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

Health System Transformation

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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

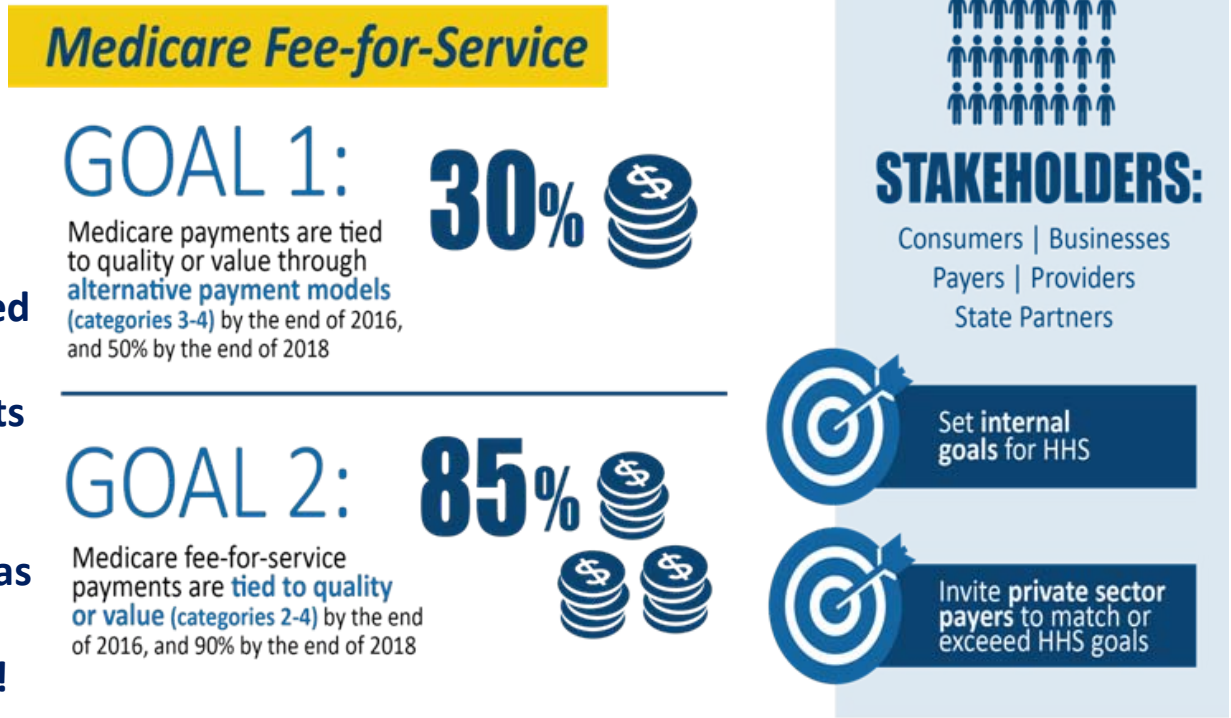
CMS has adopted a framework that categorizes payments to providers

	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

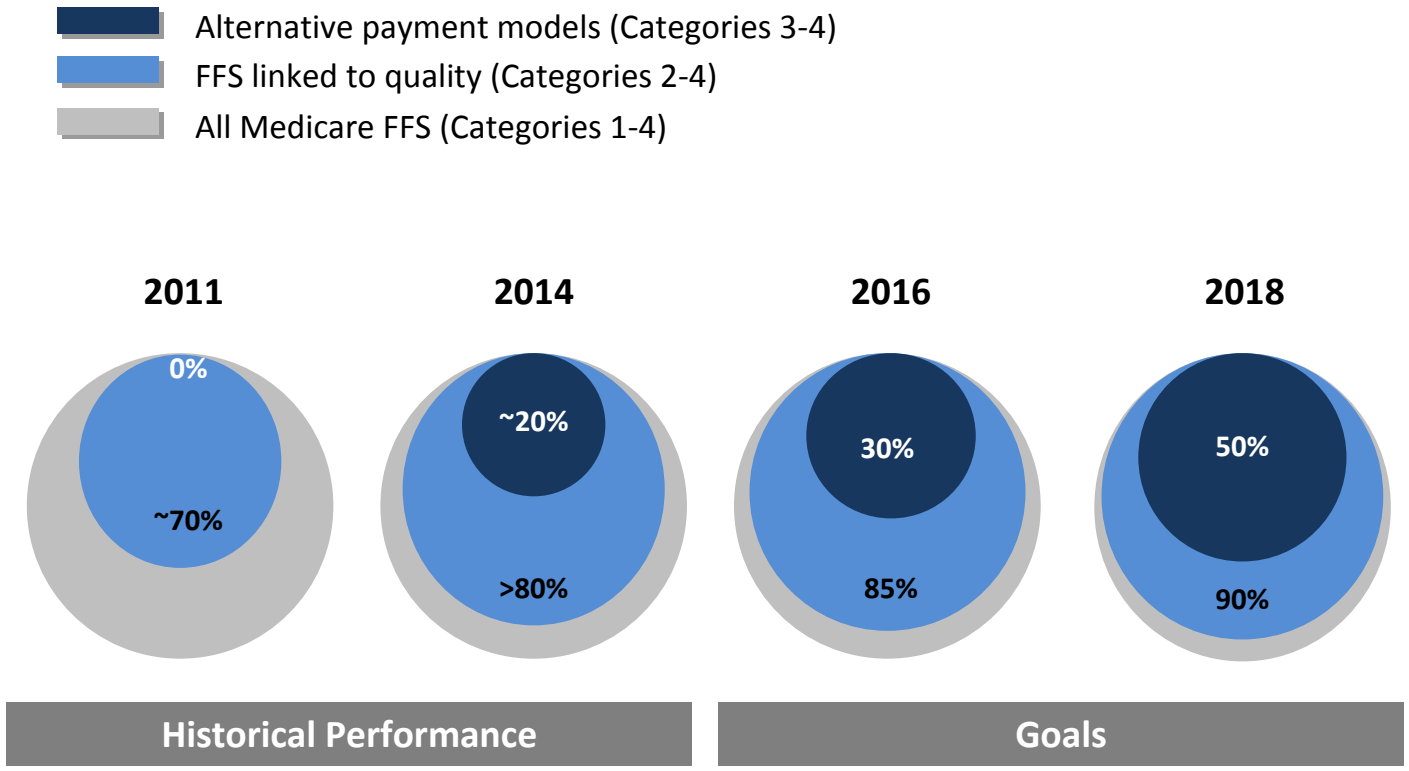
Source: Rajkumar R, Conway PH, Tavenner M. CMS — engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

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

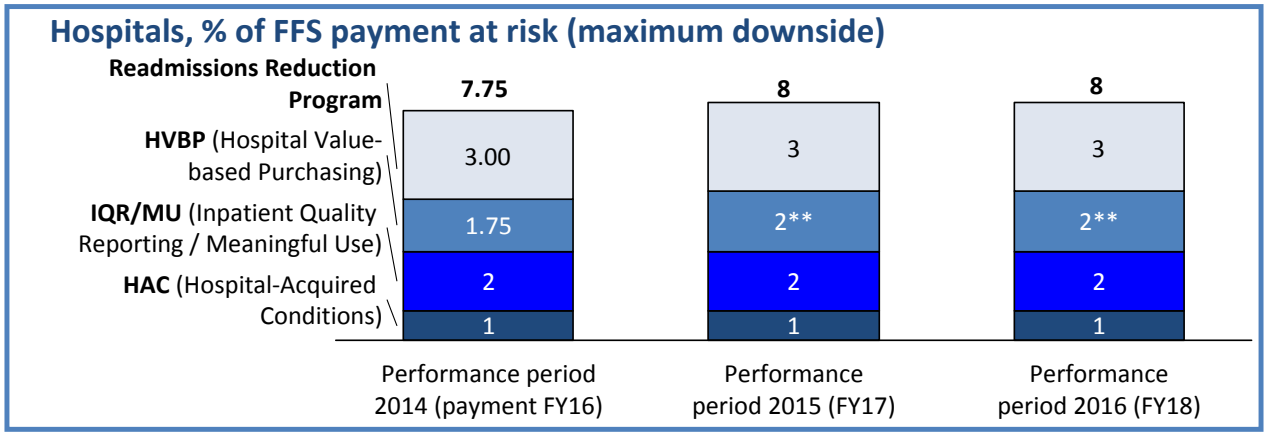
On March 3, 2016, President Obama and HHS announced that 30 percent of Medicare payments are tied to quality payments through APMs. This goal was achieved one year ahead of schedule!

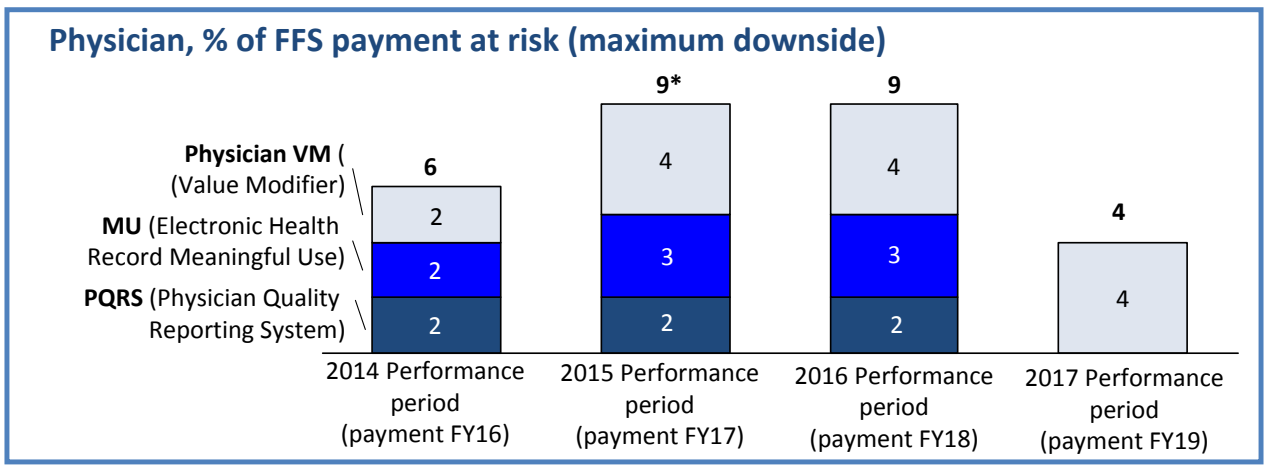


Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018



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



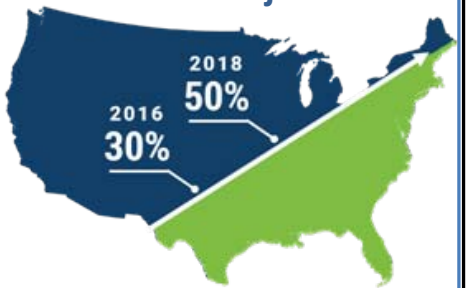


- * Physician VM adjustment depends upon group size and can range from 2% to 4%
- ** Exact percentage will vary based on market basket update

The Health Care Payment Learning and Action Network (LAN) 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



2016 30%: In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018 50%: In 2018, at least 50% of U.S. health care payments are so linked.

- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

CMS Transparency Efforts
HOSPITAL COMPARE

Number of Sessions
Hospital Compare
Total sessions: (3,872,191)
112,237 sessions for July 2015

Number of Page views
Hospital Compare
Total sessions: (18,001,685)
682,465 page views for July 2015

New and Returning Sessions
User Type Sessions
New Visitor 60,597
Returning Visitor 51,640

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Health Care Spending

On March 22, 2016, HHS announced that Medicare spent $473.1 billion less on personal health care expenditures between 2009 and 2014 than would have been spent if the 2000-2008 average growth rate had continued through 2014.

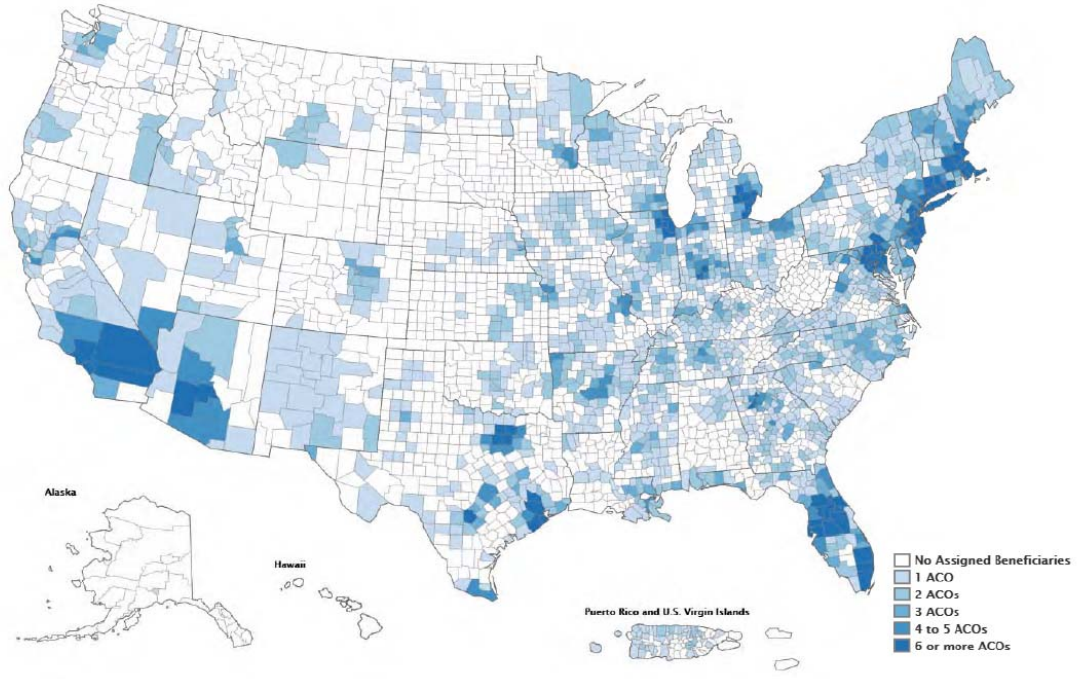
If trends continue through 2015, that amount could grow to a projected $648.6 billion.

To read the **full report**, visit: https://aspe.hhs.gov/pdf-report/health-care-spending-growth-and-federal-policy

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **477 ACOs** have been established in the MSSP, Pioneer ACO, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **121 new ACOS** in 2016 **of which 64 are risk-bearing** covering **8.9 million assigned beneficiaries** across 49 states & Washington, DC

ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

Pioneer ACOs meet requirement for expansion after two years and continued to generate savings in performance year 3

- Pioneer ACOs were designed for **organizations with experience in coordinated care** and ACO-like contracts
- Pioneer ACOs **generated savings for three years in a row**
  - **Total savings** of $92 million in PY1, $96 million in PY2, and $120 million in PY3‡
  - **Average savings per ACO increased** from $2.7 million in PY1 to $4.2 million in PY2 to $6.0 million in PY3‡
- Pioneer ACOs showed **improved quality outcomes**
  - **Mean quality score increased** from 72% to 85% to 87% from 2012–2014
  - Average performance score **improved in 28 of 33 (85%) quality measures** in PY3
- **Met criteria for expansion, including Actuary certification (improved quality and lower costs).** Elements of the Pioneer ACO have been **incorporated into track 3 of the MSSP ACO**

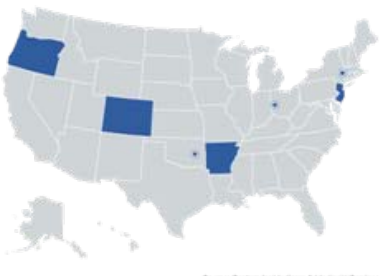
- 19 ACOs operating in 12 states (AZ, CA, IA, IL, MA, ME, MI, MN, NH, NY, VT, WI) reaching over 600,000 Medicare fee-for-service beneficiaries
- Duration of model test: January 2012 – December 2014; 19 ACOs extended for 2 additional years

‡ Results from 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

- **$14 or 2%* reduction part A and B expenditure** in year 1 among all 7 CPC regions and similar results year 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
- 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"

Maryland All-Payer Payment Model achieves $116 million in cost savings during first year

- 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**
- The All Payer Model had very positive **year 1 results** (CY 2014) in NEJM
  - **$116 million in Medicare savings**
  - **1.47% in all-payer total hospital per capita cost growth**
  - 30-day all cause **readmission rate reduced from 1.2% to 1% above national average**

- 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

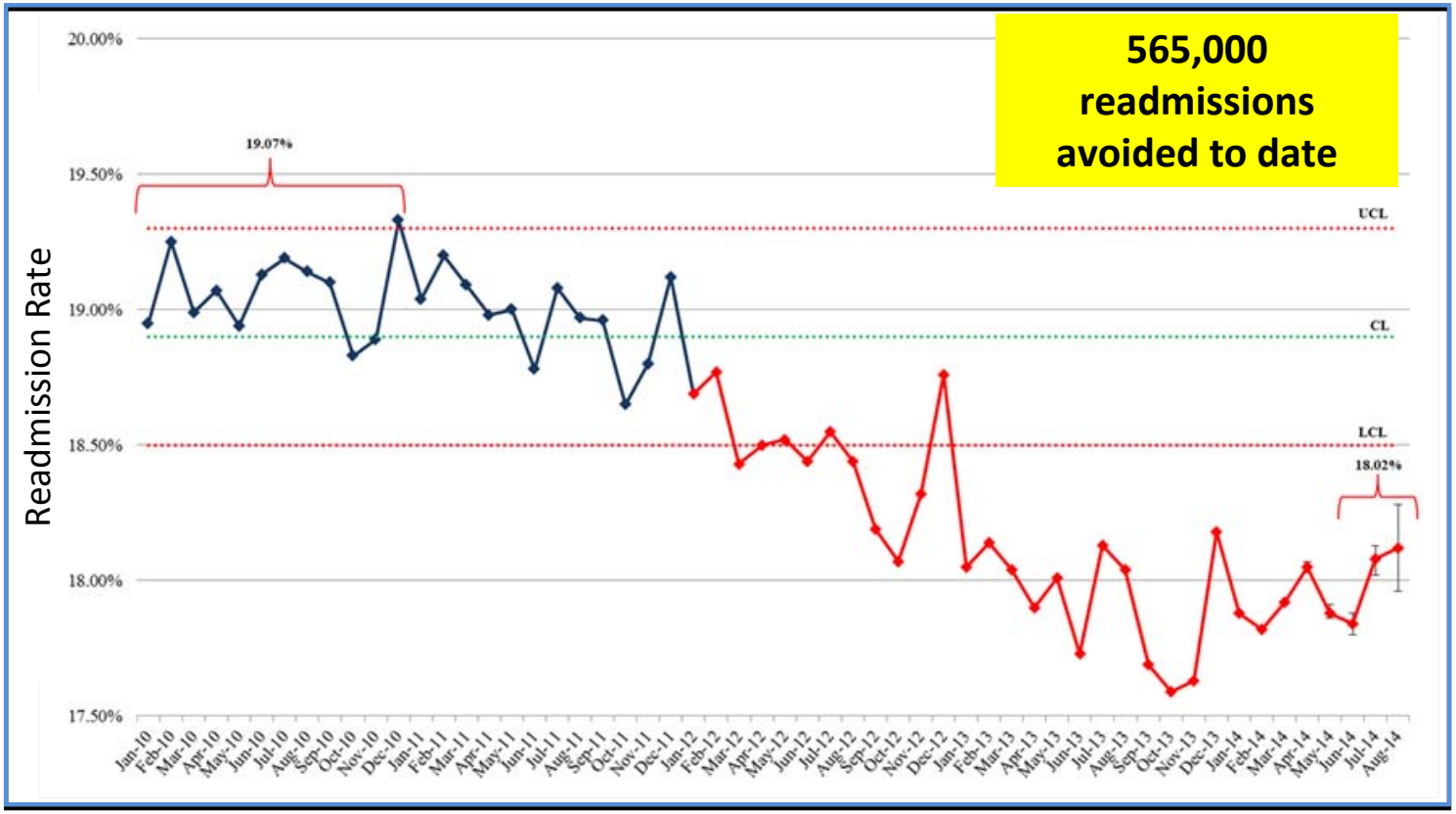
Partnership for Patients contributes to quality improvements

Data shows from 2010 to 2014…

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

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

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

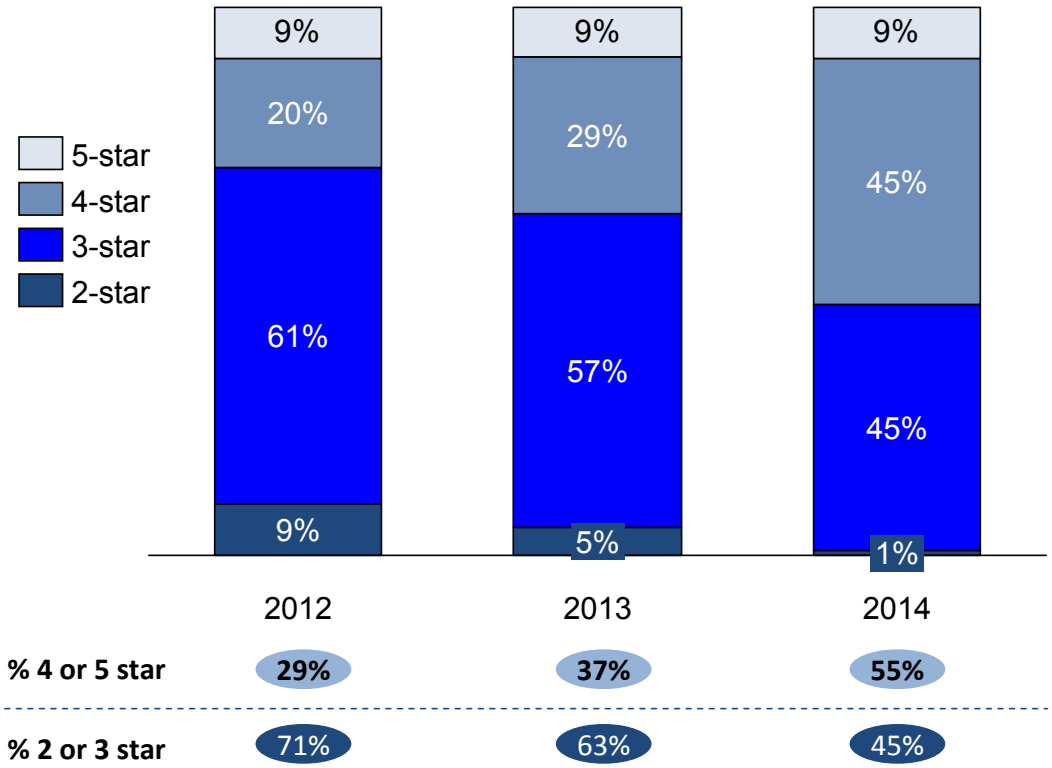
	1999	2013	Difference
All-cause mortality	5.30%	4.45%	-0.85% (approx. 300,000 deaths per year)
Total Hospitalizations/ 100,000 beneficiaries	35,274	26,930	-8,344 (approx. 3 million hospitalizations per year)
In-patient Expenditures/ Medicare fee-for-service beneficiary	$3,290	$2,801	-$489
End of Life 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

Beneficiaries move to MA plans with high quality scores

Medicare Advantage (MA) Enrollment Rating Distribution



- Sent prompt to beneficiaries enrolled in plans with 2.5 star rating or lower
- Letters only sent to beneficiaries in consistently low-rated plans
- Switch rate 44% (prompt) v. 21% (no prompt)

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 – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices ▪ **Bundled payment models** – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ **Initiatives Focused on the Medicaid** – 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 ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management
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** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model ▪ **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ **Health Care Payment Learning and Action Network** ▪ **Information to providers in CMMI models** ▪ **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas

Alternative Payment Model Impact

Bundled Payments

- **Payment or target price for all services associated with an episode of care**
- **Over 2,000 hospitals, physician groups, and post acute care providers accepting financial risk and focused on improved quality**

Accountable Care Models

- **Providers have shared responsibility for managing total cost and quality for a population of patients.**
- **Opportunity to earn shared savings payments when spending is reduced with high quality care**
- **Newer ACO models with population-based payments**

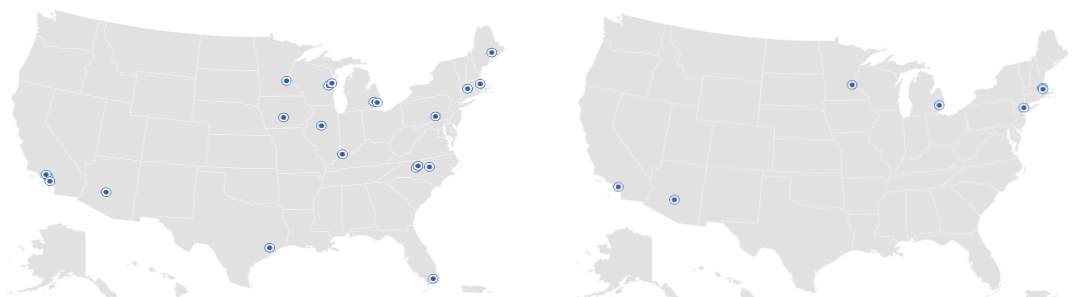
Care Coordination

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

Designed for **ACOs experienced** coordinating care for patient populations

- **Approximately 20** ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- Model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth & skilled nursing facilities)

Next Generation ACO	Pioneer ACO
21 ACOs spread among 13 states	9 ACOs spread among 7 states



Model Principles

- Prospective attribution
- Financial model for long-term stability (smooth cash flow, improved investment capability)
- Reward quality
- Benefit enhancements that improve patient experience & protect freedom of choice
- Allow beneficiaries to choose alignment

Medicare Shared Savings Program: Results to date

Financial Results

- In 2014:
  - 92 ACOs (28%) **held spending $806 million below their targets and earned performance payments of more than $341 million**

- In 2013[1]:
  - 58 ACOs (26%) **held spending $705 million below their targets and earned performance payments of more than $315 million**

Quality Results

- ACOs that reported in both 2013 and 2014 **improved average performance on 27 of 33 quality measures**

- Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, screening for tobacco use and cessation, and screening for high blood pressure

1 2013 figures include both 2012 and 2013 savings / loss generated for some ACOs that started mid-year in 2012 (these were the first ACOs in the program)

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: Prospective acute care hospital stay only

▪337 Awardees and over 1500 Episode Initiators as of January 2016

- Duration of model is scheduled for 3 years:
  - Model 1: Awardees began Period of Performance in April 2013
  - Models 2, 3, 4: Awardees began Period of Performance in October 2013

Spotlight: Bundled Payments for Care Improvement Initiative Model 2 – St. Mary Medical Center in Langhorne, PA

St. Mary's Medical Center is a 373 bed, Acute Care Hospital testing the Congestive Heart Failure (CHF) clinical episode since January 1, 2014

Care Redesign Efforts under the BPCI Initiative

- Focused on reducing preventable hospital readmissions through **transitional nurse assistance** with medical, behavioral, psychological, social, and environmental factors
- **Monthly meetings** with top 10 Skilled Nursing Facility partners to **share quality metrics data and provide education** to Skilled Nursing Facilities staff
- Established physician-led **interdisciplinary committee** to improve physician engagement in care redesign efforts
- **Transition nurse service** expanded to provide assistance to all CHF Medicare Beneficiaries

A Beneficiary Success Story

71 year old patient with CHF, CABG, sleep apnea with heavy alcohol and drug abuse history, who was estranged from family and lived alone, had no readmissions or ED visits post discharge during 90 bundle or 6 months after clinical episode concluded

Comprehensive Care for Joint Replacement (CJR) will test a bundled payment model across a broad cross section of hospitals

- The model tests bundled payment of **lower extremity joint replacement (LEJR) episodes,** including approximately **20% of all Medicare LEJR procedures**

800 Inpatient Prospective Payment System Hospitals participating in **67** **selected Metropolitan Statistical Areas (MSAs)** where 30% U.S. population resides

- The model will have 5 performance years, with the first beginning **April 1, 2016**

- Participant hospitals that achieve spending and quality goals will be **eligible to receive a reconciliation payment from Medicare** or will be held accountable for spending above a pre-determined target beginning in Year 2

- Pay-for-performance methodology will include **2 required quality measures and voluntary submission of patient-reported outcomes data**

Oncology Care Model: new emphasis on specialty care

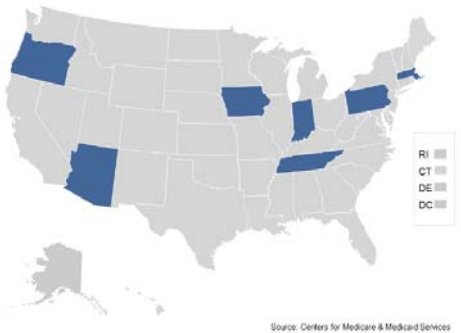
- 1.6 million people annually diagnosed with cancer; majority are over 65 years
- Major opportunity to improve care and reduce cost with expected start July 2016
- Model Objective: Provide beneficiaries with **higher intensity coordination to improve quality and decrease cost**
- Key features
  - Implement 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

Medicare Advantage Value Based Insurance Design Model offers more flexibility to Medicare Advantage Plans

- Allows MA plans to **structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use clinical services that have the greatest potential to positively impact on enrollee health**
- Will **begin on January 1, 2017 and run for 5 years**
- Plans in **7 states** will be eligible to participate
  - Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee

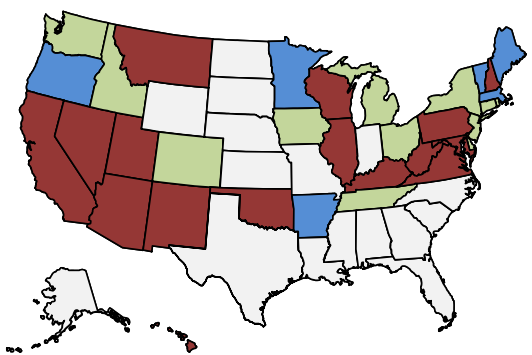


- Eligible Medicare Advantage plans in these states, upon approval from CMS, **can offer varied plan benefit design for enrollees who fall into certain clinical categories** identified and defined by CMS
- Changes to benefit design made through this model may **reduce cost-sharing and/or offer additional services to targeted enrollees**

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

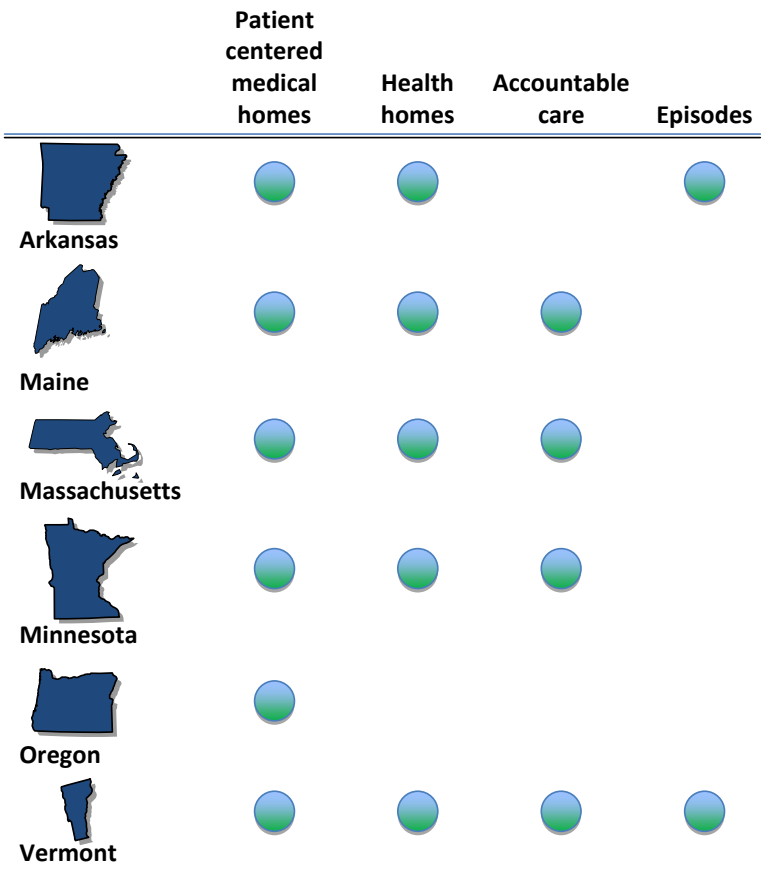
- Primary objectives include
  - Improving the **quality of care** delivered
  - Improving **population health**
  - Increasing **cost efficiency** and expand **value-based payment**



- 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
  - Support development and refinement of operational plans

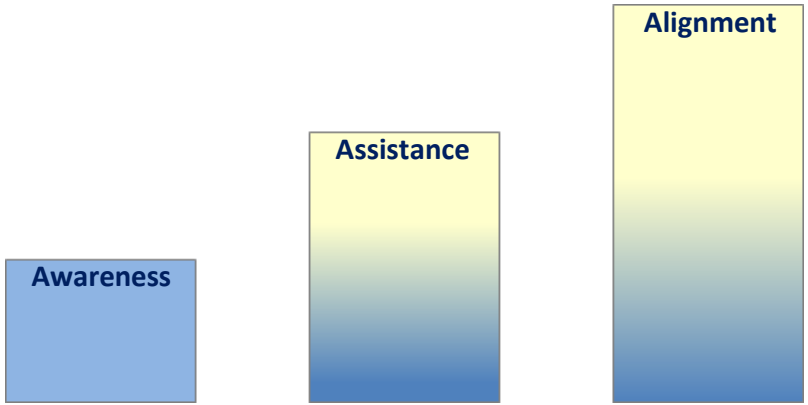
Accountable Health Communities Model

Population Health Model Addressing Health Related-Social Needs

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** and **community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

Total Investment: $157 Million
Anticipated Number of Award Sites: 44



Track 1 Awareness – Increase beneficiary ***awareness*** of available community services through information dissemination and referral

Track 2 Assistance – Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services

Track 3 Alignment – Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

HCIA: Diabetes Prevention Program (DPP) meets criteria for expansion

DPP **reduces the incidence of diabetes** through a structured health behavior change program delivered in community settings.

Timeline:

2012 – CMS Innovation Center awarded Health Care Innovation Award to The Young Men's Christian Association of the USA (YMCA) to test the DPP in **>7,000 Medicare beneficiaries with pre-diabetes** across 17 sites nationwide.

March 2016 – Secretary Burwell announced **DPP as the first ever prevention program to meet CMMI model expansion criteria.** CMS determined that DPP:

- *Improves quality of care ➡ beneficiaries lost about five percent body weight*
- *Certified by the Office of the Actuary as cost-saving ➡ up to estimated $2,650 savings per enrollee over 15 months*
- *Does not alter the coverage or provision of benefits*

Details of the expansion will be developed through notice and public comment rulemaking.

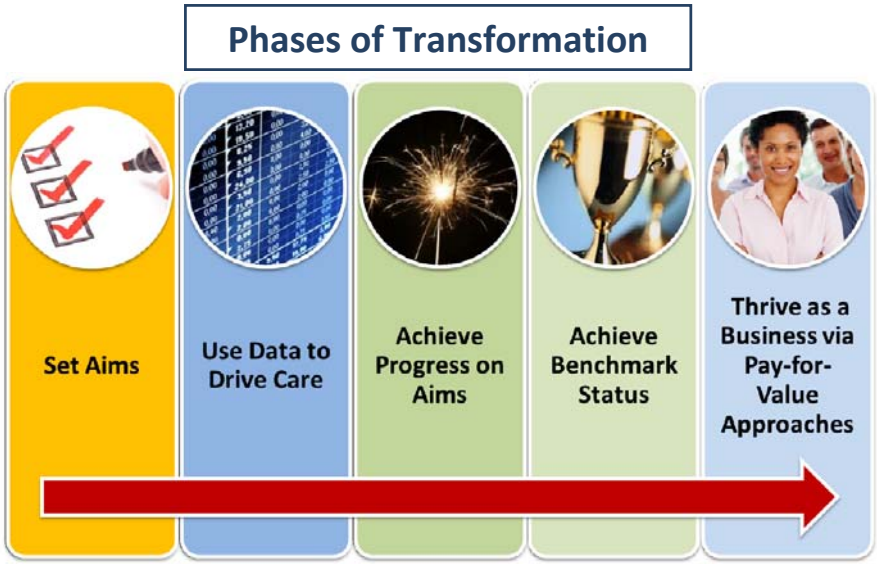
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **140,000 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

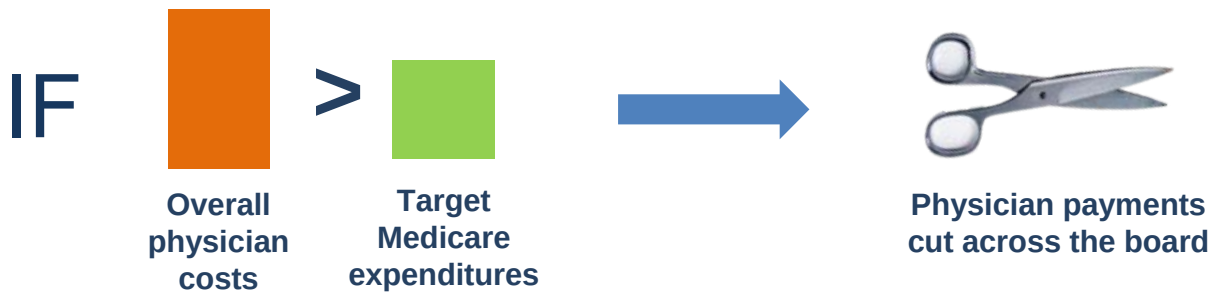


Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

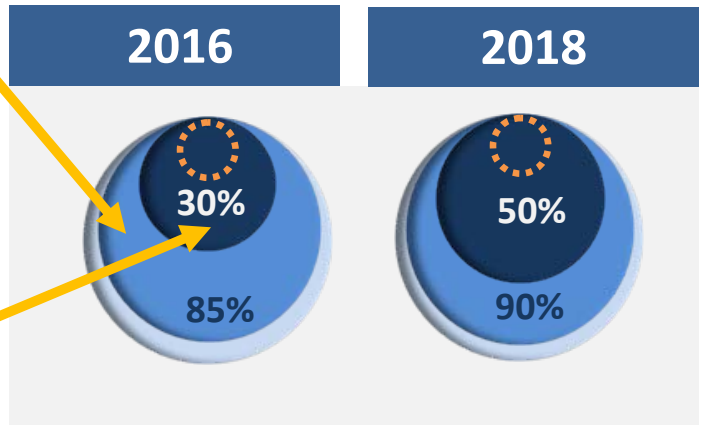
- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

How MACRA gets us closer to meeting HHS payment reform goals

The Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in Alternative Payment Models** via the bonus payment for Qualifying APM Participants (QPs) and favorable scoring in MIPS for APM participants who are not QPs.

New HHS Goals:



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare payments to QPs in eligible APMs under MACRA

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

Contact Information

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