CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

# Health Care Delivery System Reform: Opportunities for Prevention, Population Health, and Care Redesign

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# Overview

**Delivery System Reform and Our Goals**

CMS Innovation Center

Prevention and Population Health Models

# CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people


**Public and Private sectors**

## Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

## Systems and Policies

- Fee-For-Service Payment Systems

## 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

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

*Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.*

## FOCUS AREAS

- Pay Providers
- Deliver Care
- Distribute Information

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

# 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**<br>▪ **Accountable Care**<br>– Pioneer ACO Model<br>– Medicare Shared Savings Program (housed in Center for Medicare)<br>– Advance Payment ACO Model<br>– Comprehensive ERSD Care Initiative<br>– Next Generation ACO<br>▪ **Primary Care Transformation**<br>– Comprehensive Primary Care Initiative (CPC)<br>– Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration<br>– Independence at Home Demonstration<br>– Graduate Nurse Education Demonstration<br>– Home Health Value Based Purchasing<br>– Medicare Care Choices<br>▪ **Bundled payment models**<br>– Bundled Payment for Care Improvement Models 1-4<br>– Oncology Care Model<br>– Comprehensive Care for Joint Replacement<br>▪ **Initiatives Focused on the Medicaid**<br>– Medicaid Incentives for Prevention of Chronic Diseases<br>– Strong Start Initiative<br>– Medicaid Innovation Accelerator Program<br>▪ **Dual Eligible (Medicare-Medicaid Enrollees)**<br>– Financial Alignment Initiative<br>– Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents<br>▪ **Medicare Advantage (Part C) and Part D**<br>– Medicare Advantage Value-Based Insurance Design model<br>– Part D Enhanced Medication Therapy Management |
| **Deliver Care** | **Support providers and states to improve the delivery of care**<br>▪ **Learning and Diffusion**<br>– Partnership for Patients<br>– Transforming Clinical Practice<br>– Community-Based Care Transitions<br>▪ **Health Care Innovation Awards**<br>▪ **Accountable Health Communities**<br>▪ **State Innovation Models Initiative**<br>– SIM Round 1<br>– SIM Round 2<br>– Maryland All-Payer Model<br>▪ **Million Hearts Cardiovascular Risk Reduction Model** |
| **Distribute Information** | **Increase information available for effective informed decision-making by consumers and providers**<br>▪ **Health Care Payment Learning and Action Network**<br>▪ **Information to providers in CMMI models**<br>▪ **Shared decision-making required by many models** |

* Many CMMI programs test innovations across multiple focus areas

# 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**

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

As of **January 01, 2016**, the **30% goal was achieved one year ahead of schedule.**

## *Medicare Fee-for-Service*

### GOAL 1:

**30%**

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** 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 (categories 2-4)** by the end of 2016, and 90% by the end of 2018

### STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

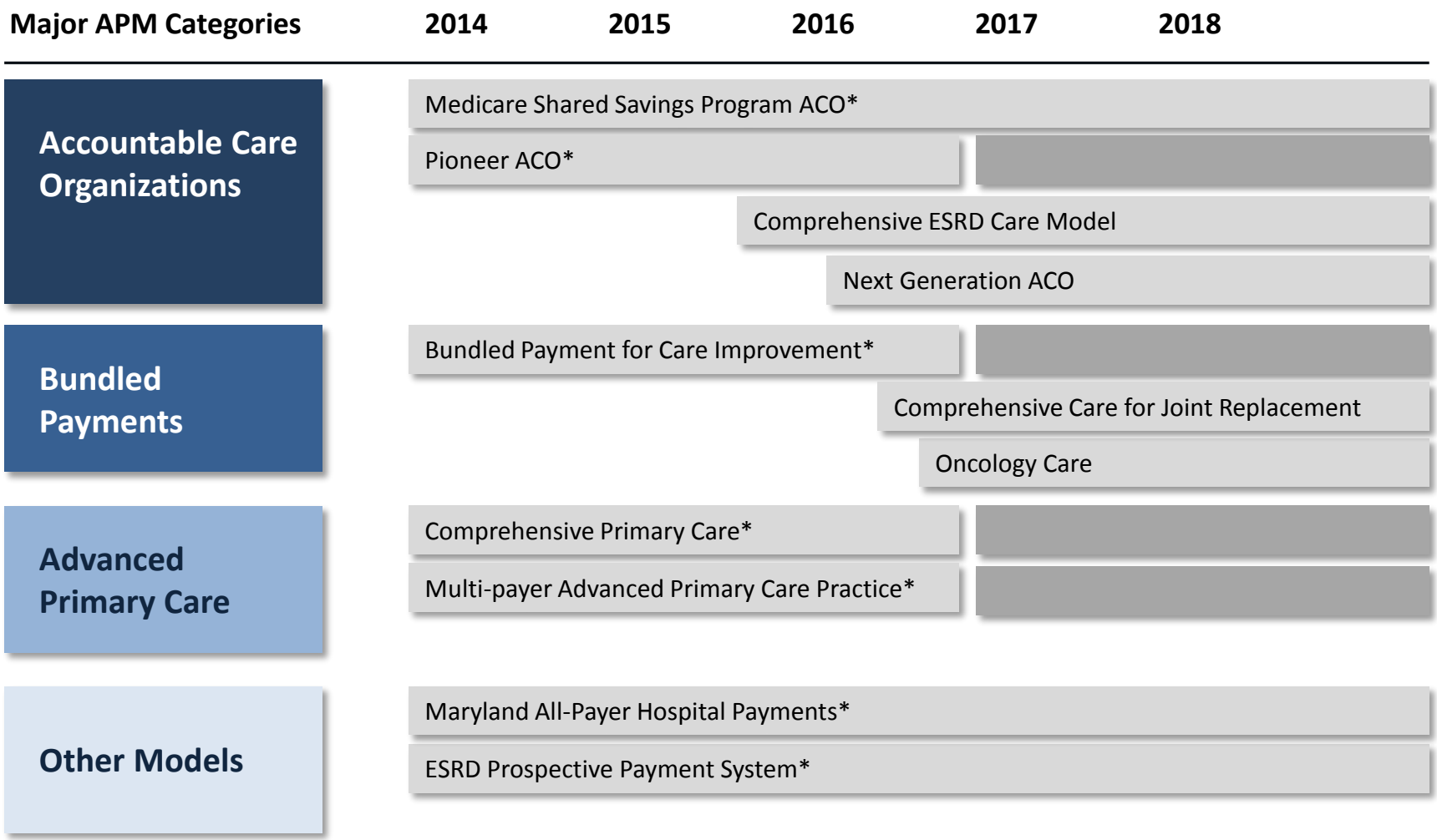
- Set **internal goals** for HHS
- Invite **private sector payers** to match or exceeed HHS goals

### 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 for payers

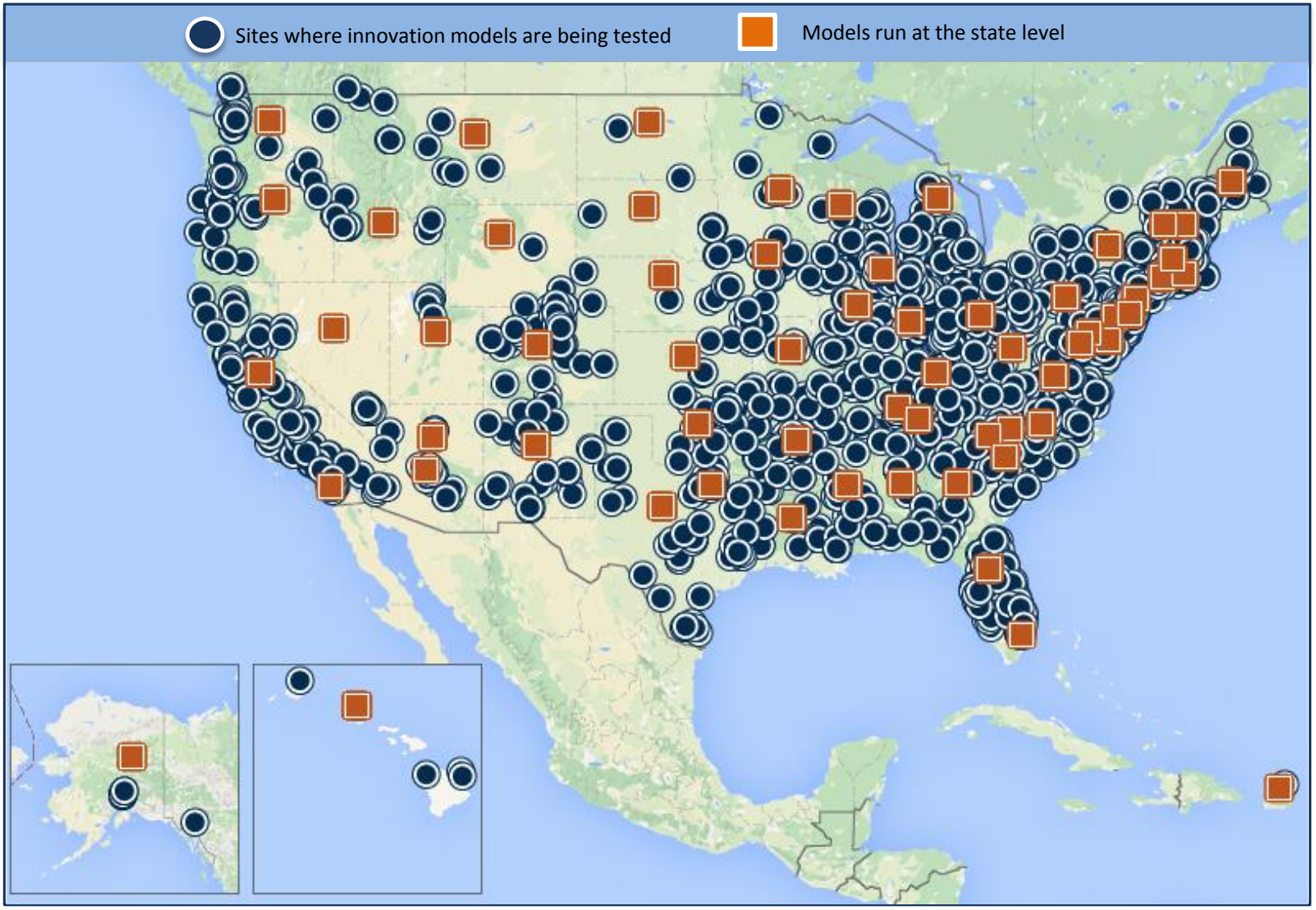
# CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality






* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

# CMS has engaged the health care delivery system and invested in innovation across the country




Source: CMS Innovation Center website, December 2015

# Innovation Center models are already improving health care quality and cost

**Pioneer ACOs:**

- First to meet requirements for expansion
- Generated > $90 million in total savings each year
- Improved quality scores from 72% to 87%

**Comprehensive Primary Care Initiative:**

- 2% reduction in part A and B expenditures 1st year
- Reduced ED visits, hospitalizations, and readmissions

**Independence at Home:**

- Home-based primary care
- Saved more than $3,000 per beneficiary
- Improved quality in at least three of six measures

**Maryland all-payer model:**

- Achieved $116 million in cost savings in 1st year
- 1.47% in all-payer total hospital per capita cost growth

**Partnership for Patients:**

- Reduced hospital acquired conditions by 17%
- 2.1 million fewer adverse events
- 87,000 preventable deaths
- $20 billion in spending avoided

**Diabetes Prevention Program:**

- Most recent model to qualify for expansion
- Reduced incidence of diabetes
- Saved estimated $2650 per enrollee

# The Health Care Payment Learning and Action Network will accelerate the transition to alternative payment models

- **Medicare alone cannot drive sustained progress** towards alternative payment models (APM)
- Success depends upon a **critical mass of partners** adopting new models
- The network will
  - **Convene** payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  - **Identify areas of agreement** around movement to APMs
  - Collaborate to **generate evidence, shared approaches, and remove barriers**
  - **Develop common approaches** to core issues such as beneficiary attribution
  - Create **implementation guides** for payers and purchasers

**Network Objectives**

- Match or exceed Medicare alternative payment model goals across the US health system
  - -30% in APM by 2016
  - -50% in APM by 2018
- Shift momentum from CMS to private payer/purchaser and state communities
- Align on core aspects of alternative payment design

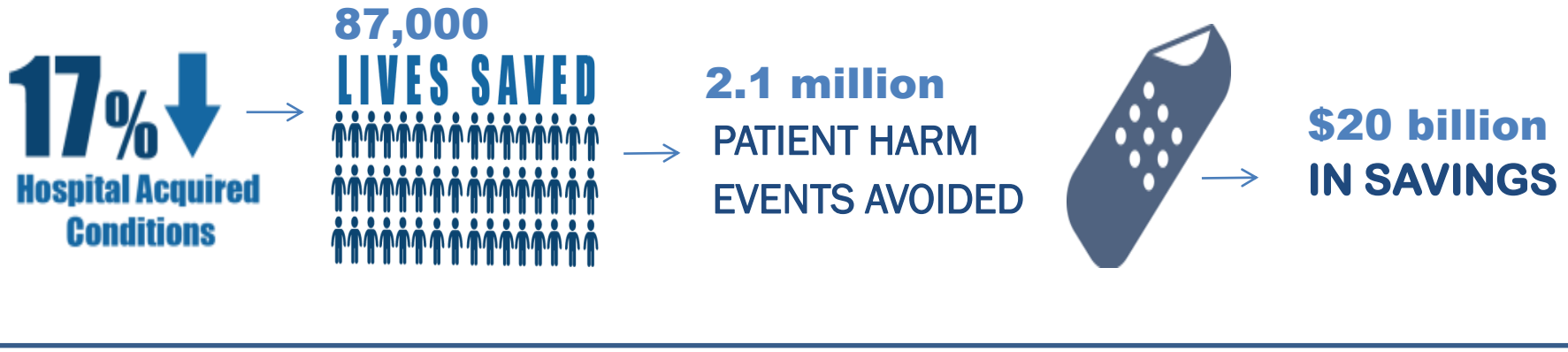
Delivery System Reform and Our Goals

CMS Innovation Center

**Prevention and Population Health Models**

# Partnership for Patients contributes to quality improvements

## Data shows from 2010 to 2014…




## 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% ↓ |

# HCIA: Diabetes Prevention Program (DPP) meets criteria for expansion

DPP **reduces the incidence of diabetes** through a structured health behavior change program delivered in community settings.

## Timeline:

**2012** – CMS Innovation Center awarded Health Care Innovation Award to The Young Men's Christian Association of the USA (YMCA) to test the DPP in **>7,000 Medicare beneficiaries with pre-diabetes** across 17 sites nationwide.

**March 2016** – Secretary Burwell announced **DPP as the first ever prevention program to meet CMMI model expansion criteria.** CMS determined that DPP:

- *Improves quality of care* ➡ *beneficiaries lost about five percent body weight*
- *Certified by the Office of the Actuary as cost-saving* ➡ *up to estimated $2,650 savings per enrollee over 15 months*
- *Does not alter the coverage or provision of benefits*

Details of the expansion will be developed through notice and public comment rulemaking.

# Million Hearts® Cardiovascular Disease Risk Reduction Model will reward population-level risk management

- Heart attacks and strokes are **a leading cause of death and disability** in the United States
  - Prevention of cardiovascular disease can significantly reduce both CVD-related and all-cause mortality
- Participant responsibilities
  - Systematic beneficiary **risk calculation* and stratification**
  - **Shared decision making** and evidence-based **risk modification**
  - **Population health management** strategies
  - **Reporting of risk score** through certified data registry
- Participant organizations
  - **516 participants** from 47 states, the District of Columbia and Puerto Rico, including **256 Control Group** and **260 Intervention Group** participants
  - **19,000+** practitioners serving over **3.3 million** Medicare beneficiaries
  - Private practices, community health centers, hospital-owned practices, hospital/physician organizations

## Payment Model

- Pay-for-outcomes approach
- Disease risk assessment payment
  - One time payment to risk stratify eligible beneficiary
  - $10 per beneficiary
- Care management payment
  - Monthly payment to support management, monitoring, and care of beneficiaries identified as high-risk
  - Amount varies based upon population-level risk reduction

*Uses American College of Cardiology/American Heart Association (ACA/AUA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

# Accountable Health Communities Model addressing health-related social needs

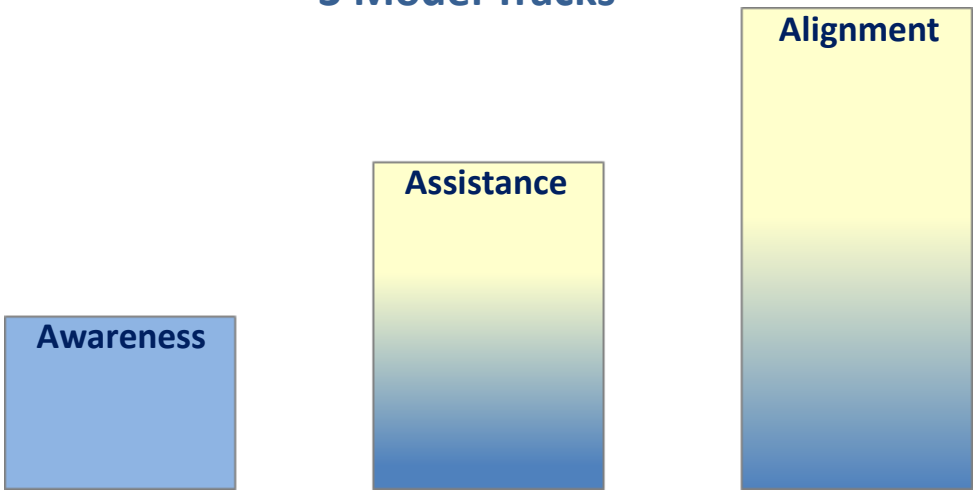
## Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** and **community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

**Total Investment > $157 million**

**44 Anticipated Award Sites**

## 3 Model Tracks




**Track 1** **Awareness –** Increase beneficiary ***awareness*** of available community services through information dissemination and referral

**Track 2** **Assistance –** Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services

**Track 3** **Alignment –** Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

# Delivery System Reform aligns health system incentives to address structural health determinants

Pay Providers

**Alternative Payment Models** – promotes health system innovation beyond fee-for-service care to invest in programs that improve the health of beneficiaries

Deliver Care

**Prevention and Population Health Models** – present use cases and evidence for integration of prevention and population health programs within health systems

Distribute Information

**Connected Health Data Systems** – provides data to monitor population health at the practice, health system, community, state, and national level

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