Health System Transformation
Post Affordable Care Act

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Weaknesses of Fee for Service Payment

- Excessive use of low-value services
- Insufficient incentives to improve quality of care
- Poor coordination of care
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.
According to the Congressional Budget Office, federal spending on major health care programs in 2020 will be $200 Billion lower than predicted in 2010.
'Jaw-dropping': Medicare deaths, hospitalizations AND costs reduced

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

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

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
Partnership for Patient contributes to quality improvements

Data shows...

17% ↓
Hospital Acquired Conditions

50,000
LIVES SAVED

1.3 million
Patient harm events avoided

$12 billion
in savings

Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>2010-2013 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>62.4% ↓</td>
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<tr>
<td>Early Elective Delivery</td>
<td>70.4% ↓</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infections</td>
<td>12.3% ↓</td>
</tr>
<tr>
<td>Venous thromboembolic complications</td>
<td>14.2% ↓</td>
</tr>
<tr>
<td>Re-admissions</td>
<td>7.3% ↓</td>
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Better Care, Smarter Spending, Healthier People

Focus Areas

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.

**Medicare Fee-for-Service**

**GOAL 1:**  
Medicare payments are tied to quality or value through alternative payment models where the provider is accountable for quality and total cost of care by the end of 2016, and 50% by the end of 2018.

**GOAL 2:**  
Medicare fee-for-service payments are tied to quality or value by the end of 2016, and 90% by the end of 2018.

**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 between public and private sector players.
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Historical Performance
  - 2011: 68% FFS linked to quality, 0% Alternative payment models
  - 2014: >80% FFS linked to quality, ~20% Alternative payment models
  - 2016: 85% FFS linked to quality, 30% Alternative payment models
  - 2018: 90% FFS linked to quality, 50% Alternative payment models

- Goals
  - 2016: 85% FFS linked to quality, 30% Alternative payment models
  - 2018: 90% FFS linked to quality, 50% Alternative payment models
Center for Medicare and Medicaid Innovation
The Innovation Center portfolio aligns with delivery system reform focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
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<tbody>
<tr>
<td><strong>Pay Providers</strong></td>
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<tr>
<td>Test and expand alternative payment models</td>
<td>Episode-Based Payment Initiatives</td>
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<tr>
<td>Accountable Care</td>
<td>- Accountable Care</td>
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<tr>
<td>- Pioneer ACO Model</td>
<td>- Bundled Payment for Care Improvement</td>
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<tr>
<td>- Next Generation ACO</td>
<td>- Model 1: Retrospective Acute Care</td>
</tr>
<tr>
<td>- Medicare Shared Savings Program (housed in Center for Medicare)</td>
<td>- Model 2: Retrospective Acute Care Episode &amp; Post Acute</td>
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<tr>
<td>- Advance Payment ACO Model</td>
<td>- Model 3: Retrospective Post Acute Care</td>
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<tr>
<td>- Comprehensive ERSD Care Initiative</td>
<td>- Model 4: Prospective Acute Care</td>
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<tr>
<td><strong>Primary Care Transformation</strong></td>
<td>- Oncology Care Model</td>
</tr>
<tr>
<td>- Comprehensive Primary Care Initiative (CPC)</td>
<td>- Maryland All-Payer Model</td>
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<td>- Multi-Payer Advanced Primary Care Practice Demo</td>
<td>- Million Hearts Initiative</td>
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<td>- Home Health Value Based Purchasing</td>
<td>- Support providers and states to improve the delivery of care</td>
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<tr>
<td>- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
<td>State Innovation Models Initiative</td>
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<td>- Independence at Home Demonstration</td>
<td>- SIM Round 1</td>
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<td>- Graduate Nurse Education Demonstration</td>
<td>- SIM Round 2</td>
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<tr>
<td>- Medicare Care Choices Model</td>
<td>- Maryland All-Payer Model</td>
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<td><strong>Deliver Care</strong></td>
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<td>Learning and Diffusion</td>
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<tr>
<td>- Partnership for Patients</td>
<td>- Initiatives Focused on the Medicaid</td>
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<tr>
<td>- Transforming Clinical Practice</td>
<td>- Medicaid Emergency Psychiatric Demonstration</td>
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<td>- Community-Based Care Transitions</td>
<td>- Medicaid Incentives for Prevention of Chronic Diseases</td>
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<tr>
<td>Health Care Innovation Awards</td>
<td>- Strong Start Initiative</td>
</tr>
<tr>
<td><strong>Distribute Information</strong></td>
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<tr>
<td>Information to providers in CMMI models</td>
<td>- Medicaid Innovation Accelerator Program</td>
</tr>
<tr>
<td>Increase information available for effective informed decision-making by consumers and providers</td>
<td>- Dual Eligible (Medicare-Medicaid Enrollees)</td>
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<tr>
<td>- Shared decision-making required by many models</td>
<td>- Financial Alignment Initiative</td>
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* 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 2\textsuperscript{nd} year in a row
  - $400M in program savings combined for two years\(^\dagger\) (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\(^\ddagger\)

- 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

\(^\dagger\) Results from regression based analysis
\(^\ddagger\) 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.
Primary Care Models improving Care

• Comprehensive Primary Care Initiative
• Independence at Home
• Various Health Care Innovation Awards
• State Innovation Model and multipayer state models
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.

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients.


* 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 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”
Bundled Payment Models
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

Over 1700 providers (e.g., hospitals, physician groups, post-acute providers) have moved into 2 sided risk, often for multiple conditions

*Bundled Payments for Care Improvement is also growing rapidly*

*Current as of January 2015*
What is the Comprehensive Care Joint Replacement model?

- The proposed model would **test bundled payments for lower extremity joint replacement (LEJR)** across a broad cross-section of hospitals.

- The payment model would **apply to most Medicare LEJR procedures within select geographic areas** with few exceptions.

- The payment model would be **implemented through rule making, and the performance period proposed to begin on January 1, 2016**.
CCJR Participants

• Participants include Inpatient Prospective Payment System (IPPS) Hospitals in select Metropolitan Statistical Areas (MSA)
  – BPCI Model 2 and Model 3 LEJR episodes initiated by participating physician group practices or post-acute care facilities would take precedence over Comprehensive Care Joint Replacement model episodes.

• 75 MSAs were proposed for selection based on a two-step randomization process.
  ➢ MSA were placed into five groups based on their historic LEJR episode payment and their population size.
  ➢ Fifteen MSAs were then randomly selected within each group.

• One of the first non-voluntary CMMI models
State Based Models
Primary objectives include

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

State Innovation Model grants have been awarded in two rounds: 38 States and Territories

- Six round 1 model test states
- Eleven round 2 model test states
- Twenty one round 2 model design states
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
Additional Models and Initiatives
Independence at Home (IAH)

- 14 practices
- 1 consortium
- ~8,400 patients enrolled in first year
- Duration: 2012-2015

IAH tests a service delivery and shared savings model using home-based primary medical care to improve health outcomes and reduce expenditures for high-risk Medicare beneficiaries.

First year results – good quality results and over $3000 per beneficiary per year savings
Medicare Care Choices

- Concurrent hospice and palliative care services along with curative care
- These services must be available 24/7, 365 calendar days per year.
- CMS will pay a $400 per beneficiary per month fee to the Medicare Care Choices Model participating hospices.
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.

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**Set Aims**

- Using Data to Drive Change
- Measuring Progress
- Achieve Benchmark Status

**Phases of Transformation**

**Thrive as a Business via Pay-for-Value Approaches**
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
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:

• 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)
Alternative Payment Model (APM) Incentive Payments:

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

• Physicians/clinicians who participate in certain types of APMs and who meet specified payment thresholds.

• 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
Contact Information

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