Health System Transformation

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November 16, 2015

#KeepingUSHealthy

Affordable Care Act Impact

- **Expansion of Health Insurance Coverage -> Decreased Uninsured Rates**
- **Slower Growth in Health Care Costs**
- **Improved Quality of Care**

Source: Furman J, Fiedler M — Continuing the Affordable Care Act's Progress on Delivery System Reform is an Economic Imperative.

'Jaw-dropping': Medicare deaths, hospitalizations AND costs reduced

Sample consisted of 68,374,904 unique Medicare beneficiaries (FFS and Medicare Advantage).

	1999	2013	Difference
All-cause mortality	5.30%	4.45%	-0.85%
Total Hospitalizations/ 100,000 beneficiaries	35,274	26,930	-8,344
In-patient Expenditures/ Medicare fee-for-service beneficiary	$3,290	$2,801	-$489
End of Life Hospitalization (last 6 months)/100 deaths	131.1	102.9	-28.2

Findings were consistent across geographic and demographic groups.

Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years or Older, 1999-2013; Harlan M. Krumholz, MD, SM; Sudhakar V. Nuti, BA; Nicholas S. Downing, MD; Sharon-Lise T. Normand, PhD; Yun Wang, PhD; *JAMA.* 2015;314(4):355-365.; doi:10.1001/jama.2015.8035

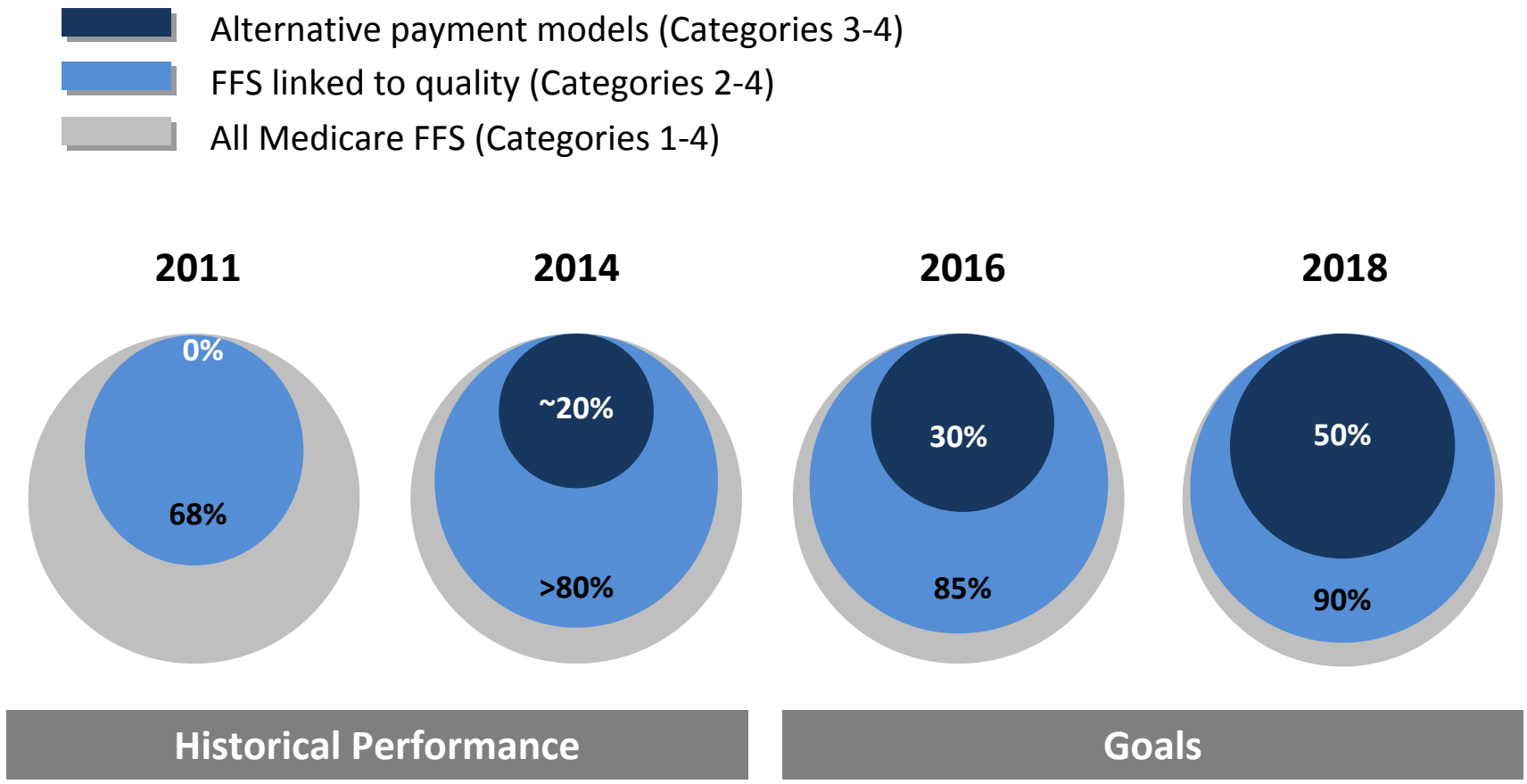
Better Care, Smarter Spending, Healthier People

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

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

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

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



Center for Medicare and Medicaid Innovation

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 – Next Generation ACO – 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 Demo – Home Health Value Based Purchasing – Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Medicare Care Choices Model ▪ **Episode-Based Payment Initiatives** – 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 – Comprehensive Care for Joint Replacement 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 (ACOs)

ACOs - Participation is Growing Rapidly

- **More than 400 ACOs participating in the Medicare Shared Savings Program**
- **Almost 8 million assigned beneficiaries in 49 states, plus D.C. and Puerto Rico**
- **MSSP rule seeks to build on this momentum.**

Achieving the Goals

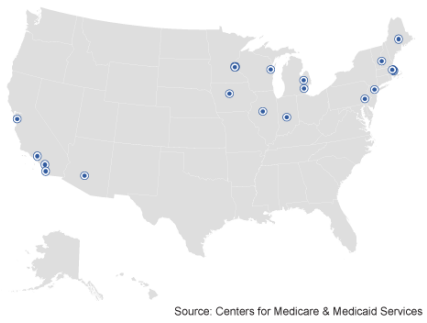
- **Accountable Care Organization (ACO) Models**
  - **Pioneer ACO Model**
  - **Next Generation ACO Model**
  - **ESRD ACO Initiative**
  - **Advance Payment Model and ACO Investment Model**
  - **Medicare Shared Savings Program – 3 Tracks**
- **Medicare Advantage also supporting ACOs**

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**
  - **$400M in program savings** combined for two years† **(Office of Actuary Certified expansion likely to reduce program expenditures)**
  - 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
- **Model certified by Actuary as likely to reduce expenditures and model improved quality**

† Results from regression based analysis
‡ Results from actuarial analysis

Next Generation ACO Model

- More predictable financial targets;
- Greater opportunities to coordinate care (e.g., telehealth, SNF); and
- High quality standards consistent with other Medicare programs and models
- Beneficiaries can select their ACO

Next Generation ACO Model Principles

- **Prospective attribution**
- **Protect Medicare FFS beneficiaries' freedom of choice;**
- **Create a financial model with long-term sustainability;**
- **Rewards quality;**
- **Offer benefit enhancements that directly improve the patient experience and support coordinated care;**
- **Allow beneficiaries a choice in their alignment with the ACO**
- **Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.**

Overview of benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps[1]:

Baseline	Trend	Risk Adjustment	Quality and Efficiency Adjustment
Determine ACO's baseline using one-year of historical baseline expenditures (2014)	Trend the baseline forward using a regional projected trend, defined as combination of national projected trend with application of regional price adjustments.	The full HCC risk score will be used. Average risk score of ACO beneficiaries allowed to grow by 3% between the baseline and the given performance year. Decrease also capped at 3%.	Apply adjustment derived from quality adjustment and efficiency adjustment.

1 Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk •80% sharing rate (PY1-3, 2016-2018) •85% sharing rate (PY4-5, 2019-2020) •15% savings/losses cap	100% Risk for Parts A and B •15% savings/losses cap

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.

Payment Mechanisms

ayment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: Capitation (2017)
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional PBPM payment to ACO.	Medicare payment redistributed through reduced FFS and PBPM payment to ACO.	Medicare payment through capitation; ACO responsible for paying ACO Provider/Supplier and Capitation Affiliate claims

- Goals of payment mechanisms:
  - Offer ACOs the opportunity for stable and predictable cash flow; and
  - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Benefit Enhancements

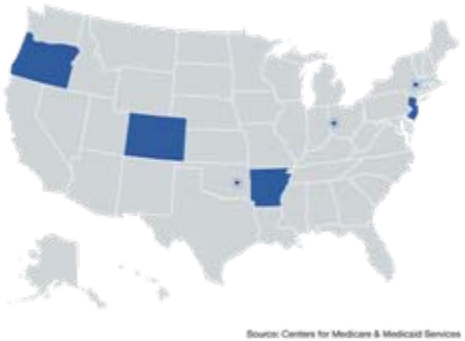
- Medicare payment rule waivers designed to improve care coordination and cost saving capabilities:
  - Telehealth expansion
  - Post-discharge home visits
  - 3-Day SNF Rule waiver
- ACO may decide which, if any, to implement.
- For each, ACOs must submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

Comprehensive Primary Care

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 reduced 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"

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

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

Transforming Clinical Practice Initiative (TCPI) Goals

- Support more than 150,000 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

Innovation Center – 2016 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 (e.g., oncology, care choices, health plan, consumer, advanced primary care)

On the Horizon

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Overview:

- Passed House 3/26/2015- Senate 4/14/2015
- Signed into Law **4/16/2015**
- Repeals 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update
- Changes Medicare PFS Payment
  - Merit-Based Incentive Payment System (MIPS) – quality, cost/resource use, clinical improvement activities, and meaningful use
  - Incentives for participation in Alternate Payment Model (APM)

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Alternative Payment Model (APM) Incentive Payments:

Beginning in 2019 and for 6 years 5% incentive payment for:

- Physicians/clinicians or groups of physicians/clinicians who participate in certain types of APMs and who meet specified payment thresholds.
- Payment is made in a lump sum on an annual basis.
- Physicians/clinicians or groups of physicians/clinicians meeting criteria to receive APM incentive payment are excluded from the requirements of MIPS.

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 better health for the patient population you serve
- **Engage** in accountable care and other alternative 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
- **Research** to inform policy and implementation research
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

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