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

Greater Philadelphia Business Coalition on Health

CMS' Perspective on Payment Reform and Value-based Purchasing

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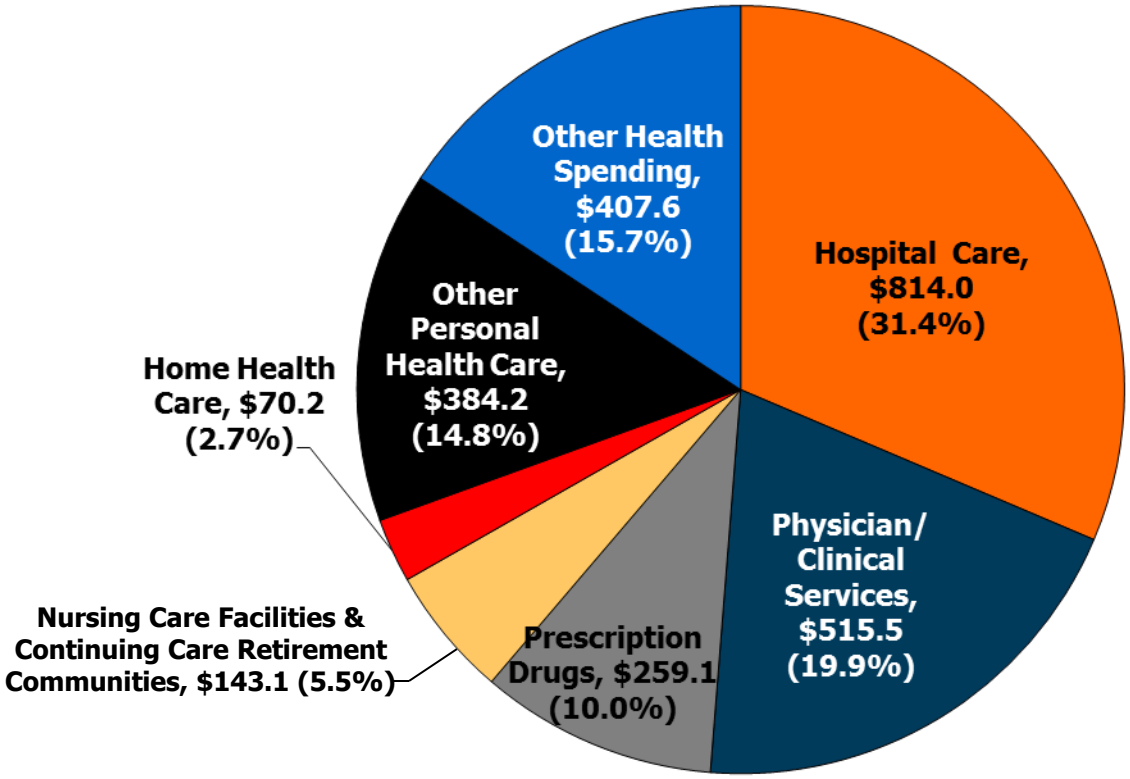
Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world (over $900B per year)
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures. (about $2.5T)
- CMS programs currently provide health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP (Children's Health Insurance Program); or roughly 1 in every 3 Americans.
- CMS answers about 75 million inquiries annually.
- Millions of consumers will receive health care coverage through new health insurance programs authorized in the Affordable Care Act.

Distribution of National Health Expenditures, by Type of Service (in Billions), 2010



NHE Total Expenditures: $2,593.6 trillion

Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).

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

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

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

- Pay Providers
- Deliver Care
- Distribute Information

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

Medicare Fee-for-Service

GOAL 1:

30%

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

GOAL 2:

85%

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

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

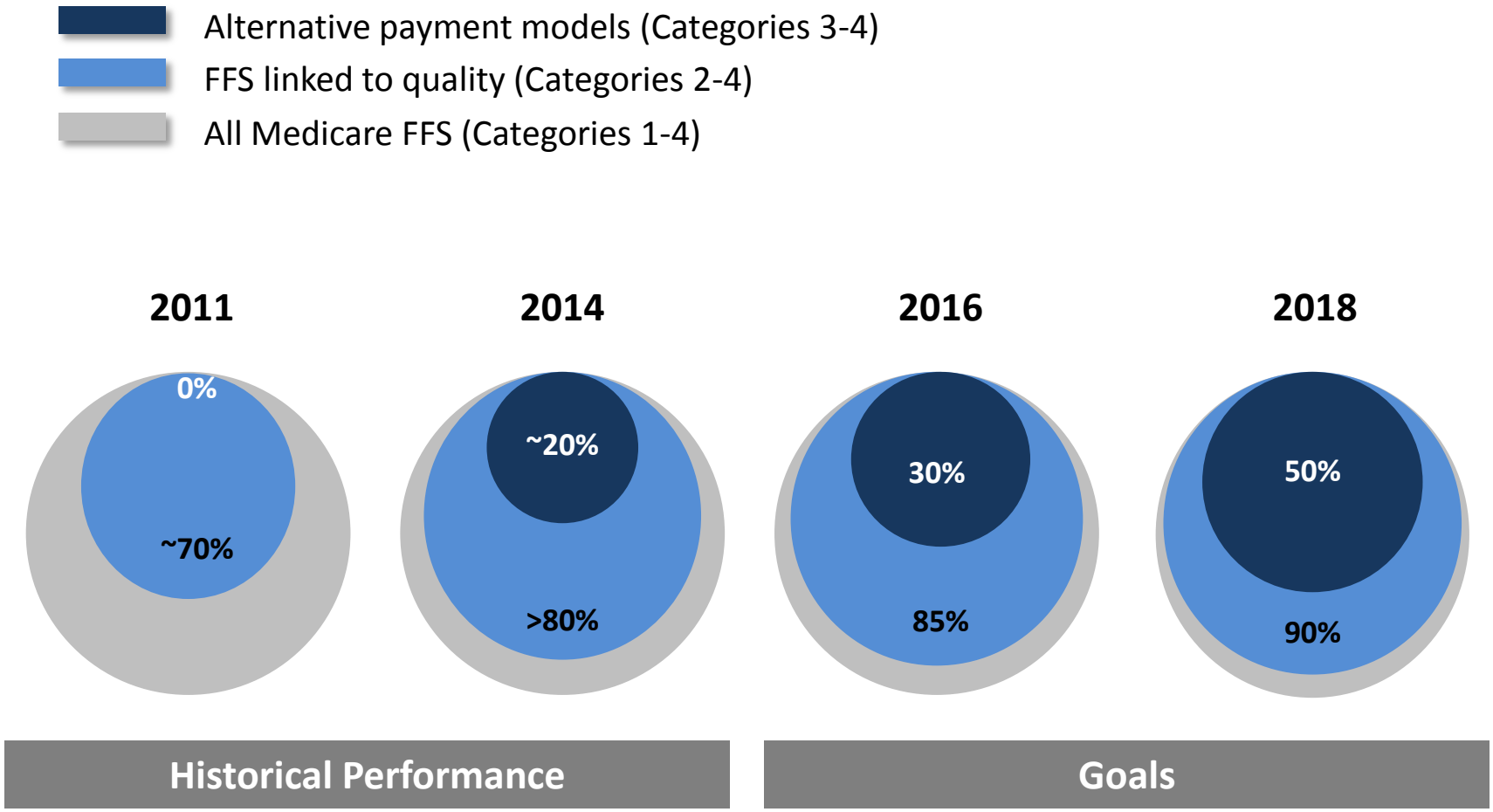
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

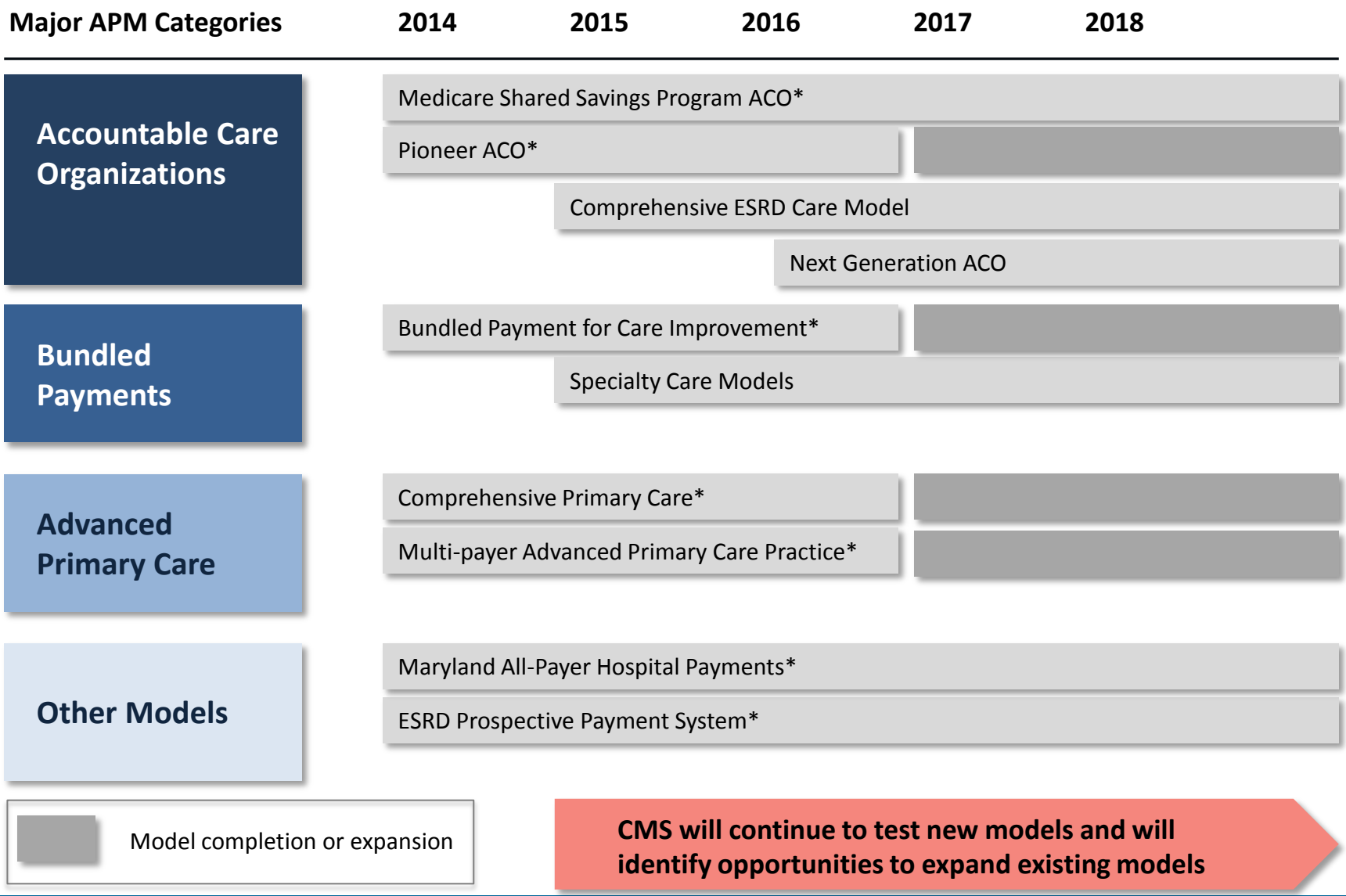
Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

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



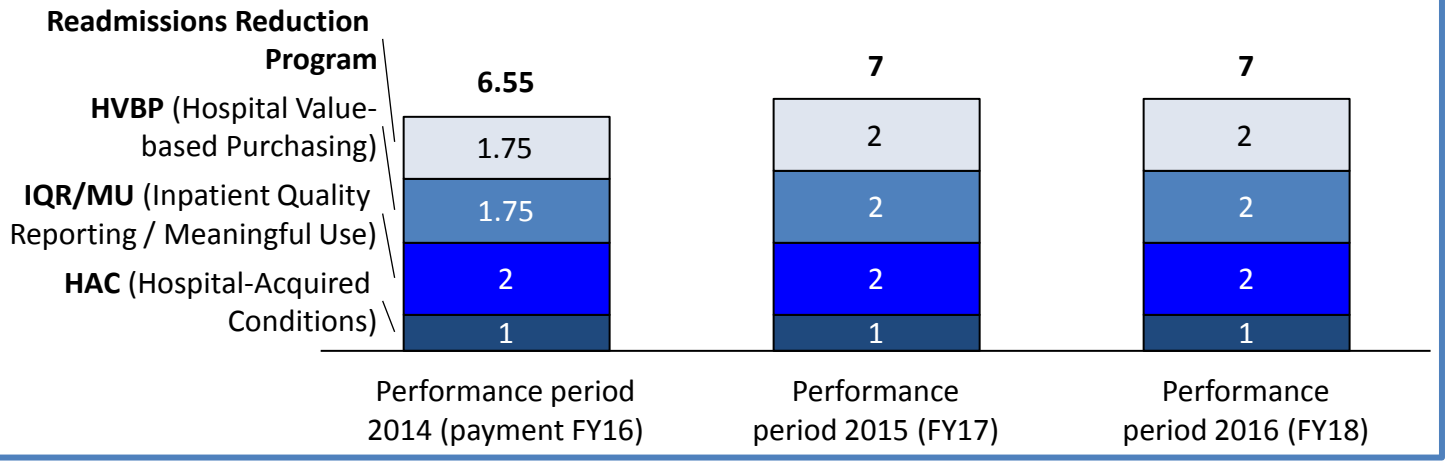
CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality



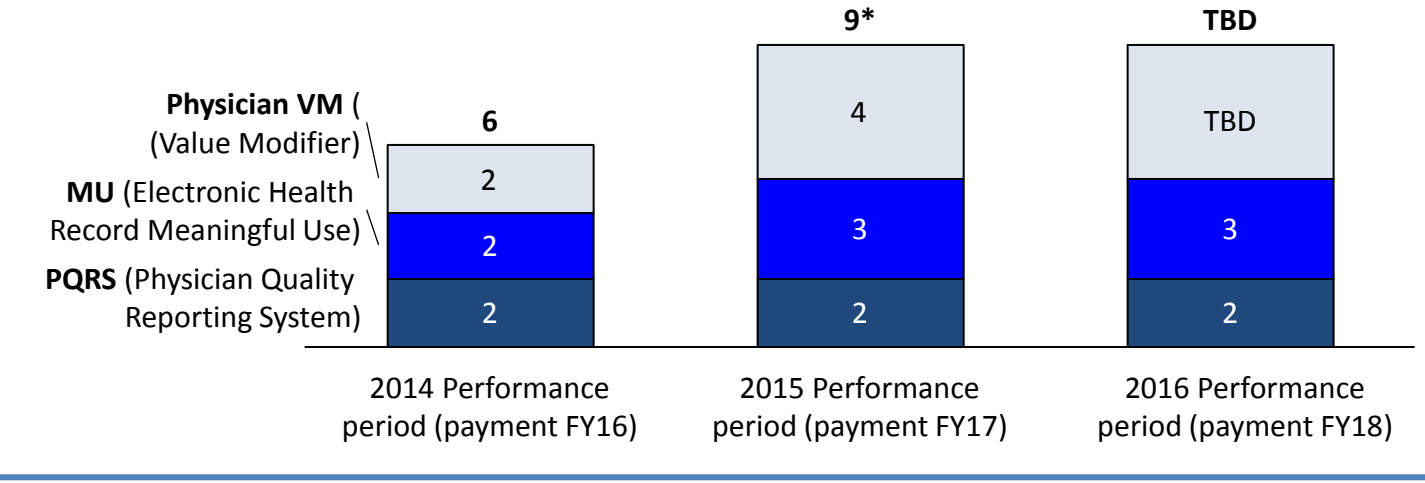
* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

CMS will reach Goal 2 through more linkage of FFS payments to quality or value

Hospitals, % of FFS payment at risk (maximum downside)



Physician, % of FFS payment at risk (maximum downside)



* Physician VM adjustment depends upon group size and can range from 2% to 4%

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

CMS Strategies for Aligning with Private Sector and states

Convening Stakeholders

Incentivizing Providers

Partnering with States

Delivery System Reform and Our Goals

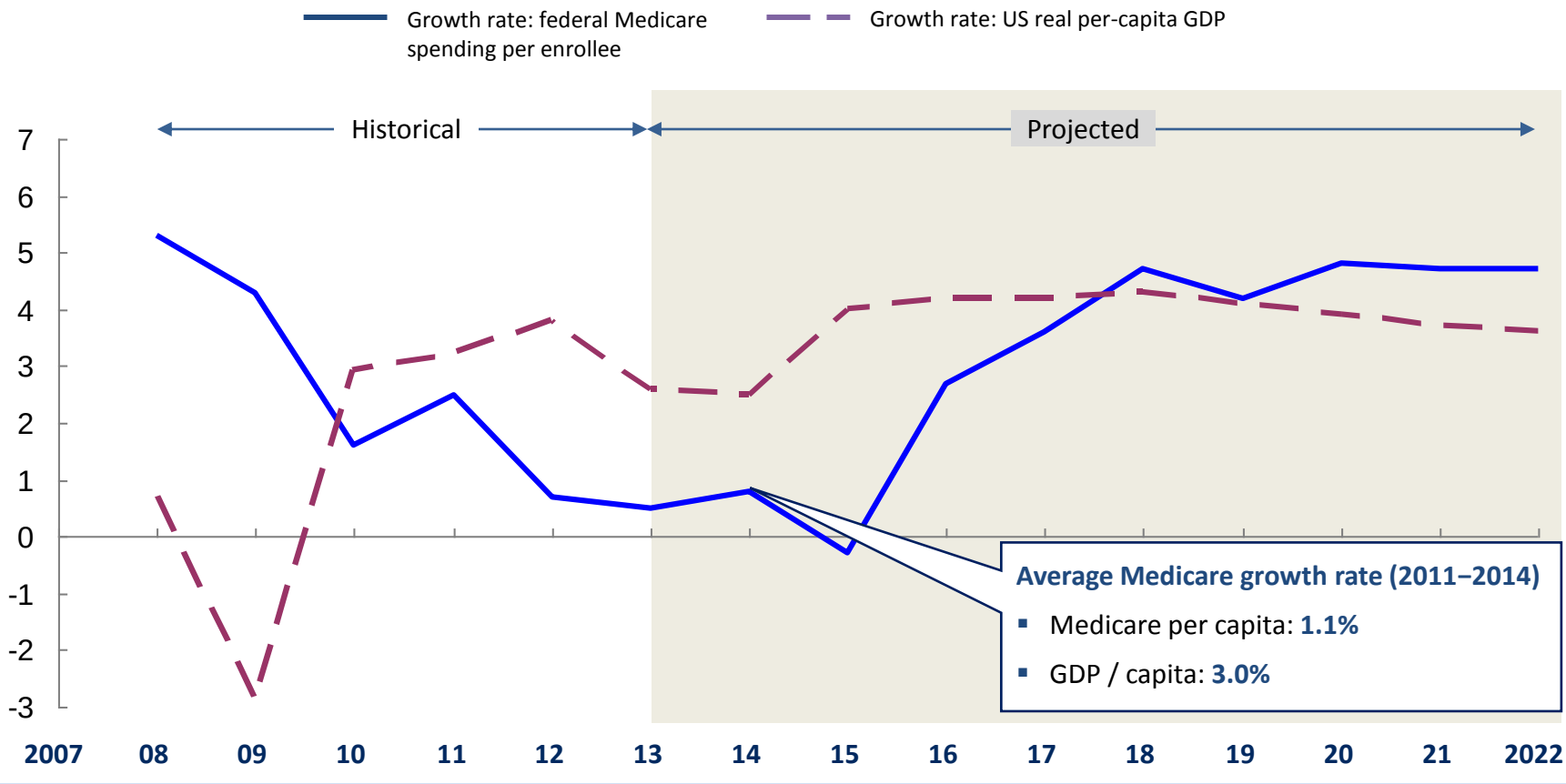
Early Results

CMS Innovation Center

Medicare growth has fallen below GDP growth since 2010 due, in part, to CMS policy changes and new models of care

Gap between growth in federal spending on Medicare and GDP growth

Annual growth for US real per-capita GDP and federal Medicare expenditures per enrollee (%)



- 2011, 2012, and 2013 saw the slowest growth in real per capital health care spending on record

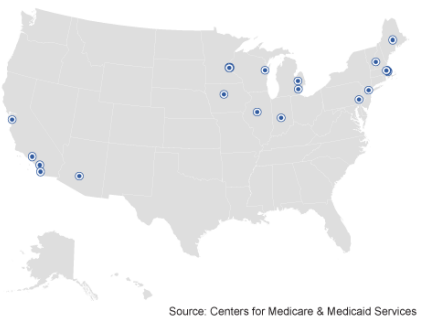
SOURCE: CMS Office of the Actuary National Health Expenditure Data (2013-2023 projections)

Pioneer ACOs meet requirement for expansion with quality improvement and $384 M in savings over two 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 84% in 2013** compared to 71% 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

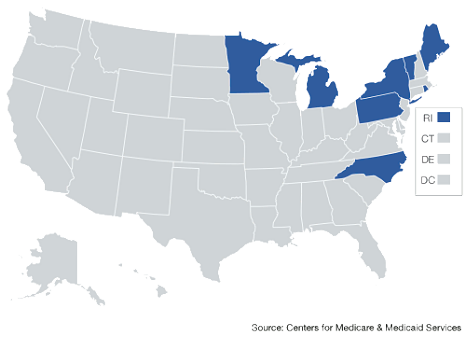
† Results from regression based analysis
‡ Results from actuarial analysis

Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration has generated net savings

- Medicare participated in 8 **state-led multi-payer patient centered medical home (PCMH) initiatives** in partnership with Medicaid and commercial payers

- CMS supports these multi-payer PCMH initiatives through:
  - Enhanced, non-visit-based payments to practices, community-based support teams, and states
  - Quarterly data feedback

- Gross savings of $40.3 million and **net savings of $4.2 million** were observed



Source: Centers for Medicare & Medicaid Services

- Initially 8 states (ME, MI, MN, NC, NY, PA, RI, VT) encompassing approximately 1000 practices, 6000 providers, and 2.9 million participants including 560,000 Medicare fee-for-service beneficiaries

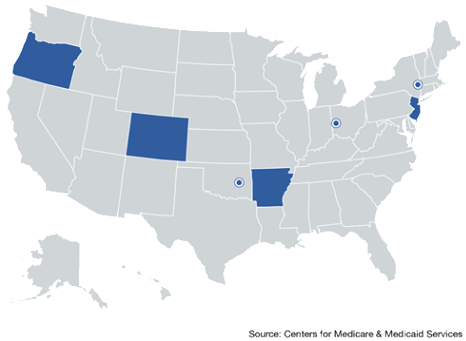
- Duration of initial model test: July 2011 – December 2014
  - ME, MI, NY, RI, VT were extended through Dec 2016

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

CPC
Comprehensive Primary Care

- 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)

Positive results in CPC were more prominent in some states

Percent change in cost and utilization by state (Oct 2012–Sept 2013)

	States							
	All	AR	CO	NJ	NY	OH/KY	OK	OR
Medicare expenditure and service use								
Expenditure without fees	-2%†	0%	1%	-5%‡	-2%	4%*	-7%‡	-2%
Hospitalizations	-2%*	2%	3%	-5%*	-6%†	4%	-7%‡	-5%
Outpatient ED visits	-3%‡	-3%	-1%	-4%	2%	-1%	-7%‡	-6%*

Green = negative and statistically significant
Red = positive and statistically significant

*/†/‡ Statistically significant to the 10%/5%/1% level, two-tailed test.

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"

Making the Case for Safety

- *Medical harm is the fourth leading cause of death in the U.S. Each year, 100,000 Americans die from preventable medical errors in hospitals– more than auto accidents, AIDS, and breast cancer combined.*

- On any given day, 1 out of every 20 patients in American hospitals is affected by a hospital-acquired infection.
- Among chronically ill adults, 22 percent report a “serious error” in their care.
- About 1,800 people living in nursing homes die each year from falls.
- Nearly 1 in 5 Medicare hospital patients readmitted within 30 days

- Despite pockets of success -- we still see massive variation in the quality of care, and no major change in the rates of harm and preventable readmissions over the past decade.

Partnership for Patient contributes to quality improvements

Data shows…

17% ↓

Hospital Acquired Conditions

50,000

LIVES SAVED

1.3 million

Patient harm events avoided

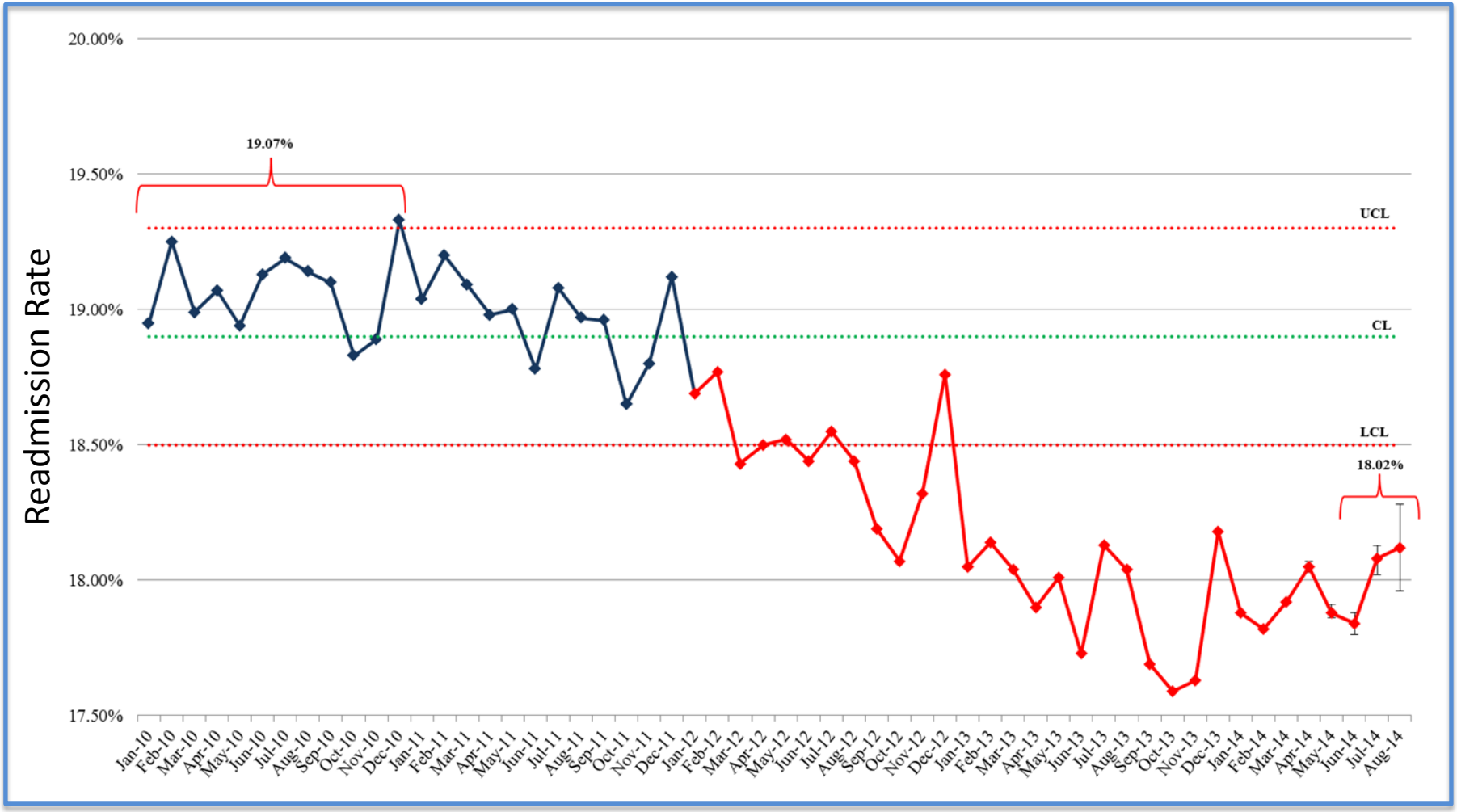
$12 billion

in savings

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% ↓

Medicare all-cause, 30-day hospital readmission rate is declining



Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

Legend: CL: control limit; UCL: upper control limit; LCL: lower control limit

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

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)**

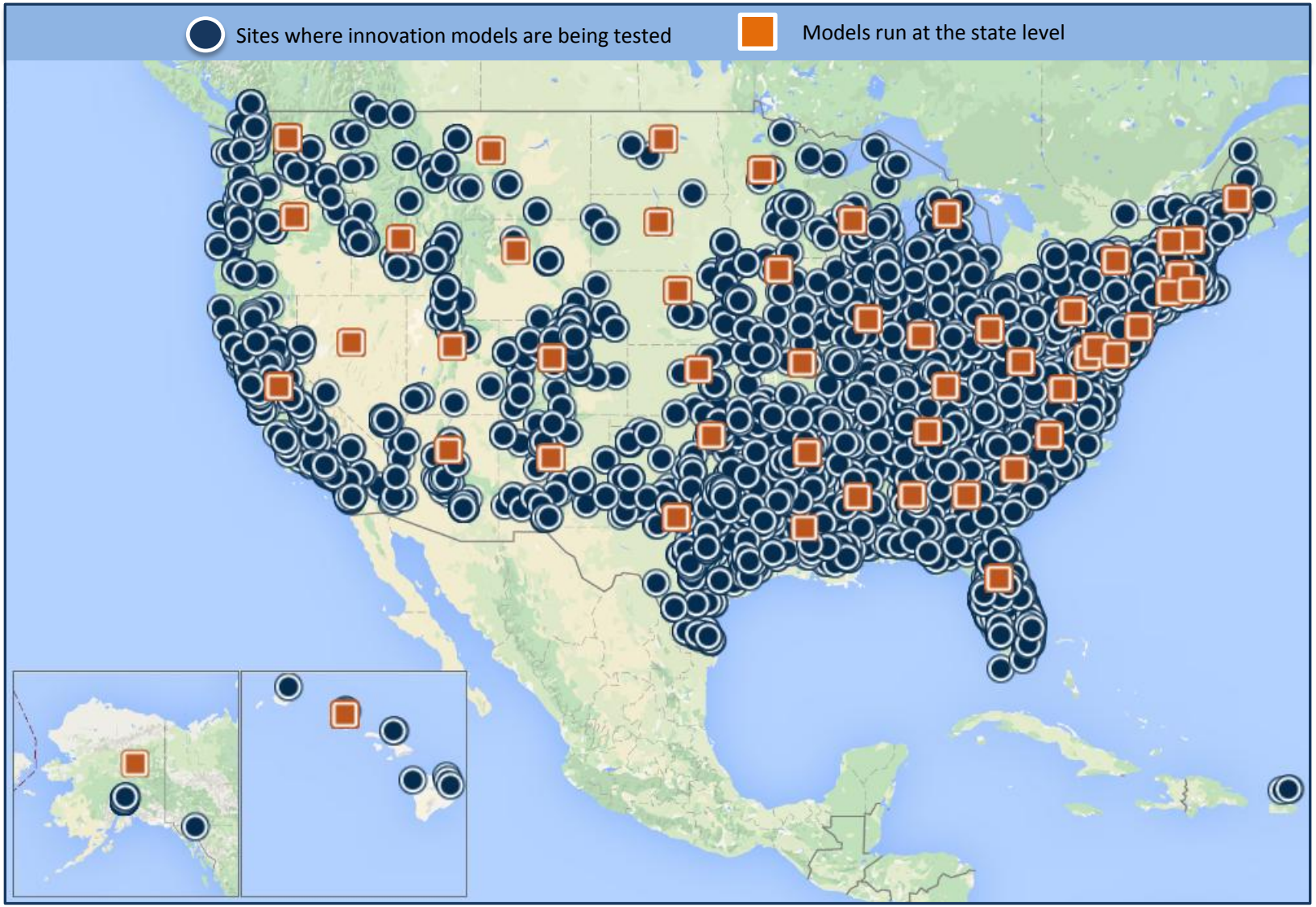
If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

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 – Next Generation ACO ▪ **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

CMS has engaged the health care delivery system and invested in innovation across the country



Source: CMS Innovation Center website, January 2015

The Health Care Payment Learning and Action Network will accelerate the transtion to alternative payment models

- **Medicare alone cannot drive sustained progress** towards alternative payment models (APM)
- Success depends upon a **critical mass of partners** adopting new models
- The network will
  - **Convene** payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  - **Identify areas of agreement** around movement to APMs
  - Collaborate to **generate evidence, shared approaches, and remove barriers**
  - **Develop common approaches** to core issues such as beneficiary attribution
  - Create **implementation guides** for payers and purchasers

Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  - -30% in APM by 2016
  - -50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

Health Care Payment Learning and Action Network

http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

- Strong emphasis on businesses in this network.
- A number of very large employers and associations are already part of this network.
- Share their ideas with CMS but also all the major insurance companies in the country.

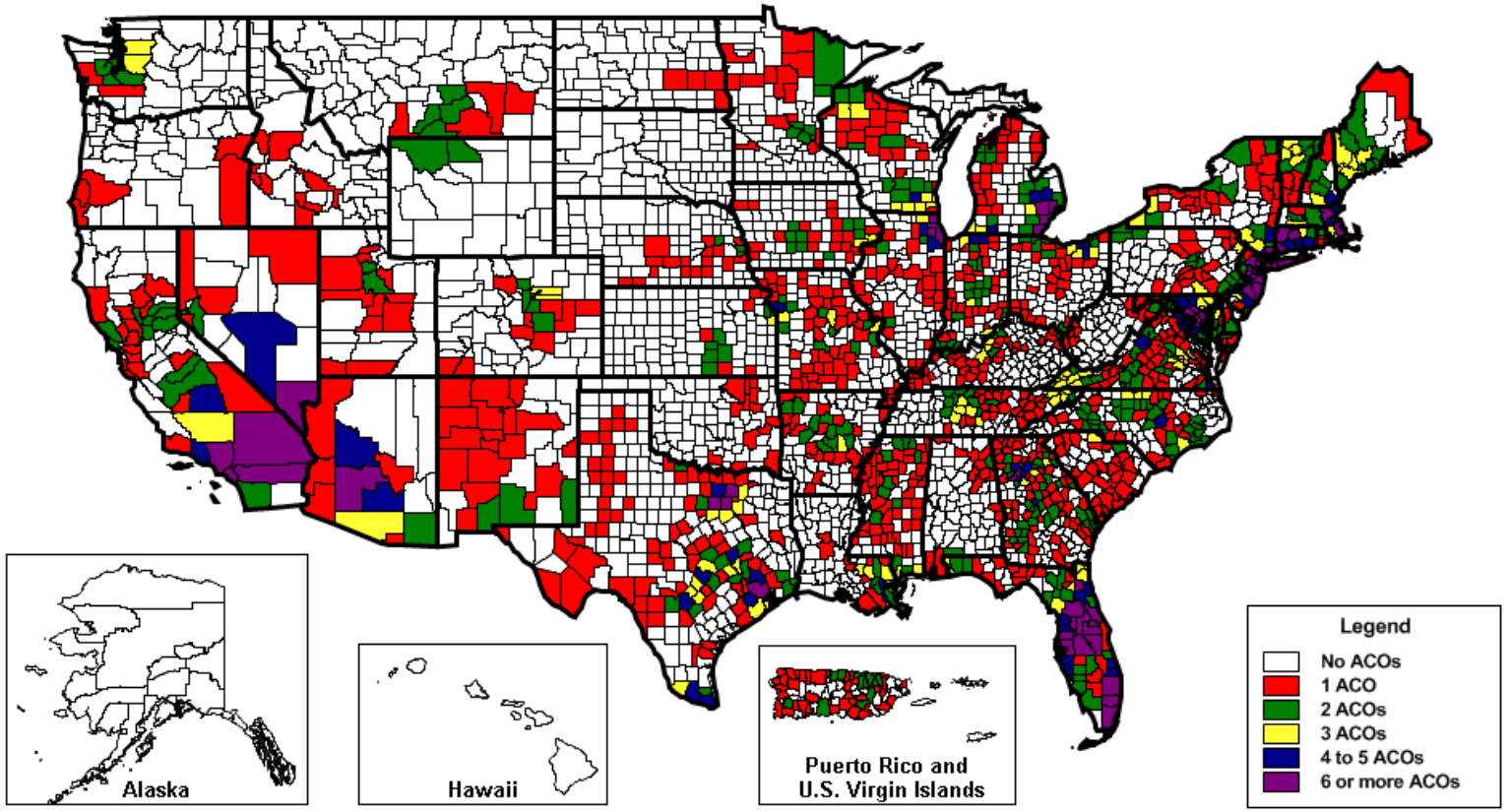
Learn about efforts by business to run their own models.

- Boeing has their own ACO.
- Caesar's Entertainment is running a bundles experiment.
- Walmart participates in a center of excellence program.

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



Next Generation ACO Model builds upon successes from Pioneer and MSSP ACOs

- Designed for **ACOs that are experienced** in coordinating care for populations of patients
- These ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- The model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth and skilled nursing facilities)
- More **predictable financial targets**

Model Principles

- Prospective attribution
- Financial model for long-term stability
- Reward quality
- Benefit enhancements that improve patient experience
- Protect freedom of choice
- Allow beneficiaries to choose alignment with ACO
- Smooth ACO cash flow and improved investment capabilities

Oncology Care Model: new emphasis on specialty care

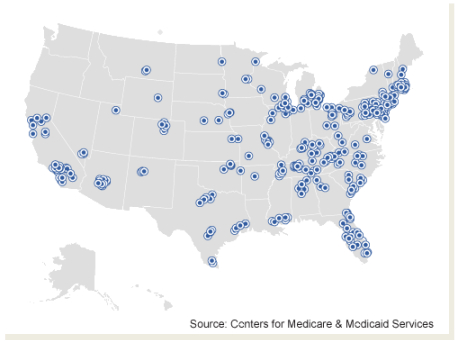
- 1.6 million people annually diagnosed with cancer; majority are over 65 years
- Major opportunity to improve care and reduce cost
- Model Objective: Provide beneficiaries with **higher intensity coordination to improve quality and decrease cost**
- Key features
  - Implement 6 part **practice transformation**
  - Create two part **financial incentive** with $160 pbpm, payment and performance based payment
  - Institute robust **quality** measurement
  - Engage **multiple payers**

Practice Transformation

1. Patient navigation
2. Care plan with 13 components based on IOM Care Management Plan
3. 24/7 access to clinician and real time access to medical records
4. Use of therapies consistent with national guidelines
5. Data driven continuous quality improvement
6. ONC certified electronic health record and stage 2 meaningful use by year 3

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
- 182 Awardees and 512 Episode Initiators in Phase 2 as of April 2015

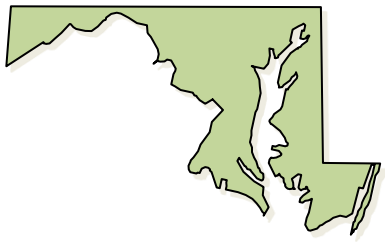


- Duration of model is scheduled for 3 years:
  - Model 1: April 2013 to present
  - Models 2, 3, 4: October 2013 to present

* Current until July 2015

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

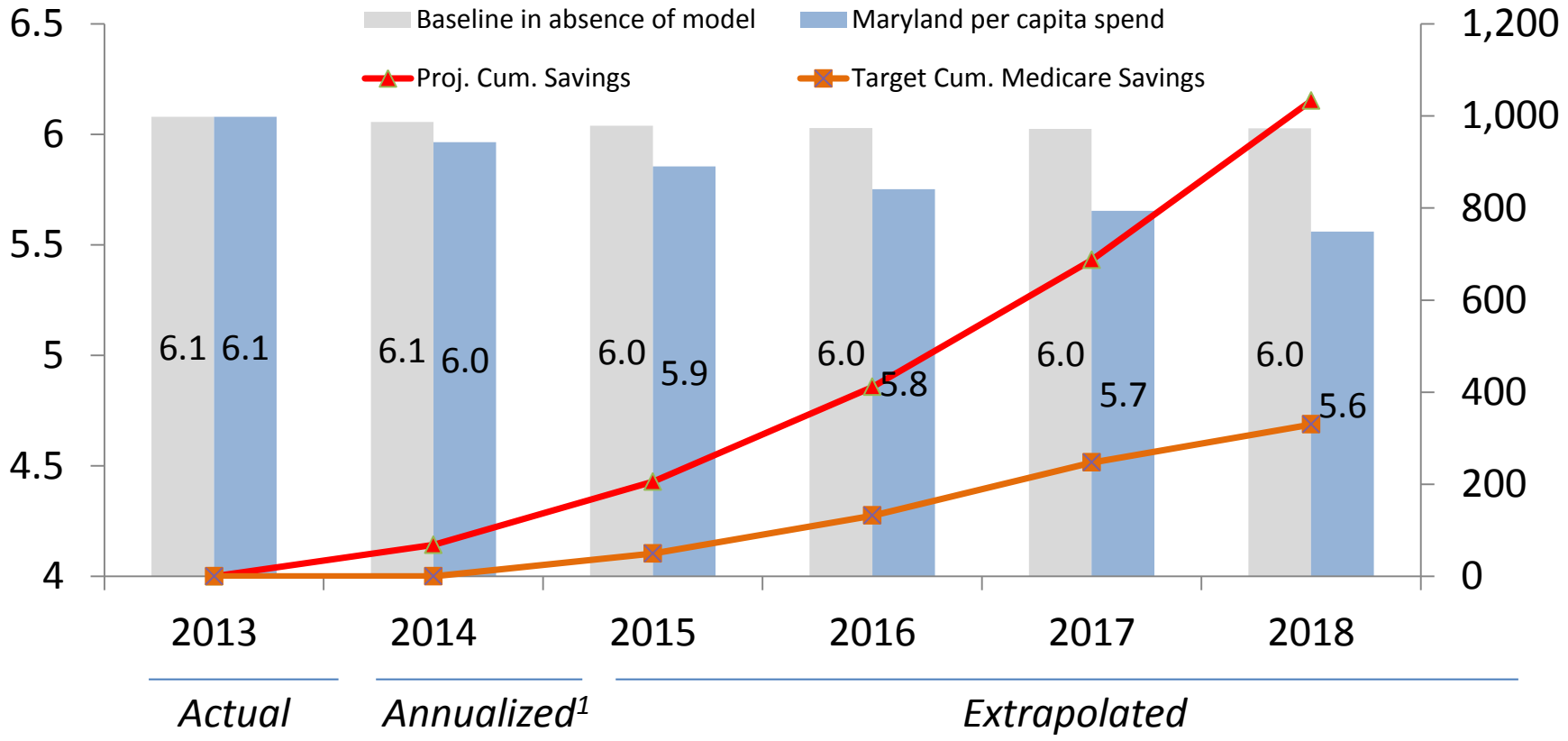


- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013

Maryland may exceed Medicare $330 M savings target if it continues to outperform national trends

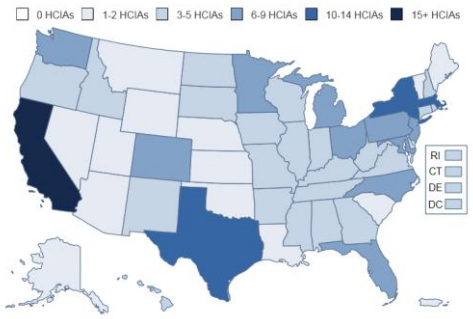
Medicare FFS per capita hospital spend and savings projections



1. CY 2013 actual values grown by Jan-Aug 2013-2014 trend
2. Trend maintained at Jan-Aug 2013-2014 trend
3. Assumes unchanged MD beneficiary count at ~750k; savings number potentially may be underestimate if beneficiary count grows (actual: grew by ~3% H1/H1 2013-2014)

Round 1 of the Health Care Innovation Awards tested a broad range of delivery system innovations

- Awards tested service delivery and payment models that improved quality and decreased cost in communities across the U.S.
- **107 projects** awarded
- Ideas tested include
  - Enhancing **primary care**
  - **Coordinating care** across multiple settings
  - New types of **health care workers**
  - Improving **decision making**
  - Testing new service delivery **technologies**

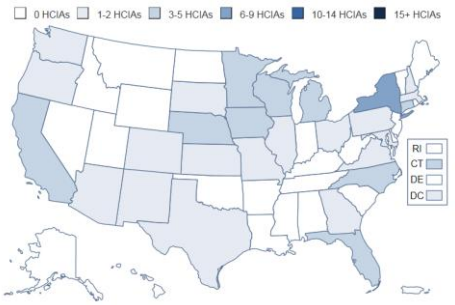


- Approximately 575,000 Medicare, Medicaid, and CHIP beneficiaries served
- Projects were funded in all 50 states*
- Awards ranged from ~$1 M to $30 M

* Darker colors on map represent more HCIA projects in that state

Round 2 of the Health Care Innovation Awards shared goals with Round 1 but focused on four themes

- **39 projects** awarded
- Increase focus on four areas that have high likelihood of driving health care system transformation and delivering better outcomes
  1. Reduce Medicare, Medicaid, and CHIP expenditure in **outpatient and/or post-acute settings**
  2. Improve care for populations with **specialized needs**
  3. **Transform the financial and clinical models** for specific types of providers and suppliers
  4. Improve the **health of populations**



- 27 states and the District of Columbia*
- Awards ranged from ~$2 M to $24 M

* Darker colors on map represent more HCIA projects in that state

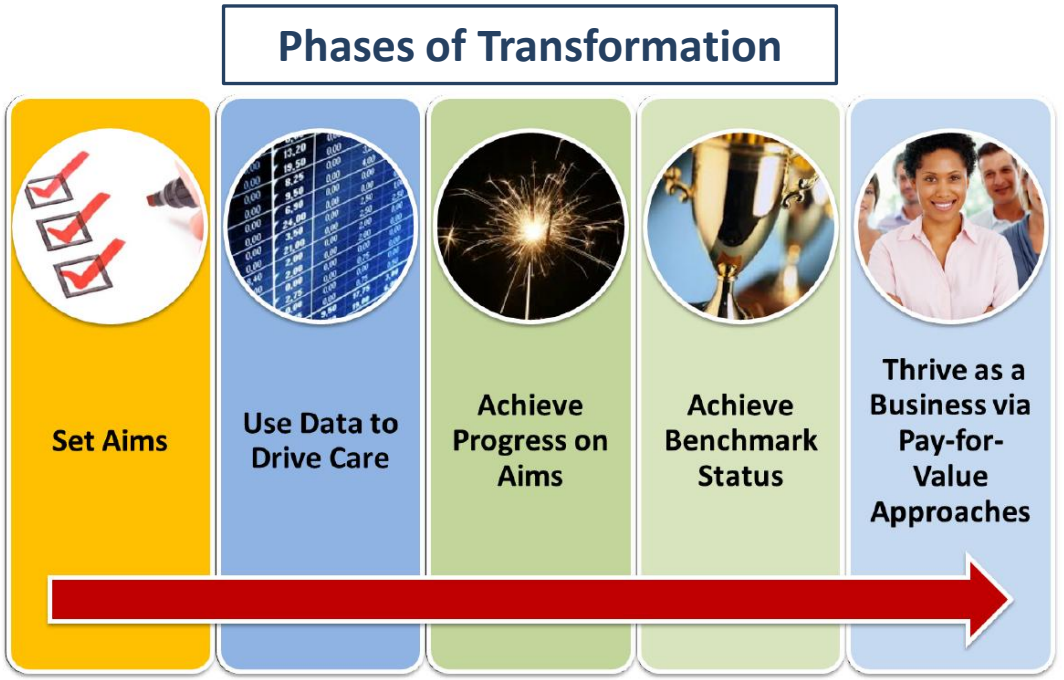
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **150,000 clinician practices** over the next four years to **improve on quality and enter alternative payment models**

- Two network systems will be created

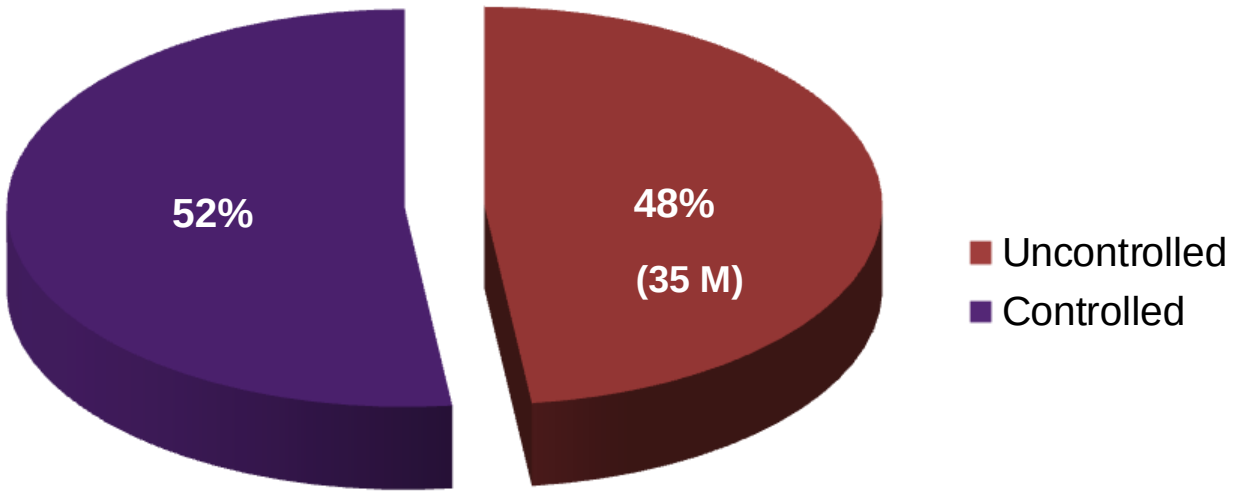
1) **Practice Transformation Networks**: peer-based learning networks designed to coach, mentor, and assist

2) **Support and Alignment Networks**: provides a system for workforce development utilizing professional associations and public-private partnerships



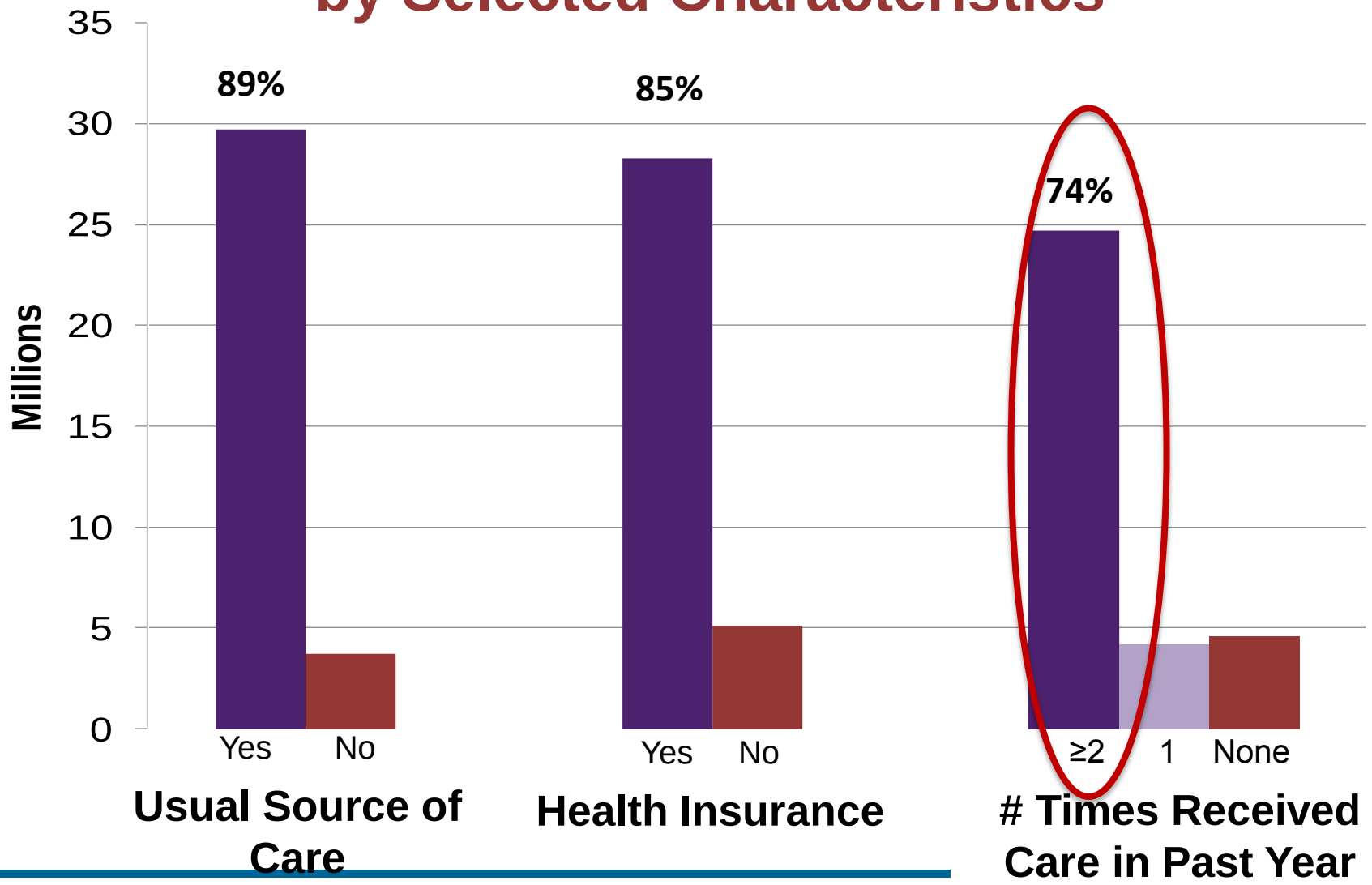
Only Half of Americans with Hypertension Have It Under Control

71 MILLION
ADULTS WITH HYPERTENSION (31%)



SOURCE: National Health and Nutrition Examination Survey 2011-2012.

35 M People with Uncontrolled Hypertension by Selected Characteristics



Source: National Health and Nutrition Examination Survey 2009-2012.

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

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