
So we will continue to work across sectors and across the aisle for the goals we share: better care, smarter spending, and healthier people.
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Systems and Policies**
- Fee-For-Service Payment Systems

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**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

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

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**FOCUS AREAS**

Pay Providers  
Deliver Care  
Distribute Information

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**CMS has adopted a framework that categorizes payments to providers**

<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
</tr>
<tr>
<td>Medicare Fee-for-Service examples</td>
<td>Limited in Medicare Fee-for-Service</td>
<td>Hospital value-based purchasing, Physician value-based Modifier, Medicare-ESRD, Hospital Acquired Condition Reduction Program</td>
<td>Accountable Care Organizations, Medical Homes, Bundled payments</td>
</tr>
<tr>
<td></td>
<td>Majority of Medicare payments now are linked to quality</td>
<td></td>
<td>Comprehensive Primary Care Initiative, Comprehensive ESRD</td>
</tr>
</tbody>
</table>
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 value in 30% of fee-for-service models (Categories 1-4) by the end of 2016 and 85% by the end of 2018.

**GOAL 2:** Medicare fee-for-service payments are tied to quality in all models (Categories 1-4) by the end of 2018, with 30% by the end of 2018.

**NEXT STEPS:** Testing of new models and expansion of existing models will be critical in reaching interim targets.

Creation of a health care payment learning and action network to align incentives for payers.

**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)

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>~70%</td>
<td>~80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Historical Performance**

**Goals**

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
Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

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

- 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 84% in 2013 compared to 71% 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‡

† Results from regression based analysis
‡ Results from actuarial analysis
Independence at Home (IAH) Demonstration saves more than $3,000 per beneficiary

- IAH tests a service delivery and shared savings model using home-based primary care to improve health outcomes and reduce expenditures for high-risk Medicare beneficiaries
- In year 1, demo produced more than $25 million in savings, an average of $3,070 per participating beneficiary per year
- CMS will award incentive payments of $1.17 million to nine practices that produced savings and met the designated quality measures for the first year
- All 17 participating practices improved quality in at least three of the six quality measures

- There are 17 total practices, including 1 consortium, participating in the model
- Approximately 8,400 patients enrolled in the first year
- Duration of initial model test: 2012 - 2015

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

- 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 fee (~$20 per month)

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 preventative 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."

- Practice Administrator
Partnership for Patient contributes to quality improvements

Data shows...
17% Hospital Avoided Conditions
50,000 Lives Saved
1.3 Million Patients Harm Reduced
$12 Billion in savings

Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>62.4%</td>
<td>70.4%</td>
<td>12.3%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Early Elective Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infections</td>
<td>14.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolic complications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data shows...

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

![Graph showing Medicare all-cause, 30-day hospital readmission rate declining]

Medicare Advantage (MA) Enrollment Rating Distribution

- Sent prompt to beneficiaries enrolled in plans with 2.5 star rating or lower
- Letters only sent to beneficiaries in consistently low-rated plans
- Switch rate 44% (prompt) v. 21% (no prompt)

Legend: CL: control limit; UCL: upper control limit; LCL: lower control limit

Beneficiaries move to MA plans with high quality scores

<table>
<thead>
<tr>
<th>Year</th>
<th>5-star</th>
<th>4-star</th>
<th>3-star</th>
<th>2-star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>20%</td>
<td>61%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>2013</td>
<td>22%</td>
<td>57%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
<td>45%</td>
<td>9%</td>
<td>9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>% 4 or 5 star</th>
<th>% 3 or 4 star</th>
<th>% 2 or 3 star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>20%</td>
<td>61%</td>
<td>9%</td>
</tr>
<tr>
<td>2013</td>
<td>22%</td>
<td>57%</td>
<td>9%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
<td>45%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Delivery System Reform and Our Goals

**CMS Innovation Center**

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and 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.

Three scenarios for success:
1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three 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:

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Providers</td>
<td>Boost and expand innovation payment models</td>
</tr>
<tr>
<td>- Accountable Care</td>
<td></td>
</tr>
<tr>
<td>- Patient-Centered Medical Home (PCMH) Model</td>
<td></td>
</tr>
<tr>
<td>- Advanced Payment Model (APM) Model</td>
<td></td>
</tr>
<tr>
<td>- Risk-Based Payment Model</td>
<td></td>
</tr>
<tr>
<td>- Primary Care Transformation</td>
<td></td>
</tr>
<tr>
<td>- Care Coordination bundled payment Model (CCBP) Model</td>
<td></td>
</tr>
<tr>
<td>- Medicaid Shared Savings Program (focused on Center for Medicare)</td>
<td></td>
</tr>
<tr>
<td>- Medicare Shared Savings Program (housed in Center for Medicare)</td>
<td></td>
</tr>
<tr>
<td>- Shared Savings Program (SSP) Model</td>
<td></td>
</tr>
<tr>
<td>- Million Hearts Initiative</td>
<td></td>
</tr>
<tr>
<td>- Comprehensive Primary Care Initiative (CPC) Model</td>
<td></td>
</tr>
<tr>
<td>- Multi-Payer Advanced Primary Care Practice (MAPCP) Model</td>
<td></td>
</tr>
<tr>
<td>- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
<td></td>
</tr>
<tr>
<td>- Graduation Nurse Education Demonstration</td>
<td></td>
</tr>
<tr>
<td>- Edible Flower Education Demonstration</td>
<td></td>
</tr>
</tbody>
</table>

* Many CMMI programs test innovations across multiple focus areas.
CMS has engaged the health care delivery system and invested in innovation across the country.

Models run at the state level.

Sites where innovation models are being tested.

Source: CMS Innovation Center website, January 2015.

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly:

- 424 ACOs have been established in the MSSP and Pioneer ACO programs.
- 7.8 million assigned beneficiaries.
- This includes 89 new ACOs covering 1.6 million beneficiaries assigned to the shared saving program in 2015.

Next Generation ACO Model builds upon successes from Pioneer and MSSP ACOs:

- Designed for ACOs that are experienced in coordinating care for populations of patients.
- These ACOs will assume higher levels of financial risk and reward than the Pioneer or MSSP ACOs.
- The model will test how strong financial incentives for ACOs can improve health outcomes and reduce expenditures.
- Greater opportunities to coordinate care (e.g., telehealth and skilled nursing facilities).
- More predictable financial targets.

Model Principles:

- Prospective attribution.
- Financial model for long-term stability.
- Reward quality.
- Benefit enhancements that improve patient experience.
- Protect freedom of choice.
- Allow beneficiaries to choose alignment with ACO.
- Smooth ACO cash flow and improved investment capabilities.
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
  - 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

Practice Transformation
1. Patient navigation
2. Care plan with 13 components based on IOM Care Management Plan
3. 24/7 access to clinician and real time access to medical records
4. Use of therapies consistent with national guidelines
5. Data driven continuous quality improvement
6. ONC certified electronic health record and stage 2 meaningful use by year 3

Comprehensive ESRD Care will improve patient centered coordination of care

- ESRD patients represent 1% of Medicare beneficiaries but account for 8% of payments
- ESRD PPS accounts for approximately 33% of total cost of care for ESRD patient
  - Opportunity exist to improve patient centered care that coordinates dialysis care with care outside of dialysis
- CEC model will improve care coordination through the creation of ESRD Seamless Care Organizations (ESCO) that will include dialysis providers, nephrologist, and other medical providers
- ESCOs can be formed by Medicare certified dialysis facilities, nephrologist, certain other Medicare enrolled providers and suppliers

Care Model
- Improve care coordination
  - Clinical and support services
  - Data driven, population care management
- Enhance communication between providers
  - Whole-patient care management
  - EHR information exchange among providers
- Increase access to care
  - After hours call in line; extended business hours
  - Enhanced convenience through on-site rounding

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
- 182 Awardees and 512 Episode Initiators in Phase 2 as of April 2015

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

Round 1 states are testing and Round 2 states are designing and implementing comprehensive reform plans

Round 1 States testing APMs

- Arkansas
- Maine
- Massachusetts
- Minnesota
- Oregon
- Vermont

Round 2 States designing interventions

- Near term CMMI objectives
  - Establish project milestones and success metrics
  - Support development of states' stakeholder engagement plans
  - Onboard states to Technical Assistance Solution Center and SIMergy Collaboration site
  - Launch State HIT Resource Center and CDC support for Population Health Plans

Round 1 of the Health Care Innovation Awards tested a broad range of delivery system innovations

- Awards tested service delivery and payment models that improved quality and decreased cost in communities across the U.S.

- 107 projects awarded

- Ideas tested include
  - Enhancing primary care
  - Coordinating care across multiple settings
  - New types of health care workers
  - Improving decision making
  - Testing new service delivery technologies

- Approximately 575,000 Medicare, Medicaid, and CHIP beneficiaries served
- Projects were funded in all 50 states*
- Awards ranged from ~$1 M to $30 M

* Darker colors on map represent more HCIA projects in that state
Round 2 of the Health Care Innovation Awards shared goals with Round 1 but focused on four themes

- 39 projects awarded
- Increase focus on four areas that have high likelihood of driving health care system transformation and delivering better outcomes
  1. Reduce Medicare, Medicaid, and CHIP expenditure in outpatient and/or post-acute settings
  2. Improve care for populations with specialized needs
  3. Transform the financial and clinical models for specific types of providers and suppliers
  4. Improve the health of populations

- 27 states and the District of Columbia*
- Awards ranged from ~$2 M to $24 M

* Darker colors on map represent more HCIA projects in that state

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

- The model will support over 150,000 clinician practices over the next four years to improve on quality and enter alternative payment models
- 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

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 healthier people within the population you serve
- Engage in accountable care and other alternative payment 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
- Help us develop specialty physician payment and service delivery models
- Test new innovations and scale successes rapidly
- Relentlessly pursue improved health outcomes