



Transforming Health Care Through Innovation

Redwood MedNet

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Overview

- **Overview of CMMI**
- **Population Health at CMMI**
- **Challenges**
- **Discussion**

The CMS Mission

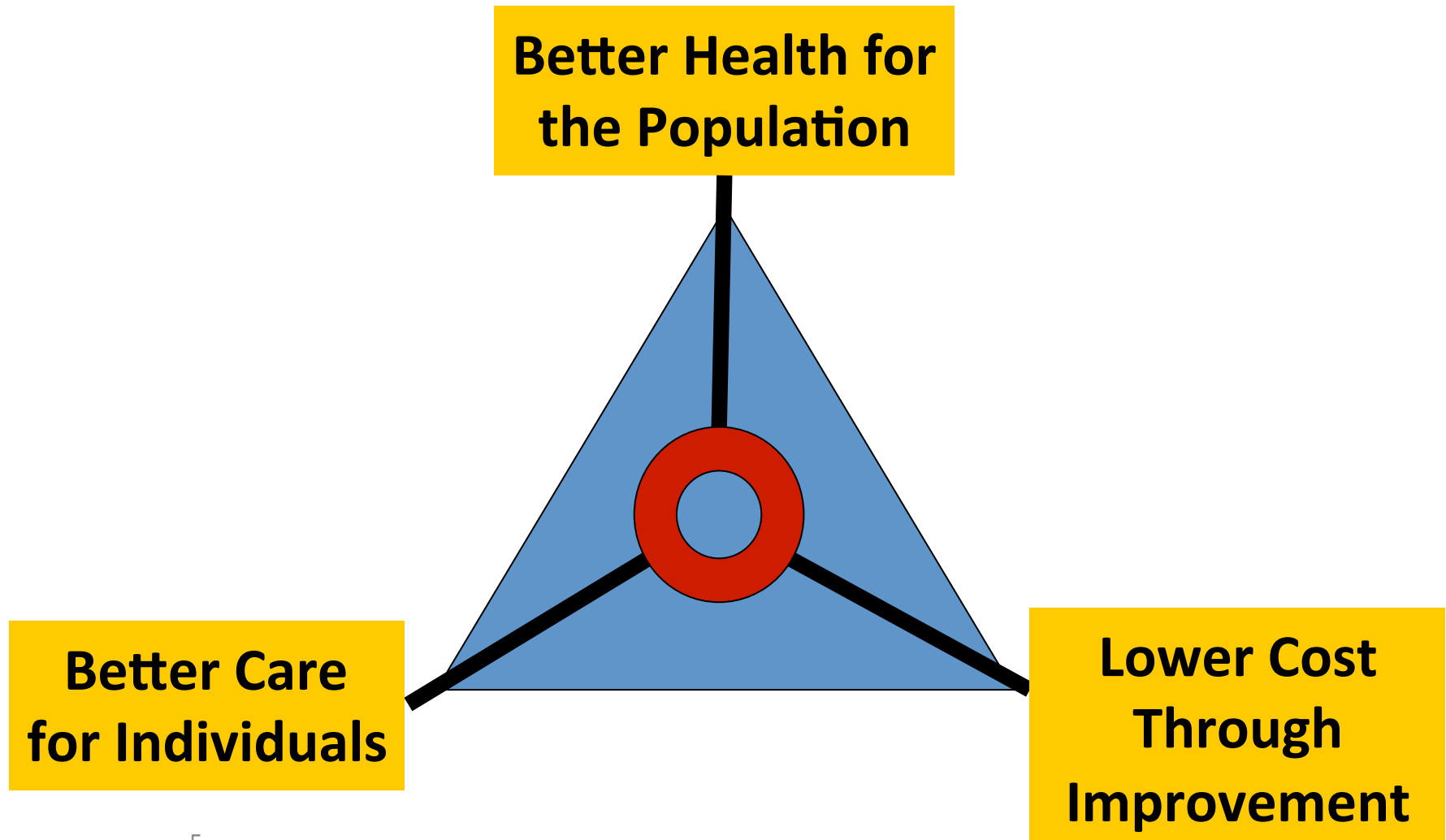
CMS is a constructive force and a trustworthy partner for the continual improvement of health and health care for all Americans.

The Innovation Center

Identify, test, evaluate, and scale innovative ways to deliver and pay for care that can lower costs and don't sacrifice quality.

- **Resources:** \$10 billion funding for FY2011 through 2019
- **Opportunity to “scale up”:** The HHS Secretary has the authority to expand successful models to the national level

Measures of Success



Innovation Can Transform American Health Care

**Current State –
Producer-Centered**

**Current payments – part
of the problem...**

- Fragmented payment systems (IPPS, OPPS, RBRVRS)
- Fee-for-service payment model
- Lack of Transparency

**PRIVATE
SECTOR**

**PUBLIC
SECTOR**

**INNOVATION
CENTER**

**Future State –
People-Centered**

**CMS –
part of the solution...**

- ACOs
- Episode-based payments
- Value-based purchasing
- Patient Centered Medical Homes
- Data Transparency

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 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.

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:

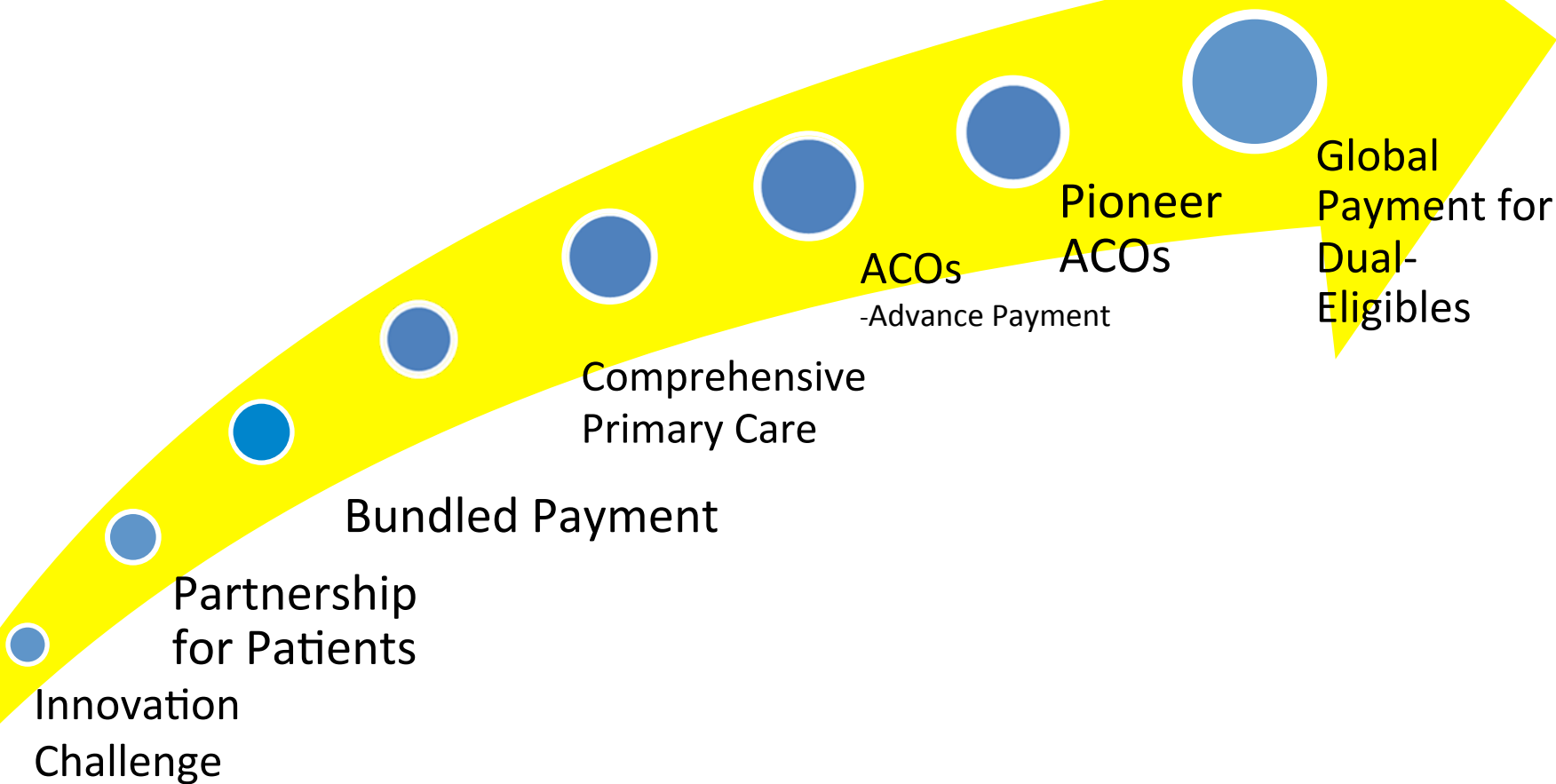
- Partnership for Patients
- Million Hearts Campaign
- Innovation Advisors Program
- Care Innovations Summit

Healthcare Innovation Challenge

Rapid Cycle Evaluation and Research

Learning and Diffusion

Delivery Transformation Continuum

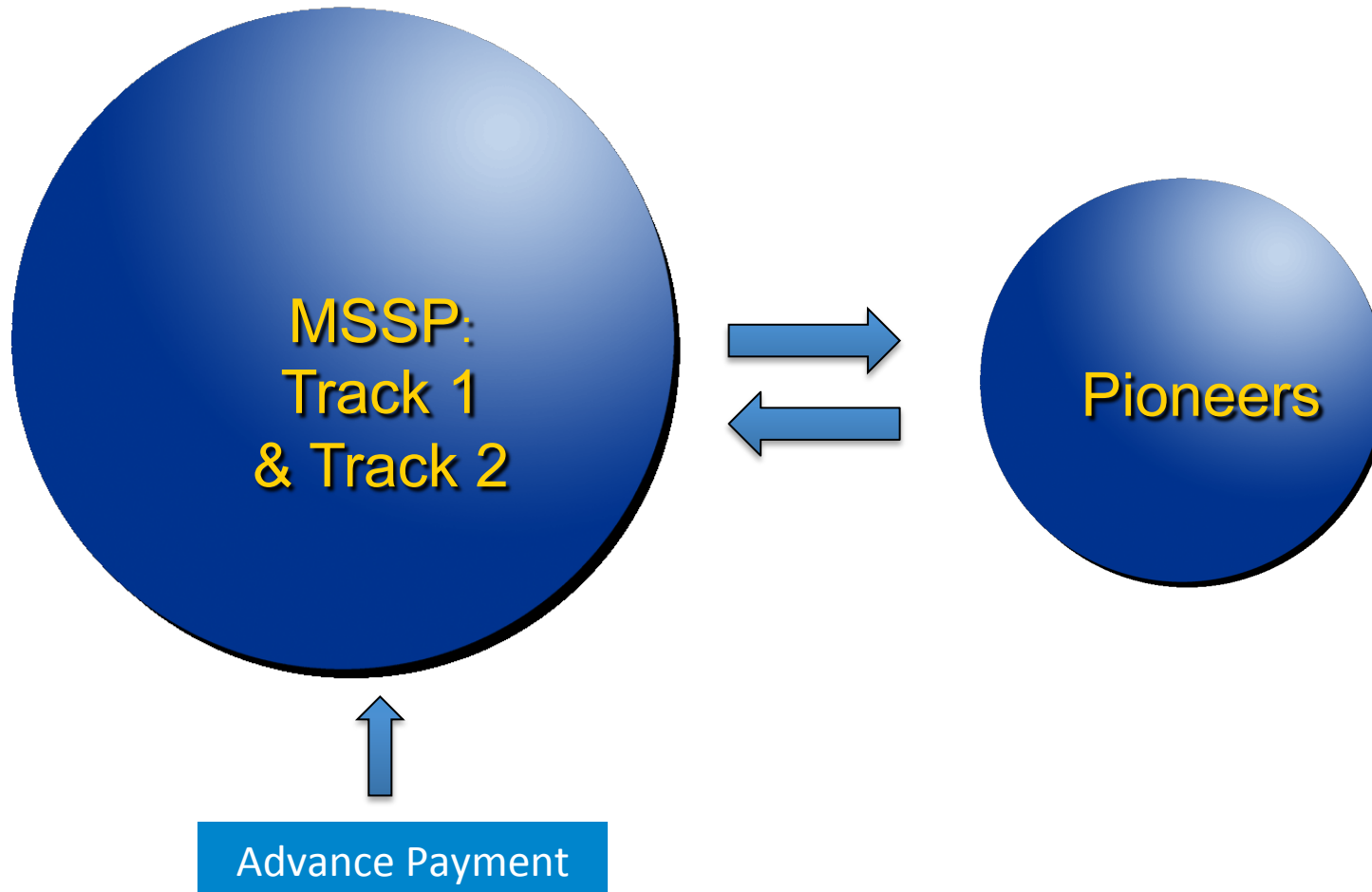


Tools to Empower Learning and Redesign:
Data Sharing, Learning Networks, RECs, PCORI, Aligned Quality Standards

Payment System Reforms

- **Accountable Care Organizations**
- **Hospital Value Based Purchasing**
- **Bundled Payment**
- **Comprehensive Primary Care Initiative**
- **Dual Eligibles**
- **Physician Value Based Modifier**

CMS's ACO Strategy: *Creating Multiple Pathways with Constant Learning and Improving*



Bundled Payments for Care Improvement

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

Practice and Payment Redesign: Comprehensive Primary Care Initiative

SUPPORTIVE MULTIPAYER ENVIRONMENT

Enhanced, accountable payment

Continuous improvement
driven by data

Optimal use of health IT

Comprehensive primary care functions:

- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care.
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood

COMPREHENSIVE
PRIMARY CARE

Aims:

- *Better health*
- *Better care*
- *Lower cost*

Dual Eligibles 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**

Delivery System Reforms

- **Partnership for Patients**
- **Million Hearts Campaign**
- **Innovation Advisors Program**
- **Healthcare Innovation Challenge**
- **State Innovation Model**

Partnership for Patients: Better Care, Lower Costs



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

GOALS:

40% Reduction in Preventable Hospital Acquired Conditions over three years.

- 1.8 Million Fewer Injuries
- 60,000 Lives Saved

20% Reduction in 30-Day Readmissions in Three Years.

- 1.6 Million Patients Recover Without Readmission
- \$35 Billion Dollars Saved in Three Years

Over 3,100 hospitals have signed pledge.

Million Hearts Campaign

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

<u>Focus</u>	simplifying and aligning quality measures; emphasizing importance of improved care of the ABCS'
<u>Health IT</u>	using electronic health records to improve care and enable quality improvement through clinical decision support, patient reminders, registries, and technical assistance.
<u>Care Innovations</u>	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.

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

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.

Health Care Innovation Awards

\$1 Billion to fund innovative service delivery & payment models that are designed to deliver better care, better health, and lower costs through improvement

Key Attributes

- Demonstrates the ability to improve care, achieve better health outcomes for a target population, and proposes a feasible plan for reducing total cost of care for the target population
- Define and test a clear pathway to sustainability
- Support care transformation with enhanced infrastructure activity
- Rapidly enhance or develop and deploy a health care workforce
- Demonstrate progress towards care improvement within 6 months of award

Applicants were encouraged but not limited to focusing on high opportunity populations

- Beneficiaries with multiple chronic diseases
- Beneficiaries with mental health and/or substance abuse issues
- Populations at risk due to socio-economic and environmental factors
- High cost populations
- The frail elderly

Challenge Award Information

Up to \$1 billion committed to 3 award cycles, with individual awards ranging from approximately \$1M to \$30M.

Important Deadlines

December 19, 2011:

Letter of Intent Due

January 27, 2012:

Application Due

March 30, 2012:

Anticipated Award Date

For more information please e-mail InnovationChallenge@cms.hhs.gov

Rapid-Cycle Evaluation

- **“Be part of the solution”**: Gather information and leverage our claims data to promote and support continuous quality improvement in the marketplace.
- **Speed**: Improve our data systems and our ability to use data so that we can frequently and rapidly assess effectiveness and provide feedback to providers.
- **Rigor**: Use advanced epidemiologic methods to measure effectiveness to meet a high standard of evidence and allow for certification.

Our Work Continues...

We are seeking innovative ideas that:

- Improve/Facilitate Coordinated Care
- Promote comprehensive Primary Care
- Align and encourage market/economic forces
- Increase efficiency and unwarranted variation
- Foster wellness and prevention
- Actively engage/activate patients
- Support the availability and use of better information by providers and patients

US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Healthy Population Centered
- Population Health Focused Strategies
- Integrated networks linked to community resources capable of addressing psycho social/ economic needs
- Population based reimbursement
- Learning Organization: capable of rapid deployment of best practices
- Community Health Integrated
- E-health and telehealth capable

Neal Halfon, UCLA Center for Healthier Children, Families

Partnership

Join us on the journey towards coordinated, seamless, reliable, and patient-centered care.

CMS wants to support and work with you to improve health care and reduce costs.



Thank You!

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Resources

- **Innovation Center**
<http://innovations.cms.gov/index.html>
- **Accountable Care Organizations:**
<https://www.cms.gov/ACO/>
- **Million Hearts Campaign:**
www.millionhearts.hhs.gov
- **Partnership for Patients:**
<http://partnershippledge.healthcare.gov/>