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

Patrick Conway, MD, MSc
Acting Principal Deputy Administrator and Chief Medical Officer, CMS
Deputy Administrator for Innovation and Quality
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

According to the Congressional Budget Office, federal spending on major health care programs in 2020 will be $200 Billion lower than predicted in 2010.

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.
\textbf{'Jaw-dropping': Medicare deaths, hospitalizations AND costs reduced}

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

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
 & 1999 & 2013 & Difference \\
\hline
All-cause mortality & 5.30\% & 4.45\% & -0.85\% \\
\hline
Total Hospitalizations/100,000 beneficiaries & 35,274 & 26,930 & -8,344 \\
\hline
In-patient Expenditures/Medicare fee-for-service beneficiary & $3,290 & $2,801 & -$489 \\
\hline
End of Life Hospitalization (last 6 months)/100 deaths & 131.1 & 102.9 & -28.2 \\
\hline
\end{tabular}
\end{table}

\textit{Findings were consistent across geographic and demographic groups.}

\textbf{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

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| **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

<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>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>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
</tr>
<tr>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Accountable Care Organizations</td>
<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
</tr>
<tr>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
<td>Medical homes</td>
<td>Maryland hospitals</td>
</tr>
<tr>
<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
<td>Comprehensive payments</td>
<td>Bundled payments</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care initiative</td>
<td>Comprehensive ESRD</td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare Fee-for-Service examples

- Hospital value-based purchasing
- Physician Value Modifier
- Readmissions / Hospital Acquired Condition Reduction Program
- Comprehensive ESRD
- Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model

---

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

**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
CMS increasingly linking FFS payments to quality or value

### Hospitals, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>Performance period 2014 (payment FY16)</th>
<th>Performance period 2015 (FY17)</th>
<th>Performance period 2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>6.75 (2)</td>
<td>8 (3)</td>
<td>8 (3)</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75 (2)</td>
<td>2 (2)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2 (2)</td>
<td>2 (2)</td>
<td>2 (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 (1)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

### Physician / Clinician, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VBM (Value-Based modifier)</td>
<td>6 (2)</td>
<td>9 (4)</td>
<td>TBD</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)</td>
<td>2 (2)</td>
<td>3 (3)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2 (2)</td>
<td>2 (2)</td>
<td>2 (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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>
</table>
| 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 Care  
| | - 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  
| | **Support providers and states to improve the delivery of care**  
| | **Learning and Diffusion**  
| | - Partnership for Patients  
| | - Transforming Clinical Practice  
| | - Community-Based Care Transitions  
| | **State Innovation Models Initiative**  
| | - SIM Round 1  
| | - SIM Round 2  
| | - Maryland All-Payer Model  
| | **Health Care Innovation Awards**  
| | **Million Hearts Initiative**  
| | **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‡

- 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

- 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.”
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

![Map showing states for different model types.
- 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

---

**Set Aims**  
**Using Data to Drive Change**  
**Measuring Progress**  
**Achieve Benchmark Status**  
**Thrive as a Business via Pay-for-Value Approaches**

---

Phases of Transformation
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)
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
Contact Information

Dr. Patrick Conway, M.D., M.Sc.
CMS Deputy Administrator for Innovation and Quality and
CMS Chief Medical Officer
410-786-6841
patrick.conway@cms.hhs.gov