CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMS Innovation and Health Care Delivery System Reform

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Better Care, Smarter Spending, Healthier People

- In three words, our vision for improving health delivery is about **better, smarter, healthier.**
- If we find better ways to **deliver care, pay providers, and distribute information,** we can receive better care, spend our dollars more wisely, and have healthier communities, a healthier economy, and a healthier country.
- We understand that it's **our role and responsibility to lead … and we will.**
- What we won't do – and can't do – is go it alone. Patients, providers, government, and business all stand to benefit if we get this right, and this **shared purpose calls out for deeper partnership**.
- So we will continue to work across sectors for the goals we share: **better care, smarter spending, and healthier people**.

Overview

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Historical state

Key characteristics

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

Systems and Policies

- Fee-For-Service Payment Systems

Public and private sectors

Evolving future state

Key characteristics

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

Systems and Policies

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

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

Focus Areas	Description
Pay Providers	▪ Promote value-based payment systems – Test alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven alternative payment models to scale
Deliver Care	▪ Encourage the integration and coordination of clinical and support services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Distribute Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	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 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value 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 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Goals

- **30%** of Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and **50%** by the end of 2018
- **85%** of all Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and **90%** by the end of 2018

Purpose

- Set **internal goals** for HHS
- Invite **private sector payers and Medicaid** to match or exceed HHS goals

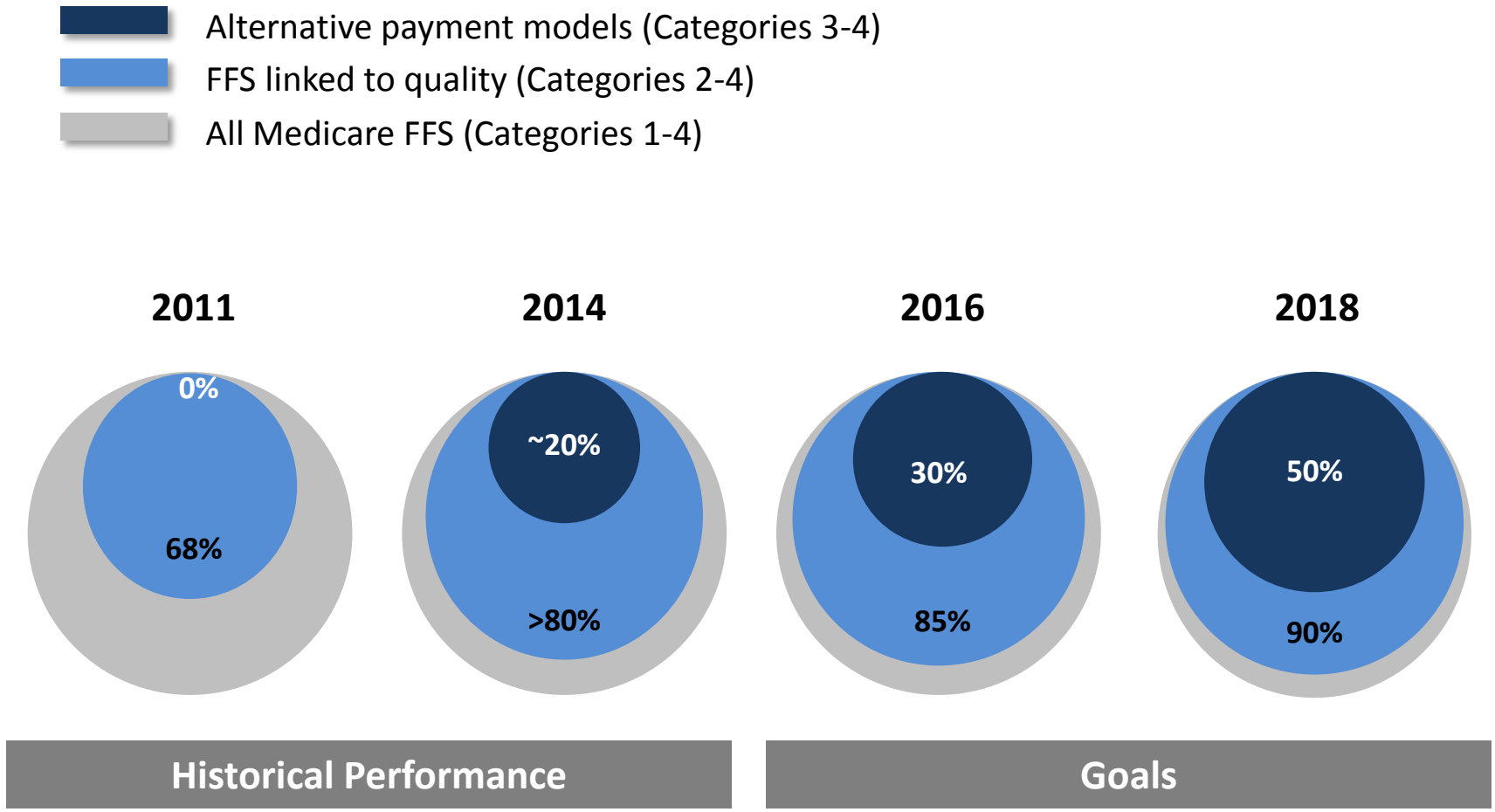
Stakeholders

- Consumers
- Businesses/Purchasers
- Payers
- Providers
- State partners (including Medicaid programs)

Next steps

- **Testing of new models and expansion of existing models** is critical to reaching incentive goals
- Creation of the Health Care Payment **Learning and Action Network** to align incentives and identify best practices

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018



CMS is aligning with private sector and states to drive delivery system reform

CMS Strategies for Aligning with Private Sector and States

Convening Stakeholders

- Convened payers in 7 markets in Comprehensive Primary Care
- Convening payers, providers, employers, consumers, and public partners through the Health Care Payment Learning and Action Network

Incentivizing Providers

- Pioneer ACOs agreements required 50% of the ACO's business to be in value-based contracts by the end of the second program year

Partnering with States

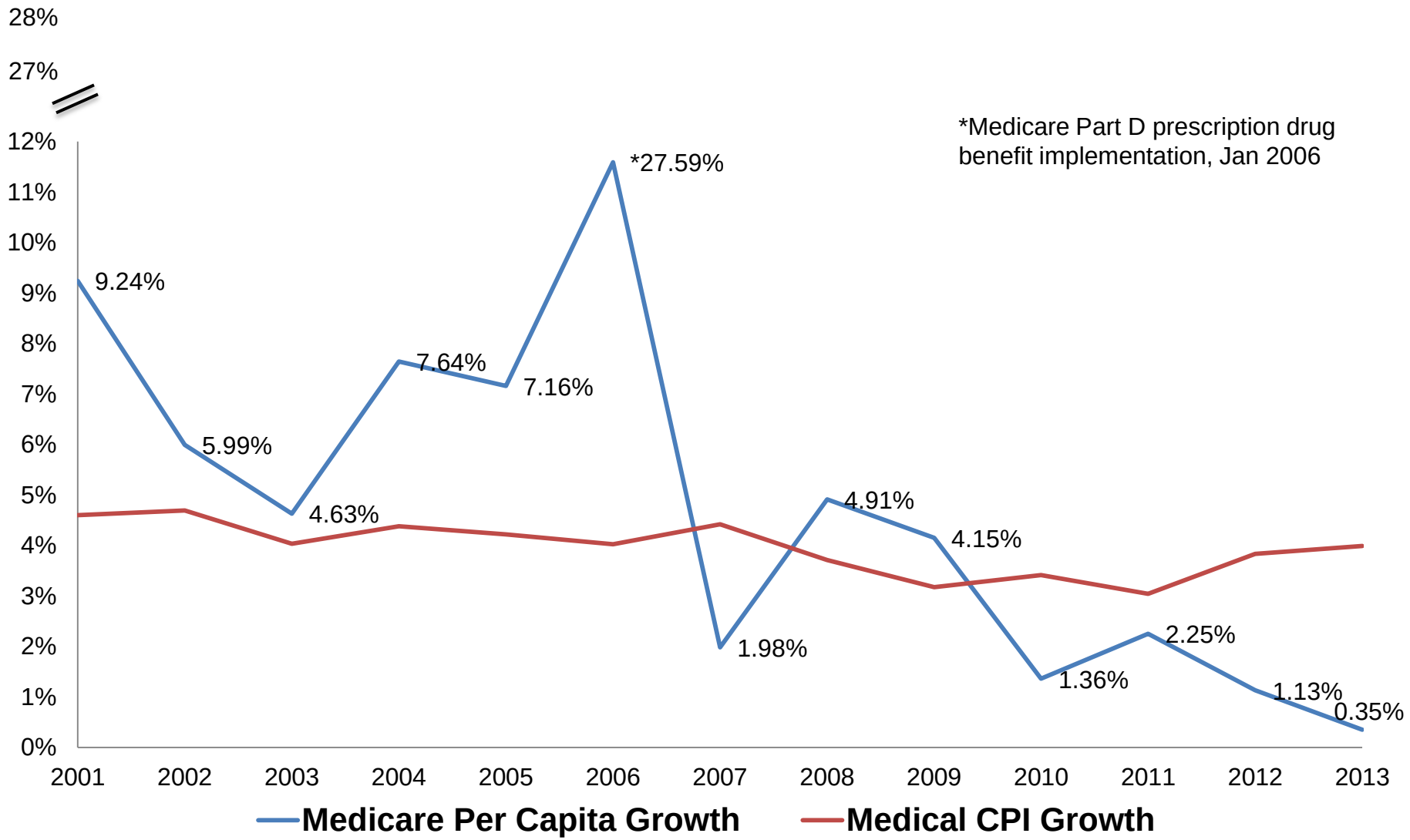
- The State Innovation Models Initiative funds testing awards and model design awards for states implementing comprehensive delivery system reform
- The Maryland All-Payer Model tests the effectiveness of an all-payer rate system for hospital payments

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Results: Per Capita Spending Growth at Historic Lows



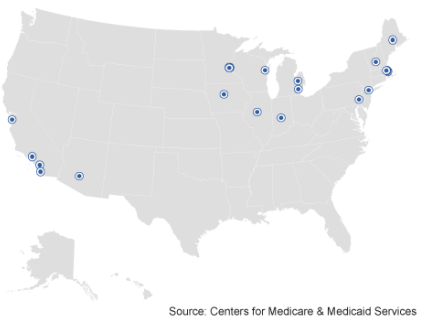
Source: CMS Office of the Actuary

Pioneer ACOs provided higher quality and lower cost care to Medicare beneficiaries in their first two performance years

- Pioneer ACOS were designed for **organizations with experience in coordinated care** and ACO-like contracts

- Pioneer ACOs showed **improved quality outcomes**
  - Quality **outperformed published benchmarks** in 15/15 clinical quality measures and 4/4 patient experience measures in year 1 and improved in year 2
  - **Mean quality score of 85.2% in 2013** compared to 71.8% in 2012
  - Average performance score **improved in 28 of 33 (85%) quality measures**

- Pioneer ACOs **generated savings for 2nd year in a row**
  - **$384M in program savings** combined for two years†
  - Average **savings per ACO increased** from $2.7 million in PY1 to $4.2 million in PY2‡



Source: Centers for Medicare & Medicaid Services

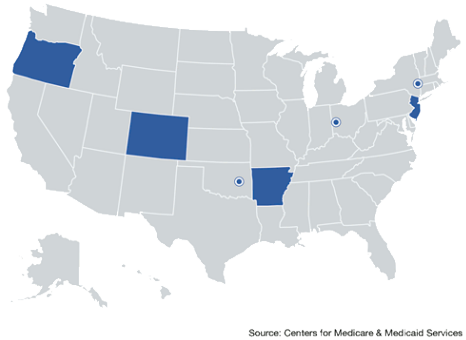
- 19 ACOs operating in 12 states (AZ, CA, IA, IL, MA, ME, MI, MN, NH, NY, VT, WI) reaching over 600,000 Medicare fee-for-service beneficiaries
- Duration of model test: January 2012 – December 2014; 19 ACOs extended for 2 additional years

† Results from regression based analysis
‡ Results from actuarial analysis

Comprehensive Primary Care (CPC) is showing early positive results

- CMS convenes Medicaid and commercial payers to support primary care practice transformation through enhanced, non-visit-based payments, data feedback, and learning systems

- Across all 7 regions, CPC **reduced Medicare Part A and B expenditures** per beneficiary by $14 or 2%*
  - Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions



Source: Centers for Medicare & Medicaid Services

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients
- Duration of model test: Oct 2012 – Dec 2016

* Reductions relative to a matched comparison group and do not include the care management fees (~$20 pbpm)

Spotlight: Comprehensive Primary Care, SAMA Healthcare

SAMA Healthcare Services is an independent four-physician family practice located located in El Dorado, a town in rural southeast Arkansas

Services made possible by CPC investment

- Care management
  - Each **Care Team** consists of a doctor, a nurse practitioner, a care coordinator, and three nurses
  - Teams drive **proactive preventive care** for approximately 19,000 patients
  - Teams use Allscripts' **Clinical Decision Support** feature to alert the team to missing screenings and lab work
- Risk stratification
  - The practice implemented the **AAFP six-level risk stratification tool**
  - Nurses mark records **before the visit** and physicians **confirm stratification during the patient encounter**

-Practice Administrator

"A lot of the things we're doing now are things we wanted to do in the past… **We needed the front-end investment** of start-up money to develop our teams and our processes"

Partnership for Patients contributes to quality improvements and cost savings

- **Data shows a 17% reduction in hospital acquired conditions across all measures from 2010 – 2013**
  - 50,000 lives saved
  - 1.3 million patient harm events avoided
  - $12 billion in savings
- **Many areas of harm dropping dramatically – patient safety improving**

Leading Indicators, change from 2010 to 2013

Ventilator-Associated Pneumonia	Early Elective Delivery	Central Line-Associated Blood Stream Infections	Venous thromboembolic complications	Re-admissions
62.4% ↓	70.4% ↓	12.3% ↓	14.2% ↓	7.3% ↓

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

The Innovation Center portfolio aligns with delivery system reform focus areas

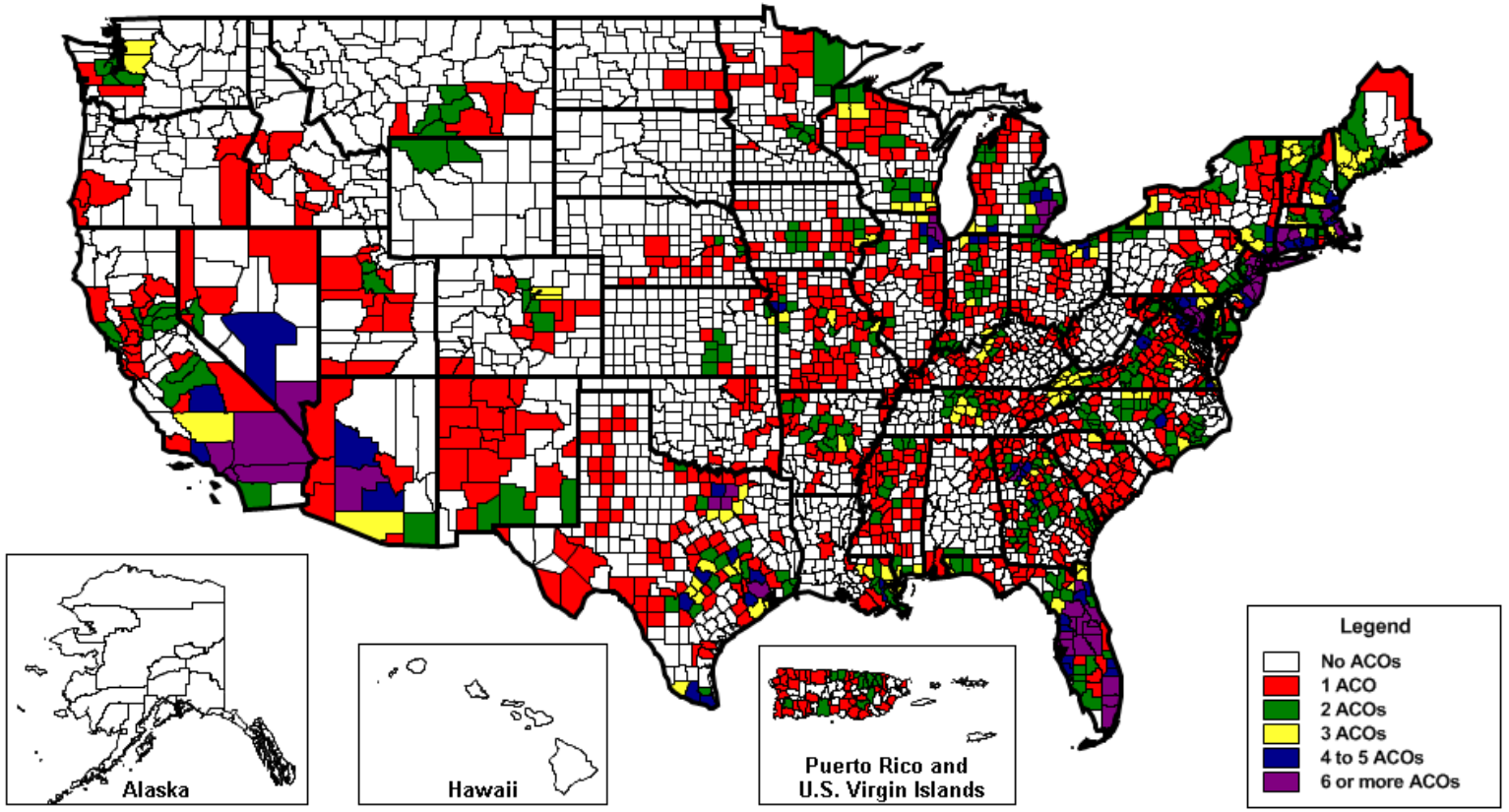
Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration ▪ **Bundled Payment for Care Improvement** – Model 1: Retrospective Acute Care – Model 2: Retrospective Acute Care Episode & Post Acute – Model 3: Retrospective Post Acute Care – Model 4: Prospective Acute Care – Oncology Care Model ▪ **Initiatives Focused on the Medicaid** – Medicaid Emergency Psychiatric Demonstration – 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
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice – Community-Based Care Transitions ▪ **Health Care Innovation Awards** ▪ **State Innovation Models Initiative** – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model ▪ **Million Hearts Initiative**
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

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

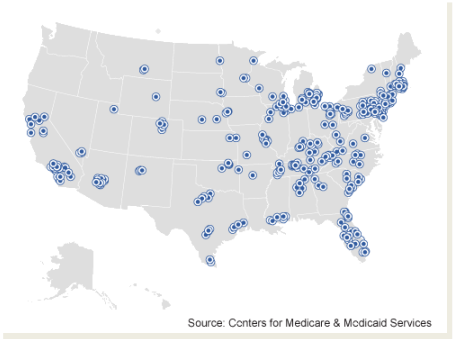
- **424 ACOs** have been established in the MSSP and Pioneer ACO programs
- **7.8 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County



Bundled Payments for Care Improvement is also growing rapidly

- The bundled payment model targets 48 conditions with a single payment for an episode of care
  - Incentivizes providers to take **accountability for both cost and quality** of care
  - **Four Models**
    - Model 1: Retrospective acute care hospital stay only
    - Model 2: Retrospective acute care hospital stay plus post-acute care
    - Model 3: Retrospective post-acute care only
    - Model 4: Acute care hospital stay only
- 102 Awardees and 167 episode initiators in phase 2 as of January 2015
- 85 new awardees and 373 new episode initiators will enter phase 2 in April 2015



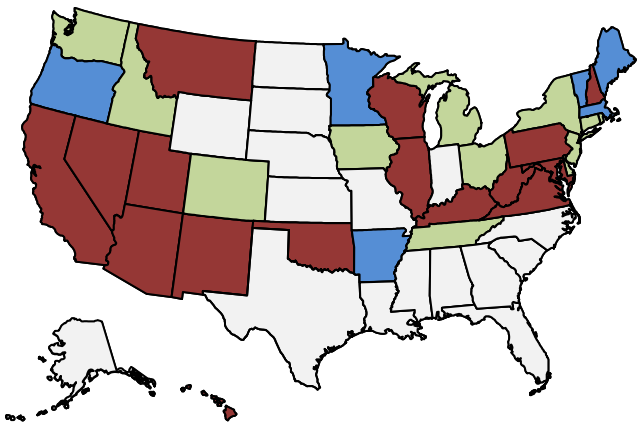
- Duration of model is scheduled for 3 years:
  - Model 1: April 2013 to present
  - Models 2,3,4: October 2013 to present

* Current as of January 2015

State Innovation Model grants have been awarded in two rounds

- CMS is testing the ability of **state governments to utilize policy and regulatory levers** to accelerate health care transformation

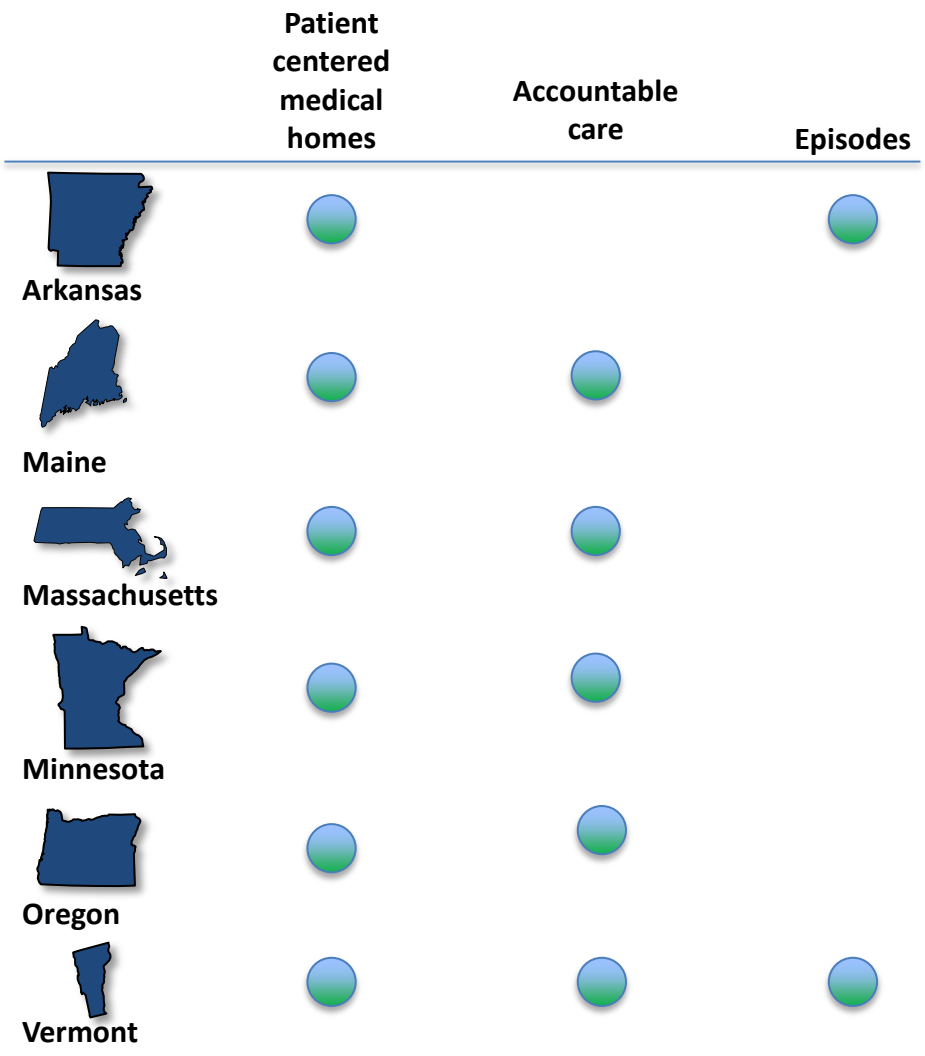
- Primary objectives include
  - Improving the **quality of care** delivered
  - Improving **population health**
  - Increasing **cost efficiency** and expand **value-based payment**



- Six round 1 model **test states**
- Eleven round 2 model **test states**
- Twenty one round 2 model **design states**

Round 1 states are testing and Round 2 states are designing and implementing comprehensive reform plans

Round 1 States testing APMs

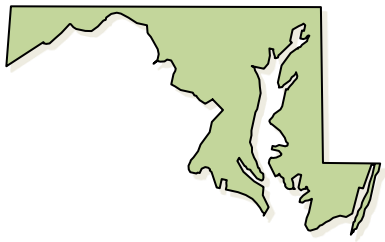


Round 2 States designing interventions

- **Near term CMMI objectives**
  - Establish project milestones and success metrics
  - Support development of states' stakeholder engagement plans
  - Onboard states to Technical Assistance Solution Center and SIMergy Collaboration site
  - Launch State HIT Resource Center and CDC support for Population Health Plans

Maryland is testing an innovative All-Payer Payment Model

- Maryland is the nation's only **all-payer hospital rate regulation system**
- Model will test whether effective accountability for both cost and quality can be achieved within all-payer system based upon **per capita total hospital cost growth**
- **Quality of care** will be measured through
  - Readmissions
  - Hospital Acquired Conditions
  - Population Health



- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

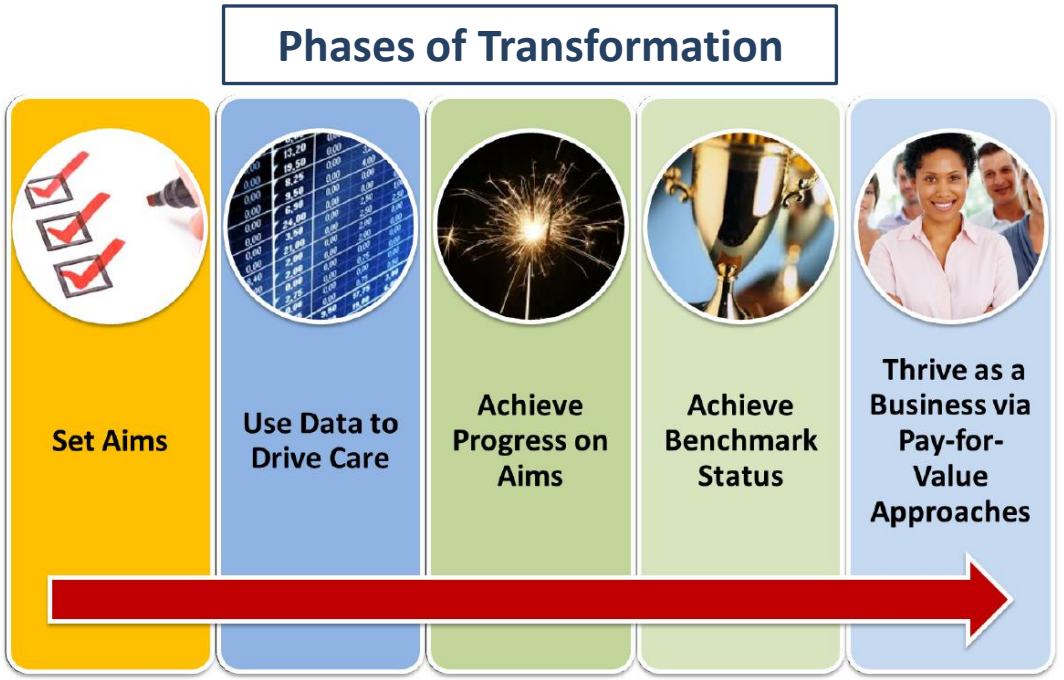
* US census bureau estimate for 2013

Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **150,000 clinician practices** over the next four years to **improve on quality, lower costs, and enter alternative payment models**
- Two network systems will be created

1) **Practice Transformation Networks**: peer-based learning networks designed to coach, mentor, and assist

2) **Support and Alignment Networks**: provides a system for utilizing professional associations and public-private partnerships to drive improvement



Innovation Center – 2015 Looking Forward

We are focused on:

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

Next Generation ACO Model

- A new opportunity in accountable care:
  - More predictable financial targets;
  - Greater opportunities to coordinate care;
  - High quality standards consistent with other Medicare programs and models.
- The Model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Original Medicare beneficiaries.

Model Principles

- Protect Medicare FFS beneficiaries' freedom of choice;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark that:
  - Rewards quality;
  - Rewards both attainment of and improvement in efficiency; and
  - Ultimately transitions away from updating benchmarks based on ACO's recent expenditures;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care (e.g., telehealth);
- Allow beneficiaries a choice in their alignment with the ACO
  - Mitigates fluctuations in aligned beneficiary populations
  - Respects beneficiary preferences;
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms (e.g. population-based payments).

What can you do to help our system achieve the goals of Better Care, Smarter Spending, and Healthier People?

- **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
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

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28