

CMS Innovation and Health Care Delivery System Reform



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Delivery System Reform and Our Goals

Early Results

Bundled Payments

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

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.....
} *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

CMS has adopted a framework that categorizes payments to providers

**Category 1:
Fee for Service –
No Link to Value**

- Payments are based on volume of services and not linked to quality or efficiency

**Category 2:
Fee for Service –
Link to Quality**

- At least a portion of payments vary based on the quality or efficiency of health care delivery

**Category 3:
Alternative Payment Models Built
on Fee-for-Service Architecture**

- 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

**Category 4:
Population-Based Payment**

- 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)

Description

**Medicare
Fee-for-
Service
examples**

- Limited in Medicare fee-for-service
- Majority of Medicare payments now are linked to quality

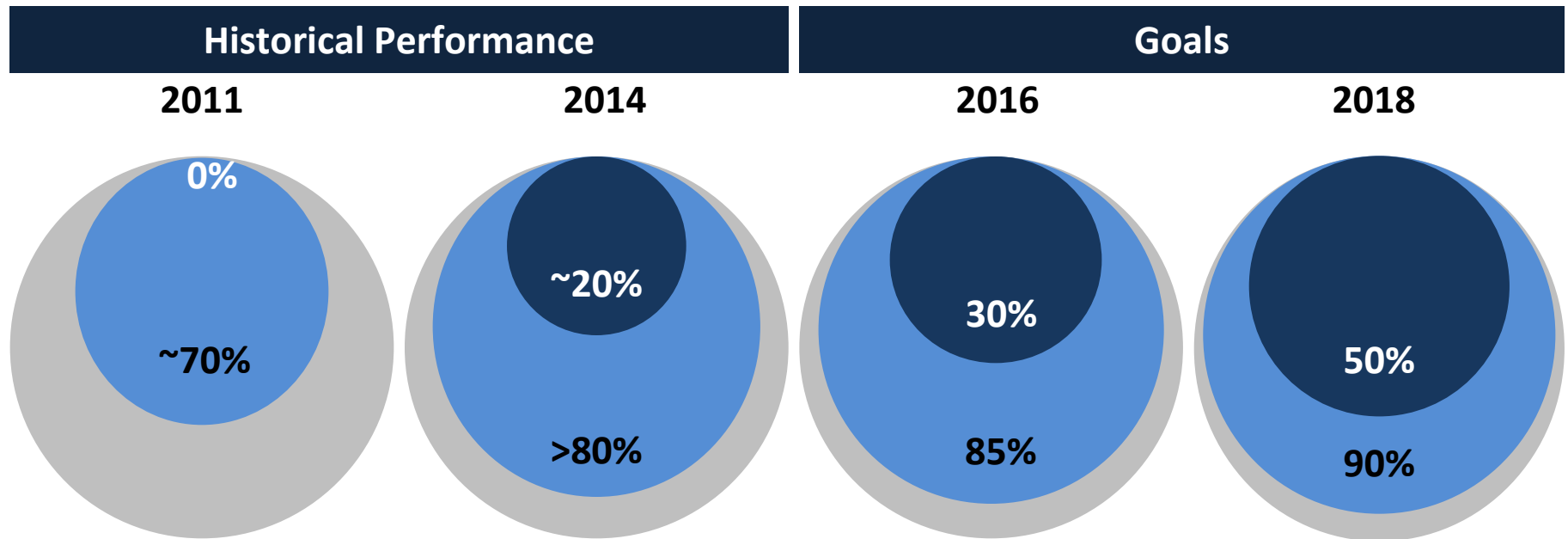
- Hospital value-based purchasing
- Physician Value Modifier
- Readmissions / Hospital Acquired Condition Reduction Program

- 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

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)



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**

The CMS Innovation Center was created by the Affordable Care Act to test new payment and service 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**

Two criteria for expansion of models authorized by Section 1115A of Social Security Act:

1. Reduce spending without reducing quality or
2. Improve quality without increasing spending

If an expansion of a model meets one of these two 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 models

- **Accountable Care**
 - Pioneer ACO Model
 - Medicare Shared Savings Program (housed in Center for Medicare)
 - Advance Payment ACO Model
 - Comprehensive ERSD Care Initiative
 - ACO Investment Model
 - 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
- **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
- **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**
- **Medicare Care Choices Model**
- **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

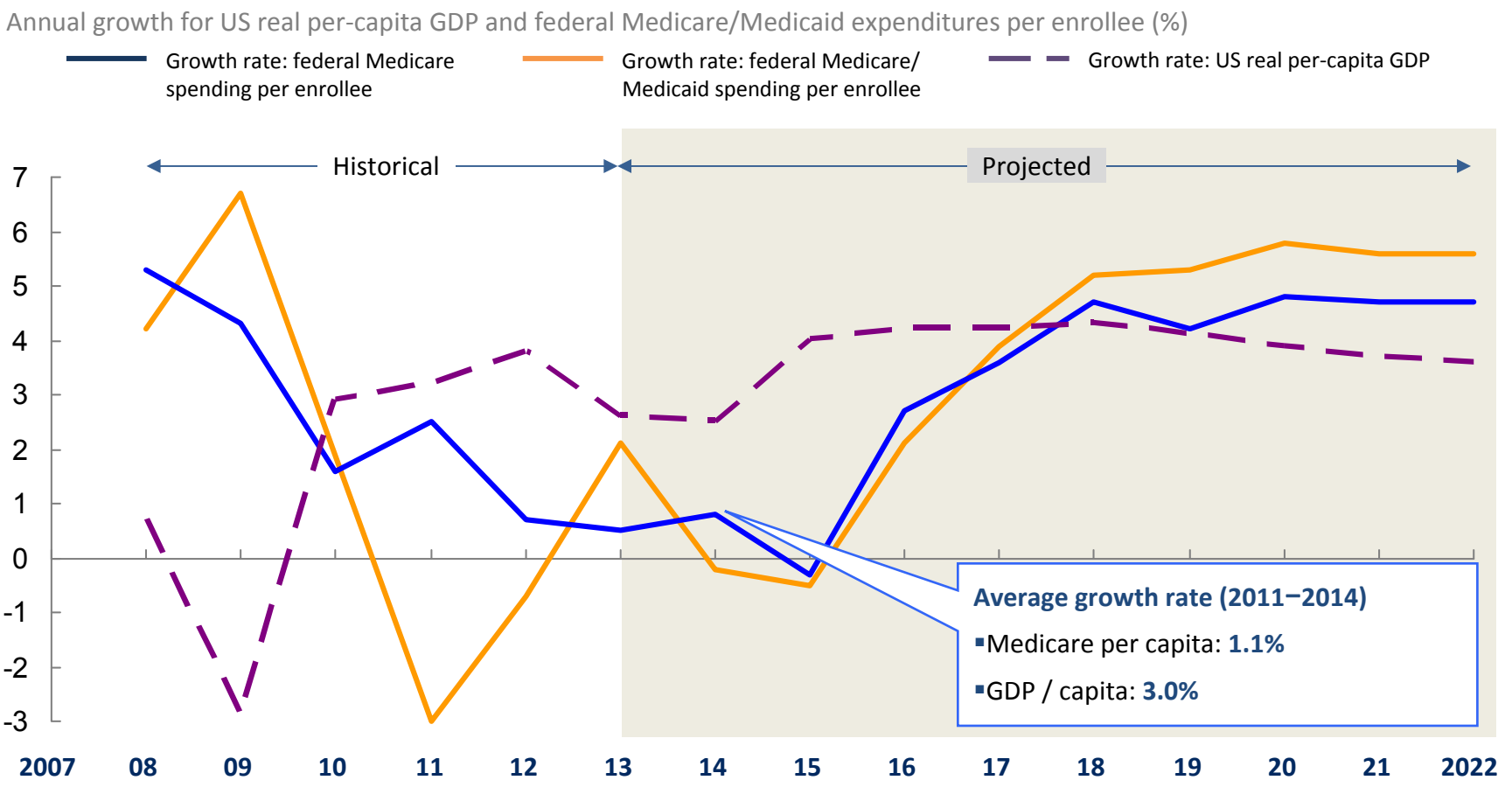
Delivery System Reform and Our Goals

Early Results

Bundled Payments

Medicare/Medicaid growth has fallen below GDP growth since 2010 due, in part, to CMS policy changes and new models of care

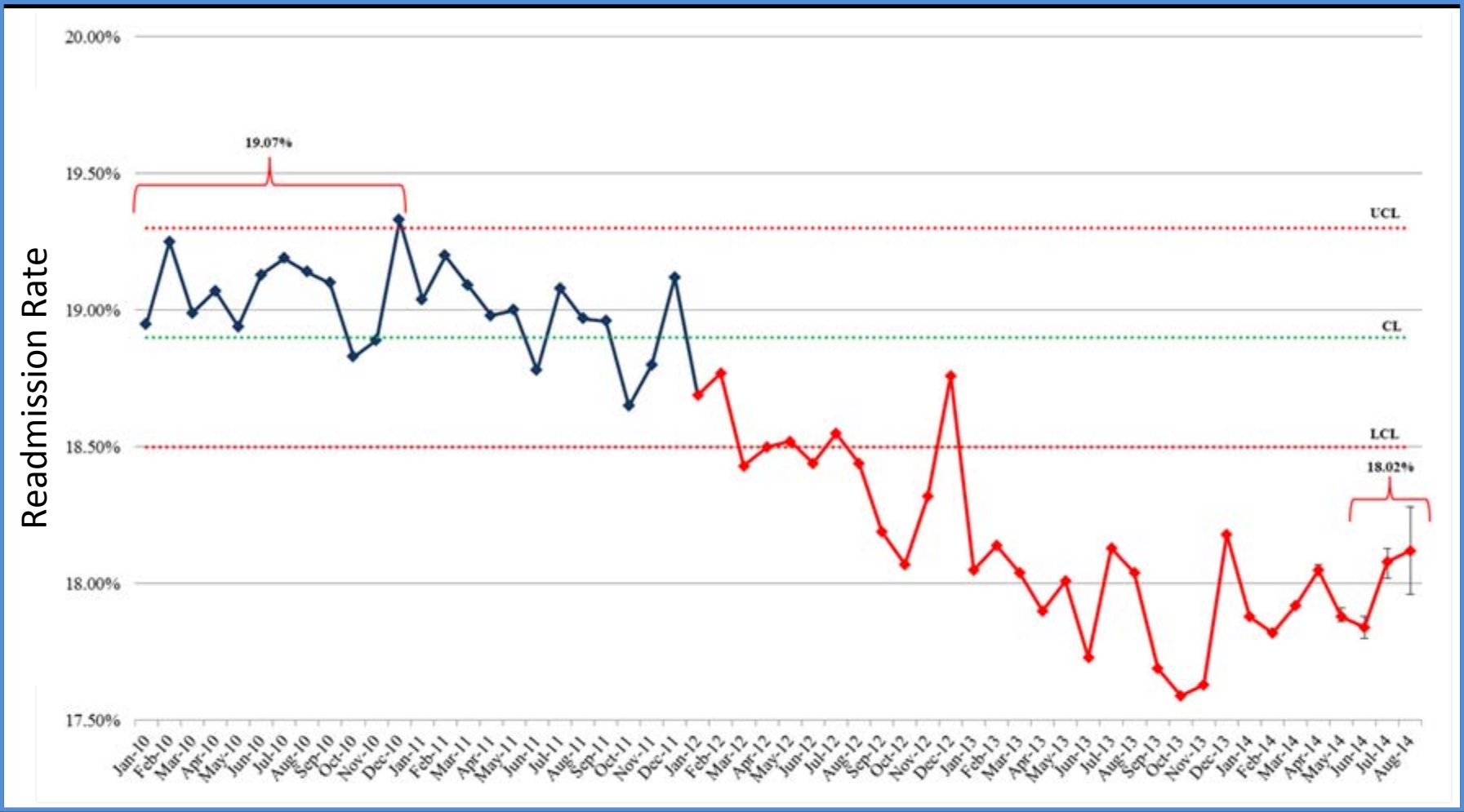
Gap between growth in federal spending on Medicare/Medicaid and GDP growth



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

SOURCE: CMS Office of the Actuary National Health Expenditure Data (2013-2023 projections)

Medicare all-cause, 30-day hospital readmission rate is declining

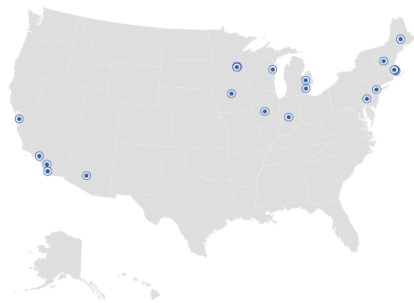


Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

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**
 - **\$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

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Early Results

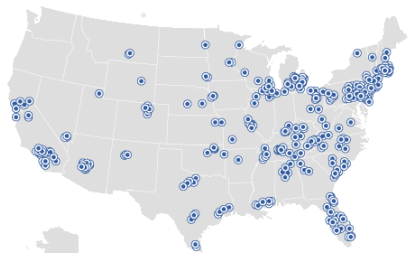
Bundled Payments

The Case for Bundled Payments

- Large opportunity to reduce costs from waste and variation
- Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
- Improvements “spillover” to private payers
- Strategies learned in bundled payments lay the foundation for success in a value driven market
- Adoption of bundled payments is accelerating across both private and public payers
- Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives

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
- 179 Awardees and 499 Episode Initiators in Phase 2 as of April 2015



Source: Centers for Medicare & Medicaid Services

- Duration of model is scheduled for 3 years:
 - Model 1: April 2013 to present
 - Models 2, 3, 4: October 2013 to present

Bundled Payments for Care Improvement: Models Overview

Model 1

Retrospective bundled payment models for the acute inpatient hospital stay only (11 Awardees)

Model 2

Retrospective bundled payment models for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care (104 Awardees)

Model 3

Retrospective bundled payment models for post-acute care where the bundle does not include the acute inpatient hospital stay (56 Awardees)

Model 4

Prospectively administered bundled payment models for hospitals and physicians for the acute inpatient hospital stay only (8 Awardees)

History of BPCI Models 2-4 Transition to Phase 2

Description of Entry Instructions and Cohort

Q4 2013
Phase 2 Begins

- The first quarter of the period of performance (Phase 2).
- Participants and their Episode Initiators could move clinical episodes into risk.
- This first cohort was fairly small in number and reflective of early adopters.

Q1 2014

- Additional Participants and their Episode Initiators began their period of performance through moving at least one clinical episode into risk (Phase 2).
- Awardees, already in their period of performance, were also allowed to move additional clinical episodes into risk.

Q3 2015
*All entities must
be in Phase 2*

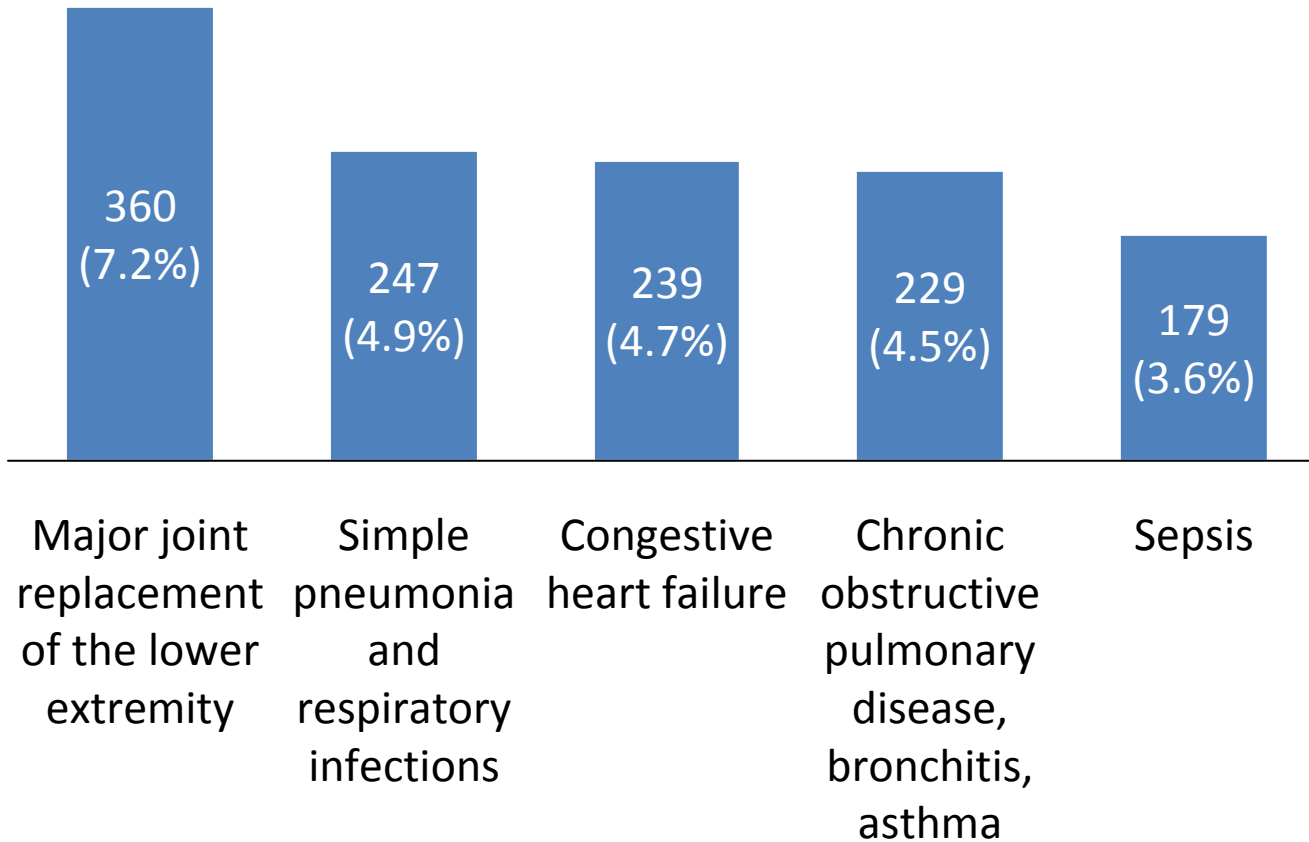
- Two open periods were offered, Q4 2013 and Q1 2014, resulting in tremendous growth in Participants entering Phase 1, the program preparatory period.
- Program instructed all Awardees that all entities must enter the period of performance (Phase 2) in Q3 2015.

Q4 2015
*All entities and
clinical episodes
in Phase 2*

- All Awardees and Episode Initiators must move all clinical episodes into Phase 2 by Q4 2015 as Phase 1 of BPCI will come to an end.

BPCI: Most Prevalent Clinical Episodes in Models 2-4

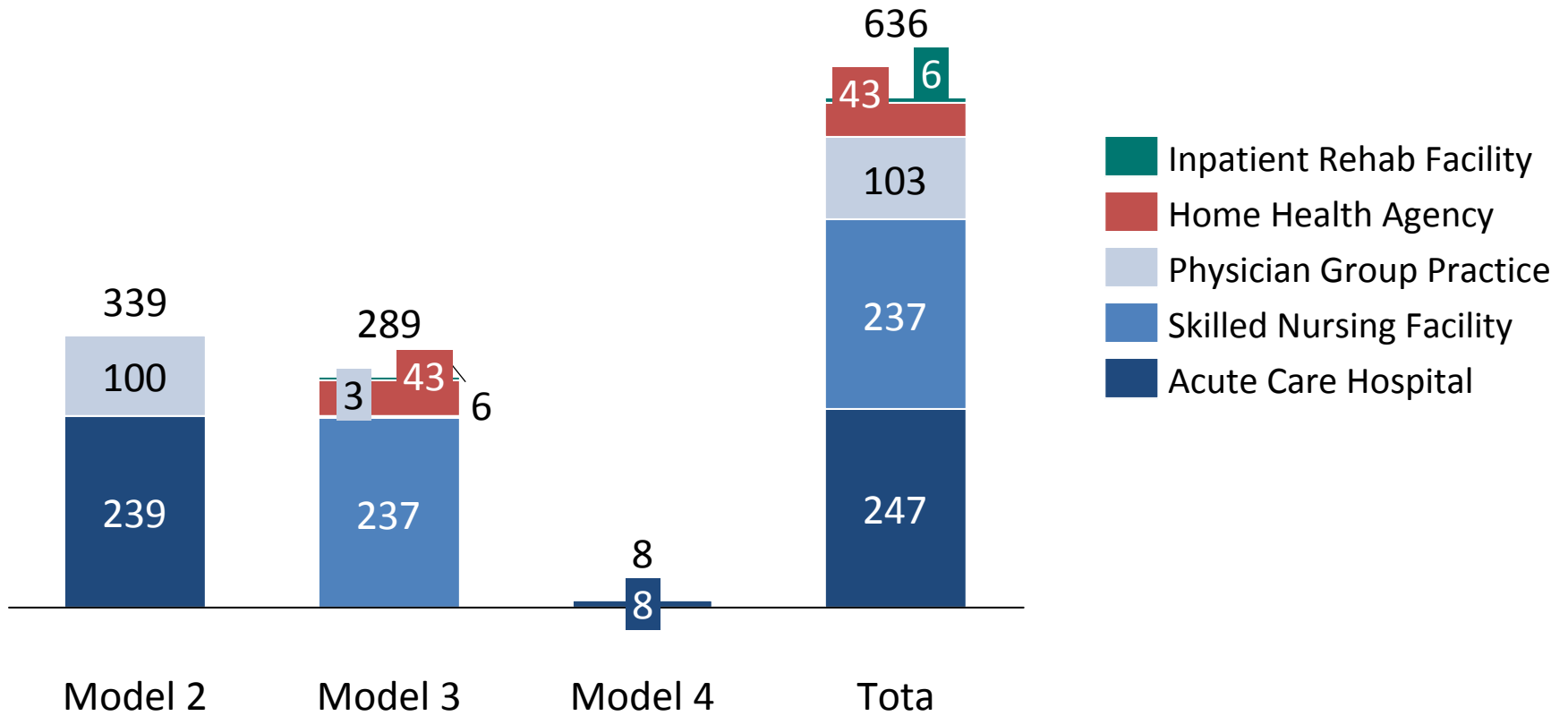
Most Prevalent BPCI Clinical Episodes in Models 2-4 Number of episodes, (percent of total episodes)



The five most prevalent Clinical Episodes account for 1,254 episodes, 24.9% of the Clinical Episodes currently being tested in BPCI

BPCI Provider Types

BPCI Provider Types in Models 2-4
Number of providers



BPCI Model 2 Summary of Evaluation Results

- Within 90 days of discharge from the hospital, costly institutional Post-Acute Care was substituted by less costly home health care.
- As a result, there were reductions in Medicare Part A payments to Skilled Nursing Facilities (SNF) and Inpatient Rehabilitation Facilities (IRF) accompanied by an increase of Part A payments to Home Health Agencies (HHA).
- There were also reductions in the anchor inpatient length of stay and the 30-day readmission rate.
- In the first quarter, BPCI awardees participated mostly with clinical episodes that fall into orthopedic surgery excluding the spine. Thus, Model 2 results were driven by patient episodes in this clinical episode group.

BPCI Model 3 Summary of Evaluation Results

- Majority of Episode Initiators are Skilled Nursing Facilities (SNF), followed by Home Health Agencies (HHA); few Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals (LTCH)
- Phase 2 SNFs likelier to be urban and not small compared to non-BPCI SNFs
- Model 3 interviewees mentioned the same reasons as Model 2 Awardees for joining BPCI:
 - Anticipate payment reform
 - Opportunities for quality improvement
 - See themselves as leaders and innovators
- Preliminary results for orthopedic-surgical episodes in SNFs suggest:
 - Institutional number of days lower across the baseline and intervention period than for comparison group
 - No difference in the change in Part A payments between the intervention and comparison groups

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
- Model Objective: Provide beneficiaries with **higher intensity coordination to improve quality and decrease cost**
- Key features
 - Invite Medicare **physician practices**, including those in clinical trials, that furnish chemotherapy to apply to participate
 - 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**

Episode Definition: OCM-FFS

	<u>Description</u>
Types of cancer	<ul style="list-style-type: none">Nearly all cancer types
Episode initiation	<ul style="list-style-type: none">When a beneficiary starts chemotherapyThe Innovation Center has devised a list of chemotherapy drugs that trigger OCM-FFS episodes, including endocrine therapies but excluding topical formulations of drugs
Included services	<ul style="list-style-type: none">All Medicare A and B services that Medicare FFS beneficiaries receive during episodeCertain Part D expenditures
Episode duration	<ul style="list-style-type: none">Extend six months after a beneficiary's chemotherapy initiationBeneficiaries may initiate multiple episodes during the five-year model performance period

Two-Part Payment Approach: OCM-FFS

During OCM, participating practices will be paid Medicare FFS payments.

Additionally, OCM has a two-part payment approach:

(1) Per-beneficiary-per-month (PBPM) payment

- \$160 PBPM payment for enhanced services required by OCM that is paid during the chemotherapy episode
- OCM-FFS practices are eligible for the PBPM monthly for each month of the 6-month episode, unless beneficiary enters hospice

(2) Performance-based payment

- Incentive to lower the total cost of care and improve quality of care for beneficiaries over the 6-month episode period
- Retrospective payment that is calculated based on the practice's historical Medicare expenditures and achievement on selected quality measures

Practice requirements to drive practice transformation (1/2)

Description

1 24/7 patient access

- Aim to better meet patients' needs by providing around-the-clock access to a clinician who can provide real-time, individualized medical advice
- Provide 24/7 patient access to an appropriate clinician who has real-time access to patient's medical records

2 EHR

- OCM Practices must demonstrate progress by attesting to MU Stage 1 by end of the first model performance year
- Use an ONC-certified EHR and attest to Stage 2 of meaningful use (MU) by the end of the third model performance year

3 Quality improvement

- The Innovation Center will provide participating practices with rapid cycle data feedback reports to aid in quality improvement
- Practices are expected to use this data to continuously improve OCM patient care management

Practice requirements to drive practice transformation (2/2)

Description

4

Patient navigation

- Practices are required to provide patient navigation to all OCM patients. The National Cancer Institute provides a sample list of patient navigation activities (see Appendix B of the RFA)

5

Care plan

- Document a care plan for every OCM patient that contains the 13 components in the Institute of Medicine Care Management Plan
- Plan components include treatment goals, care team, psychosocial support, and estimated patient out-of-pocket cost (see Appendix A of the RFA for full list)

6

Clinical guidelines

- Practices must report which clinical guidelines (NCCN or ASCO) they follow for OCM patients, or provide a rationale for not following the clinical guidelines

Performance-Based Payments– OCM-FFS

- 1) CMS will calculate **benchmark** episode expenditures for participating practices
 - Based on historical data
 - Risk-adjusted, adjusted for geographic variation
 - Trended to the applicable performance period
- 2) A discount will be applied to the benchmark to determine a **target price** for OCM-FFS episodes
 - Example: Benchmark = \$100 → Discount = 4% → Target Price = \$96
- 3) If **actual** OCM-FFS episode Medicare expenditures are **below target** price, the practice could receive a performance-based payment
 - Example: Actual = \$90 → Performance-based payment up to \$6
- 4) The amount of the performance-based payment may be reduced based on the participant's achievement and improvement on a range of **quality measures**

Risk Arrangement Options– OCM-FFS

One-side risk

- Participants are NOT responsible for Medicare expenditures that exceed target price
- 5-year model duration
- Medicare discount = 4%
- *Must qualify for performance-based payment by end of Year 3*

OR

Two-sided risk

- Participants are responsible for Medicare expenditures that exceed target price
- Option to take downside risk, beginning in Year 3 (one-sided risk for Years 1 and 2)
- Medicare discount = 2.75%
- *Must qualify for performance-based payment by end of Year 3*

Participants in the same risk arrangement structure will all receive the same discount

Risk Adjustment– OCM-FFS

OCM-FFS will risk adjust for several factors that affect episodic expenditures. Possible risk adjustment factors include:

- 1)Beneficiary characteristics** (such as age strata or comorbidities)
- 2)Episode characteristics** (such as whether an episode is the first for that beneficiary)
- 3)Disease characteristics** (such as cancer type)
- 4)Types of services furnished** (such as provision of radiation therapy or initiation with an endocrine therapy)

Risk adjustment in Year 1 will be based solely on information available in claims data. Risk adjustment in subsequent years may incorporate additional factors not captured in claims data, such as cancer staging.

Winsorization– OCM-FFS

Practices may have a small number of **patients with unexpected events or outcomes that greatly increase their total cost of care**. To lessen the impact of these outlier cases on a practice's overall performance, CMS intends to utilize a process called Winsorization.

- Winsorization replaces extreme values above a certain threshold (e.g. 95th or 99th percentile) with less extreme values to lessen the potential impact of outliers.
- Ex: If a beneficiary were involved in a severe motor vehicle accident during an OCM episode, thus greatly increasing his/her costs, the total cost of care of the episode would be truncated at the Winsorization threshold based on the national distribution of expenditures for that type of episode.

Quality Measures – OCM-FFS

Data sources:

- Practice-reported
- Medicare claims
- Patient surveys

Quality measure domains:

- Clinical quality of care
- Communication and care coordination
- Person and caregiver centered experience and outcomes
- Population health
- Efficiency and cost reduction
- Patient safety

Lists still in progress – will be finalized prior to practices signing agreements

Payer Requirements

Description

1 Operational

- Commit to participation in OCM for its 5-year duration
- Sign a Memorandum of Understanding with the Innovation Center
- Enter into agreements with OCM practices that include requirements to provide high quality care
- Share model methodologies with the Innovation Center
- Provide payments to practices for enhanced services and performance as described in the RFA

2 Quality measures

- Align practice quality and performance measures with OCM, when possible

3 Data sharing

- Provide participating practices with aggregate and patient-level data about payment and utilization for their patients receiving care in OCM, at regular intervals

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