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

Update on CMS Transparency Initiatives

Dr. Patrick Conway, M.D., MSc

CMS Chief Medical Officer and Deputy Administrator for Innovation and Quality

Director, Center for Medicare and Medicaid innovation

Director, Center for Clinical Standards and Quality

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Better**Smarter.** *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

Overview

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

CMS support of Health Care Delivery System Reform (DSR)

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 focus areas

> *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 payment to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Value	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 and/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 examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value-Based Modifier ▪ Readmissions / Hospital Acquired Conditions Reduction Program	▪ Accountable care organization ▪ 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

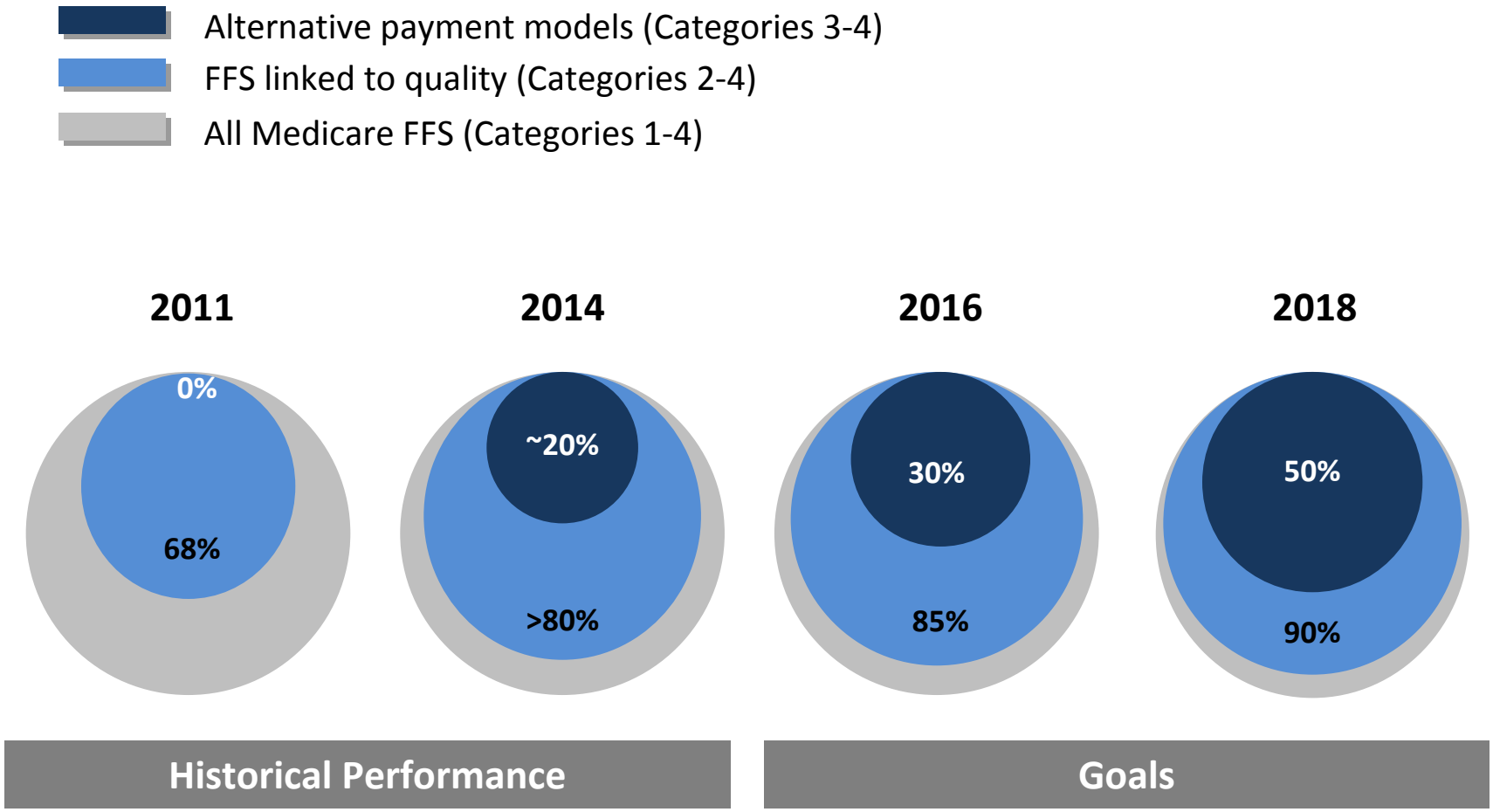
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

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

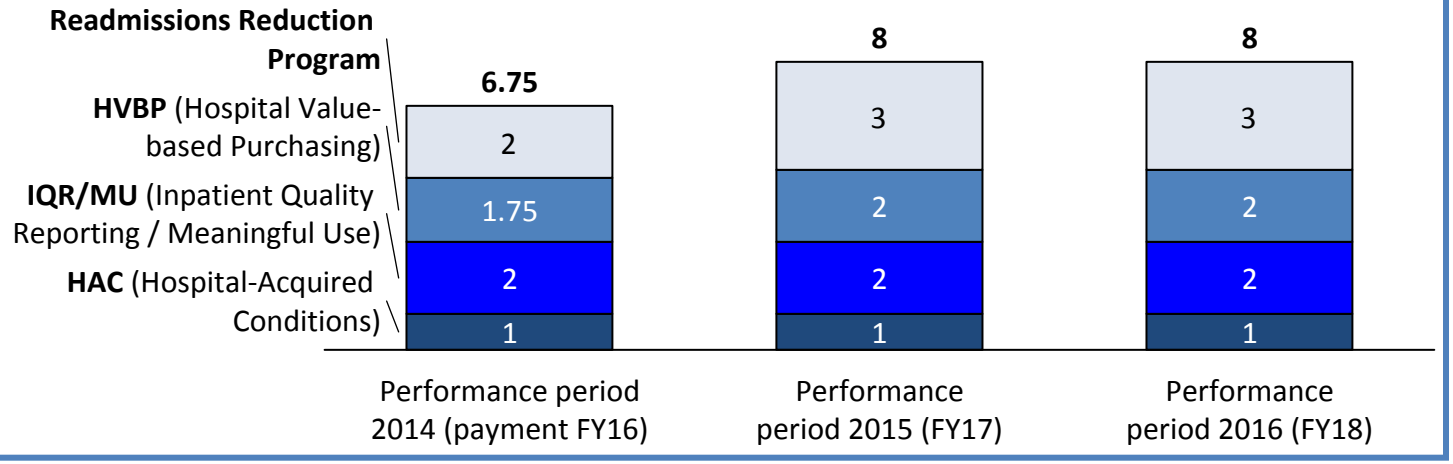
Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

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

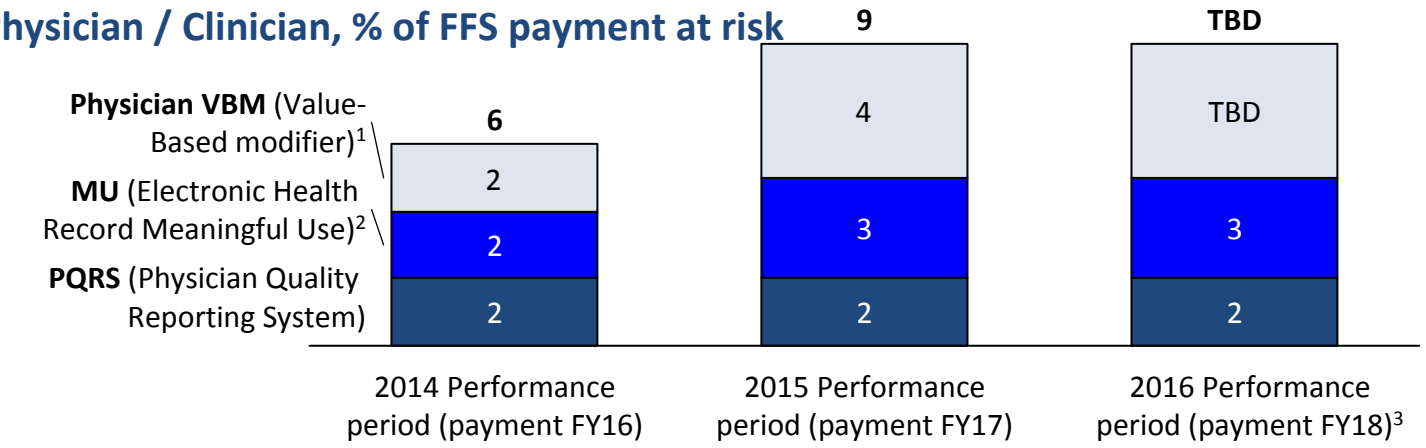


CMS increasingly linking FFS payments to quality or value

Hospitals, % of FFS payment at risk



Physician / Clinician, % of FFS payment at risk



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

Data Transparency

Data transparency is a component of all CMS quality programs

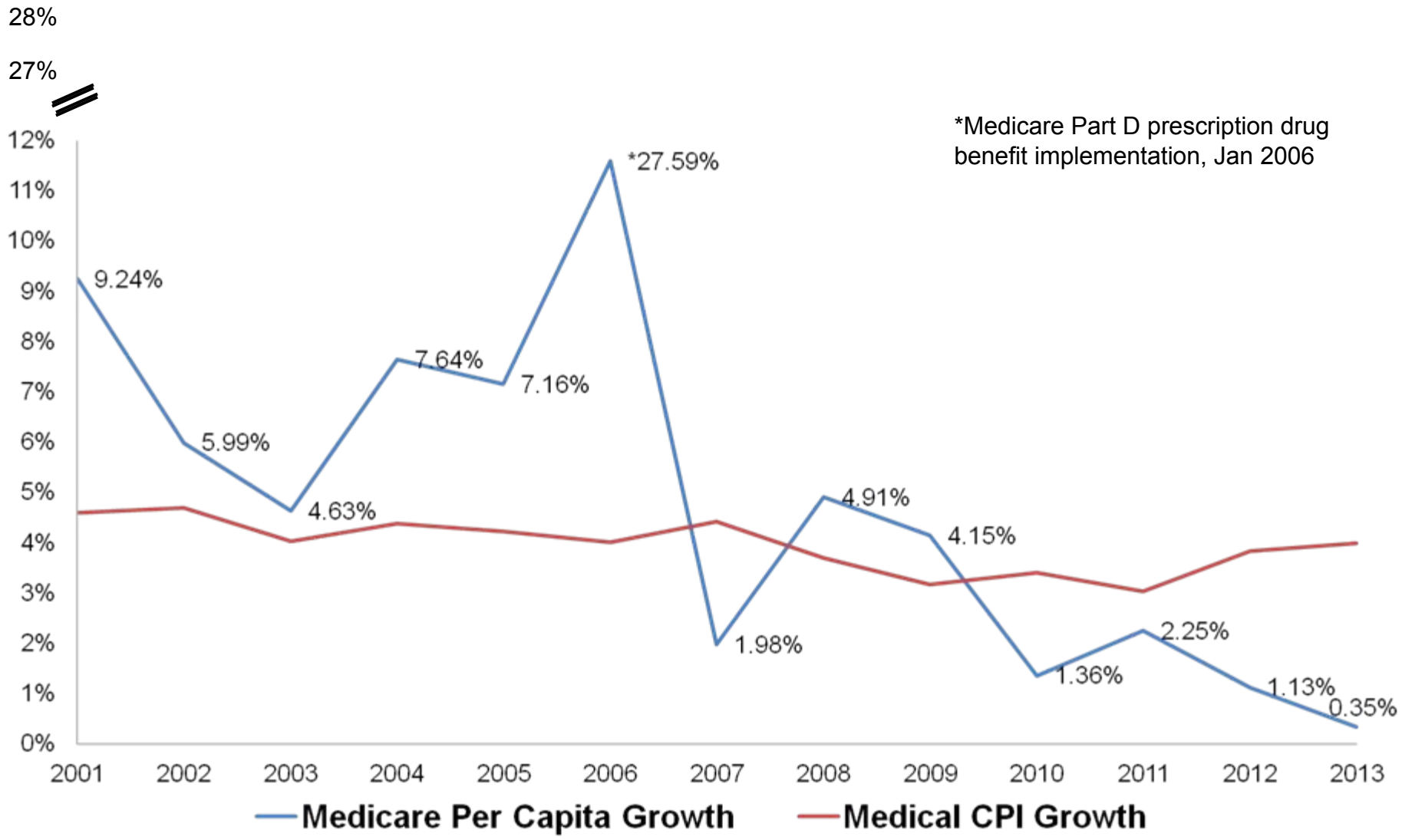
- Hospital Compare http://www.medicare.gov/hospitalcompare
- Physician Compare http://www.medicare.gov/physiciancompare
- Dialysis Facility Compare
http://www.medicare.gov/dialysisfacilitycompare
- Nursing Home Compare
http://www.medicare.gov/nursinghomecompare
- Home Health Compare
http://www.medicare.gov/homehealthcompare

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Results: Per Capita Spending Growth at Historic Lows



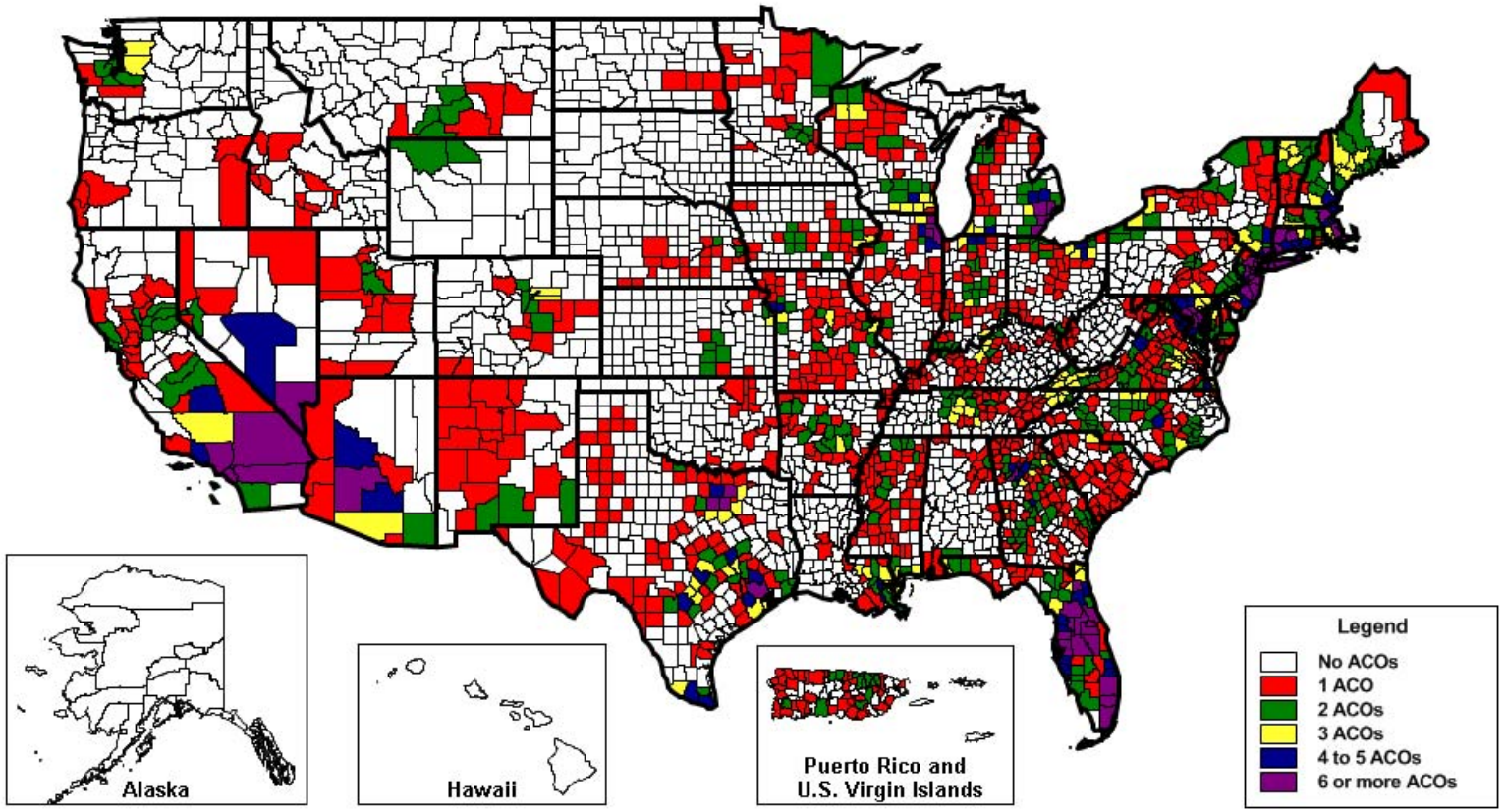
*Medicare Part D prescription drug benefit implementation, Jan 2006

Source: CMS Office of the Actuary

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

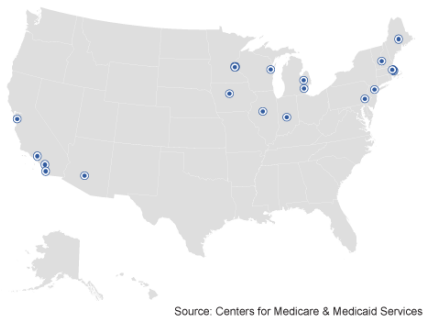
- **424 ACOs** have been established in the MSSP and Pioneer ACO programs
- **7.8 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County



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**
  - **$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

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

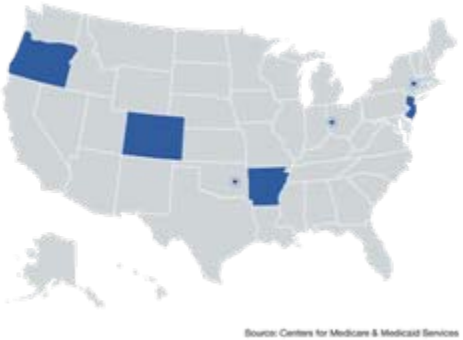
Model Principles

- **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.**

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



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"

Partnership for Patient contributes to quality improvements

Data shows…

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% ↓

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 payment reforms

Section 3021 of Affordable Care Act

"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

Three scenarios for success

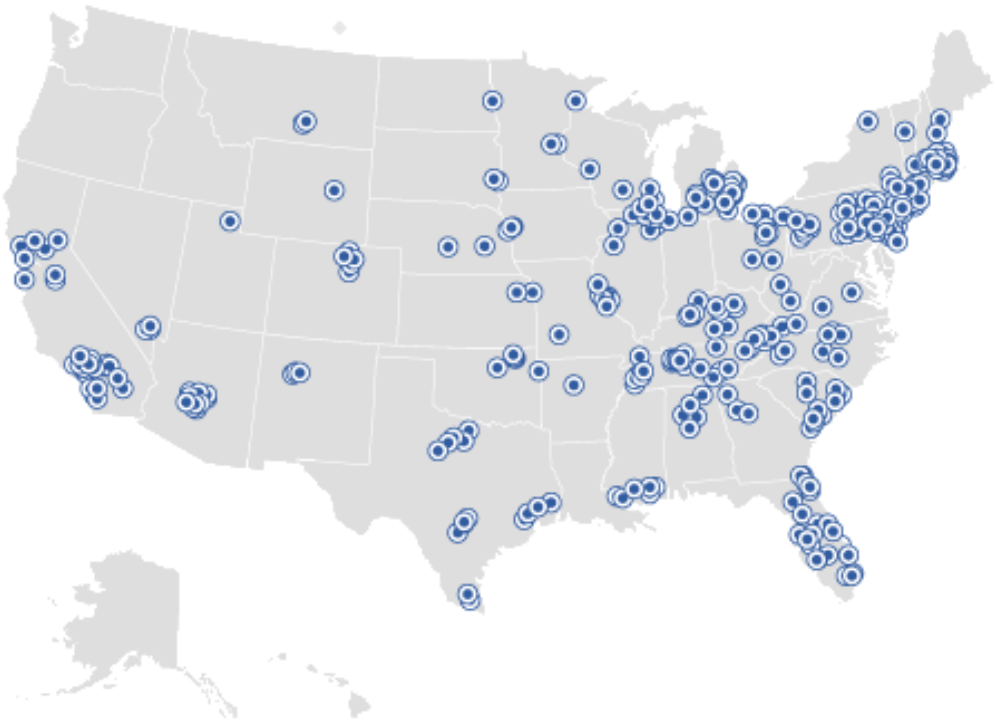
1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

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 ▪ Primary Care Transformation ▪ Bundled Payment for Care Improvement ▪ Initiatives Focused on the Medicaid ▪ Dual Eligible (Medicare-Medicaid Enrollees)
Deliver Care	**Support providers and states to improve the delivery of care** ▪ Learning and Diffusion ▪ Health Care Innovation Awards ▪ State Innovation Models Initiative ▪ Million Heart Initiative
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ Information to providers in CMMI models

Bundled Payments for Care Improvement is also growing rapidly

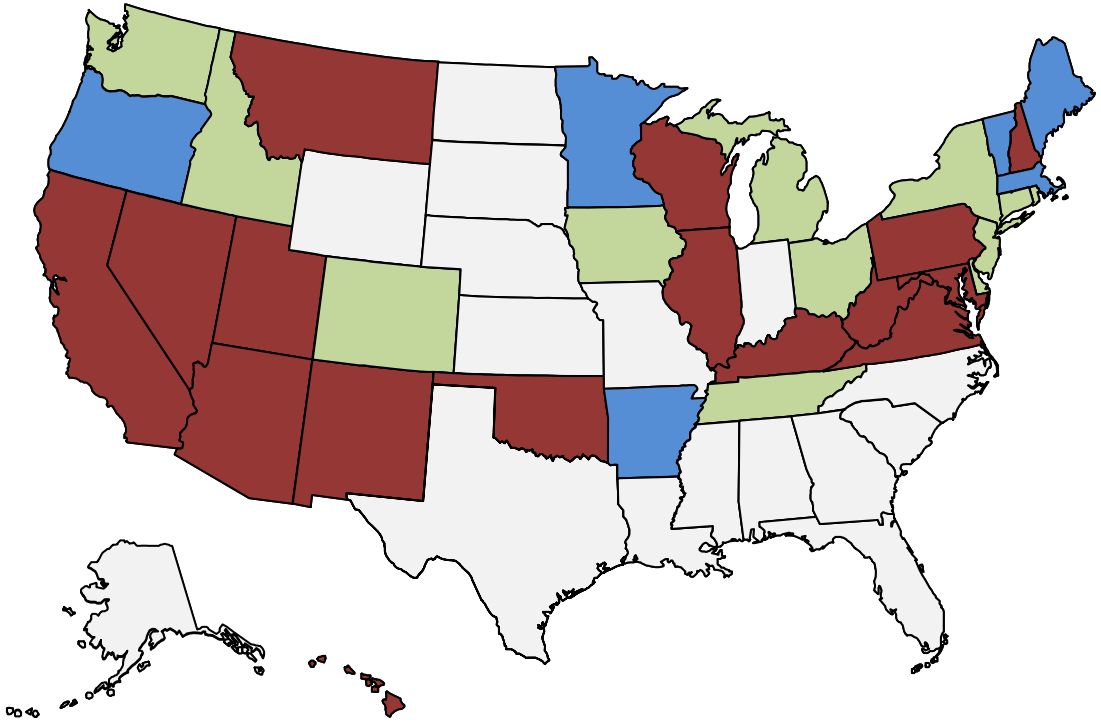


Source: Centers for Medicare & Medicaid Services

- 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
- 102 Awardees and 167 episode initiators in phase 2 as of January 2015
- 85 new awardees and 373 new episode initiators will enter phase 2 in April 2015

* Current as of January 2015

State Innovation Model grants have been awarded in two rounds



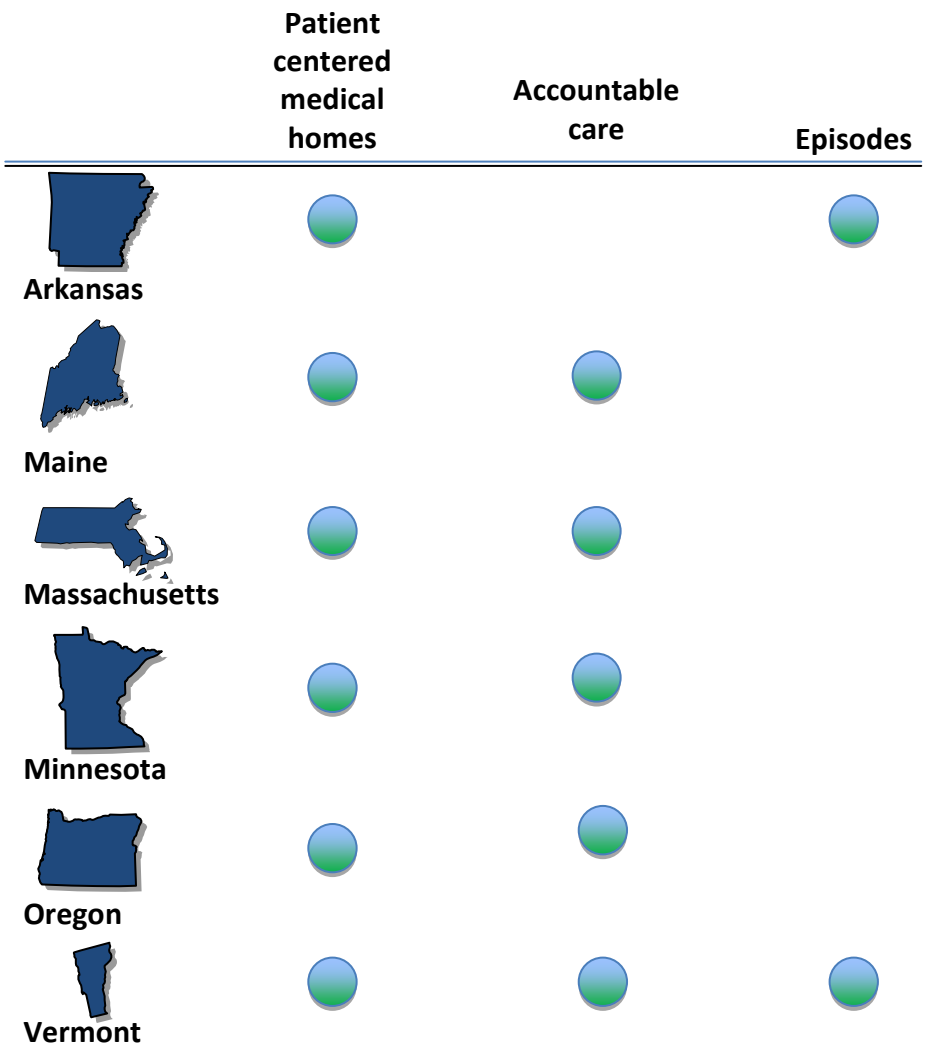
- Six round 1 model **test states**
- Eleven round 2 model **test states**
- Twenty one round 2 model **design states**

Primary objectives include

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

Round 1 states are testing and Round 2 states are designing and implementing comprehensive reform plans

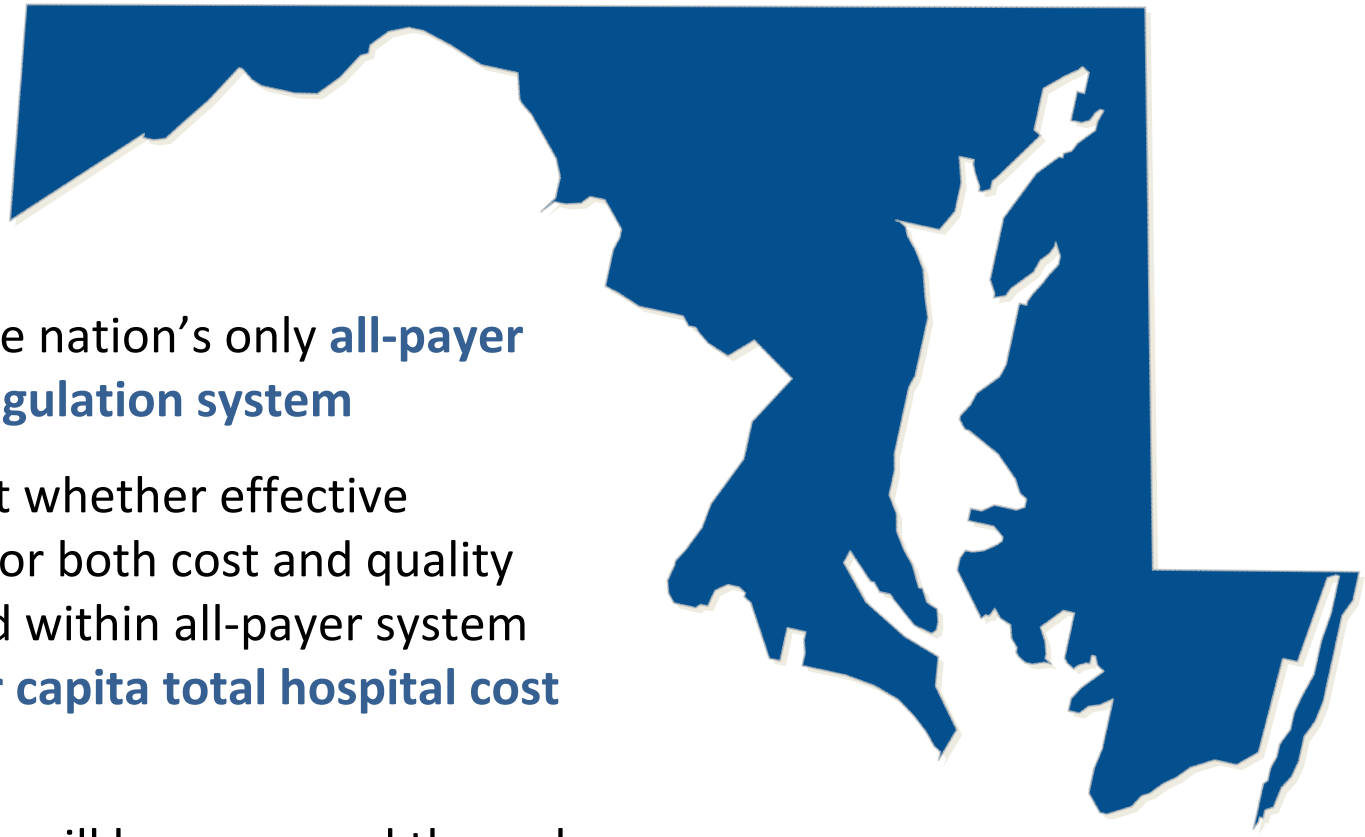
Round 1 States testing APMs



Round 2 States designing interventions

- **Near term CMMI objectives**
  - Establish project milestones and success metrics
  - Support development of states' stakeholder engagement plans
  - Onboard states to Technical Assistance Solution Center and SIMergy Collaboration site
  - Launch State HIT Resource Center and CDC support for Population Health Plans

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

* US census bureau estimate for 2013

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

Two network systems will be created with goal to support 150,000 clinicians

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

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 (e.g., oncology, care choices)

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 health, better care, and lower costs 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
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Contact Information

Dr. Patrick Conway, M.D., M.Sc.
CMS Acting Principal Deputy Administrator and
CMS Chief Medical Officer
410-786-6841
patrick.conway@cms.hhs.gov

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