Achieving the Goals of Better, Smarter, Healthier Care: The Transition from Volume to Value

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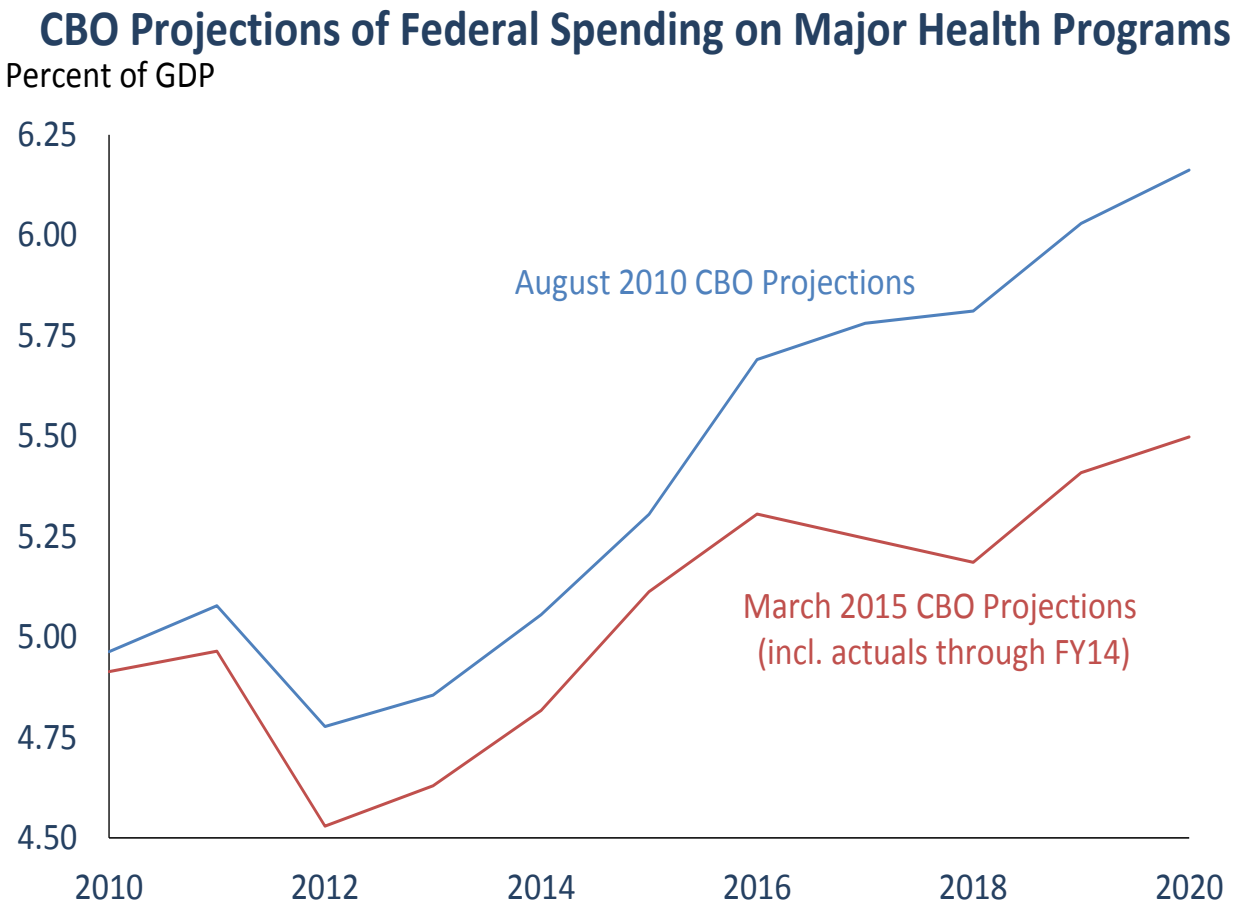
November 6, 2015

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.

Results: Higher Value, Lower Costs



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

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

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 payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	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 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 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

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 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

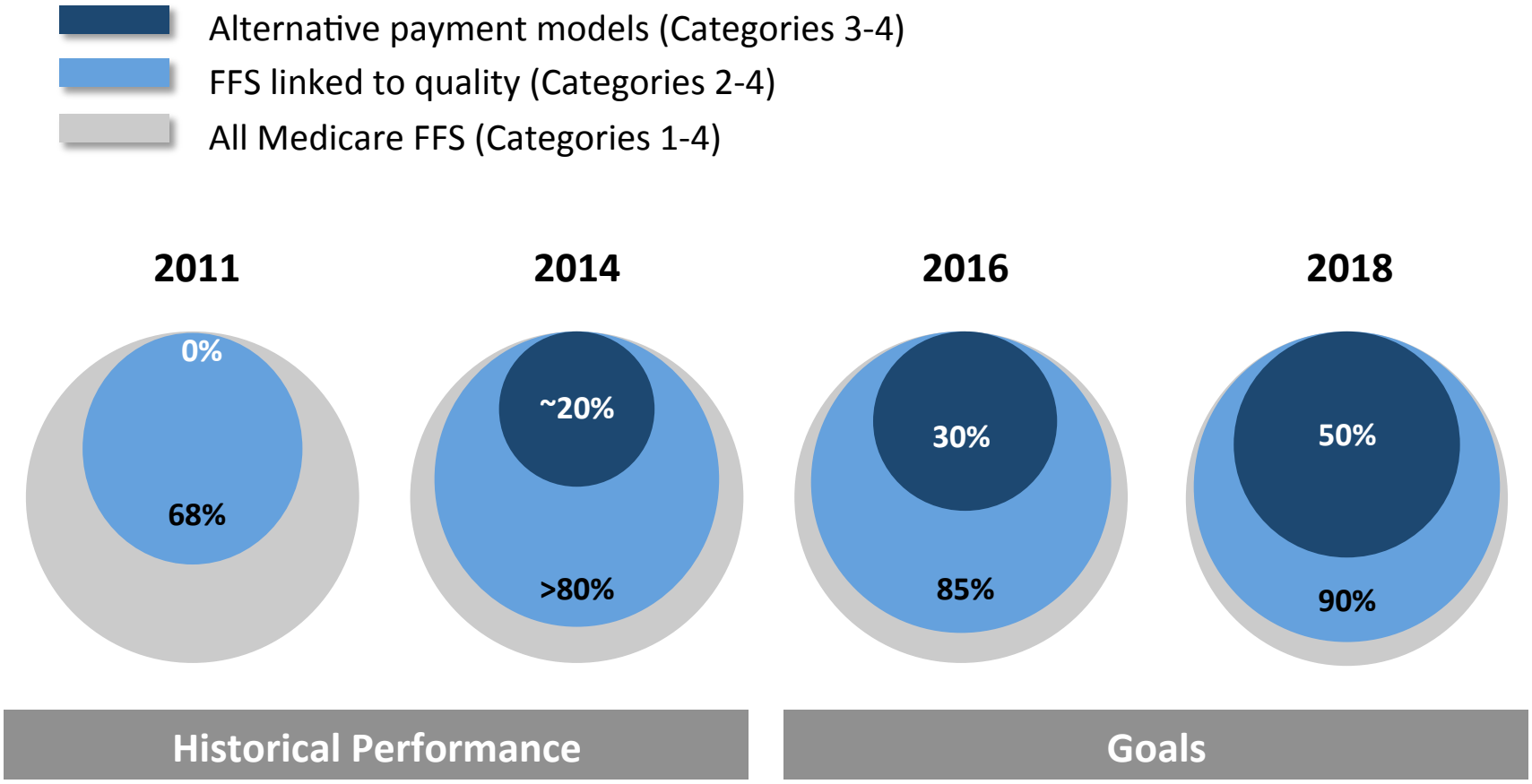
Invite **private sector players** to match or exceeed HHS goals

NEXT STEPS:

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

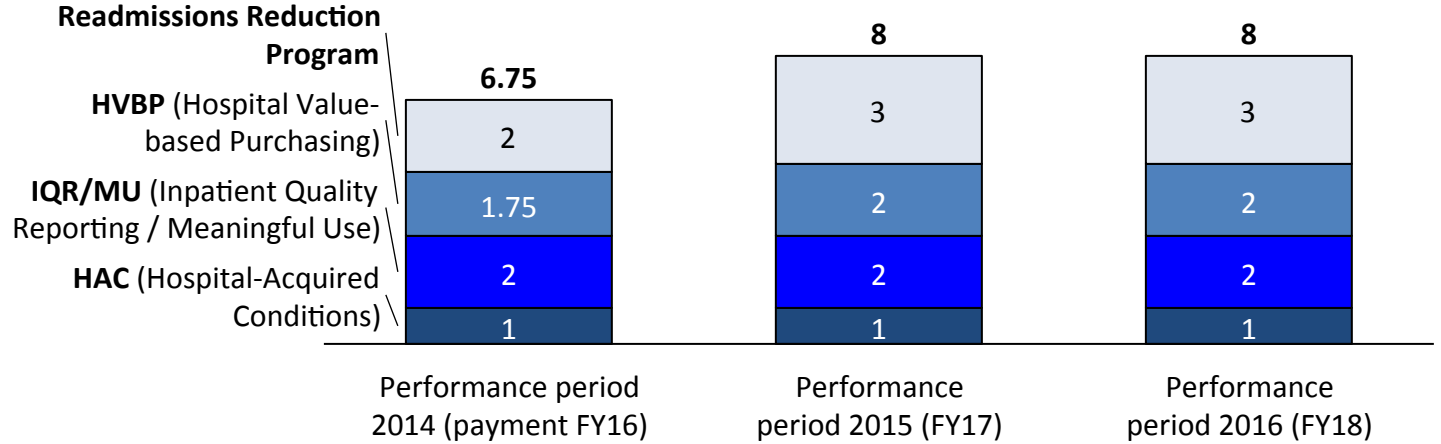
Creation of a Health Care Payment **Learning and Action Network** to align incentives between public and private sector players

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

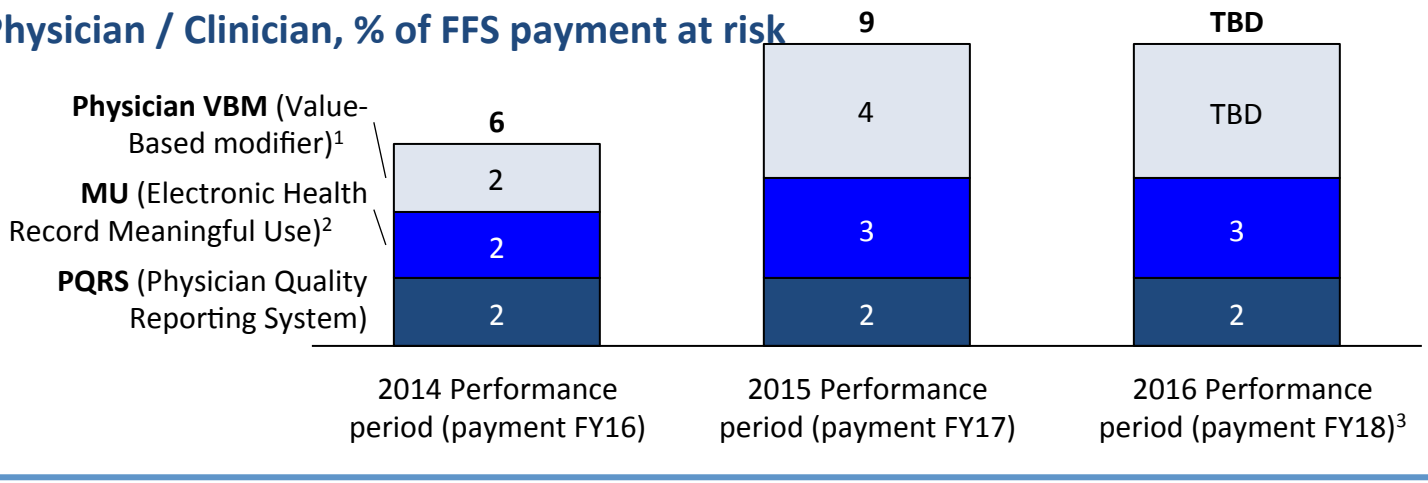


CMS increasingly linking FFS payments to quality or value

Hospitals, % of FFS payment at risk



Physician / Clinician, % of FFS payment at risk



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

ACOs - Participation is Growing Rapidly

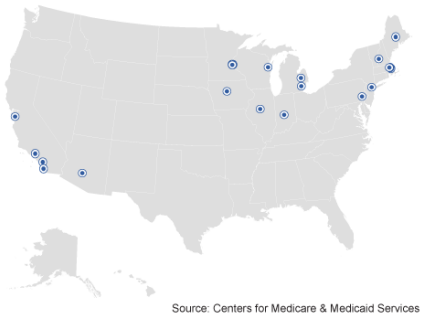
- **More than 400 ACOs participating in the Medicare Shared Savings Program**
- **Almost 8 million assigned beneficiaries in 49 states, plus D.C. and Puerto Rico**
- **MSSP rule seeks to build on this momentum.**

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

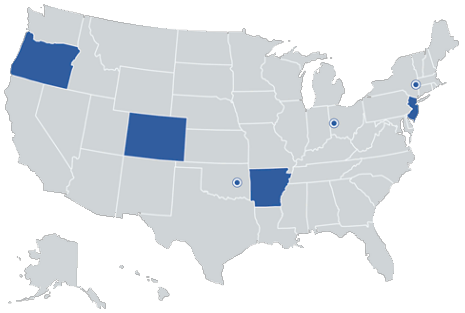
Next Generation ACO Model

- Prospective attribution
- Full or almost full population-based (capitated) payment
- More predictable financial targets;
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms
- Opportunities to coordinate care (e.g., telehealth)
- High quality standards consistent with other Medicare programs and models; and
- Patients can select their ACO

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**

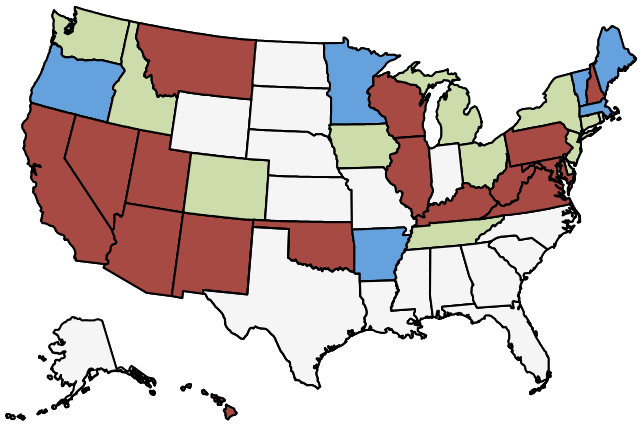
-Practice Administrator

"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"

State Innovation Model grants have been awarded in two rounds

- CMS is testing the ability of **state governments to utilize policy and regulatory levers** to accelerate health care transformation

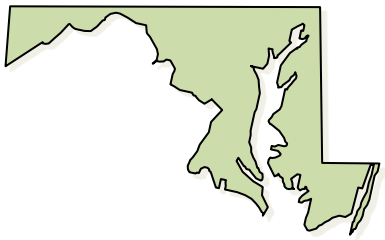
- Primary objectives include
  - Improving the **quality of care** delivered
  - Improving **population health**
  - Increasing **cost efficiency** and expand **value-based payment**



- 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



- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

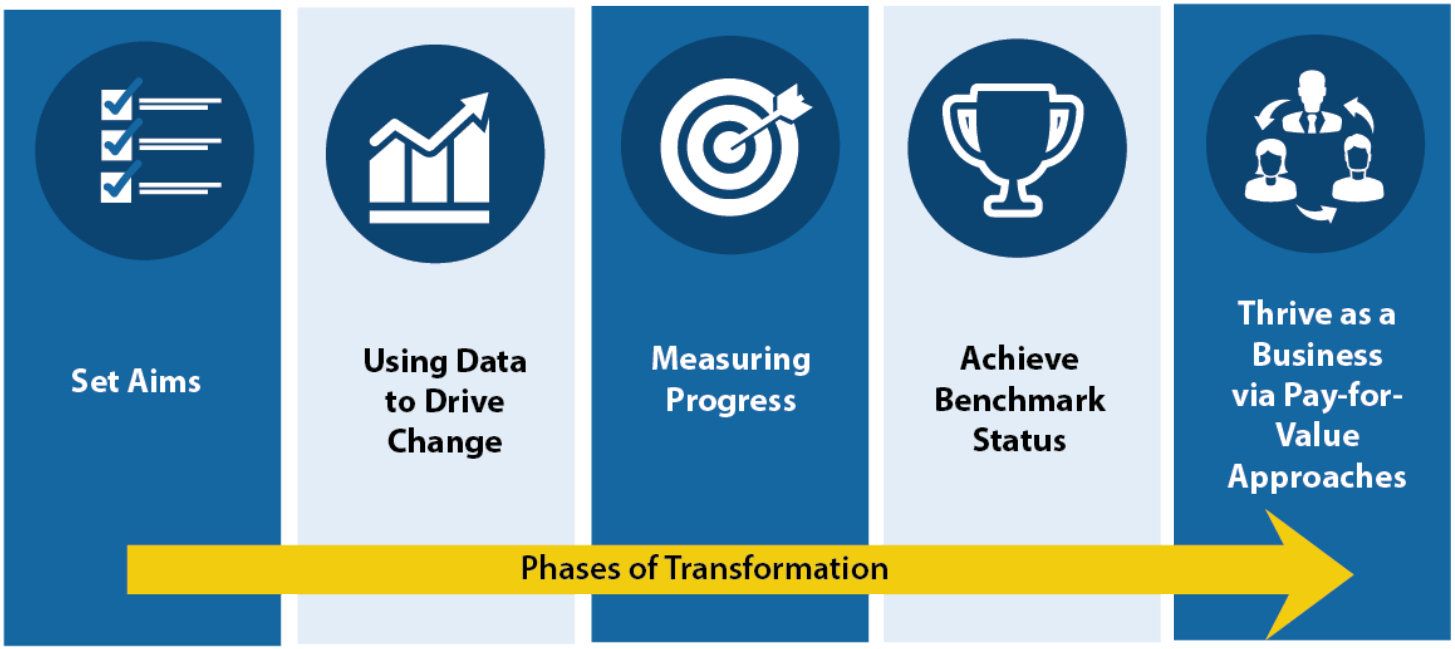
* US census bureau estimate for 2013

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

Investment of **over $650M to support over 140,000 physicians and clinicians** with improvement

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

Innovation Center – 2016 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, health plan, consumer, advanced primary care)

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
- **Health plans** are major drivers of positive change
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

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