Paving the Way to Higher Performing HealthCare in New Jersey

Jackie Cornell-Bechelli
U.S. Department of Health and Human Services
Region II Director
The Problem – Two Years Ago

How many of the non-elderly uninsured are eligible for financial assistance?

- **INELIGIBLE FOR FINANCIAL ASSISTANCE**
  Includes those whose income is too high to be eligible for tax credits, who have affordable employer coverage available, or who are undocumented immigrants.

- **ELIGIBLE FOR TAX CREDITS**
  People with incomes 100-400% of the poverty level who are eligible to buy coverage in Marketplaces and do not have other affordable coverage available.

- **ELIGIBLE FOR MEDICAID/CHIP**
  Includes people newly eligible under the ACA coverage expansion and those who were previously eligible for Medicaid/CHIP but not enrolled.

Note: Subtotals may not sum due to rounding. Undocumented immigrants cannot be broken out in some states due to insufficient statistical reliability.

Data include non-elderly individuals who were uninsured prior to the ACA coverage expansions.
The Solution to Expand Coverage

The Affordable Care Act is Signed

New Jersey Decides in Favor of

Federal Marketplace

Medicaid Expansion
The Number of Uninsured Reduced

2015

- **200,000** + have been enrolled under the ACA
- **465,000** + have been covered by Medicaid
- **38%** paid $100 or less per month after tax credits
- Gallop announced that the uninsured rate in 2014 was **11.7%**, down from **14.9%** in 2013.

Increasing the insured is only part of the equation. Innovative Delivery System Reform is happening now – with a focus on better care, smarter spending, and healthier people.
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”

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.
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

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

Systems and Policies
- Fee-For-Service Payment Systems

Systems and Policies
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
CMS has adopted a framework that categorizes payments to providers

<table>
<thead>
<tr>
<th>Description</th>
<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></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>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
</tr>
<tr>
<td></td>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
</tr>
<tr>
<td>Medicare Fee-for-Service examples</td>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
<td>Accountable Care Organizations</td>
<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
<td>Medical homes</td>
<td>Maryland hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bundled payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive Primary Care initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive ESRD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></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:** 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

**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

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

Set internal goals for HHS
Invite private sector payers to match or exceed HHS goals
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

Historical Performance

- 2011: ~70%
- 2014: >80%

Goals

- 2016: 85%
- 2018: 90%

Legend:
- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)
CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pioneer ACO*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comprehensive ESRD Care Model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next Generation ACO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Care Models</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multi-payer Advanced Primary Care Practice*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ESRD Prospective Payment System*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS will continue to test new models and will identify opportunities to expand existing models.

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

**Gap between growth in federal spending on Medicare and GDP growth**

Annual growth for US real per-capita GDP and federal Medicare expenditures per enrollee (%)

- **Growth rate: federal Medicare spending per enrollee**
  - **Historical**
  - **Projected**

**Average Medicare growth rate (2011–2014)**

- Medicare per capita: **1.1%**
- GDP / capita: **3.0%**

- 2011, 2012, and 2013 saw the slowest growth in real per capital health care spending on record.

Pioneer ACOs meet requirement for expansion with quality improvement and $384 M in savings over two 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 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‡

- 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

† Results from regression based analysis
‡ Results from actuarial analysis
Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration has generated net savings

- Medicare participated in 8 state-led multi-payer patient centered medical home (PCMH) initiatives in partnership with Medicaid and commercial payers.

- CMS supports these multi-payer PCMH initiatives through:
  - Enhanced, non-visit-based payments to practices, community-based support teams, and states
  - Quarterly data feedback

- Gross savings of $40.3 million and net savings of $4.2 million were observed.

- Initially 8 states (ME, MI, MN, NC, NY, PA, RI, VT) encompassing approximately 1000 practices, 6000 providers, and 2.9 million participants including 560,000 Medicare fee-for-service beneficiaries.

- Duration of initial model test: July 2011 – December 2014
  - ME, MI, NY, RI, VT were extended through Dec 2016.
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)
Positive results in CPC were more prominent in some states

Percent change in cost and utilization by state (Oct 2012–Sept 2013)

<table>
<thead>
<tr>
<th>States</th>
<th>All</th>
<th>AR</th>
<th>CO</th>
<th>NJ</th>
<th>NY</th>
<th>OH/KY</th>
<th>OK</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare expenditure and service use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure without fees</td>
<td>-2%†</td>
<td>0%</td>
<td>1%</td>
<td>-5%‡</td>
<td>-2%</td>
<td>4%*</td>
<td>-7%‡</td>
<td>-2%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>-2%*</td>
<td>2%</td>
<td>3%</td>
<td>-5%*</td>
<td>-6%†</td>
<td>4%</td>
<td>-7%‡</td>
<td>-5%</td>
</tr>
<tr>
<td>Outpatient ED visits</td>
<td>-3%‡</td>
<td>-3%</td>
<td>-1%</td>
<td>-4%</td>
<td>2%</td>
<td>-1%</td>
<td>-7%‡</td>
<td>-6%*</td>
</tr>
</tbody>
</table>

Green = negative and statistically significant
Red = positive and statistically significant

*/†/‡ Statistically significant to the 10%/5%/1% level, two-tailed test.
Partnership for Patient contributes to quality improvements

Data shows...

- **17%↓** Hospital Acquired Conditions
- **50,000 LIVES SAVED**
- **1.3 million Patient harm events avoided**
- **$12 billion in savings**

Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>62.4%</td>
<td>↓</td>
</tr>
<tr>
<td>Early Elective Delivery</td>
<td>70.4%</td>
<td>↓</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infections</td>
<td>12.3%</td>
<td>↓</td>
</tr>
<tr>
<td>Venous thromboembolic complications</td>
<td>14.2%</td>
<td>↓</td>
</tr>
<tr>
<td>Re-admissions</td>
<td>7.3%</td>
<td>↓</td>
</tr>
</tbody>
</table>
Medicare all-cause, 30-day hospital readmission rate is declining

Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

Legend: CL: control limit; UCL: upper control limit; LCL: lower control limit
Beneficiaries move to MA plans with high quality scores

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)
# 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><strong>Pay Providers</strong></td>
<td><strong>Test and expand alternative payment models</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Accountable Care</strong></td>
</tr>
<tr>
<td></td>
<td>- Pioneer ACO Model</td>
</tr>
<tr>
<td></td>
<td>- Medicare Shared Savings Program (housed in Center for Medicare)</td>
</tr>
<tr>
<td></td>
<td>- Advance Payment ACO Model</td>
</tr>
<tr>
<td></td>
<td>- Comprehensive ERSD Care Initiative</td>
</tr>
<tr>
<td></td>
<td>- Next Generation ACO</td>
</tr>
<tr>
<td></td>
<td><strong>Primary Care Transformation</strong></td>
</tr>
<tr>
<td></td>
<td>- Comprehensive Primary Care Initiative (CPC)</td>
</tr>
<tr>
<td></td>
<td>- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
</tr>
<tr>
<td></td>
<td>- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
</tr>
<tr>
<td></td>
<td>- Independence at Home Demonstration</td>
</tr>
<tr>
<td></td>
<td>- Graduate Nurse Education Demonstration</td>
</tr>
<tr>
<td></td>
<td><strong>Bundled Payment for Care Improvement</strong></td>
</tr>
<tr>
<td></td>
<td>- Model 1: Retrospective Acute Care</td>
</tr>
<tr>
<td></td>
<td>- Model 2: Retrospective Acute Care Episode &amp; Post Acute</td>
</tr>
<tr>
<td></td>
<td>- Model 3: Retrospective Post Acute Care</td>
</tr>
<tr>
<td></td>
<td>- Model 4: Prospective Acute Care</td>
</tr>
<tr>
<td></td>
<td>- Oncology Care Model</td>
</tr>
<tr>
<td></td>
<td><strong>Initiatives Focused on the Medicaid</strong></td>
</tr>
<tr>
<td></td>
<td>- Medicaid Emergency Psychiatric Demonstration</td>
</tr>
<tr>
<td></td>
<td>- Medicaid Incentives for Prevention of Chronic Diseases</td>
</tr>
<tr>
<td></td>
<td>- Strong Start Initiative</td>
</tr>
<tr>
<td></td>
<td>- Medicaid Innovation Accelerator Program</td>
</tr>
<tr>
<td></td>
<td><strong>Dual Eligible (Medicare-Medicaid Enrollees)</strong></td>
</tr>
<tr>
<td></td>
<td>- Financial Alignment Initiative</td>
</tr>
<tr>
<td></td>
<td>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
</tr>
<tr>
<td><strong>Deliver Care</strong></td>
<td><strong>Support providers and states to improve the delivery of care</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Learning and Diffusion</strong></td>
</tr>
<tr>
<td></td>
<td>- Partnership for Patients</td>
</tr>
<tr>
<td></td>
<td>- Transforming Clinical Practice</td>
</tr>
<tr>
<td></td>
<td>- Community-Based Care Transitions</td>
</tr>
<tr>
<td></td>
<td><strong>State Innovation Models Initiative</strong></td>
</tr>
<tr>
<td></td>
<td>- SIM Round 1</td>
</tr>
<tr>
<td></td>
<td>- SIM Round 2</td>
</tr>
<tr>
<td></td>
<td>- Maryland All-Payer Model</td>
</tr>
<tr>
<td></td>
<td><strong>Health Care Innovation Awards</strong></td>
</tr>
<tr>
<td><strong>Distribute Information</strong></td>
<td><strong>Increase information available for effective informed decision-making by consumers and providers</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Information to providers in CMMI models</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Shared decision-making required by many models</strong></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

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
The bundled payment model targets 48 conditions with a single payment for an episode of care

- Incentivizes providers to take \textit{accountability for both cost and quality} of care

- \textbf{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

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

Bundled Payments for Care Improvement is also growing rapidly
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
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
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