CMS Innovation and Health Care Delivery System Reform

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Spotlight: Comprehensive Primary Care, SAMA Healthcare

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

-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”
Overview

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center
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.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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</table>
| 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       | - Create transparency on cost and quality information  
                  - Bring electronic health information to the point of care for meaningful use 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Medicare Fee-for-Service examples</th>
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<tbody>
<tr>
<td>Category 1: Fee for Service – No Link to Value</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>Limited in Medicare fee-for-service</td>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Hospital value-based purchasing</td>
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<td>Category 2: Fee for Service – Link to Quality</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
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<td>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
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<tr>
<td>Category 4: Population-Based Payment</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
<td>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)

2011 2014 2016 2018

Historical Performance Goals

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

- 2014:
  - FFS linked to quality (>80%)
  - Alternative payment models (~20%)
  - All Medicare FFS (>80%)

- 2016:
  - FFS linked to quality (85%)
  - Alternative payment models (30%)
  - All Medicare FFS (85%)

- 2018:
  - FFS linked to quality (90%)
  - Alternative payment models (50%)
  - All Medicare FFS (90%)
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
Medicare/Medicaid growth has fallen below GDP growth since 2010 due, in part, to CMS led policy changes and new models of care

### Gap between growth in federal spending on Medicare/Medicaid and GDP growth

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

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

2011, 2012, and 2013 saw the slowest growth in real per capital health care spending on record
Medicare spending per beneficiary was essentially flat in nominal dollars in fiscal year 2014

Average growth rate (2010–2014)
- Medicare/Medicaid per capita: 0.2%
- GDP / capita: 3.0%

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
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
  - $184M 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
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

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<th>Leading Indicators, change from 2010 to 2013</th>
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<td>Ventilator-Associated Pneumonia</td>
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<td>62.4% ↓</td>
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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.”

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

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<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
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<td><strong>Pay Providers</strong></td>
<td>Test and expand alternative payment models</td>
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<td></td>
<td>▪ Accountable Care</td>
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<tr>
<td></td>
<td>  – Pioneer ACO Model</td>
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<td></td>
<td>  – Medicare Shared Savings Program (housed in Center for Medicare)</td>
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<td>  – Advance Payment ACO Model</td>
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<td></td>
<td>  – Comprehensive ERSD Care Initiative</td>
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<td></td>
<td>▪ Primary Care Transformation</td>
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<td>  – Comprehensive Primary Care Initiative (CPC)</td>
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<td>  – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<td>  – Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
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<td>  – Independence at Home Demonstration</td>
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<td>  – Graduate Nurse Education Demonstration</td>
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<td>▪ Bundled Payment for Care Improvement</td>
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<td></td>
<td>  – Model 1: Retrospective Acute Care</td>
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<td>  – Model 2: Retrospective Acute Care Episode &amp; Post Acute</td>
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<td>  – Model 3: Retrospective Post Acute Care</td>
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<td>  – Model 4: Prospective Acute Care</td>
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<td>  – Oncology Care Model</td>
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<td>▪ Initiatives Focused on the Medicaid</td>
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<td></td>
<td>  – Medicaid Emergency Psychiatric Demonstration</td>
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<td>  – Medicaid Incentives for Prevention of Chronic Diseases</td>
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<td>  – Strong Start Initiative</td>
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<td></td>
<td>  – Medicaid Innovation Accelerator Program</td>
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<td></td>
<td>▪ Dual Eligible (Medicare-Medicaid Enrollees)</td>
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<td>  – Financial Alignment Initiative</td>
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<td>  – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td><strong>Deliver Care</strong></td>
<td>Support providers and states to improve the delivery of care</td>
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<td>▪ Learning and Diffusion</td>
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<td>  – Partnership for Patients</td>
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<td>  – Transforming Clinical Practice</td>
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<td>  – Community-Based Care Transitions</td>
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<td></td>
<td>▪ Health Care Innovation Awards</td>
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<td>▪ State Innovation Models Initiative</td>
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<td></td>
<td>  – SIM Round 1</td>
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<td>  – SIM Round 2</td>
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<td>  – Maryland All-Payer Model</td>
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<td>▪ Million Hearts Initiative</td>
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<td><strong>Distribute Information</strong></td>
<td>Increase information available for effective informed decision-making by consumers and providers</td>
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<td>▪ Information to providers in CMMI models</td>
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<td></td>
<td>▪ Shared decision-making required by many models</td>
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* 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
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

![Map of ACO-assigned beneficiaries by county](image)
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