Paving the Way to Higher Performing HealthCare in New Jersey

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The Problem – Two Years Ago

New Jersey

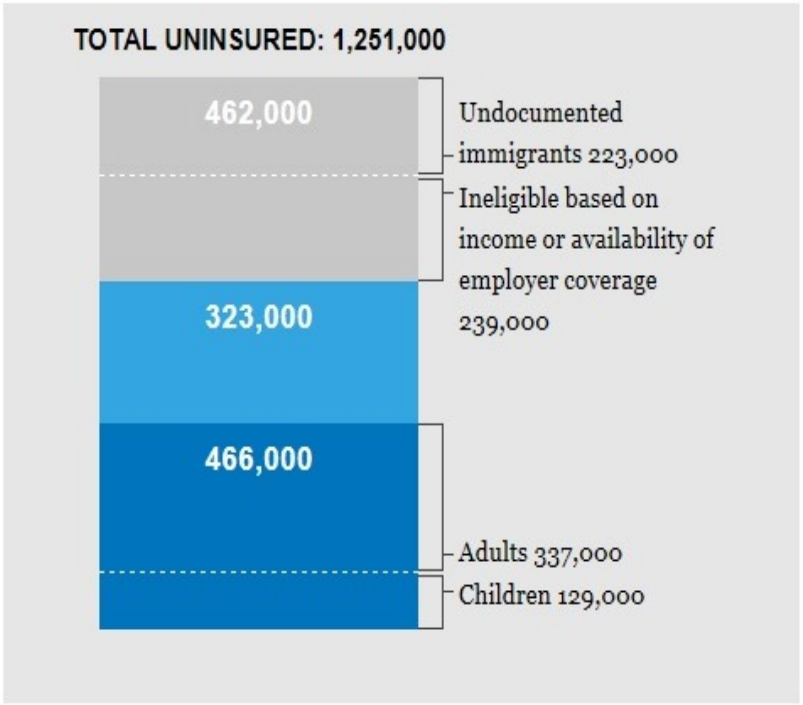
✓ New Jersey is implementing the Medicaid Expansion under the ACA.

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

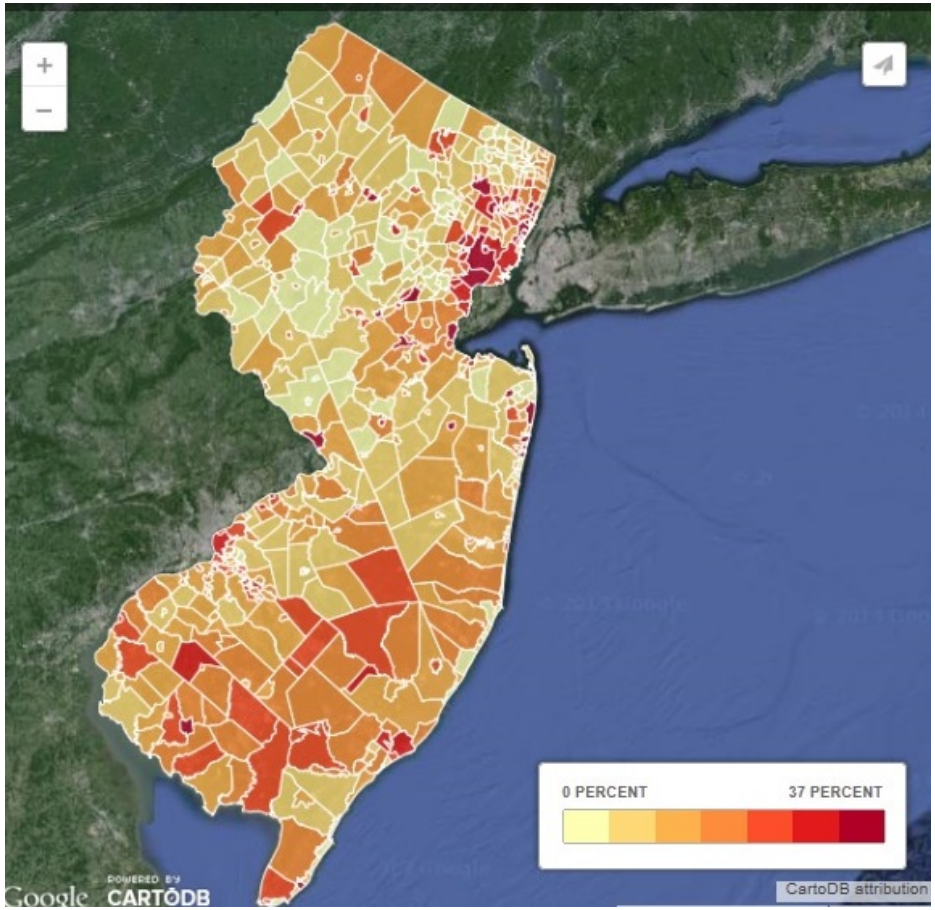
New Jersey Decides in Favor of

- 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.



Better. **Smarter.** *Healthier.*

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"

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

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

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 (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

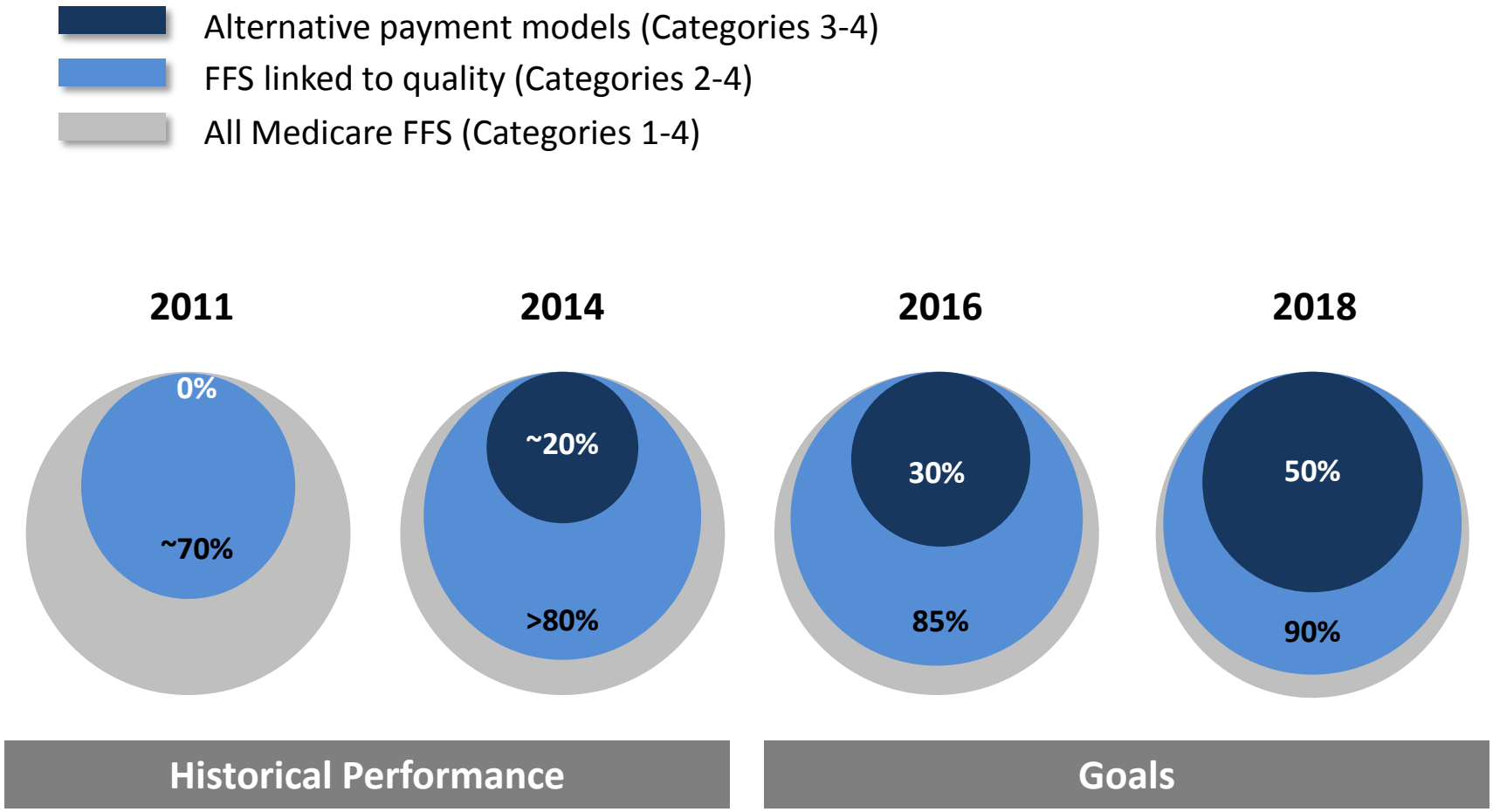
Invite **private sector payers** to match or exceeed HHS goals

NEXT STEPS:

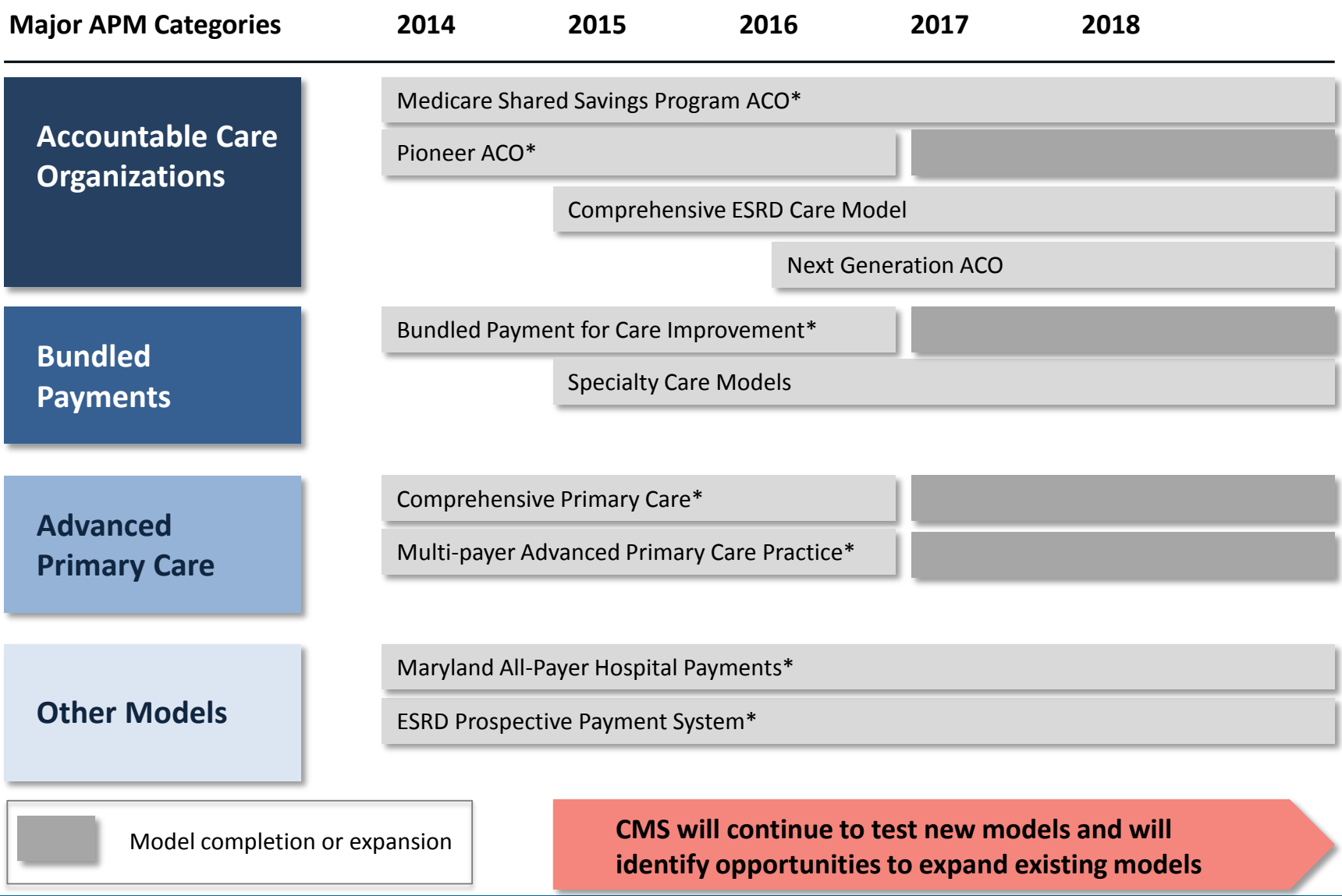
Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

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



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

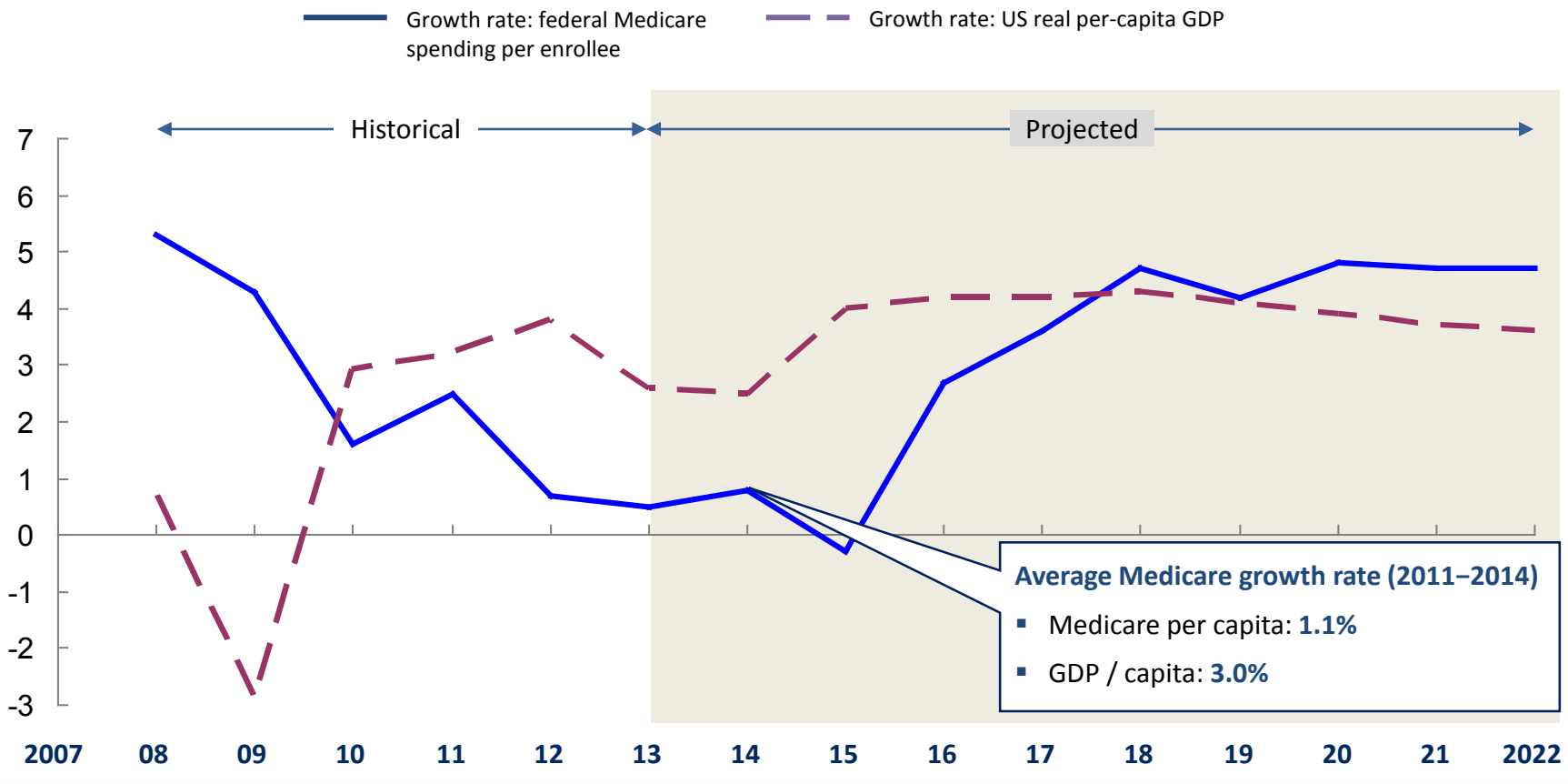


* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

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 (%)



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

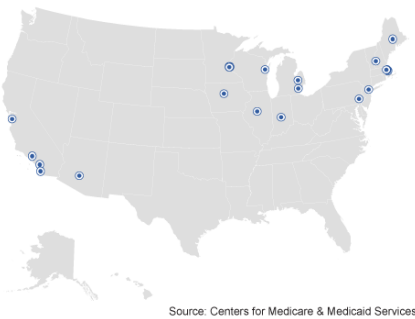
SOURCE: CMS Office of the Actuary National Health Expenditure Data (2013-2023 projections)

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‡



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

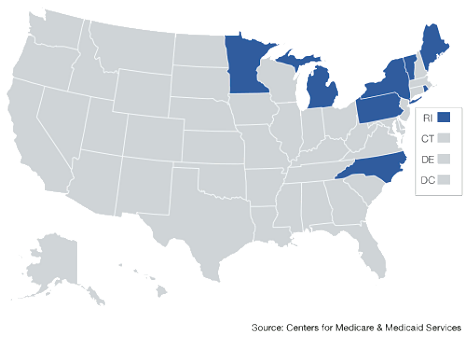
† Results from regression based analysis
‡ Results from actuarial analysis

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



Source: Centers for Medicare & Medicaid Services

- 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

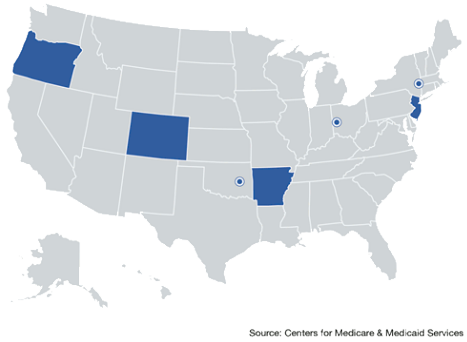
- Duration of initial model test: July 2011 – December 2014
  - ME, MI, NY, RI, VT were extended through Dec 2016

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

CPC
Comprehensive Primary Care

- 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)

Positive results in CPC were more prominent in some states

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

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

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

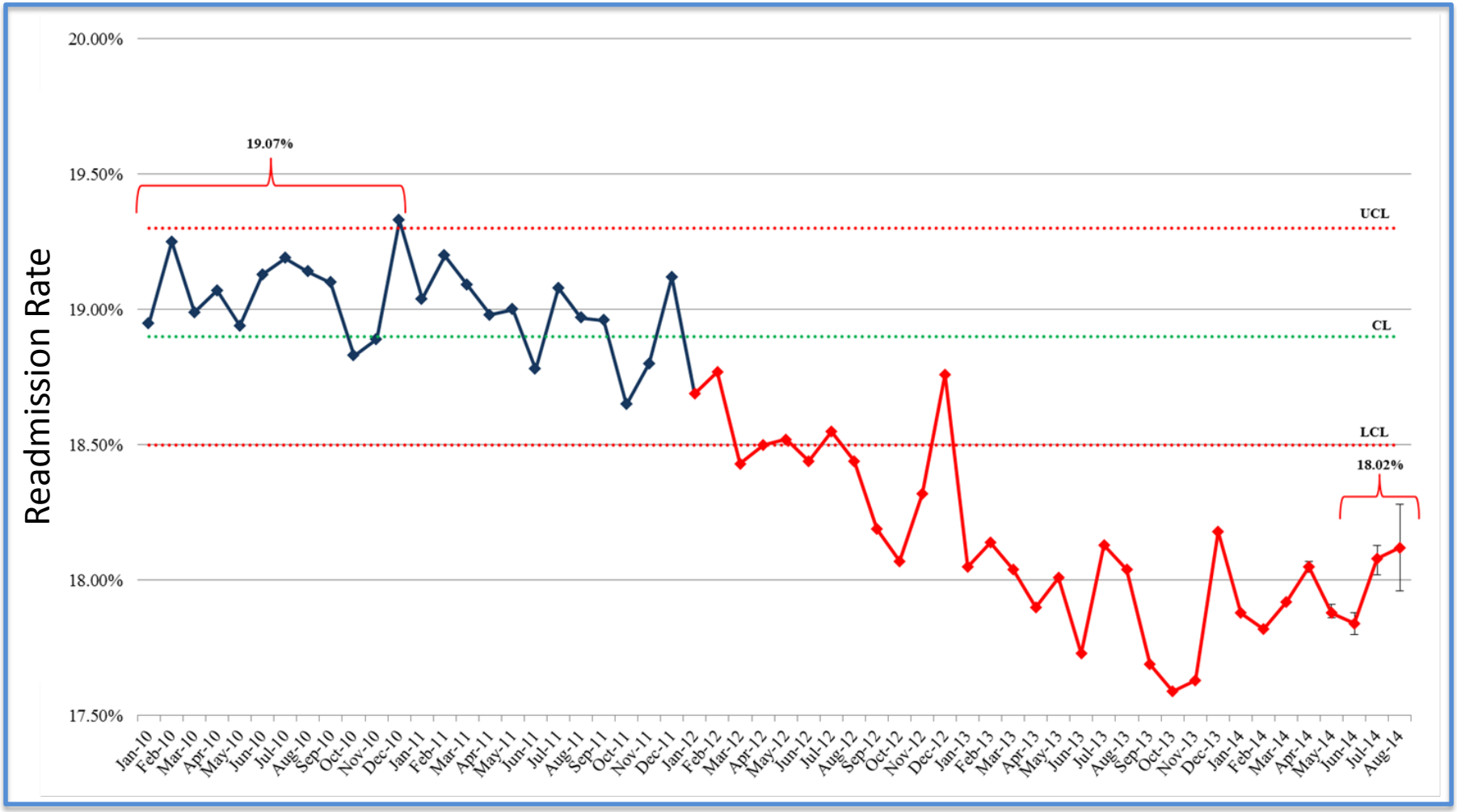
$12 billion

in savings

Leading Indicators, change from 2010 to 2013

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% ↓

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

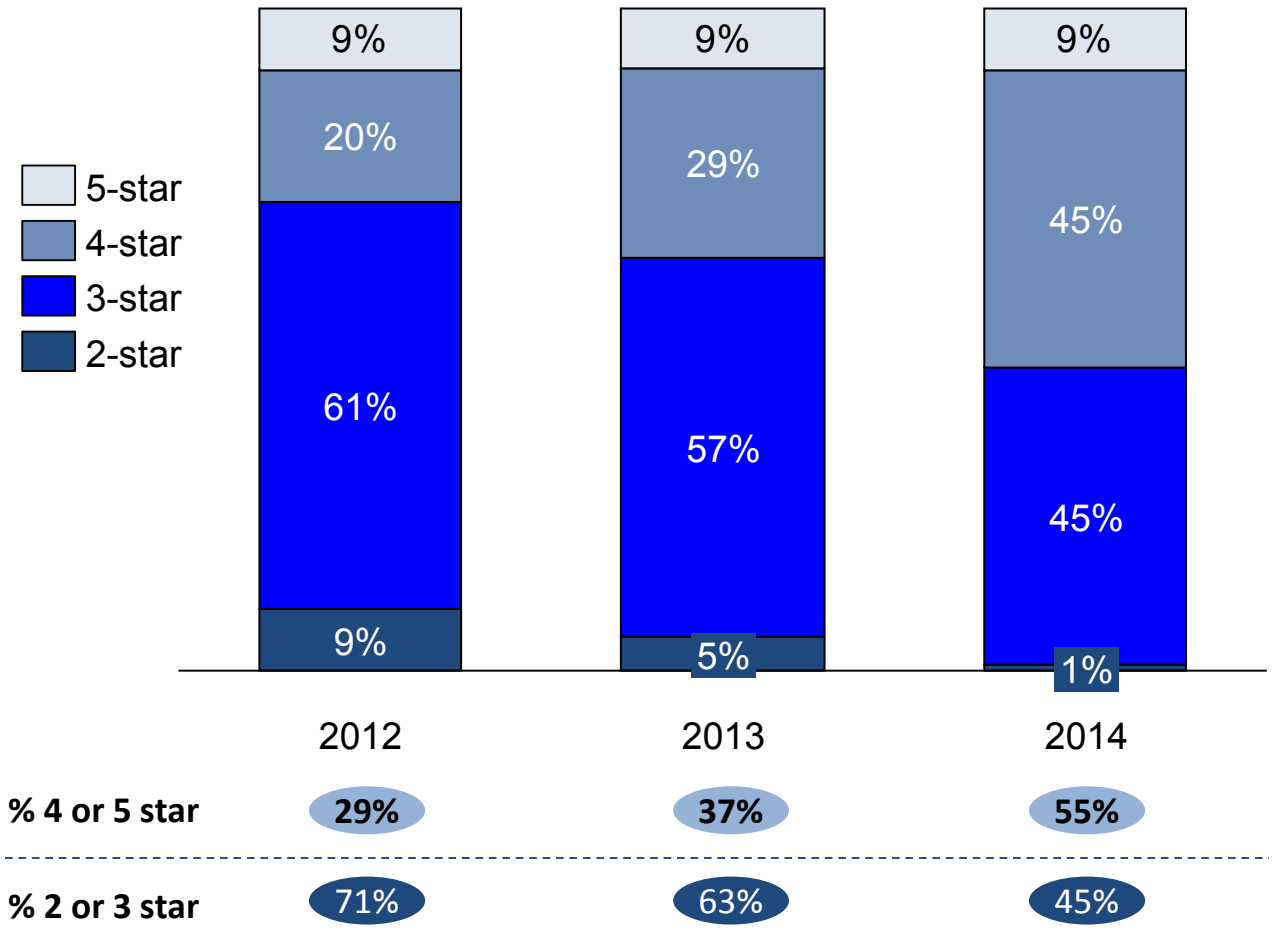


Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. April 2014 – August 2014 readmissions rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.

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



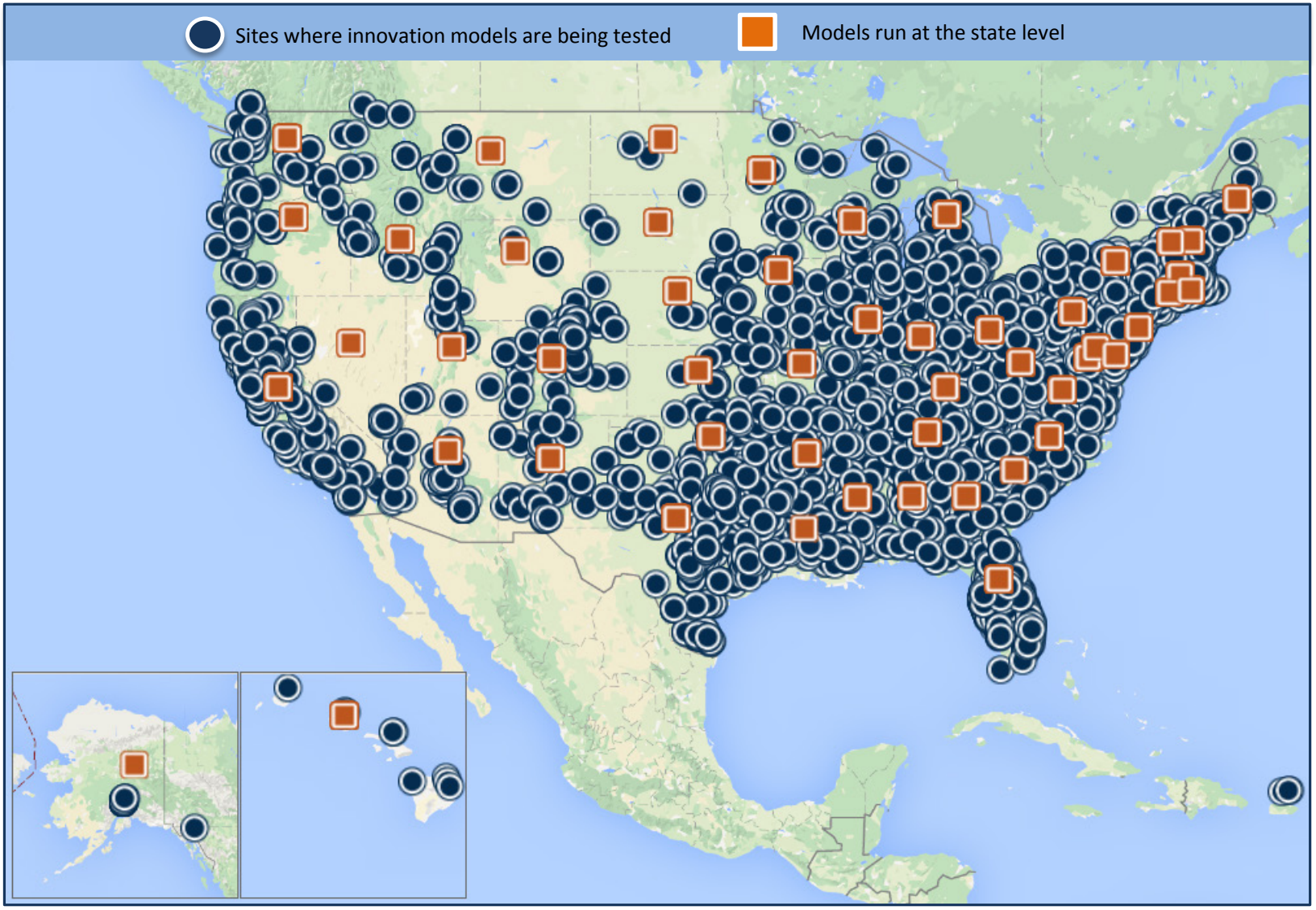
- Sent prompt to beneficiaries enrolled in plans with 2.5 star rating or lower
- Letters only sent to beneficiaries in consistently low-rated plans
- Switch rate 44% (prompt) v. 21% (no prompt)

The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration ▪ **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 ▪ **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

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

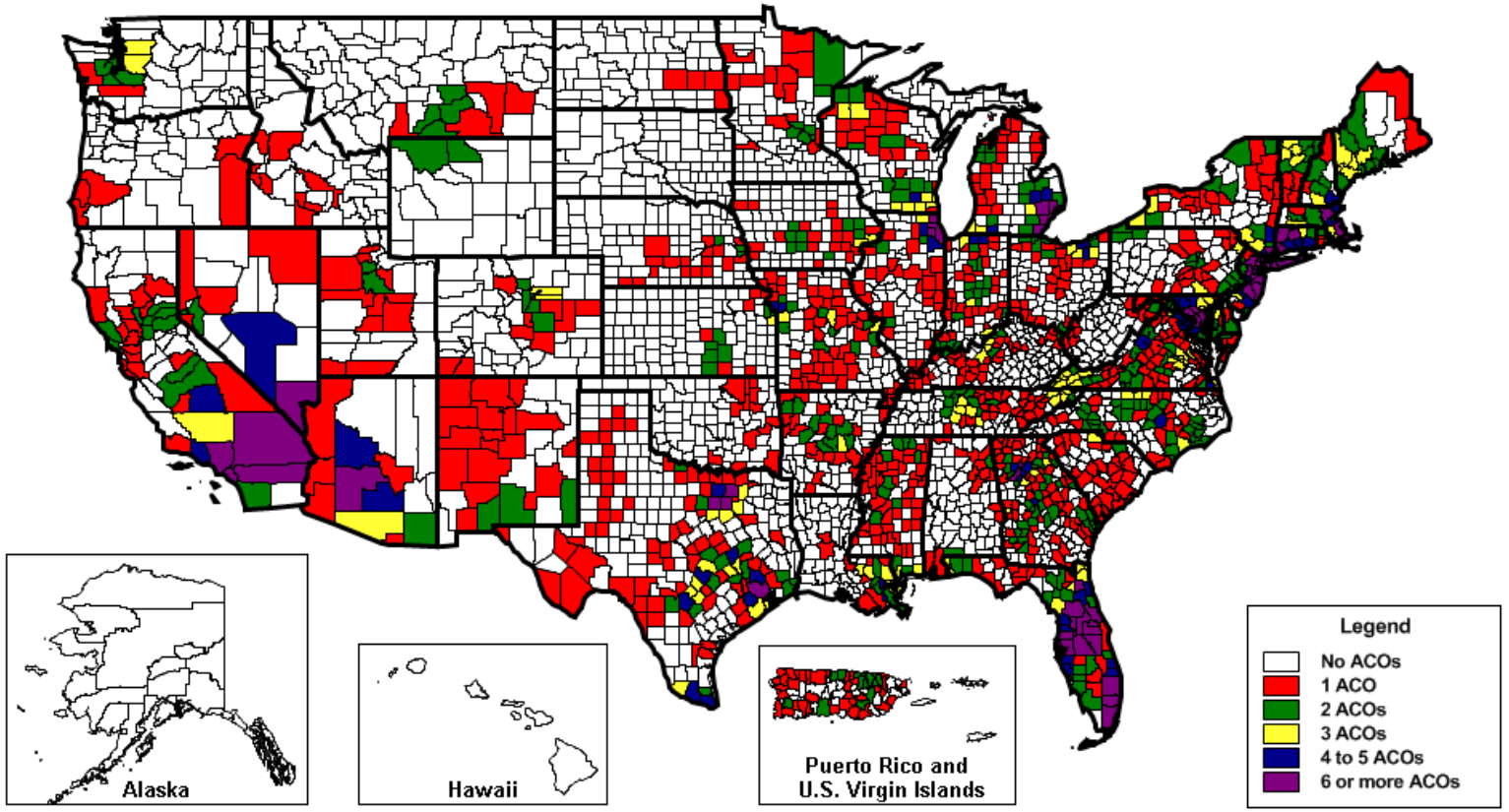


Source: CMS Innovation Center website, January 2015

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

ACO-Assigned Beneficiaries by County



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

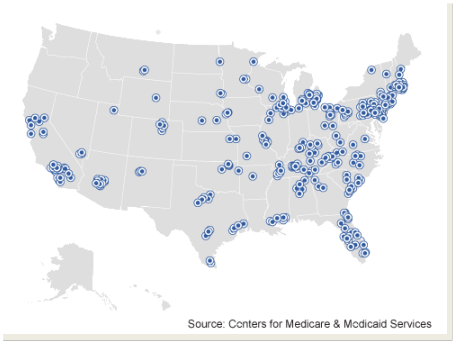
- Designed for **ACOs that are experienced** in coordinating care for populations of patients
- These ACOs will assume **higher levels of financial risk and reward** than the Pioneer or MSSP ACOS
- The model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce 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

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

* Current until July 2015

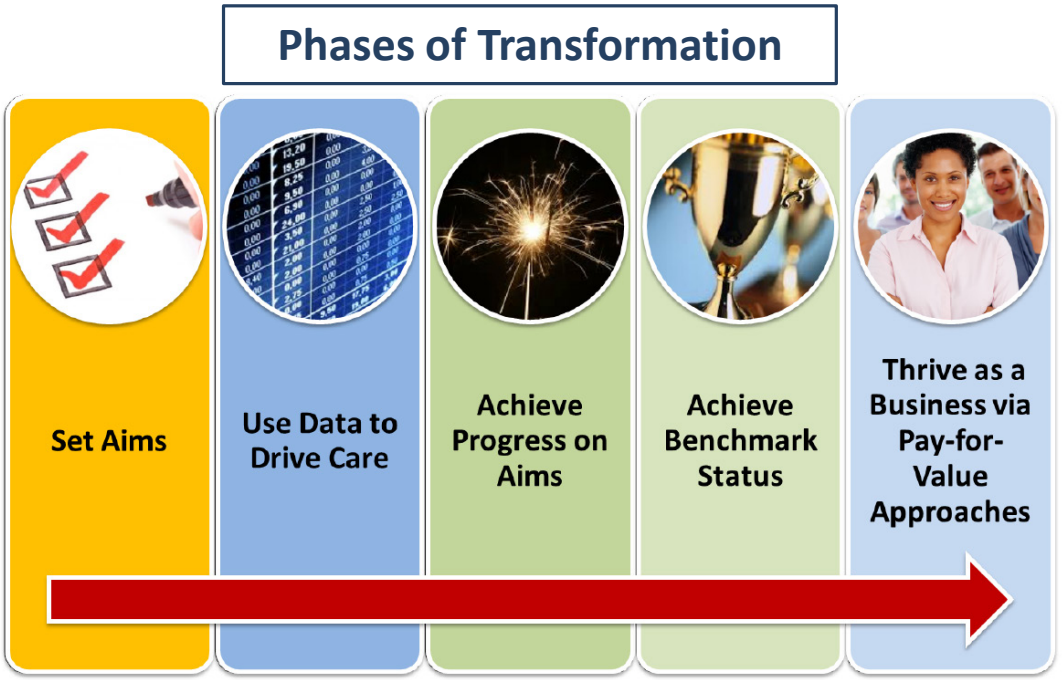
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- 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



Innovation Center – 2015 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

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