

Accelerating Health Care Innovation to Achieve System-Wide Impact: The Role of the Center for Medicare and Medicaid Innovation

Engelberg Center for Health Care Reform

October 18, 2010

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Mark McClellan, MD, PhD

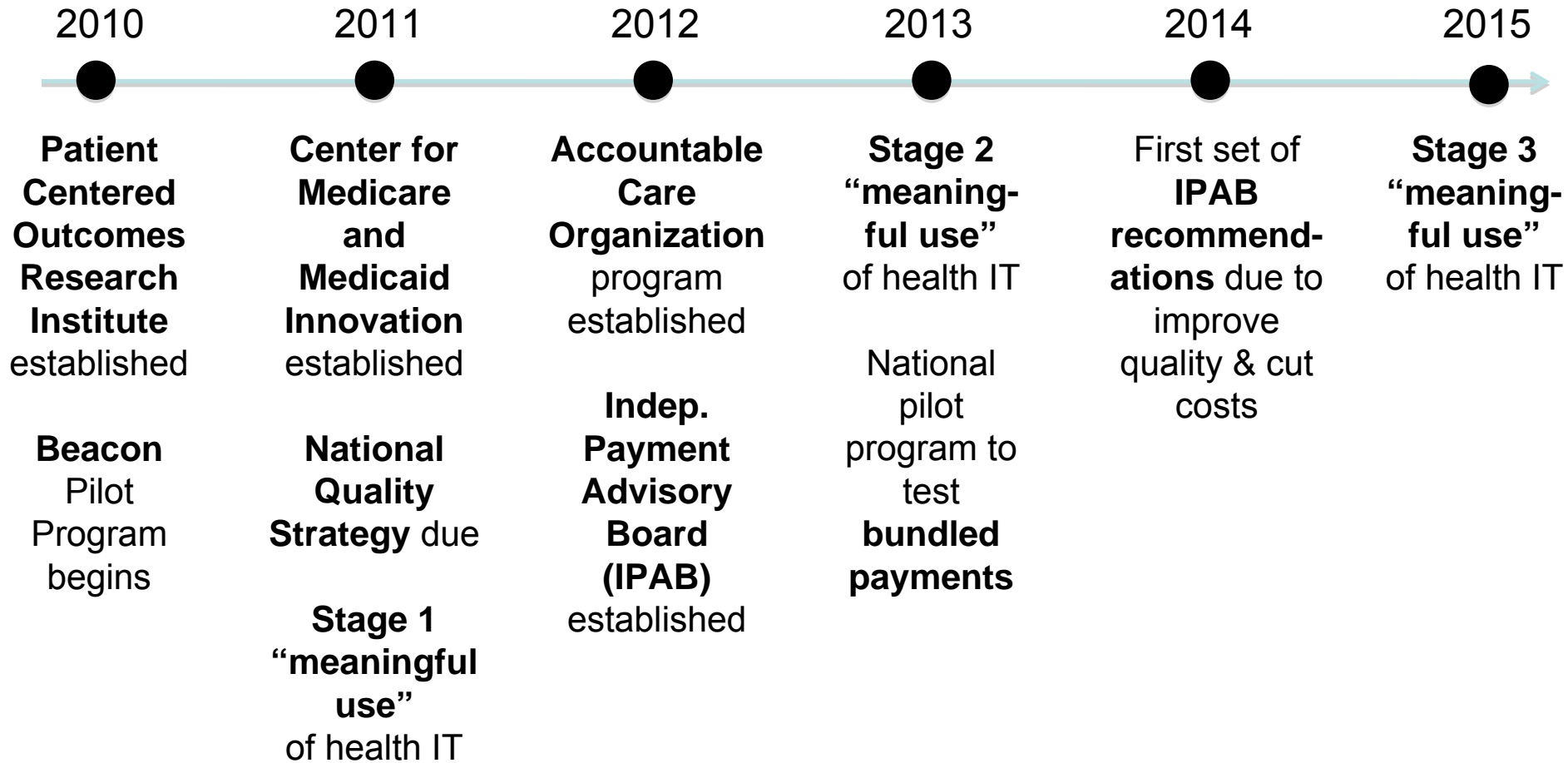
Director, Engelberg Center for Health Care Reform

Senior Fellow, Economic Studies

Leonard D. Schaeffer Chair in Health Policy Studies

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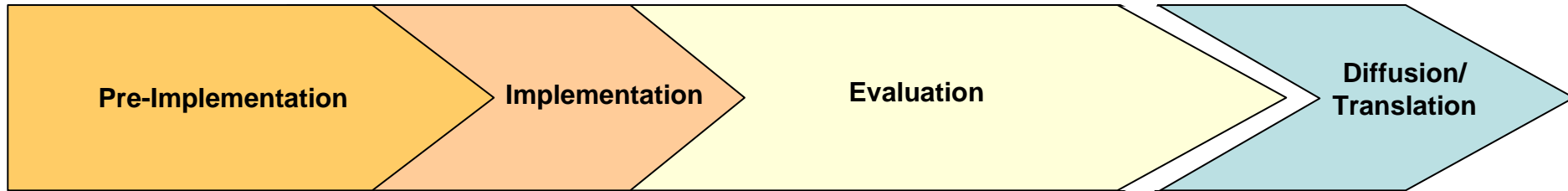
Timelines Established by ACA & ARRA



Case Study: Physician Group Practice Demonstration

Years

1 2 3 4 5 6 7 8 9 10 11 12...



- **Congressional mandate:** Section 412 of (BIPA) mandated PGP Demonstration

- **Defining and redefining design:** 2001 to 2002

- **Solicitation** began in September 2002

- **Site Selection:** August 2003

- **Waiver approved** in October 2004

- **Instruments submitted to OMB for approval** in February 2005;

- **Official start date of demonstration:** April 1st 2005

- **Initial evaluation result** in 2006. However, quality and expenditure performance data were not available

- **Follow-up evaluation:** in 2009, using the data from the first two years of demonstration (i.e. April 2005 to March 2006 and April 2006 to March 2007)

- **Demonstration project ended** on March 31, 2010

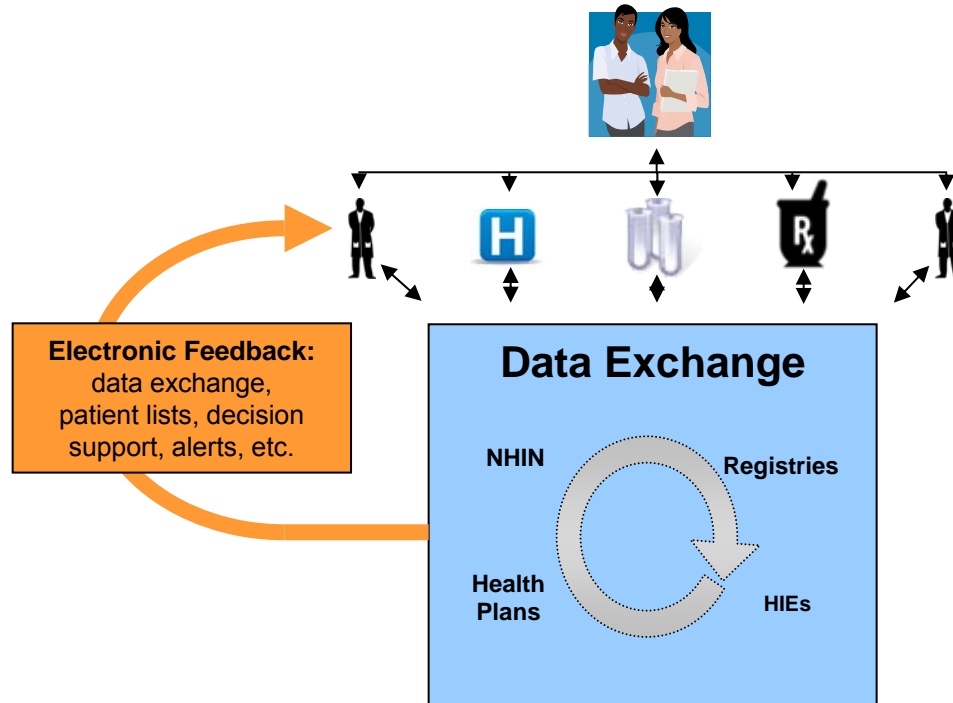
- **Final evaluation** is in the works, should be published in the next year or two (~2011 or 2012)

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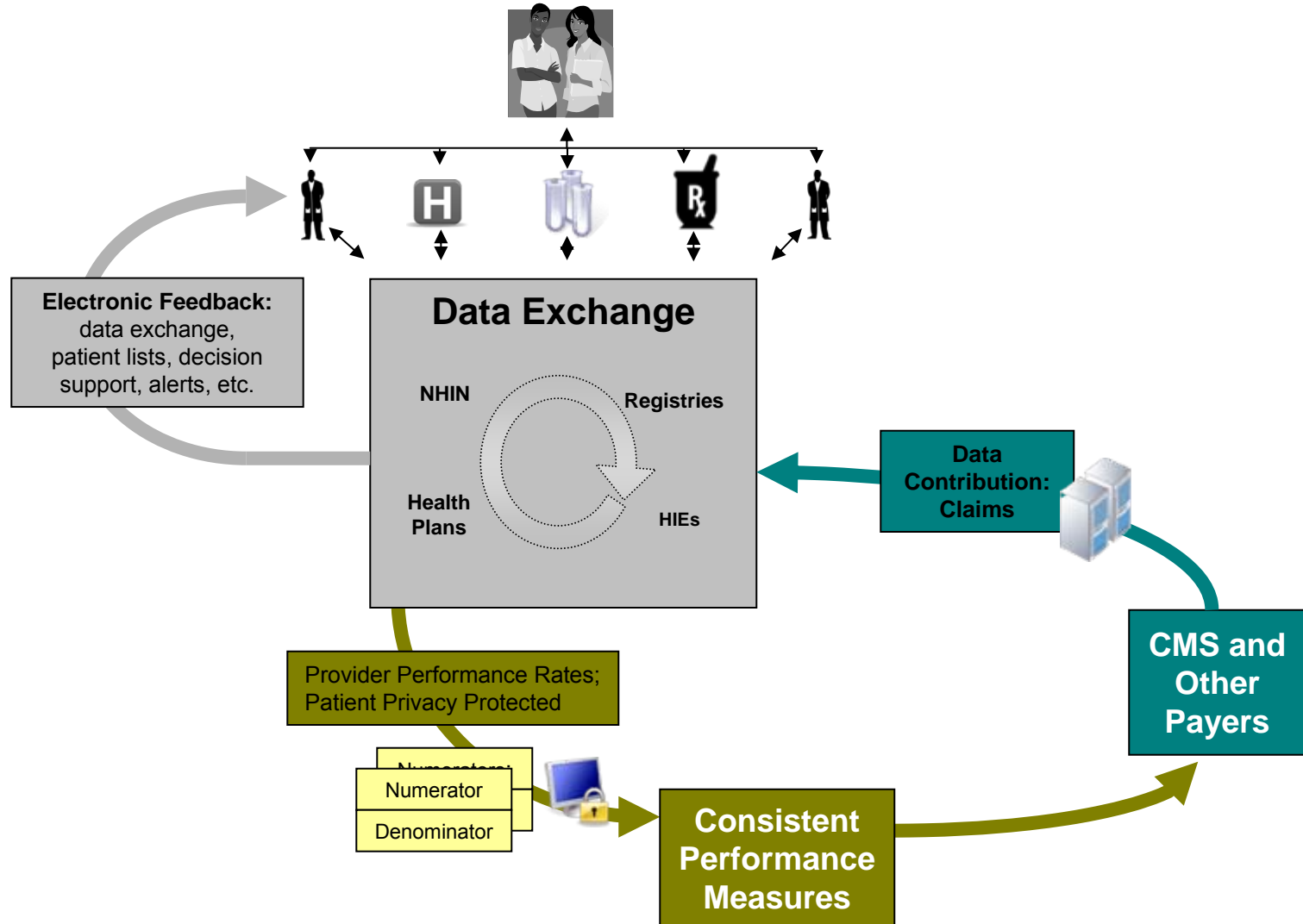
Center for Medicare & Medicaid Innovation (CMI)

- **Purpose:** To test innovative payment & delivery models that lower cost while enhancing or maintaining care quality
- **Established** by January 1, 2011
- **Funding:** \$5 million in 2010 for implementation; \$10 billion for pilots initiated in 2011-2019
- **Two-Stage Structure**
 - Stage 1: selecting and testing innovative models
 - Stage 2: expanding successful models through regulation
- **Greater Flexibility**
 - Successful models (i.e. cost-saving, as determined by OACT) can be expanded by regulation without further legislation
 - Waiver authority, budget neutrality waived (stage 1) and Paperwork Reduction Act waived (stage 1 and 2)
 - Model designs not pre-specified (18 potential models are suggested)

Service Delivery: Better Coordinated and Improved Care Through Data Exchange and Feedback



Payment Models as Levers for Service Delivery Reform



▲ Payment → ▲ Service Delivery → ▲ Quality & Cost

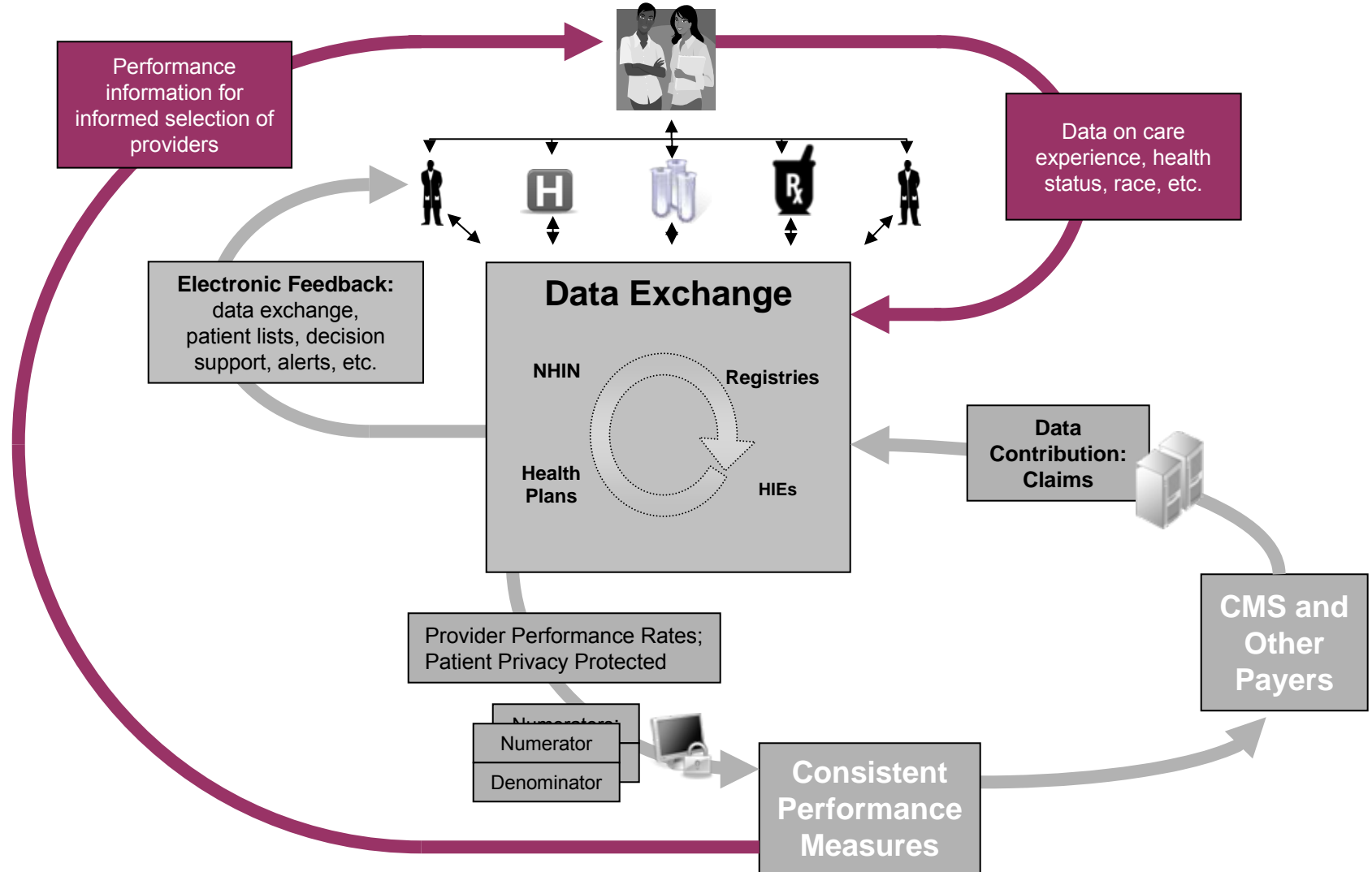
Examples of Payment Models Being Tested to Support Better Care at a Lower Cost

Provider Payment Reforms Support Health Care Reform

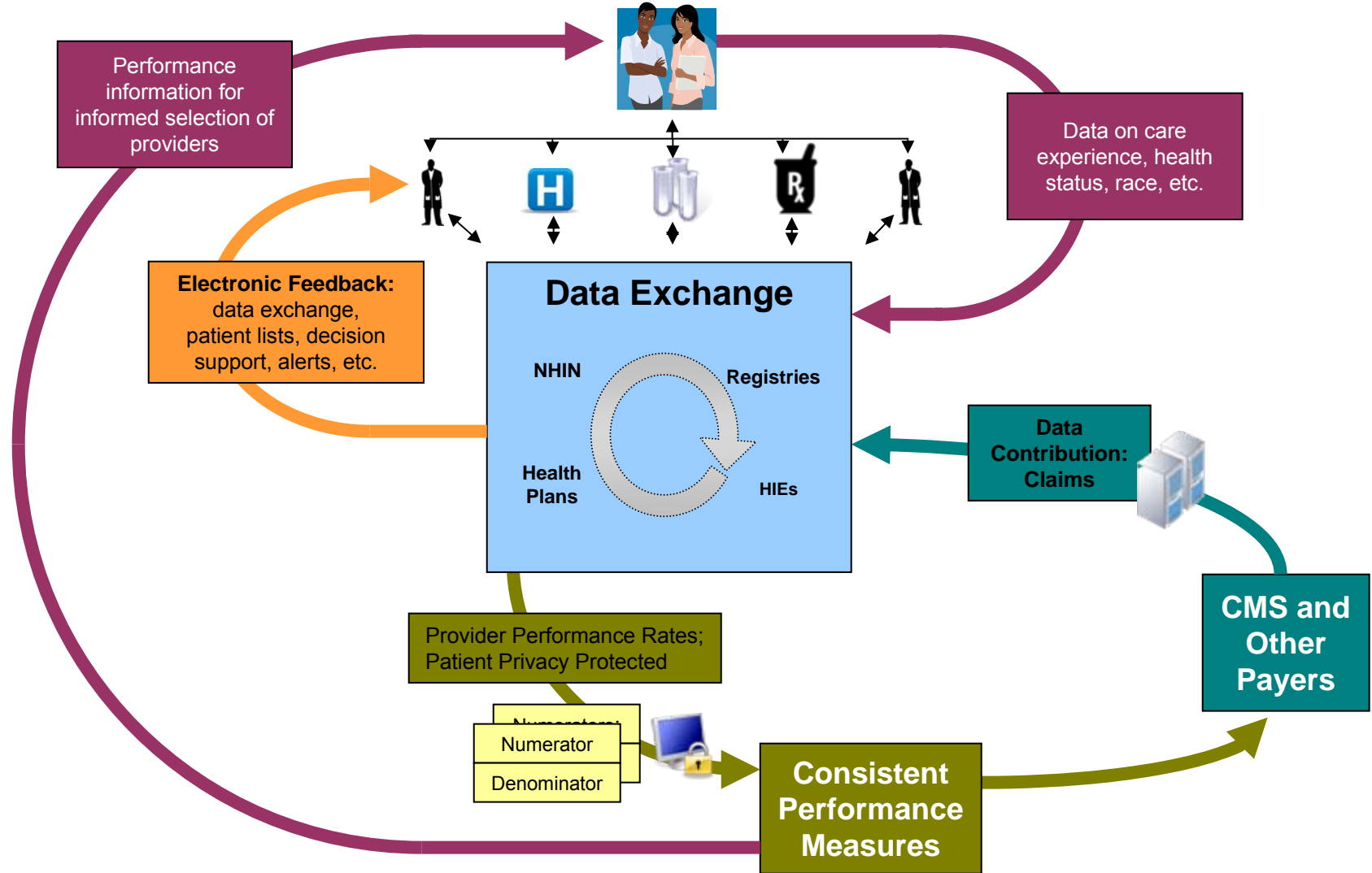


Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
<p>Pay for reporting.</p> <p>Physician Quality Reporting Initiative (PQRI)</p>	<p>Payment for coordination.</p> <p>TransforMED medical home pilots</p>	<p>Pay for performance.</p> <p>Integrated Healthcare Association P4P Program</p>	<p>Episode-based payments.</p> <p>Medicare Acute Care Episode (ACE) Demonstration</p>	<p>Shared savings with quality improvement.</p> <p>Brookings-Dartmouth Accountable Care Organization Pilot Sites</p>	<p>Partial or full capitation with quality improvement.</p> <p>Blue Cross Blue Shield of Massachusetts Alternative Quality Contract</p>

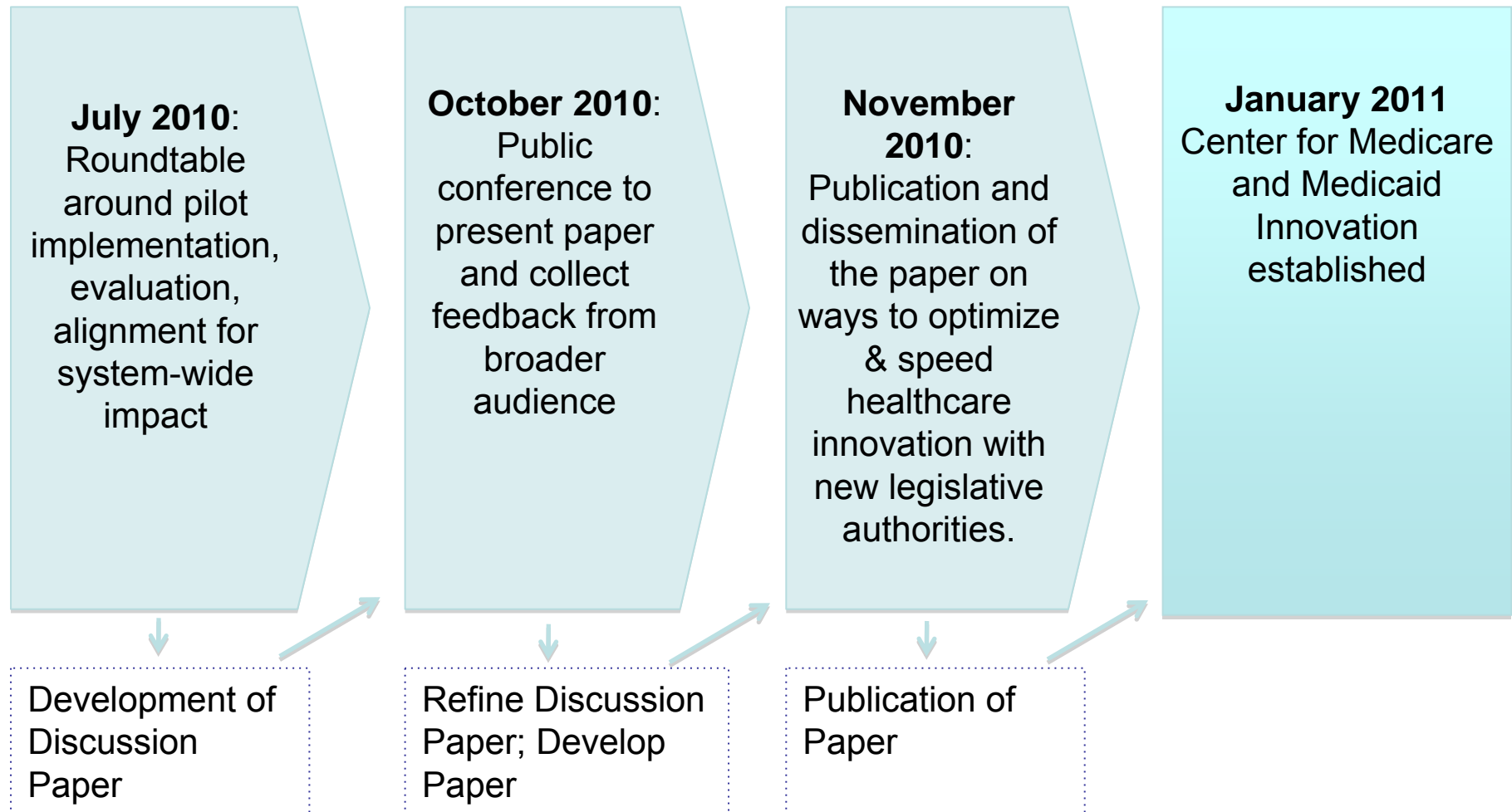
Involving the Consumer



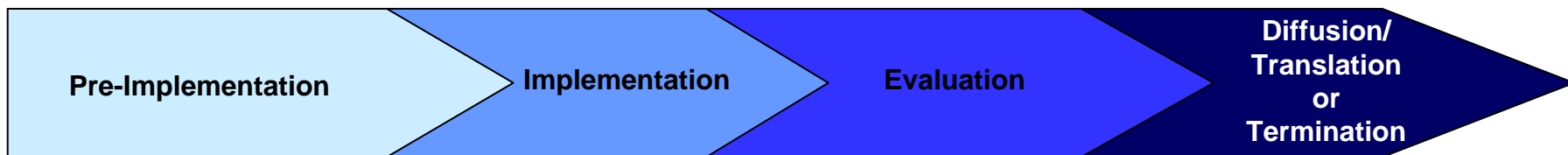
The Result: Better Care at Lower Costs



Development Process for “Accelerating Health Care Innovation to Achieve System-Wide Impact” Paper



Reducing Cycle Time & Assessing System-Wide Impact



Streamlining Pre-Implementation for System-Wide Impact

- **Align investment and performance metrics** with the National Quality Strategy
- **Define clear priorities, results, and performance metrics** with multi-stakeholder collaboration
- **Design with the end in mind:** ensure pilots can be evaluated
- **Optimize pre-implementation process through standardized selection criteria** (e.g. standardized application templates for CMI funding)
- **Leverage projects that have already demonstrated “proof of concept”**

Implementation Strategies to Enable Rapid Evaluation

- **Leverage health IT** for real-time data collection and evaluation
- **Promote nationally consistent data exchange** across payers
- **Utilize alternative research designs** that do not rely on “control counties” and “interventions” (e.g. “enhanced use” of EHR networks for pre/post evaluations).
- **Use data for continuous performance tracking**

Strategies to Reduce Evaluation Time

- **Evaluate system-wide impacts: effects outside of Medicare need to be assessed:**
 - Private sector impacts
 - Impacts on safety net providers
 - Potential disparities
- **Evaluate a model’s efficacy in different settings, markets, and populations**
- **Identify performance measures a priori** to examine evidence of cost and quality impacts & to ensure data capabilities
- **Implement a standard subset of measures** (e.g. overall PMPM costs) to facilitate relative comparisons of pilot impacts

Determining Scaling Up or Termination

- **Facilitate a national platform for knowledge sharing**
- **Determine different management tracks** for sites quickly showing positive results, sites that need to be terminated, and sites meriting continuation and further analysis
- **Ensure upfront understanding of expectations & potential barriers** to ensure pilots are designed to explicitly measure and evaluate for clear outcomes and are aware of challenges.

Format for Today's Meeting

- **Panel I:** Implementing CMI for Efficient Evaluation and System-Wide Impact
- **Keynote:** Overview of CMI and Its Role in Broader Health Care Reform
- **Panel II:** Federal Leadership for System-Wide Impact and Continuous Quality Improvement

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***Implementing the Center for Medicare and
Medicaid Innovation for Efficient Evaluation
and System-Wide Impact***

Allen Dobson, MD FAAFP

Community Care of North Carolina
Carolinas Healthcare System

Implementation and Evaluation Needs for Rapid-Cycle Testing and Learning

- Selecting Promising Payment/Delivery Models
 - Clear templates for evaluating payment reform (*rather than negotiating model designs individually*)
 - Leverage models with demonstrated proof of concept and build the evidence base: ACOs, medical homes, bundled payments
- Implementing Models: Design with end in mind
 - Ability to assess impacts beyond Medicare and unintended consequences
 - All- or multi-payer models
 - Core set of common metrics (including cost measures)
 - Clear performance standards and results (*rather than design standards*)

Implementation and Evaluation Needs for Rapid-Cycle Testing and Learning

- Timely, relevant data and information exchange for continuous real-time evaluation
 - Post-hoc evaluations lead to suboptimal results and potentially long, costly failures
 - Bi-directional data feeds from payers to providers are important for continuous, real-time performance monitoring
 - Timely claims data feeds from CMS and private plans in user-friendly formats for ongoing performance monitoring
 - Ability for providers to report quality and performance information back to CMS and private plans

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Federal Leadership for System-Wide Impact and Continuous Quality Improvement

Jeff Kang, MD, MPH

CIGNA Corporation

Asserting Federal Leadership for System Wide Impact and Continuous Quality Improvement

- Needs
 - **Need #1:** Consistent signals to entire health care system for system-wide impact
 - **Need #2:** Common core quality and cost measures
- Policy Lever: **The National Quality Strategy**
 - Opportunity to articulate clear national priorities, goals, and metrics to guide and align health reform efforts
 - Use of consistent measures in Beacon program and ACOs could enhance collective impact

Asserting Federal Leadership for System Wide Impact and Continuous Quality Improvement

- Needs
 - **Need #3:** Enhanced claims and clinical data availability
 - **Need #4:** Infrastructure for bi-directional data feeds of claims and quality data
 - **Need #5:** Infrastructure for pre/post evaluation of payment and delivery models; performance measurement; comparative effectiveness research; and public health surveillance
- Policy Lever: **ARRA Health IT Funding & MU**
 - Meaningful Use measures will enhance availability and secure exchange of clinical data
 - CMS claims data feeds
 - ARRA funding for data infrastructure

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