



Intermountain®
Healthcare

Presents

HEALTHY DIALOGUES

**Health System Transformation
Post Affordable Care Act**

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#KeepingUSHealthy



Weaknesses of Fee for Service Payment



Excessive use of
low-value
services



Insufficient
incentives to
improve quality
of care



Poor
coordination of
care



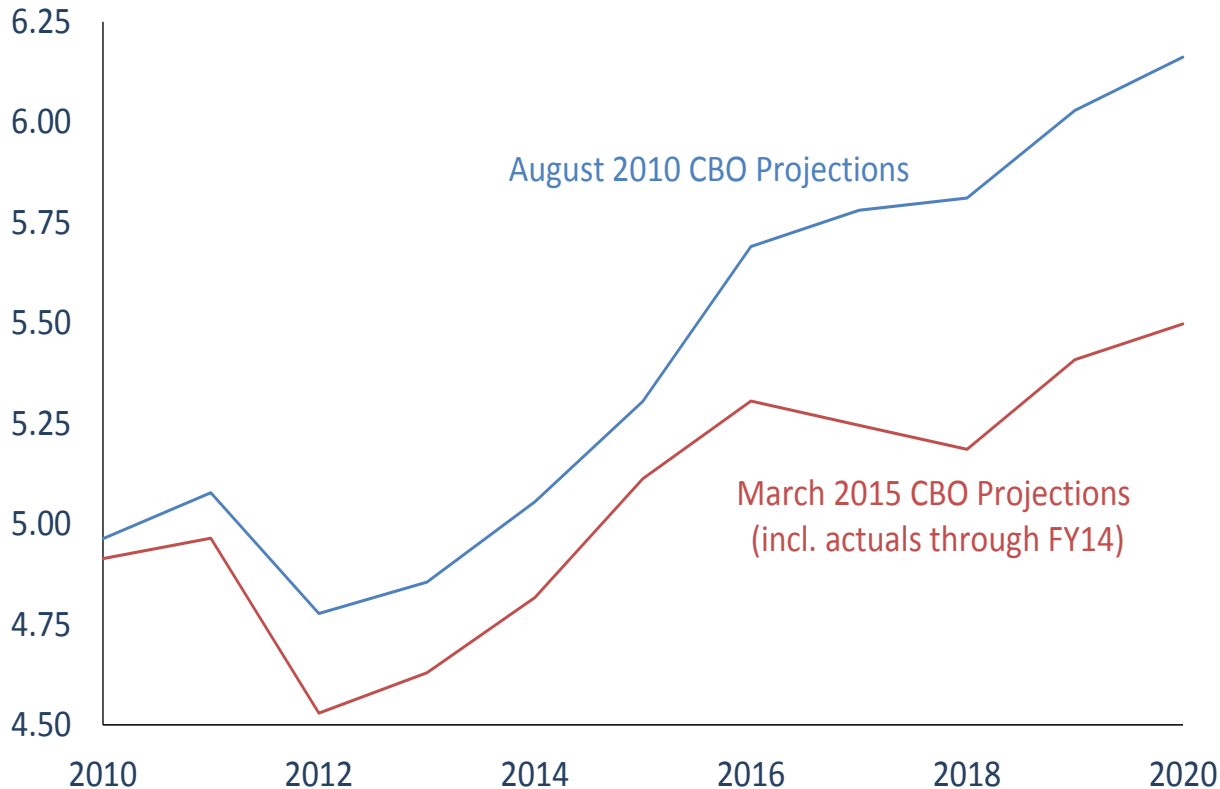
Affordable Care Act Impact

- **Expansion of Health Insurance Coverage -> Decreased Uninsured Rates**
- **Slower Growth in Health Care Costs**
- **Improved Quality of Care**

Results: Higher Value, Lower Costs

CBO Projections of Federal Spending on Major Health Programs

Percent of GDP



Source: Congressional Budget Office; CEA calculations.

Note: The August 2010 GDP estimates have been adjusted for major NIPA revisions in the summer of 2013. Without these revisions, the decline since August 2010 would be larger.

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).

	1999	2013	Difference
All-cause mortality	5.30%	4.45%	-0.85%
Total Hospitalizations/ 100,000 beneficiaries	35,274	26,930	-8,344
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

Partnership for Patient contributes to quality improvements

Data shows...

17% ↓

**Hospital Acquired
Conditions**



1.3 million 
Patient harm events avoided

\$12 billion
in savings

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% ↓

Better Care, Smarter Spending, Healthier People

Focus Areas

Description

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

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 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: **85%** 

Medicare fee-for-service payments are **tied to quality or value** 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 players** to match or exceed HHS goals

NEXT STEPS:

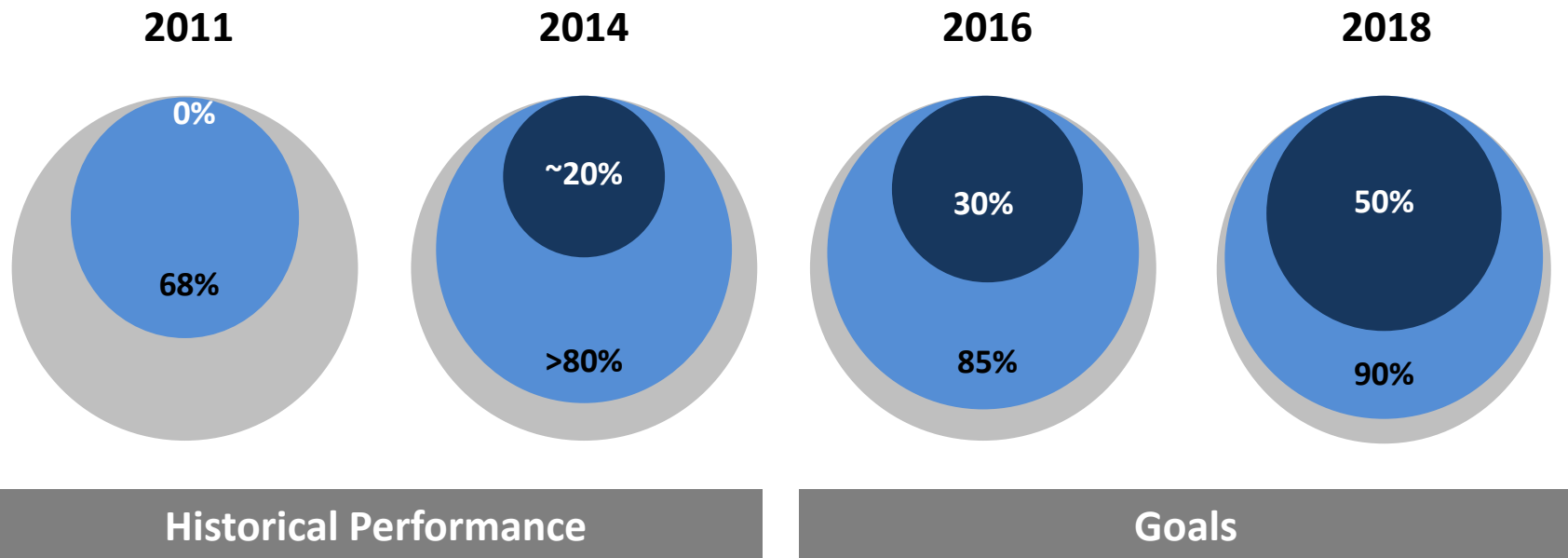


Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives between public and private sector players

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)



Center for Medicare and Medicaid Innovation

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
- Next Generation ACO
- Medicare Shared Savings Program (housed in Center for Medicare)
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

▪ **Primary Care Transformation**

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice Demo
- Home Health Value Based Purchasing
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration
- Medicare Care Choices Model

▪ **Episode-Based Payment Initiatives**

- 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
- Comprehensive Care for Joint Replacement 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**

▪ **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

Accountable Care Organizations (ACOs)

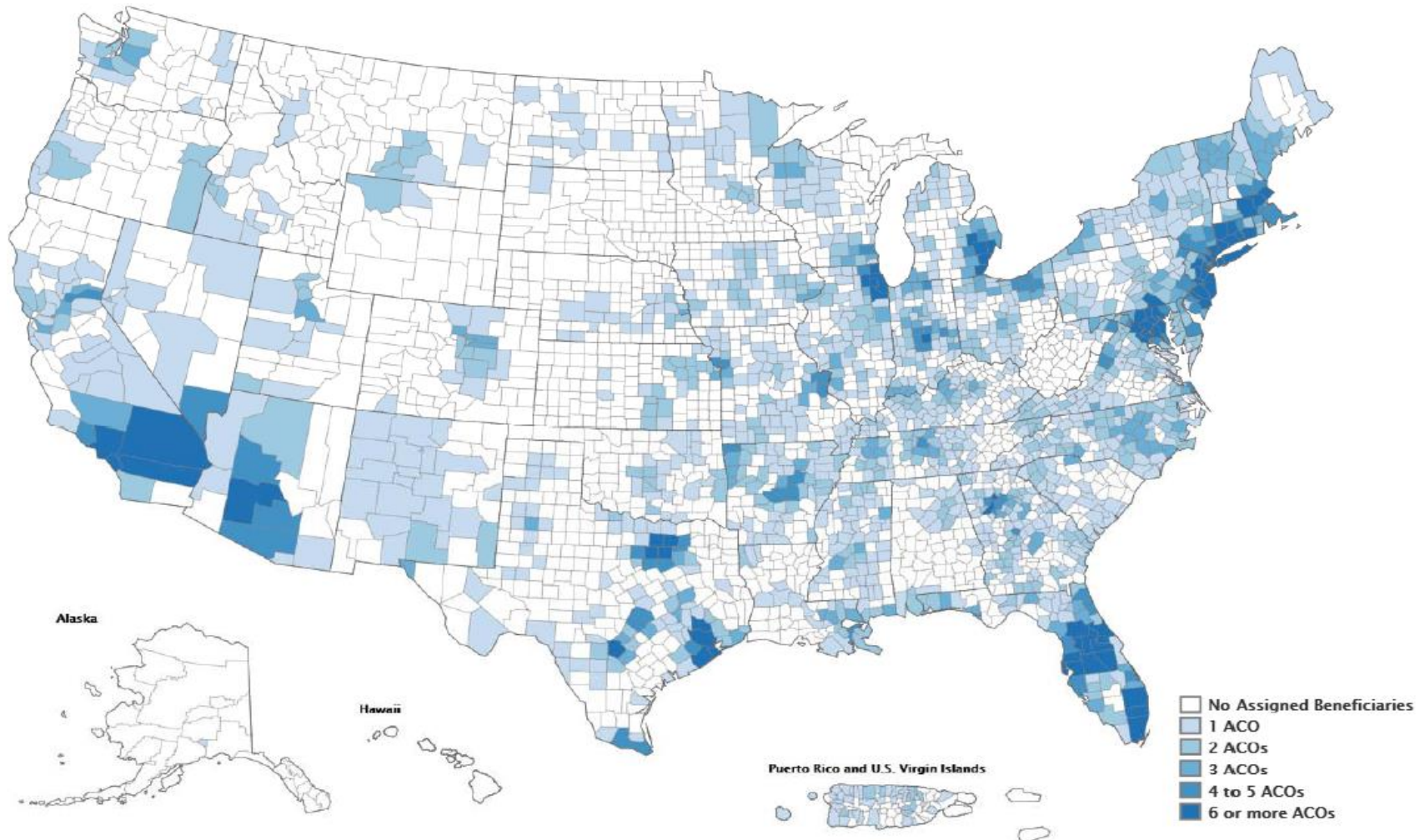
ACOs - Participation is Growing Rapidly

- 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.



ACO Participation

ACO-Assigned Beneficiaries by County

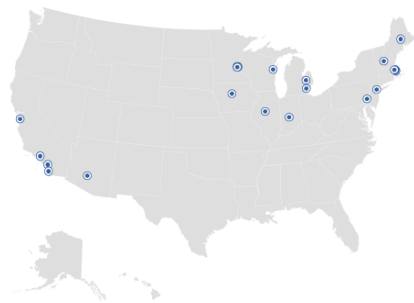


Achieving the Goals

- **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 2nd year in a row**
 - **\$400M in program savings** combined for two years[†] (**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[‡]



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
- **Model certified by Actuary as likely to reduce expenditures and model improved quality**

[†] 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**

Next Generation ACO Model Principles

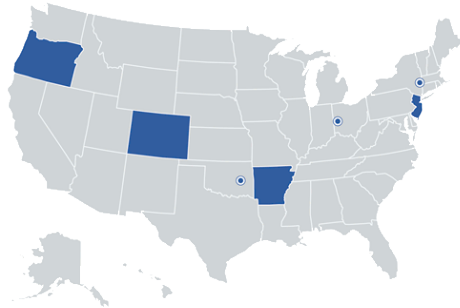
- **Prospective attribution**
- **Protect Medicare FFS beneficiaries' freedom of choice;**
- **Create a financial model with long-term sustainability;**
- **Rewards quality;**
- **Offer benefit enhancements that directly improve the patient experience and support coordinated care;**
- **Allow beneficiaries 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

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 reduced 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 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**

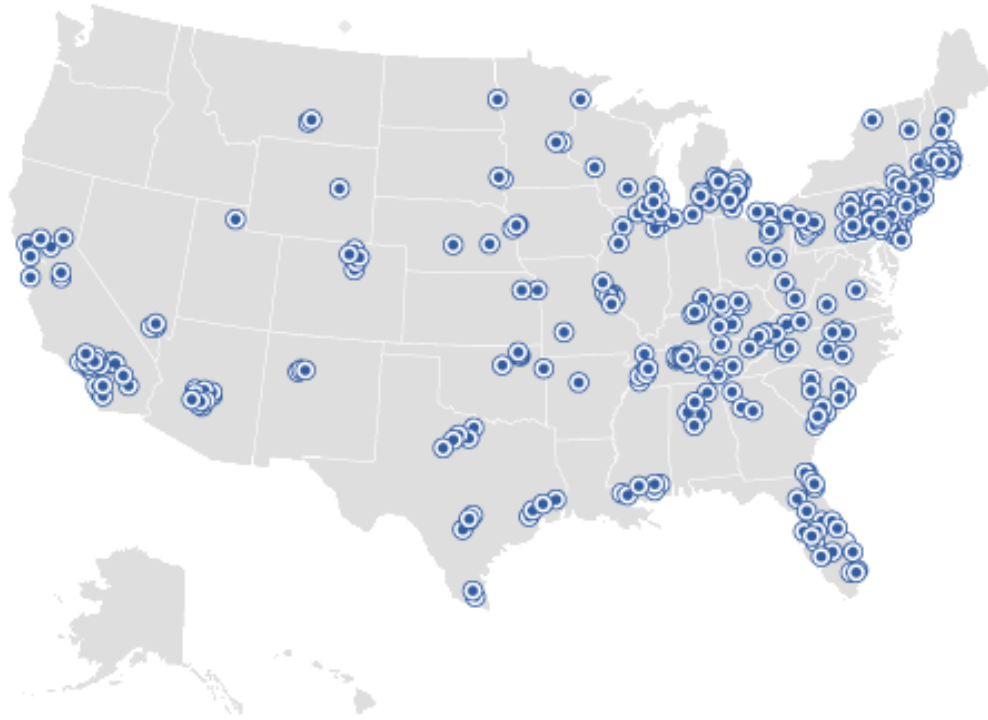


-Practice Administrator

“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

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

What is the Comprehensive Care Joint Replacement model?

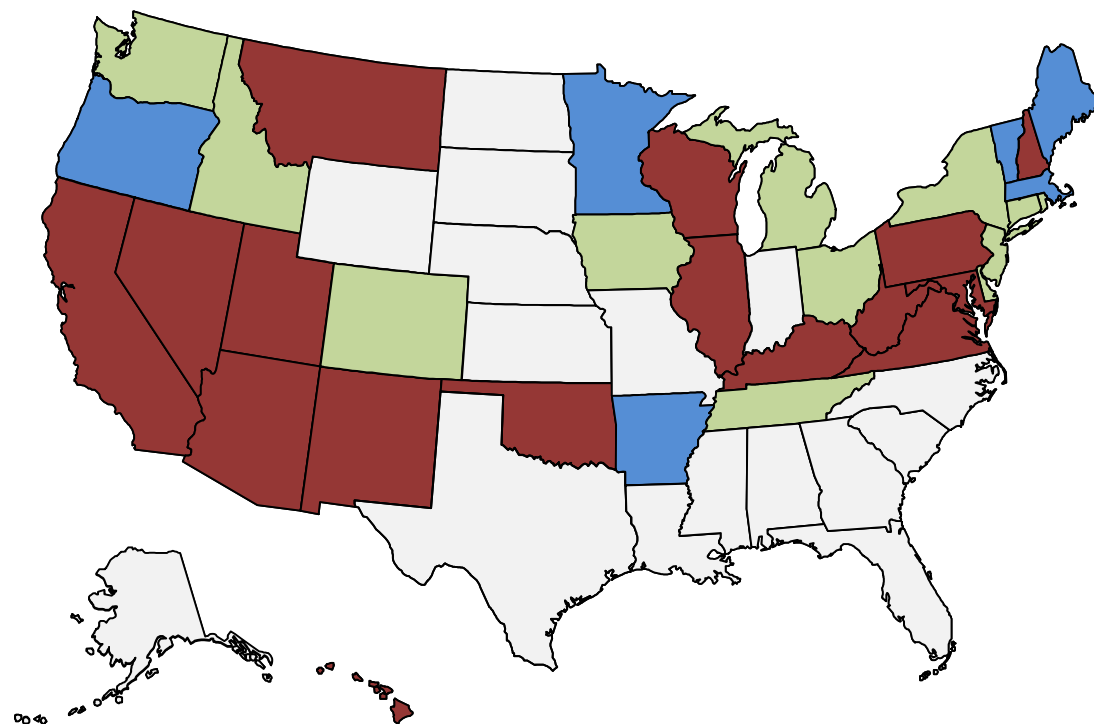
- The proposed model would **test bundled payments for lower extremity joint replacement (LEJR)** across a broad cross-section of hospitals.
- The payment model would **apply to most Medicare LEJR procedures within select geographic areas** with few exceptions.
- The payment model would be **implemented 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

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



Primary objectives include

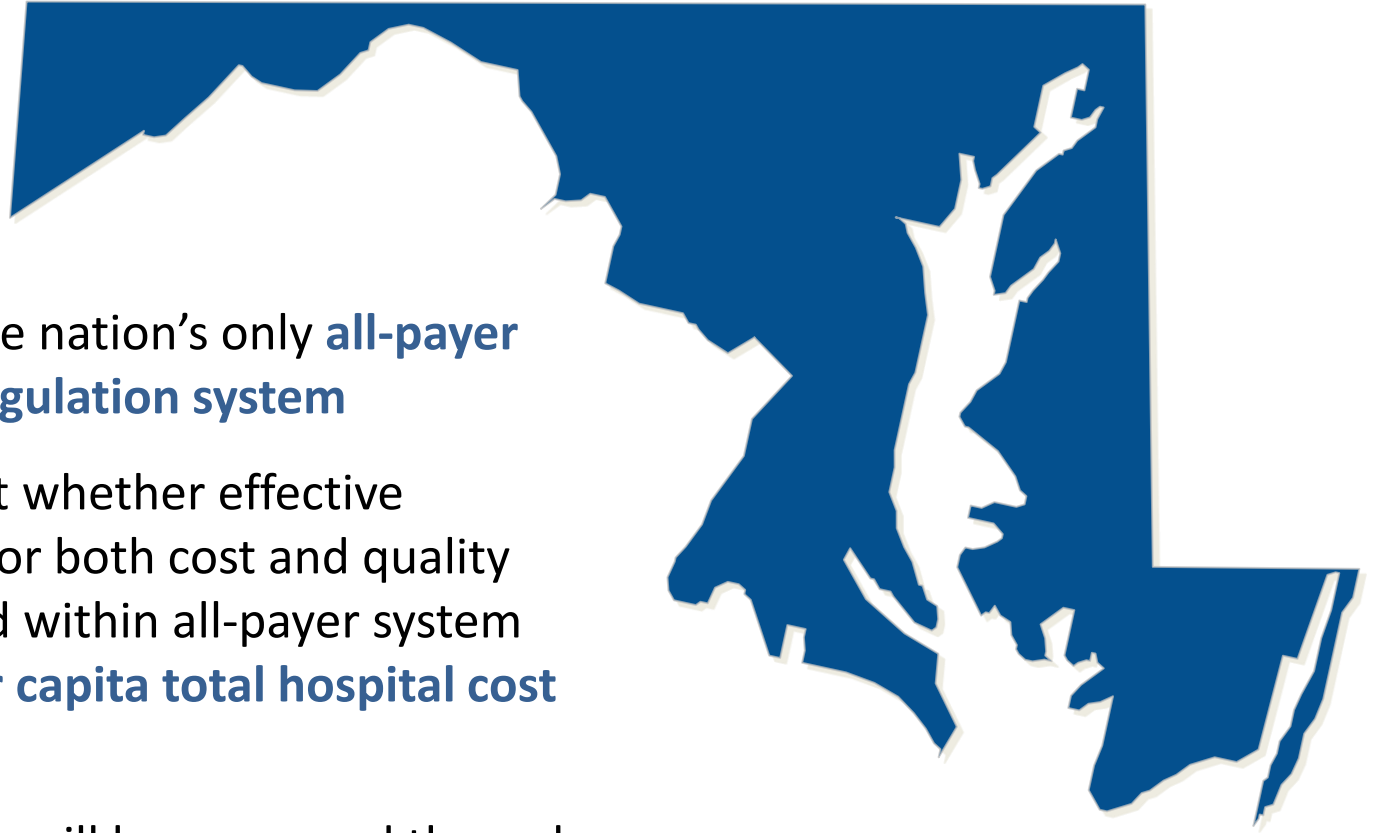
- Improving the **quality of care** delivered
- Improving **population health**
- Increasing **cost efficiency** and expand **value-based payment**

■ Six round 1 model **test states**

■ Eleven round 2 model **test states**

■ Twenty one round 2 model **design states**

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

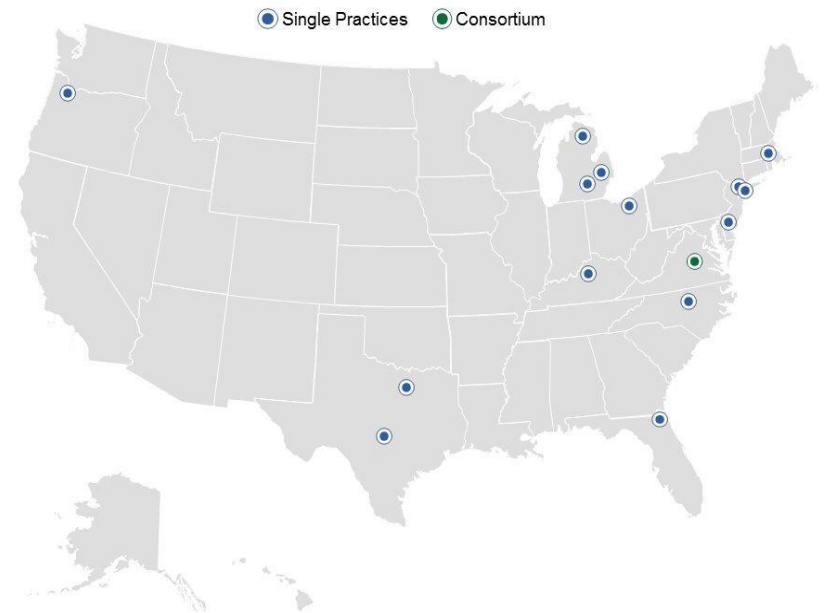
Additional Models and Initiatives

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



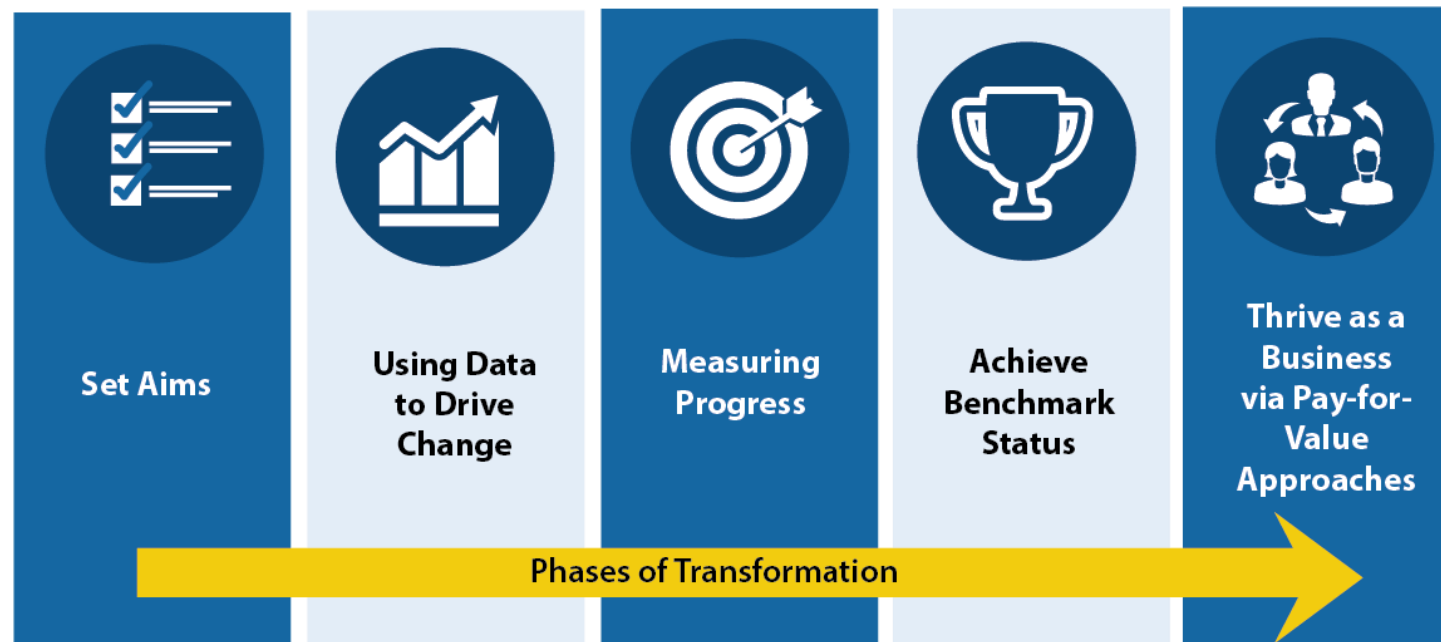
Medicare Care Choices

- **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.**

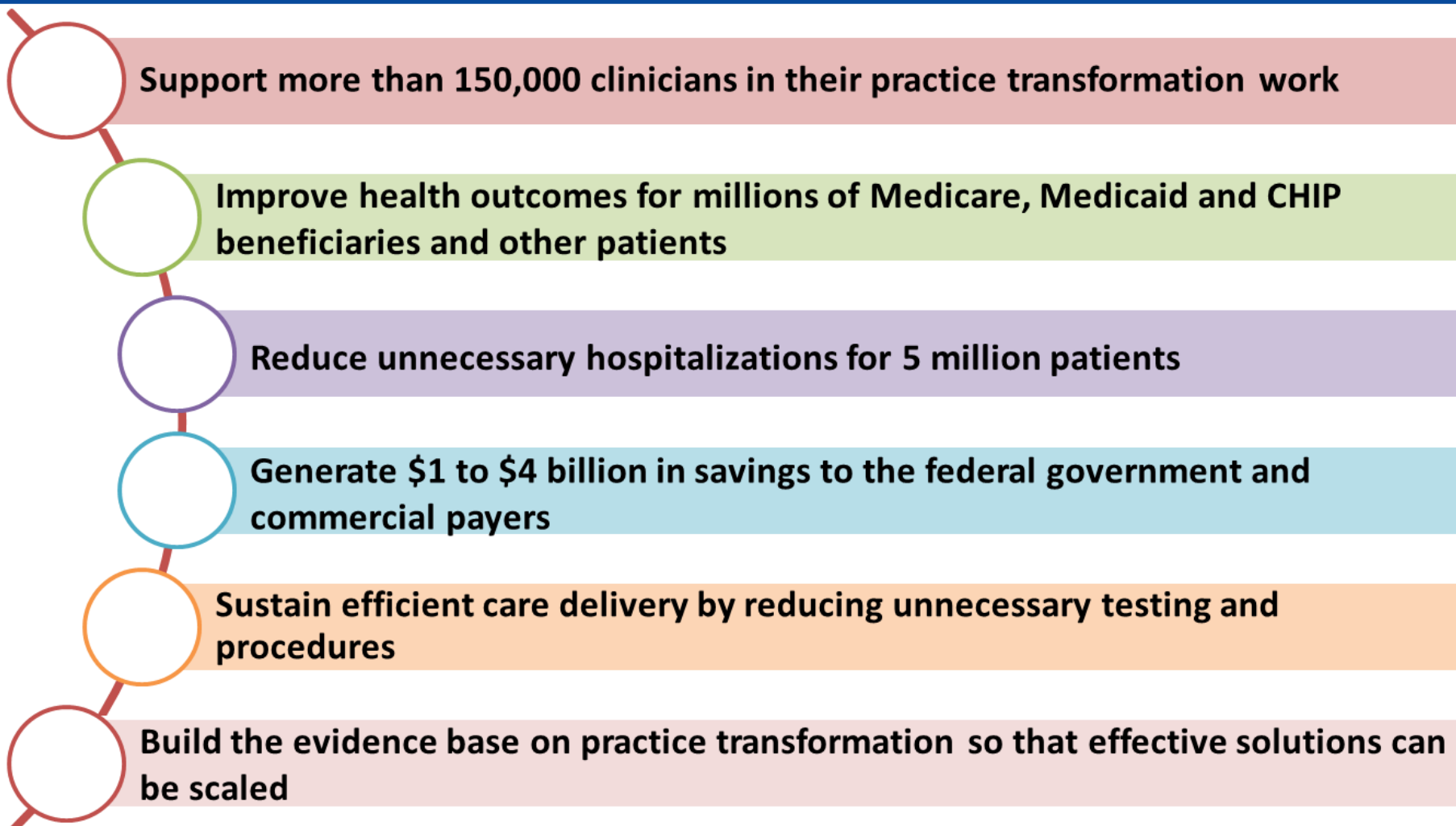
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

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



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

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