



Center for Medicare and Medicaid Innovation Center Update



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Discussion

- **Our Goals and Early Results**
- **Center for Medicare and Medicaid Innovation**
- **Model Updates**
- **Looking Forward**

Delivery system and payment transformation

Historical State –

Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems

PRIVATE
SECTOR

PUBLIC
SECTOR

Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems and other Policies

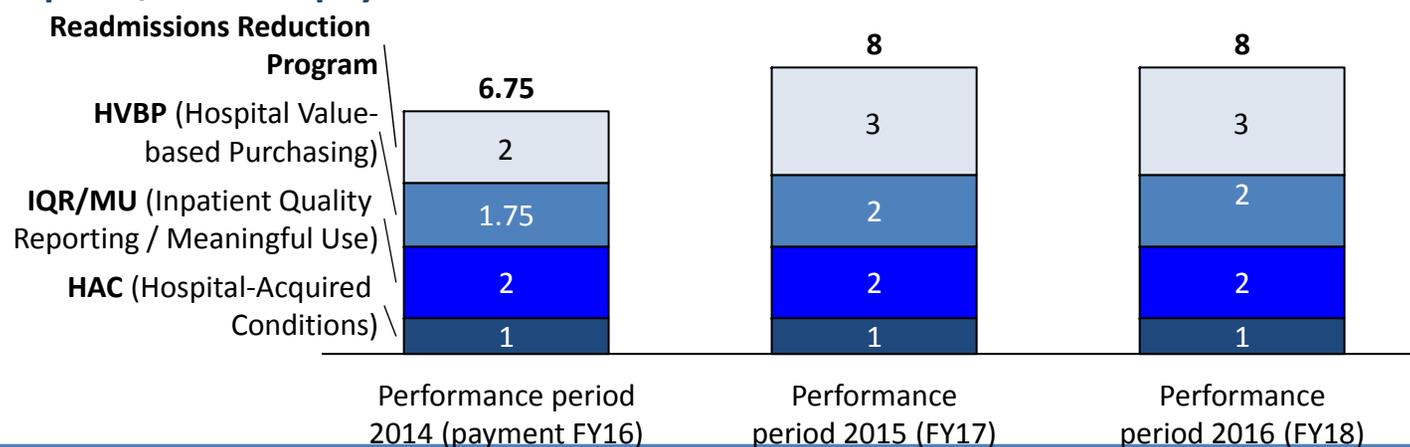
- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care management
- Data Transparency

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

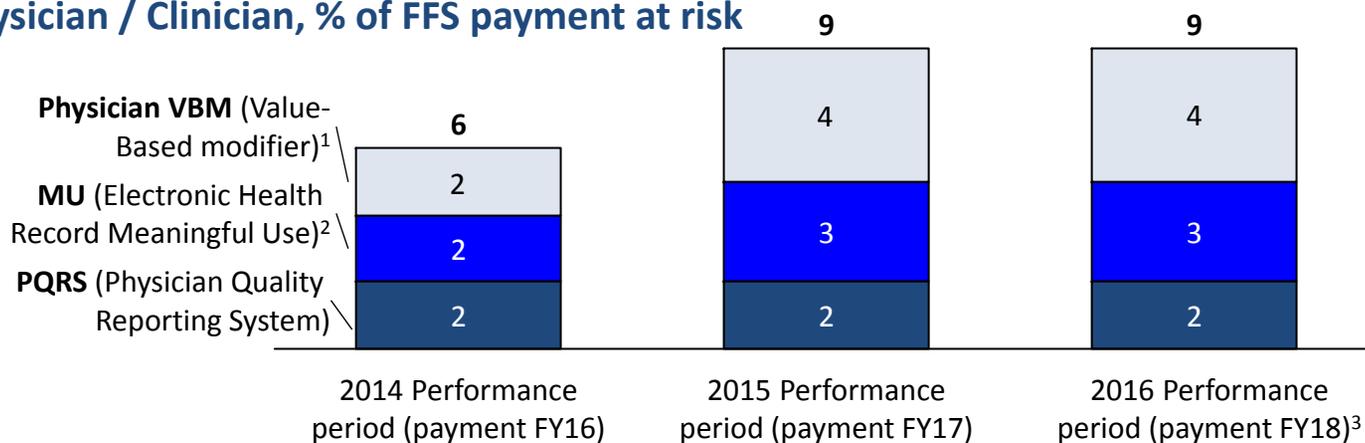
	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 (eg, >1 yr)
Examples				
Medicare	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable Care Organizations Medical Homes Bundled Payments 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3 – 5 Some Medicare Advantage plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	<ul style="list-style-type: none"> Primary Care Case Management Some managed care models 	<ul style="list-style-type: none"> Integrated care models under fee for service Managed fee-for-service models for Medicare-Medicaid beneficiaries Medicaid Health Homes Medicaid shared savings models 	<ul style="list-style-type: none"> Some Medicaid managed care plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

CMS is increasingly linking Fee-for-service payment to value

Hospitals, % of FFS payment at risk



Physician / Clinician, % of FFS payment at risk



1- Physician VBM for 2014 Performance period is being phased in as follows: Physicians in groups of 10+ EPs only for 2014 performance period ; all physicians, groups and EPs starting in 2015 performance period. For the 2015 performance period, 4% is proposed maximum downward VBM adjustment. For 2016 performance period, amount at risk to be proposed in next year's rulemaking and will depend in part on the final value for 2015 performance period.

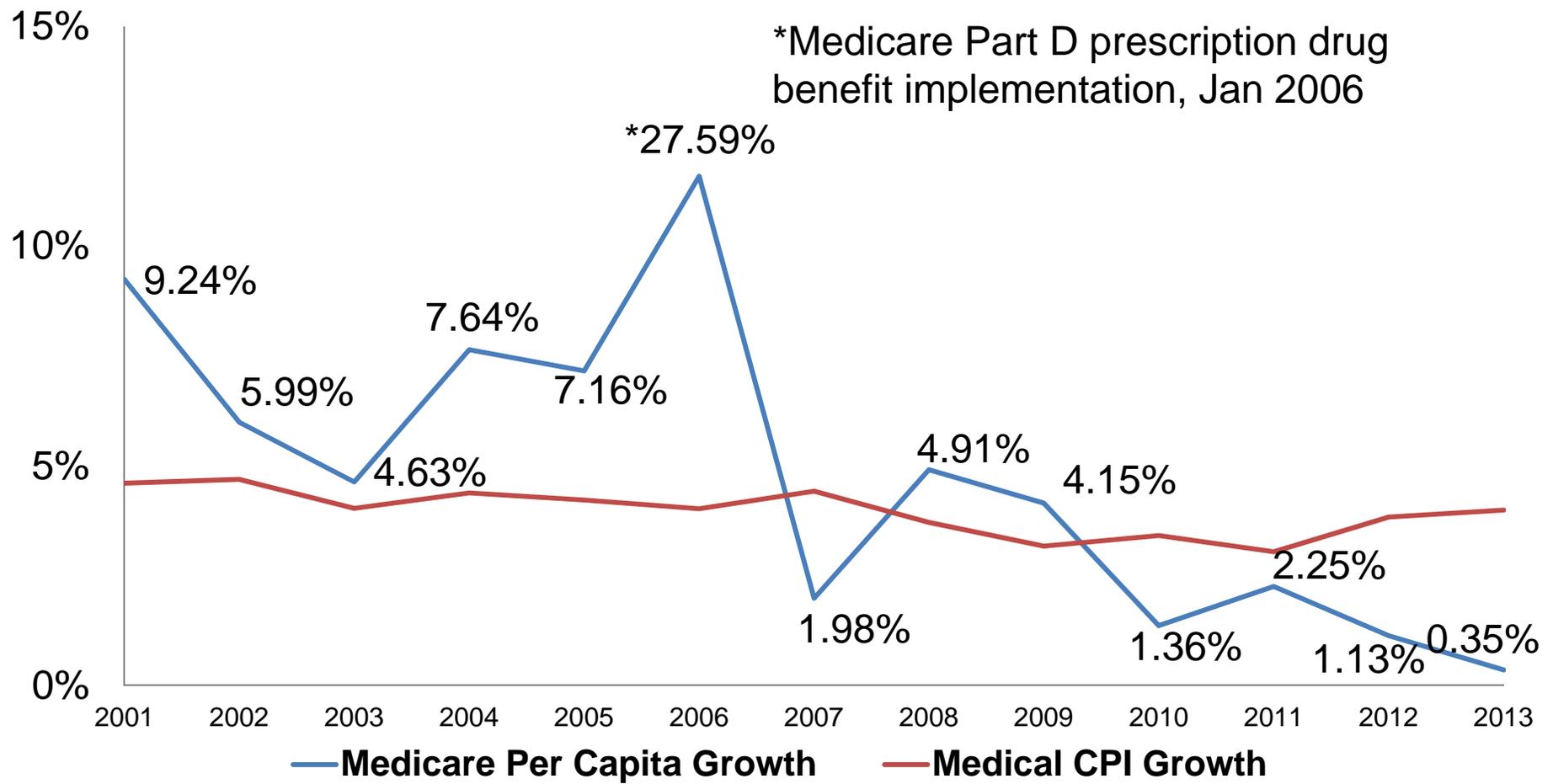
2 - For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75%, then the amount at risk would go up to 4%

3 - Proposed rule for 2016 performance year will be written in 2015. No cap on percent at risk for physician value-based modifier but unclear what the proposed rule will contain.

Early Example Results

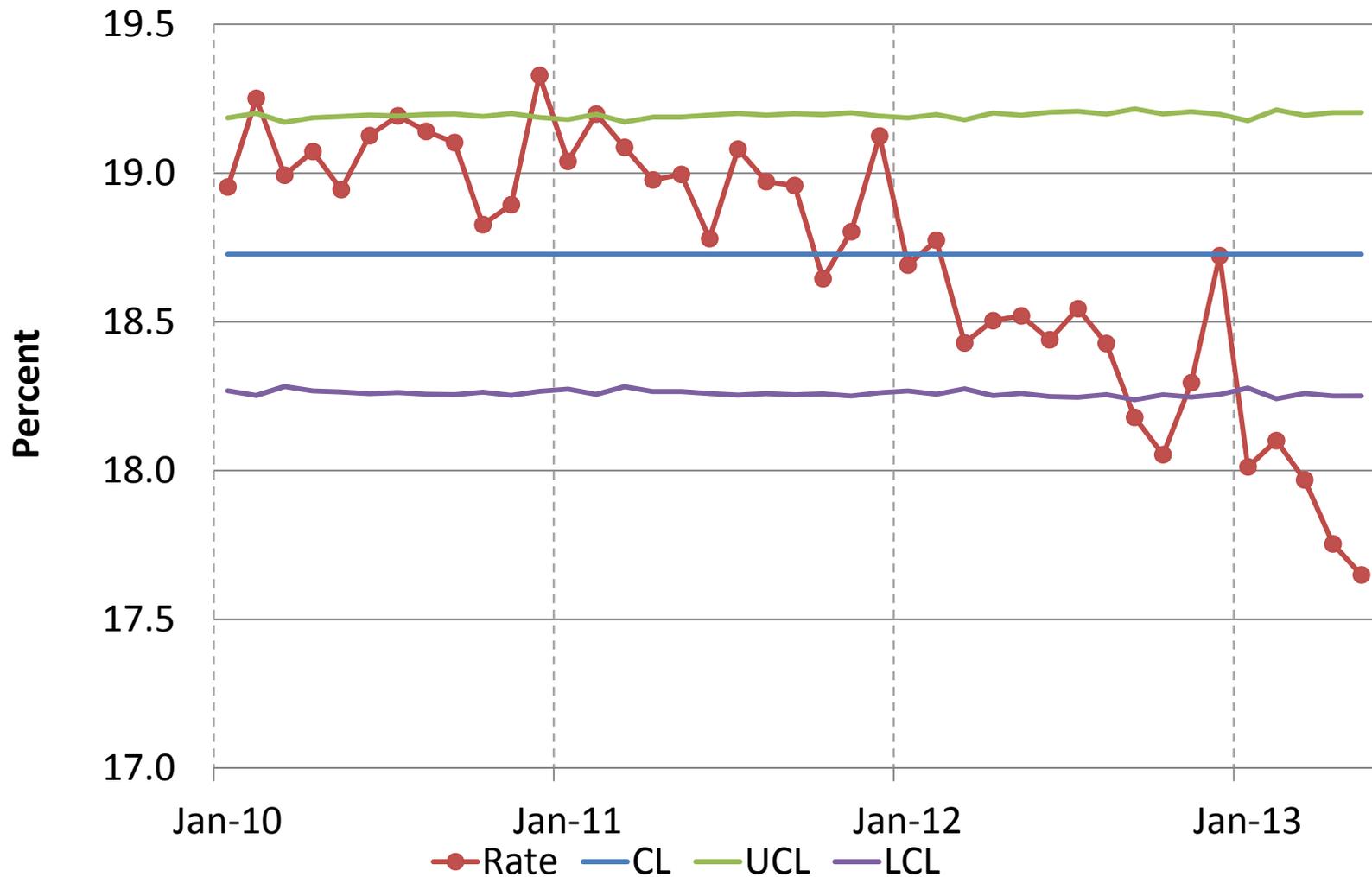
- Cost growth leveling off - actuaries and multiple studies indicated partially due to “delivery system changes”
- Moving the needle on some national metrics, e.g.,
 - Readmissions
 - Safety Measures
- Increasing value-based payment and accountable care models

Results: Medicare Per Capita Spending Growth at Historic Lows



Source: CMS Office of the Actuary

Medicare All Cause, 30 Day Hospital Readmission Rate



Source: Office of Information Products and Data Analytics, CMS

Hospital Acquired Condition (HAC) Rates Show Improvement

- 2010 to 2012: Data show a 9% reduction in HACs across all measures
- Estimated 15,000 lives saved, 540,000 injuries, infections, and adverse events avoided, and over \$4 billion in cost savings
- Many areas of harm dropping dramatically (2010 to 2013 for these leading indicators)

Hospital Acquired Condition	Ventilator-Associated Pneumonia (VAP)	Early Elective Delivery (EED)	Obstetric Trauma Rate (OB)	Venous thromboembolic complications (VTE)	Falls and Trauma	Pressure Ulcers
Percent Decrease	55.3%	52.3%	12.3%	12.0%	11.2%	11.2%

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The CMS Innovation Center

Identify, Test, Evaluate, Scale

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.

- *The Affordable Care Act*

CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice 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

Capacity to Spread Innovation

- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

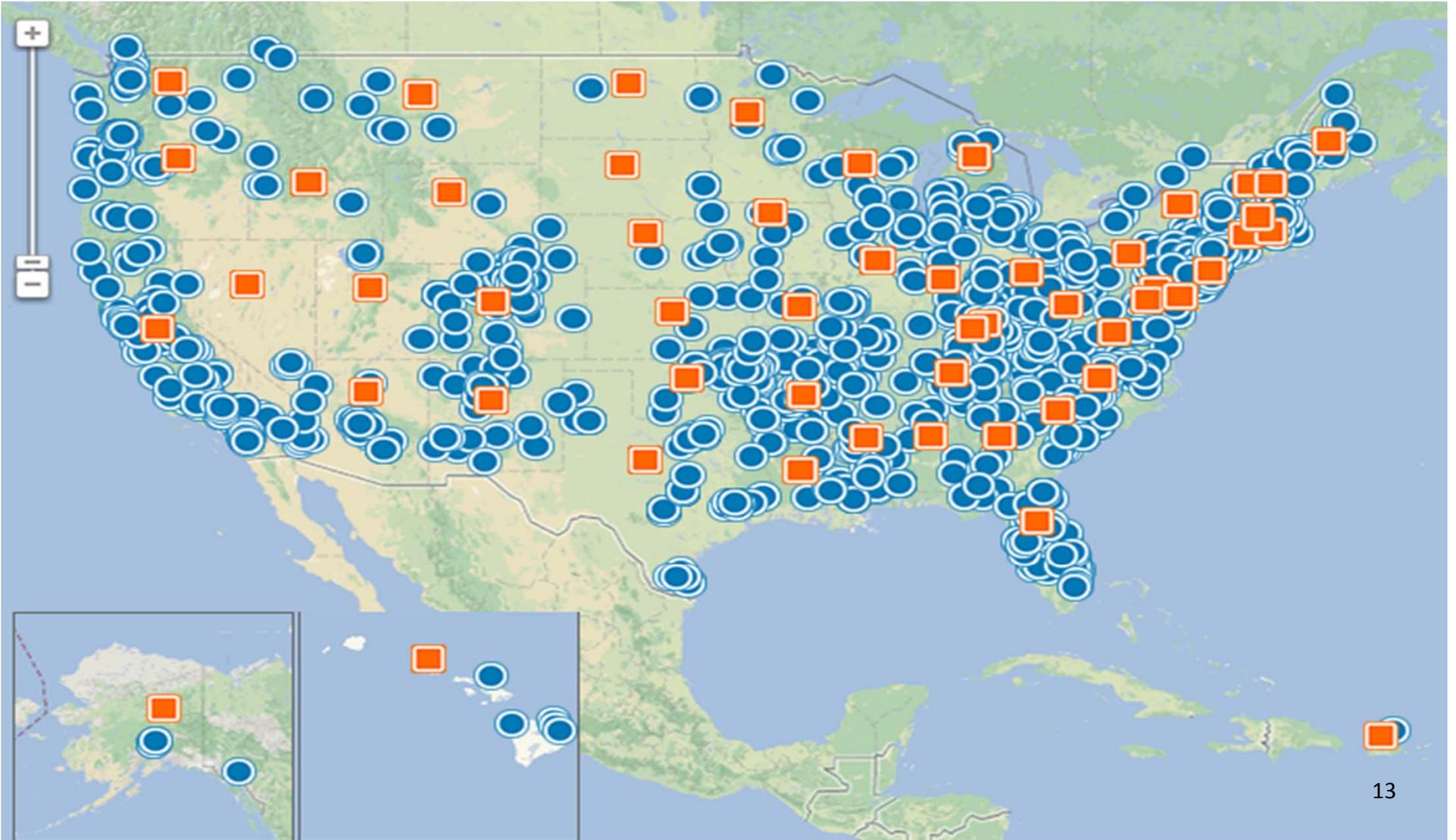
Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

Innovation is happening broadly across the country



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Accountable Care Organization Goals

- Improve the safety and quality of patient care while lowering costs
- Promote shared accountability across providers
- Increase coordination of care
- Invest in infrastructure and redesigned care services
- Achieve better health and better care at lower costs
- Medicaid and private payers increasingly launching both Accountable Care Organizations and “alternative” contracts

Accountable Care Organizations (ACOs)

- An ACO promotes coordinated care and population management
- Over 350 ACOs serving over 5 million Medicare beneficiaries
- Over \$380 million of savings combined year 1 of Medicare Shared Savings Plan (MSSP) and Pioneer ACOs
- Pioneer model with early promising results
 - Generated shared savings and low cost growth (0.3%)
 - Outperformed published benchmarks on 15 of 15 clinical quality measures and 4 of 4 patient experience measures

Accountable Care Organizations

Year 2 results

- Pioneer and Medicare Shared Savings ACO Programs program savings of \$372 million
- Majority of ACOs in both programs generated savings
- Improved quality and patient experience on almost all measures
 - Pioneer ACOs improved in 28 out of 33 quality measures with mean improvement from 70.8% to 84.0%¹
 - Improved patient experience in 6 out of 7 measures
 - Medicare shared savings ACOs also improved quality and patient experience for almost all measures

¹ Pham H, Cohen M, Conway PH. The Pioneer Accountable Care organization Model: Improving quality and lowering costs. JAMA 2014 Sept 17.

State Innovation Models

- Partner with states to develop broad-based State Health Care Innovation Plans
- 6 Implementation and 19 Design/Pre-testing States in round 1
- Plan, Design, Test and Support of new payment and service and delivery models
- Utilize the tools and policy levers available to states
- Engage a broad group of stakeholders in health system transformation
- Coordinate multiple strategies, payers, and providers into a plan for health system improvement
- Round 2 announced in May 2014 and over 30 states applied in August, plan to announce later this year

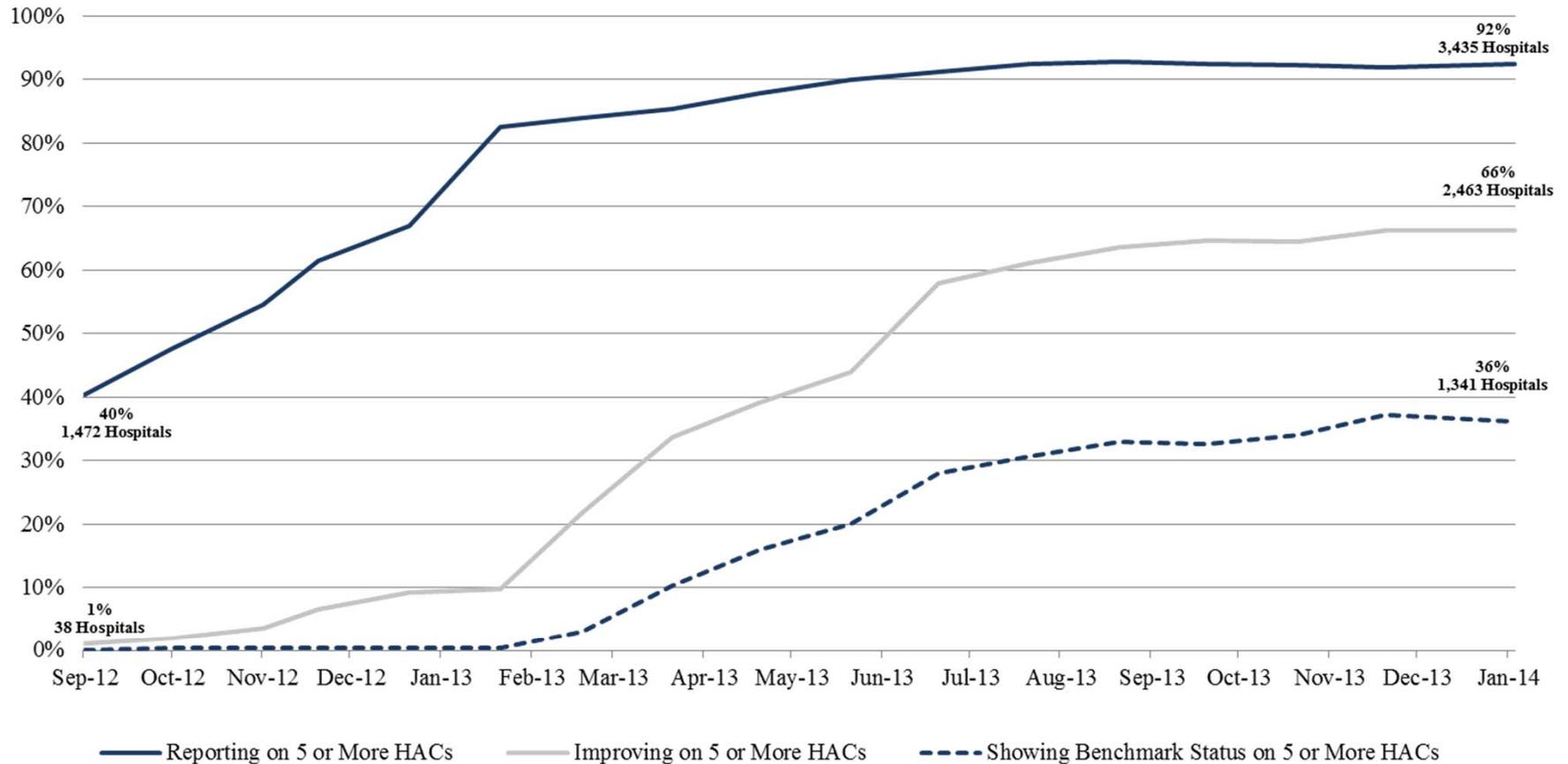
Medicaid Innovator Accelerator Program

- Announced July 2014 and represents over \$100 million investment
- Partnership between Medicaid and CMMI
- Offering states technical assistance in:
 - Data analytics
 - Quality measures
 - Model development
 - Disseminating best practices
 - Rapid cycle evaluation
- Initial work may include changes in care delivery such as:
 - Substance Use Disorder (SUD) Changes in care delivery
 - Behavioral health
 - Long- term services and supports & community integration
 - Superutilizers
 - Perinatal

Bundled Payment Projects

- Testing three types of bundles: acute care, acute and post-acute, post acute alone
- Bundles cost of services for an episode of care with quality measures related to episode
- For example from hospitalization to 30/60/90 days post episode or some models are just bundled price for all hospitalization costs
- One of several Innovation Center projects to test innovative methods of care delivery to improve quality and reduce cost across episodes of care
- Thousands of participants and growing
- Challenging program to implement

Partnership for Patients Hospital Engagement Network Improvement September 2012 – January 2014



Note : As of March 2013, the method for classifying hospitals as improving and meeting benchmark status was changed and clarified, making data for the “Showing Benchmark Status” for March onwards non-comparable to those shown in earlier months.

Patient-Centered Medical Home Models

It takes time for practices to transform

- Implementation of structural and process changes do not happen instantly...
 - At least 12-18 months to fully integrate an electronic health record (EHR) in a small practice
 - Physicians and staff need time to adjust to new priorities/workflows
- Short term difficulty in reducing costs have been observed elsewhere...
 - Practice level structural and process changes are, by their nature, disruptive
 - Potentially divides staff attention between implementing transformation and delivering care
 - Short term losses can be balanced out with long term gains if proper mitigation strategies are in place

Innovation Center

Patient-Centered Medical Home Models

- Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Comprehensive Primary Care (CPC) Initiative

Comprehensive Primary Care (CPC) Overview

- CMS convened Medicaid and commercial payers in discrete geographic areas to support primary care practice transformation through: enhanced, non-visit-based payments; data feedback; and technical assistance
- Aligned set of quality measures
- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, 500 practices, and 2.6 million patients
- CMS-defined, standardized intervention, includes 5 functions:
 - Risk-stratified care management
 - Access and continuity
 - Planned care for chronic conditions
 - Coordination of care across the medical neighborhood
 - Patient and caregiver engagement

CPC Key Findings from Year 1

- CPC practices added 1,100 care managers, who are staff providing intensive care management to patients at highest risk
- 97% of eligible providers have attested to at least stage one Meaningful Use of Health IT
- Deployed patient shared decision-making tools to address prostate cancer screening, diabetes medications, management of acute low back pain, and others
- Early results indicate that expenditures are trending downward

Overarching Patient-Centered Medical Home (PCMH) Early Results

- With some exceptions, too early in model tests to see changes in key outcomes
 - Primary care practice transformation takes time to implement
 - Benefits of better primary care and care coordination take time to improve health and reduce downstream events
 - Seeing some promising results, suggesting cost savings, though they are preliminary and not consistent
- Seeing steady improvements in PCMH capabilities
- Spreading learnings across CMMI models and into core payment programs

Independence at Home

GOAL: Testing the effectiveness of providing chronically ill beneficiaries with home-based primary care.

- Medical practices provide chronically ill beneficiaries with home-based primary care.
- Practices must serve at least 200 targeted beneficiaries living with multiple chronic diseases to be eligible.
- Incentive payments for practices successful in:
 - meeting quality standards; and
 - reducing total expenditures.
- 14 independent practices and 1 consortia participating in IAH.
- Early results promising

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Innovation Center

2014 Looking Forward

We're Focused On

- Portfolio analysis and launch new models to round out portfolio
- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS

Possible Model Concepts

- Transforming Clinical Practice – announced in Oct 2014
- Outpatient specialty models
- Health Plan Innovation
- Consumer Incentives
- ACOs version 2.0
- Home Health
- More.....

What can we do?

- Eliminate patient harm
- Focus on better care, better health, and lower costs for the patient population you serve
- Engage in accountable care and other alternative contracts based on achieving better outcomes at lower cost
- Participate in CMMI and other innovative models of care delivery – test new models
- Test models to better coordinate care for people with multiple chronic conditions
- Invest in the quality infrastructure necessary to improve and engage in collaborative Quality Improvement and learning networks
- Relentless pursuit of improving health outcomes

Contact Information

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