What's Going on at CMMI?

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Thank You

- For the hard work you are doing to improve our nation's healthcare system.
- For being a part of this critical dialogue.
- We're ready as never before for a leap forward into the health care system we want, need, and can have.

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CMS Mission

CMS is a constructive force and a trustworthy partner for the continual improvement of health and health care for all Americans.

Measures of Success

Better healthcare - Improve individual patient experiences of care along the IOM 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity*

Better health - Focus on the overall health outcomes of populations by addressing underlying causes of poor health, such as: physical inactivity, behavioral risk factors, lack of preventive care, and poor nutrition

Reduced costs - Lower the total cost of care resulting in reduced monthly expenditures for Medicare, Medicaid or CHIP beneficiaries by improving care

The Current System

- **Greatest Acute Care in the World:** People come from around the world to be treated
- **But:** 46 Million Americans lack coverage
  - **Uncoordinated –** Fragmented delivery systems with variable quality
  - **Unsupportive –** of patients and physicians
  - **Unsustainable –** Costs rising at twice the inflation rate

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A Future System

- **Affordable**
- **Accessible** – to care and to information
- **Seamless and Coordinated**
- **High Quality** – timely, equitable, safe
- **Person and Family-Centered**
- **Supportive of Clinicians** in serving their patients needs

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Transforming Health Care

- We can invent our way to success
- We can improve our way to a sustainable, proud, and excellent American health care system
- We can make health care more affordable for our country by making it better for the people who depend on it
- <u>Better care will be, overall, less costly care</u>

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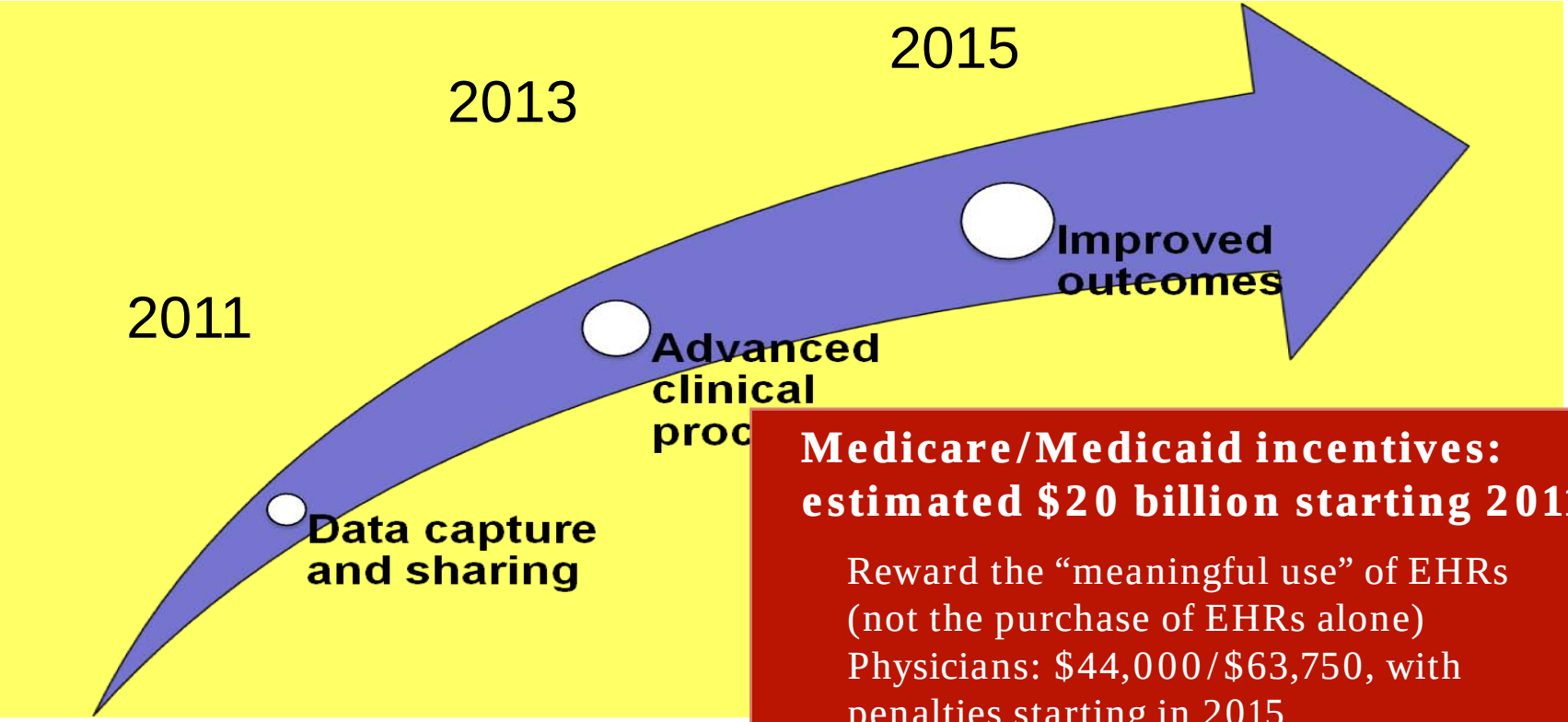
The Foundation for Healthcare Transformation: Meaningful Use



Medicare/Medicaid incentives: estimated $20 billion starting 2011

- Reward the "meaningful use" of EHRs (not the purchase of EHRs alone)
- Physicians: $44,000/$63,750, with penalties starting in 2015
- Hospitals: $2M plus bonuses for higher Medicare, Medicaid volume
- Escalating requirements – 2011, 2013, 2015

New Tools in the CMS Toolbox

- Medical Homes
- Hospital-Acquired Conditions (HAC) Payment Rules
- Value-Based Purchasing
- Reducing Fraud, Waste & Abuse
- Medicare and Medicaid Coordination Office
- CMS Innovation Center
- Medicare ACO Shared Saving Program

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The Innovation Center

"The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and CHIP…while preserving or enhancing the quality of care furnished…"

- "Preference to models that improve coordination, quality and efficiency of health care services."

- **Resources** - $10 Billion in funding for FY2011 through 2019
- **Opportunity to "scale up"**: HHS Secretary authority to expand successful models to the national level

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The Innovation Center

Mission Statement

"Be a constructive and trustworthy partner in identifying, testing and spreading new models of care and payment that continuously improve health and healthcare for all Americans."

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Initial Programs

- ACO Initiatives: Shared Savings Program, Pioneer, Advance Payment, Learning Sessions
- Bundled Payments for Care Improvement
- Multi-Payer Advanced Primary Care Practice Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Medicaid Health Home State Plan Option
- State Demonstrations to Integrate Care for Dual Eligible Individuals
- Demonstration to Improve Quality of Care for Nursing Facility Residents
- Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees
- Partnership for Patients

CMS ACO Initiatives

ACO Initiatives at CMS:

- Shared Savings Program
- Pioneer ACO Model
- Advance Payment Initiative
- ACO Accelerated Development Learning Sessions

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The Pioneer ACO Model

- Designed for organizations that
  - Are well on their way to changing care delivery and business model
  - Interested in being the leading edge
  - Able to show the country what is possible
- Allows ACOs to move more rapidly from a shared savings payment model to a population-based payment model
- Applications were due August 19th - applications are currently under review
- First performance period will begin in the last quarter of 2011

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Advance Payment Initiative

- The Innovation Center sought public comments on whether it should offer an Advance Payment Initiative.
- The Advance Payment Initiative would give certain ACOs participating in the Medicare Shared Savings Program access to part of their shared savings up front.
- ACOs would need to provide a plan for using these funds to build care coordination capabilities, and meet other organizational criteria.
- Advance payments would be recouped through the ACOs' earned shared savings.
- Comments were due June 17th. The Innovation Center staff is exploring various alternatives.

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Accelerated Development Learning Sessions

- The goal of the ACO Accelerated Development Learning Sessions is to prepare participants to:
  - Understand their current readiness to become an ACO.
  - Identify organization-specific goals for achieving the three-part aim of improving care delivery, improving health, and reduced costs through improvement.
  - Begin to develop an action plan for establishing essential ACO functions.
- Additional sessions in 2011
  - September 15-16 – San Francisco, California
  - October/November – Philadelphia, PA area
- More information and registrations is available at https://acoregister.rti.org

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Bundled Payments for Care Improvement

- Testing “bundling” payments for multiple services patients receive during an episode of care
- Applicants choose from one of four models:
  1. Acute care hospital stay only
  2. The acute care hospital stay plus post-acute care associated with the stay
  3. Post-acute care only, beginning with the initiation of post-acute care services after discharge from an acute inpatient stay
  4. Prospective payment of all services furnished during an inpatient stay by the hospital, physicians and other practitioners
- Application deadlines vary – more info on the website

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Multi-payer Advanced Primary Care Practice Model

- Evaluate the effectiveness of doctors and other health professionals receiving a common payment method from Medicare, Medicaid, and private health plans
- Medicare will participate in existing State multi-payer health reform initiatives that currently include participation from both Medicaid and private health plans.
- The demonstration program will pay a monthly care management fee for beneficiaries receiving primary care from APC practices
- Eight states selected to participate: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota will participate

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Federally Qualified Health Center Advanced Primary Care Demonstration

- Evaluate the impact of the advanced primary care practice model on the accessibility, quality, and cost of care provided to Medicare beneficiaries served by Federally Qualified Health Centers (FQHCs).
- FQHC receives care management fee for each Medicare beneficiary enrolled at the FQHC
- Applications due August 26, 2011

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Medicaid Health Home State Plan Option

- Option open to all states
- Allows Medicaid beneficiary with at least two chronic conditions to designate a single provider as their “health home”
- Participating states will receive enhanced financial resources from the federal government to support “health homes”
- The Innovation Center will be assisting with learning, technical assistance and evaluation activities.

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Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

- CMS provided guidance to states on two models designed to align financing and improve care for dual eligible populations.
- Capitated Model:
  - State, CMS, and a health plan enter into a three-way contract,
  - Health plan receives a prospective blended payment
- Managed Fee-for-Service Model:
  - State and CMS enter into an agreement
  - State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.
- All states that meet standards and conditions will have the option to pursue either or both of these models.

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State Demonstrations to Integrate Care for Dual Eligible Individuals

- CMS awards contracts to states for design of models aimed at improving the quality, coordination, and cost effectiveness of care for dual eligible individuals
- 15 states have received contracts of up to $1 million:
  - California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin

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Demonstration to Improve Quality of Care for Nursing Facility Residents

- Focused on reducing preventable inpatient hospitalizations among residents of nursing facilities by providing treatment without having to go to a hospital.
- 40 percent of hospital admissions among dual eligible nursing facility residents were preventable in 2005
  - 314,000 potentially avoidable hospitalizations
  - $2.6 billion in Medicare expenditures.
- This fall, CMS will competitively select independent organizations to partner with and implement evidence-based interventions at interested nursing facilities

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Partnership for Patients: Better Care, Lower Costs

New nationwide public-private partnership to tackle all forms of harm to patients. Our goals:

- **40% Reduction in Preventable Hospital Acquired Conditions over three years**
  - 1.8 Million Fewer Injuries
  - 60,000 Lives Saves
- **20% Reduction in 30-Day Readmissions in Three Years**
  - 1.6 Million Patients Recover Without Readmission

$35 Billion Dollars Saved in Three Years

- Over 2500 hospitals have signed the pledge

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Improving Patient Safety

- The Centers for Medicare and Medicaid Services has committed **up to $500 million to help hospitals and health care organizations to improve patient care to:**
  - Design intensive programs to teach and support hospitals in making care safer
  - Provide technical assistance for hospitals and care providers
  - Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
  - Engage Patients and Families
  - Establish a network of “Vanguard Hospitals” to work on new ways to reduce all cause harm in hospitals.
- Award comings in the Fall of 2011

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Community-based Care Transitions Program (CCTP)

- The CCTP, mandated by section 3026 of the Affordable Care Act, provides the opportunity for community based organizations to partners with hospitals to improve transitions between care settings
  - $500 million available for community-based organizations
  - Applications now being accepted and awarded on a rolling basis
- The goals of the Community-based Care Transitions Program are to:
  - Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
  - Reduce readmissions for high risk beneficiaries
  - Document measurable savings to the Medicare program
- Learn more: www.healthcare.gov/partnershipforpatients

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Partnership

- Join us on this journey to provide coordinated, seamless, reliable, and patient-centered care that is rooted in health, grounded in primary care, and economically sustainable.
- CMS wants to support your transformation and work with you to improve care and reduce costs.

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Thank You

Questions?

Suggestions?

How can we work together?

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