CMS Innovation and Health Care Delivery System Reform

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Office of the Director, Center for Medicare and Medicaid Innovation
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“Tumor is out!”

Press MJ. Instant Replay. NEJM 2014
1 patient, 11 clinicians, 80 days
PCP calls to patient: 12
PCP calls to clinicians: 8
PCP emails to clinicians: 32
Procedures: 5
Appointments: 11
Appointments with PCP: 0
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.

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

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

Systems and Policies
- Fee-For-Service Payment Systems

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.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>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</td>
<td>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)</td>
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Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

Alternative payment models (Categories 3-4)
FFS linked to quality (Categories 2-4)
All Medicare FFS (Categories 1-4)

**Historical Performance**

- **2011**: ~70% FFS linked to quality, 0% Alternative payment models, 0% All Medicare FFS

- **2014**: >80% FFS linked to quality, ~20% Alternative payment models, 0% All Medicare FFS

- **2016**: 85% FFS linked to quality, 30% Alternative payment models, 0% All Medicare FFS

- **2018**: 90% FFS linked to quality, 50% Alternative payment models, 0% All Medicare FFS

**Goals**

- **2011**: ~70% FFS linked to quality, 0% Alternative payment models, 0% All Medicare FFS

- **2014**: >80% FFS linked to quality, ~20% Alternative payment models, 0% All Medicare FFS

- **2016**: 85% FFS linked to quality, 30% Alternative payment models, 0% All Medicare FFS

- **2018**: 90% FFS linked to quality, 50% Alternative payment models, 0% All Medicare FFS
CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care Model</td>
<td>Next Generation ACO</td>
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<tr>
<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
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<td>Specialty Care Models</td>
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<tr>
<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
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<td></td>
<td>Multi-payer Advanced Primary Care Practice*</td>
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<tr>
<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
<td>ESRD Prospective Payment System*</td>
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</table>

CMS will continue to test new models and will identify opportunities to expand existing models.

* 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
The Health Care Payment Learning and Action Network will accelerate the transition 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
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 (%)

- Growth rate: federal Medicare spending per enrollee
- Growth rate: US real per-capita GDP

Historical

Projected

Average Medicare growth rate (2011–2014)
- Medicare per capita: 1.1%
- GDP / capita: 3.0%

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

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‡

- 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

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients


* Reductions relative to a matched comparison group and do not include the care management fees (~$20 pbpm)
SAMA Healthcare Services is an independent four-physician family practice 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**.

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*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 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

<table>
<thead>
<tr>
<th></th>
<th>Ventilator-Associated Pneumonia</th>
<th>Early Elective Delivery</th>
<th>Central Line-Associated Blood Stream Infections</th>
<th>Venous thromboembolic complications</th>
<th>Re-admissions</th>
</tr>
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<tbody>
<tr>
<td>Change</td>
<td>62.4% ↓</td>
<td>70.4% ↓</td>
<td>12.3% ↓</td>
<td>14.2% ↓</td>
<td>7.3% ↓</td>
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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.
CMS has engaged the health care delivery system and invested in innovation across the country.

Source: CMS Innovation Center website, January 2015
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
- 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
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

State Innovation Model grants have been awarded in two rounds:
- 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

<table>
<thead>
<tr>
<th>Patient centered medical homes</th>
<th>Health homes</th>
<th>Accountable care</th>
<th>Episodes</th>
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<td>Arkansas</td>
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<td>Vermont</td>
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### 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
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
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
- **Help us** develop specialty physician payment and service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes