

# The Centers for Medicare and Medicaid Services

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Moving the Dial on Quality

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# Thank You

- For the hard work you are doing to improve our nation's health care system.
- For being a part of this critical dialogue.

**We're ready as never** before to create the health care system we want, need, and can have.

# INNOVATION



# *Transforming Health Care*

- We can innovate and improve our way to a sustainable and high quality 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.

# *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

# *The Three I's Strategy*

- Ideas – Innovate and Create New Models

*Drive development of new models to deliver better health care, better health, and reduced cost.*

- Incentives – Test New Care and Payment Models

*Test models that align payment and clinical practice to achieve better value in health care.*

- Improvement - Rapidly Spread Better Care

*Support development and diffusion of knowledge, models, and operational methods.*

# *Delivery System Transformation Strategy: How do we get from here to there*

- Step 1: Providers commit to change their business and clinical model
- Step 2: CMS, and other payers, provide alternative models to support providers
- Step 3: Providers select their models
- Step 4: Explore new models together
- Step 5: Evaluate and Spread successful models

# Innovation Center Initiatives

## ACO Suite:

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

## Primary Care Suite

- Comprehensive Primary Care Initiative (CPCI)
- Federally Qualified Health Center Advanced Primary Care Practice Demonstration
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Independence at Home
- Medicaid Health Home State Plan Option

## Bundled Payment Suite

- Bundled Payment for Care Improvement

## Dual Eligible Suite:

- State Demonstration to Integrate care for Dual Eligible Individuals
- Financial Alignment to Support State Efforts to Integrate Care
- Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents
- Medicaid Health Home State Plan Option

## Diffusion and Scale Suite:

- Partnership for Patients
- Million Hearts Campaign
- Innovation Advisors Program
- Care Innovations Summit

## Healthcare Innovation Challenge

## Rapid Cycle Evaluation and Research

## Learning and Diffusion



# ACO SUITE

- Shared Savings Model
- Pioneer ACO Model
- Advanced Payment Model
- Accelerated Development and Learning Sessions

# Advance Payment Model

GOAL: Provide additional support to physician-based and rural ACOs participating in the Medical Shared Savings Program.

- Will test whether pre-paying a portion of future shared savings will increase participation of physician-**owned and rural ACO's**.
- Payments will be recouped through shared savings earned by ACO.
- Open to ACOs participating in Shared Savings Program
  - Only available for April 1, 2012 and July 1, 2012 start dates
- Application Deadlines:
  - April 1 start date: applications accepted Jan 3 – Feb 1, 2012
  - July 1 start date: applications accepted Mar 1 – Mar 30, 2012 (consistent with Shared Savings Program)
- E-mail questions to [advpayaco@cms.hhs.gov](mailto:advpayaco@cms.hhs.gov)

# *The Pioneer ACO Model*

GOAL: Test the transition from a shared-savings payment model to a population-based payment.

- Designed for health care organizations and providers that are already experienced in coordinating care
- Requires ACOs to create similar arrangements with other payers.
- Expected to improve the health and experience of care for individuals, improve population health, and reduce the rate of growth in health care spending
- CMS will publicly report the performance of Pioneer ACOs on quality metrics
- 32 Participating ACOs announced in December 2011
- First performance period scheduled to began in January 2012.

# Primary Care Suite

- Comprehensive Primary Care Initiative (CPCI)
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# *Bundled Payment Suite*

**GOAL: Testing the effect of “bundling” payments for multiple services that a patient receives during a single episode of care. Fostering better care coordination and improved care quality through payment innovation.**

Four patient-centered approaches:

- Acute care hospital stay only
- Acute care hospital stay plus post-acute care associated with the stay
- Post-acute care only
- Prospective payment of all services during inpatient stay

# *Duals Eligible Suite*

- State Demonstration to Integrate Care for Dual Eligible Individuals
- Financial Alignment to Support State Efforts to Integrate Care
- Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents

# *Diffusion and Scale Suite*

- Partnership for Patients
  - Community Based Care Transition Program
- Million Hearts
- Innovation Advisors Program
- Care Innovations Summit

# *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
- Potential to save \$35 Billion Dollars over three Years
- Over 7,100 partners – including 3,200 hospitals – have signed pledge



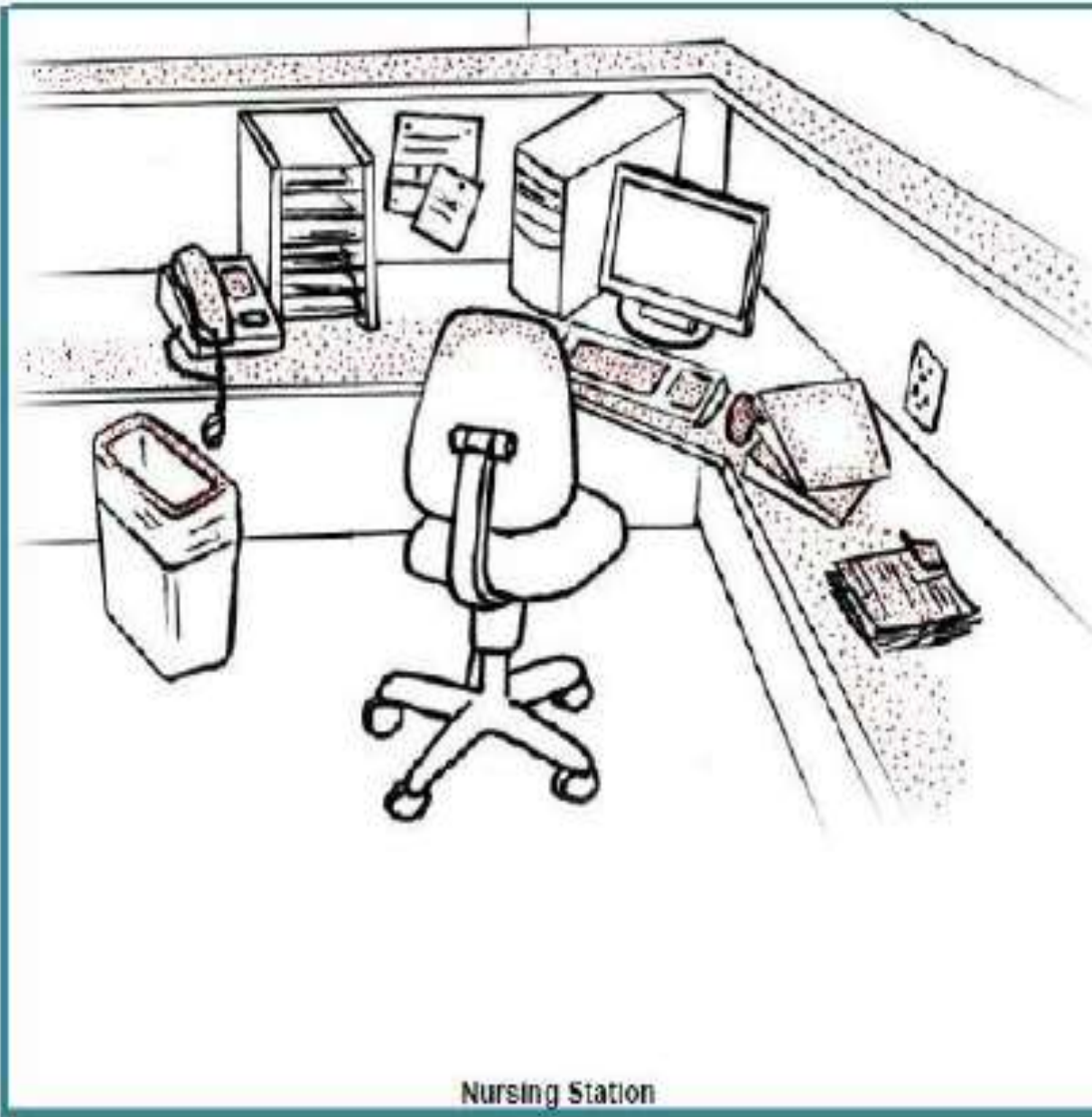
Hallway on Patient/Resident Floor



Transport Items



Wheelchair



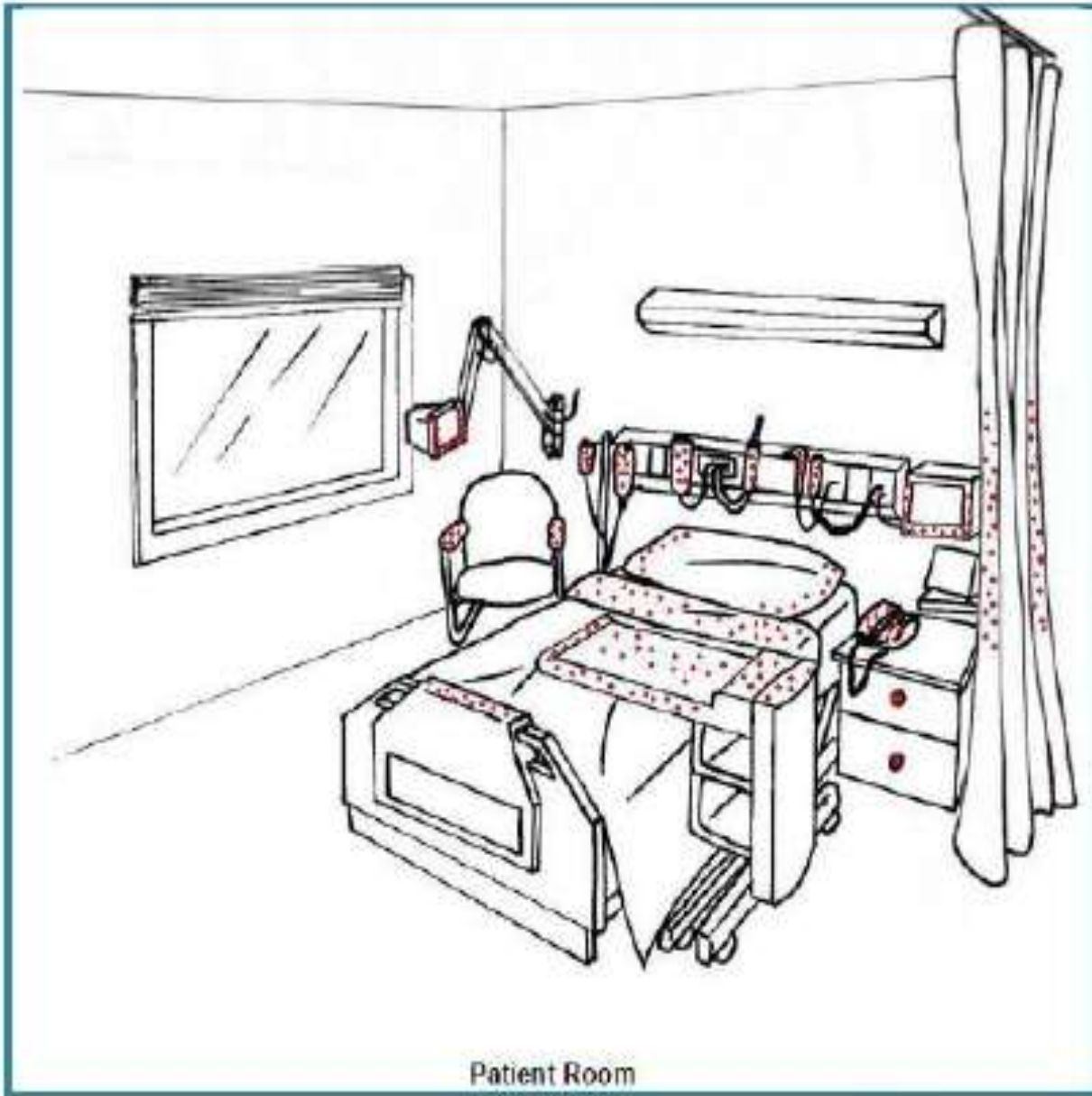
Nursing Station



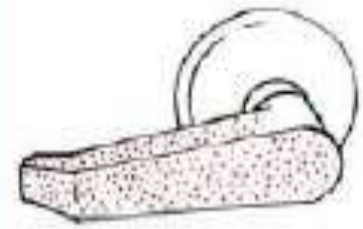
ECG Cart



Computer on Wheels



Patient Room



Door Handle



Light Switch

# Improving Patient Safety



GOAL: Testing intensive programs of support hospitals as they make care safer.

- Provide national-level content for anyone and everyone
- Support every facility to take part in cooperative learning
- Establish an Advanced Participants Network for ambitious organizations to tackle all-cause harm
- Engage patients and families in making care safer
- Improve measurement and data collection, without adding burdens to hospitals

\$218 million awarded to 26 organizations to operate hospital networks across the country that will make patient care safer

# Community-based Care Transitions Program

\$500 million available for community-based organizations partnered with hospitals to reduce 30-day hospital readmissions.

## GOALS:

- Improve transitions of beneficiaries from inpatient hospitals to home or other care settings.
- Reduce readmissions for high risk beneficiaries.
- Document measurable savings to the Medicare program.
- Applications now being accepted and awarded on a rolling basis.
- First program participants selected in November 2011.
- Learn more at [www.healthcare.gov/partnershipforpatients](http://www.healthcare.gov/partnershipforpatients)

# Million Hearts Campaign

[www.millionhearts.hhs.gov](http://www.millionhearts.hhs.gov)



GOAL: Prevent 1 million heart attacks and strokes over the next 5 years.

Clinical Prevention: improving care of the ABCS through

Focus simplifying and aligning quality measures; emphasizing **importance of improved care of the ABCS'**

Health IT using electronic health records to improve care and enable quality improvement through clinical decision support, patient reminders, registries, and technical assistance.

Care Innovations team-based care, interventions to promote medication adherence.

Community prevention: reducing the need for treatment through

- Prevention of tobacco use.
- Improved nutrition: decreasing sodium and artificial trans-fat consumption

# Status of the ABCS

<b>A</b> spirin	People at increased risk of cardiovascular disease who are taking aspirin	<b>47%</b>
<b>B</b> lood pressure	People with hypertension who have adequately controlled blood pressure	<b>46%</b>
<b>C</b> holesterol	People with high cholesterol who have adequately controlled hyperlipidemia	<b>33%</b>
<b>S</b> moking	People trying to quit smoking who get help	<b>23%</b>

Source: *MMWR: Million Hearts: Strategies to Reduce Cardiovascular Disease Risk Factors --- United States, 2011*, Release, Vol. 60

# *Innovation Advisors Program*

**GOAL:** Support the Innovation Center's development and testing of new models of payment and care delivery in their home organizations and communities.

- Opportunity to deepen key skill sets in:
  - Health care economics and finance
  - Population health
  - Systems analysis
  - Operations research and quality improvement

1 year commitment; 6 months of intensive training.

Up to \$20K Stipend available to home organizations.

73 Advisors selected in December 2011; up to 200 individuals will be selected within the first year.

For further information, see: [www.orise.orau.gov/IAP](http://www.orise.orau.gov/IAP)

# Care Innovations Summit

**GOAL:** Bringing together leading innovators from inside and outside the health care industry to facilitate dialogue and drive cooperative action towards achieving better health care, better health, and reduced cost.

- January 26<sup>th</sup> 2012 in Washington D.C.
- Co-hosted by the Innovation Center, Office of the National Coordinator for Health IT, West Wireless Health Institute, and Health Affairs.
- Showcasing innovations in health care delivery and payment.
- Forty (40) or more innovators will be selected to present their work.

**Learn more, including how to register for the Summit and apply to present your work at: <http://hcidc.org/>**

# Health Care Innovation Challenge

**GOAL:** To identify and support a broad range of innovative service delivery and payment models that achieve better care, better health and lower costs through improvement in communities across the nation.

Innovation Challenge projects will:

- Improve care and lower costs for Medicare, Medicaid, and CHIP beneficiaries.
- Reach populations with the greatest health care needs.
- Rapidly implement the proposed model.
- Develop, train, and deploy workforce in support of innovative health care payment and delivery models.

# *Our Work Continues.....*

- ESRD Integrated Care Model
- Appropriate Use of Imaging Services
- Strong Start Mothers and Infants
- State Innovation Initiative Programs

# Contact Information

*Join me on this Journey.*

***Let's create our better future!***



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[www.innovation.cms.gov](http://www.innovation.cms.gov)