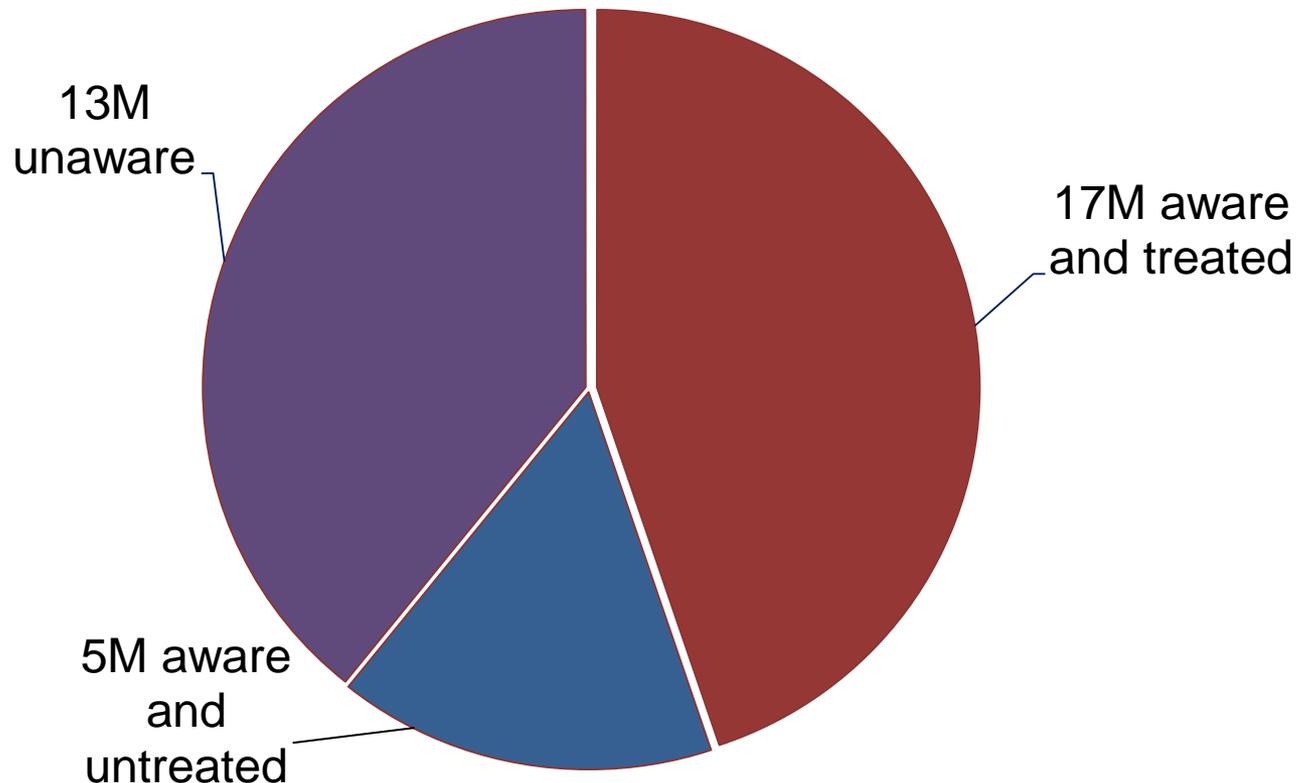


What does the data show?

70 Million Adults with Hypertension (29.1%)

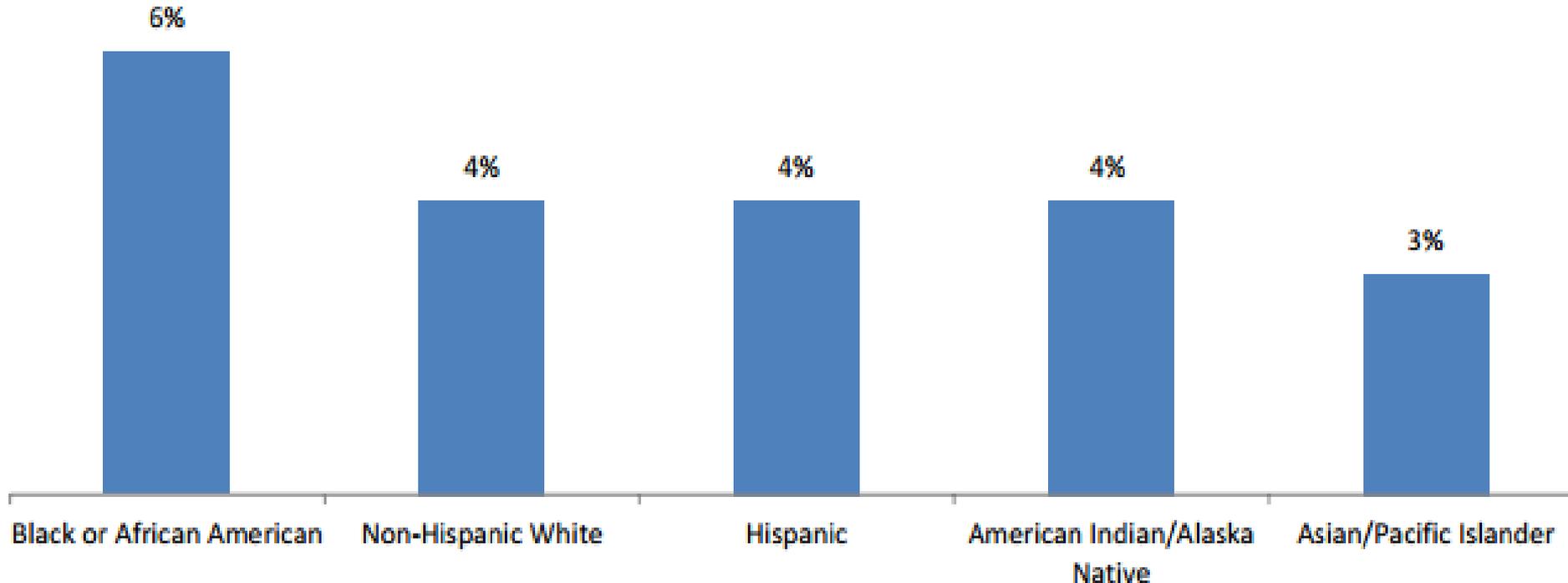


34M Adults With Uncontrolled Hypertension (by Awareness And Treatment Status)



Source: 2009-2010 National Health and Nutrition Examination Survey
Data may not add due to rounding.

Prevalence of Strokes and TIAs by Race/Ethnicity



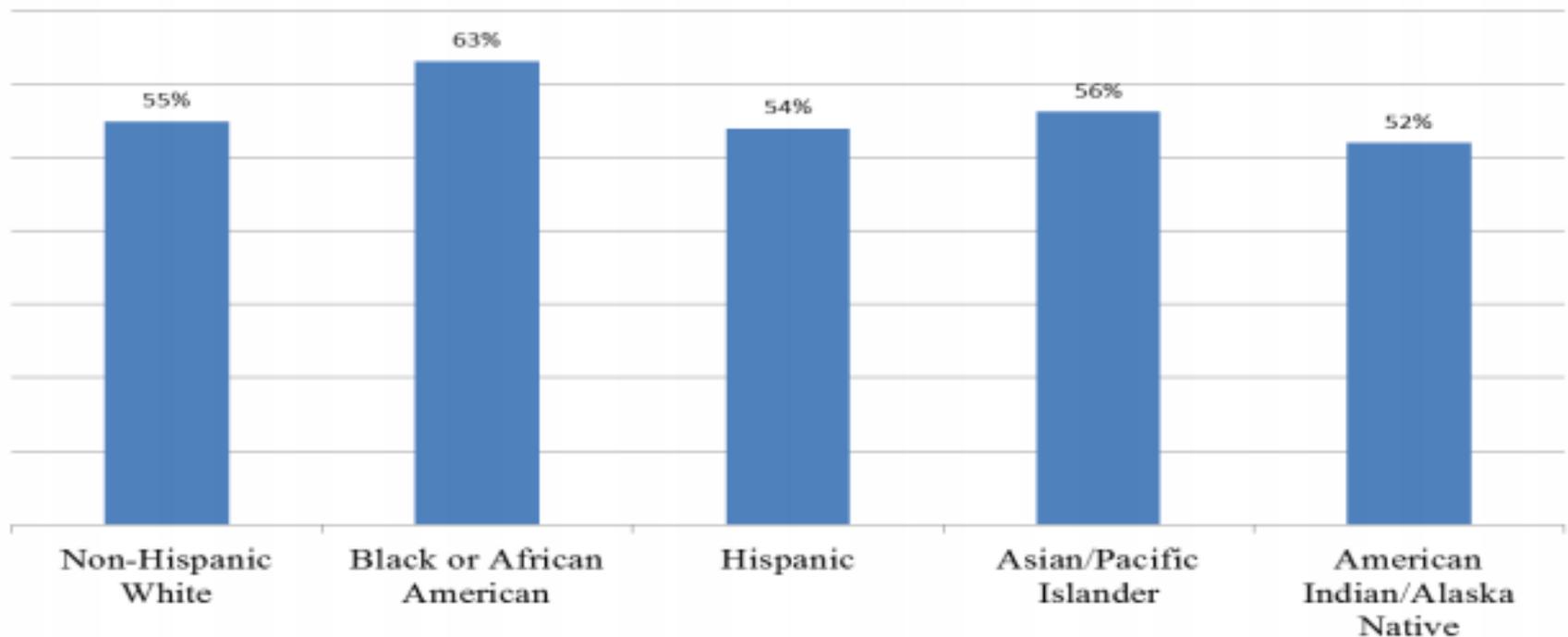
Source: Centers for Medicare & Medicaid Services, Chronic Condition Data Warehouse (CCW)

Note: Population is limited to Medicare Fee-For-Service beneficiaries. RTI Race Code used for analysis.

<https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-DataSnapshots.html>. October 2015

Hypertension by Race/Ethnicity

Medicare Beneficiaries with Claims Related to Hypertension, by Race/Ethnicity, 2012

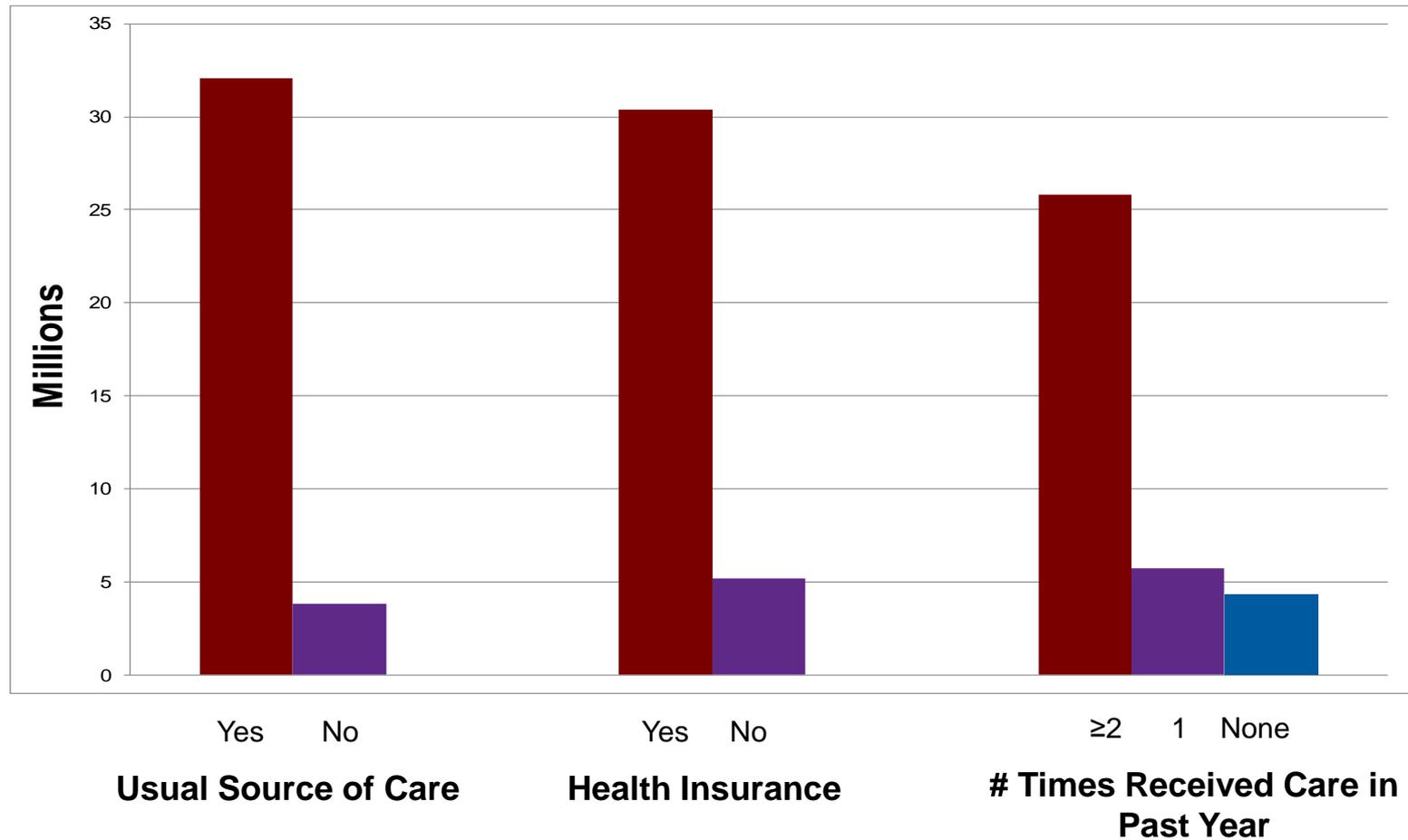


Source: Centers for Medicare & Medicaid Services. Chronic Condition Data Warehouse (CCW)

Note: Population is limited to Medicare Fee-For-Service beneficiaries. RTI Race Code used for analysis.

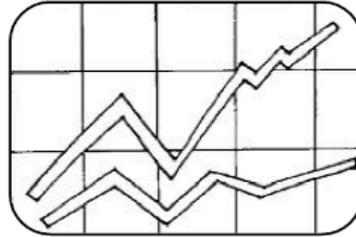
<https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-DataSnapshots.html>. June 2015

Uncontrolled Hypertension and Access to Care



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 Must Happen To Prevent a Million?

Reduce Smoking

6.3M fewer smokers

- Year-round media campaigns; pricing interventions
- Targeted outreach to drive uptake of covered benefits
- Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff
- Widespread adoption of smoke-free space policies
- Awareness of risks of second-hand smoke and the health benefits of smoke-free environments

Control Hypertension

10M more patients

- Detection of those with undiagnosed hypertension
- Systematic use of treatment protocols & other select QI tools
- Practice of self-measured BP monitoring with clinical support
- Recognition of high performers; dissemination of best practices
- Connection of clinical & community resources to benefit people with HTN
- Enhanced medication adherence
- Intense focus on those with high burden and at high risk

Decrease Sodium Intake

20% reduction

- Adoption of Healthy Food Service Guidelines
- Voluntary sodium reduction and expansion of choices by food industry
- Recognition of high performers and dissemination of best practices
- Clear communication of the evidence supporting the health benefits of population-level sodium reduction



Events will also be prevented by improving aspirin use, cholesterol management, and utilization of cardiac rehab, and by eliminating artificial trans-fat consumption

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/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

Focus on Social Determinants of Health: Addressing Social Needs

- Hospital Readmission Reduction...what's the problem?
 - **High re-admission rates could indicate breakdowns in care delivery systems**
 - Payment systems incentivized fragmentation
 - More complicated cases = more “hands in the pot”
 - Expectation of patients to self-manage is great

Clinician-patient interaction

- Episodic treatment
- Unmanaged condition worsening
- Use of suboptimal medication regimens
- Lack of primary care or social support



- Return to ER

No community infrastructure to achieve common care goals

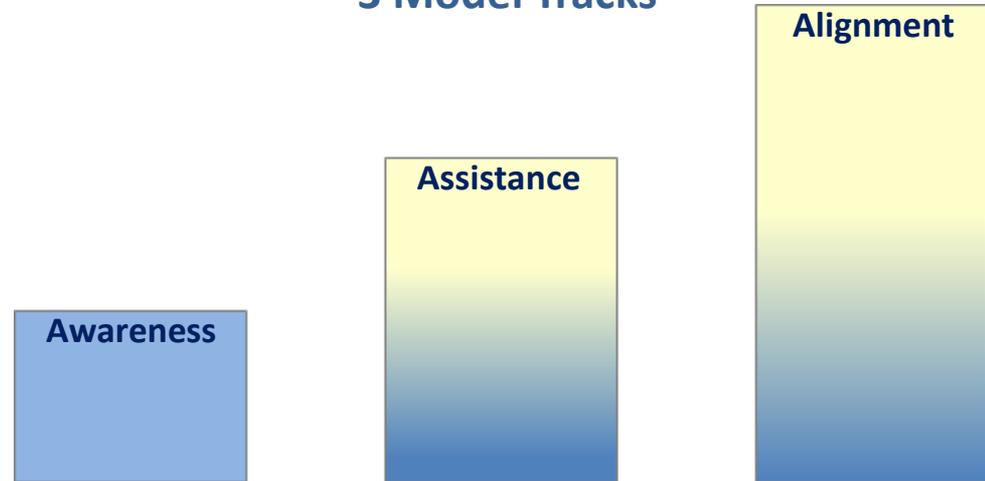
- Lack of standard communication
- Unreliable information transfer
- Unsupported patient/family engagement during transfers
- Lack of follow-up to address prevention

Accountable Health Communities Model addresses health-related social needs

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** and **community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

3 Model Tracks



Track 1 Awareness – Increase beneficiary *awareness* of available community services through information dissemination and referral

Track 2 Assistance – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services

Track 3 Alignment – Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

Total
Investment > **\$157**
million

44 Anticipated Award Sites

<https://innovation.cms.gov/initiatives/ahcm>

CMS Quality Strategy Goals



“Working to Achieve Health Equity”

CMS Health Equity Plan for Medicare



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



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



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



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



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



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



CMS Office of Minority Health

- **Strengthening CMS Data & Systems**
 - Improving CMS data on race and ethnicity and other demographics
 - Reporting stratified quality measures
 - Developing measures to identify beneficiaries who are sexual and gender minorities
- **Building the Business Case for Health Equity**
 - Creating an evidence base that demonstrates the economic/financial return on investing in health equity
- **Creating & Disseminating Data Products & Tools**
 - Quarterly data briefs
 - ResDAC training module for health disparities researchers



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 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>
 - HIV and Hepatitis C
 - Medical Oncology
 - Obstetrics and Gynecology
 - Orthopedics
- 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

Quality data from health care providers is essential...



www.bls.gov

Western Region Information Office
(San Francisco)
415-625-2270

Covering AK, AZ, CA, HI, ID, NV, OR, and WA

- Ensure an effective health care marketplace that accounts for:
 - High wages in the West
 - Growth in the number of health care employees
- Provide the most accurate measures for cost adjustment
- Support workforce planning

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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