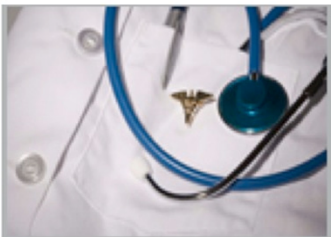


The Center for Medicare and Medicaid Innovation



Brian J. Isetts and John M. O'Brien
COMPREHENSIVE MEDICATION MANAGEMENT AS A
CRITICAL COMPONENT IN COORDINATED CARE
SYSTEMS

October 12, 2011

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.
- We value your insights and commitments to achieving our mission.

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

Meet Josie King



Unfortunately, Josie King's story is not rare.

- On any given day, 1 out of every 20 patients in American hospitals is affected by a hospital-acquired infection.
- Among chronically ill adults, 22 percent report a “serious error” in their care.
- One out of seven Medicare beneficiaries is harmed in the course of their care, costing the federal government over \$4.4 billion each year.
- Medical harm is the fourth leading cause of death in the U.S. Each year, 100,000 Americans die from preventable medical errors in hospitals– more than auto accidents, AIDS, and breast cancer combined.
- Despite pockets of success -- we still see massive variation in the quality of care, and no major change in the rates of harm and preventable readmissions over the past decade.

We can do much better – and we must.

A Future System

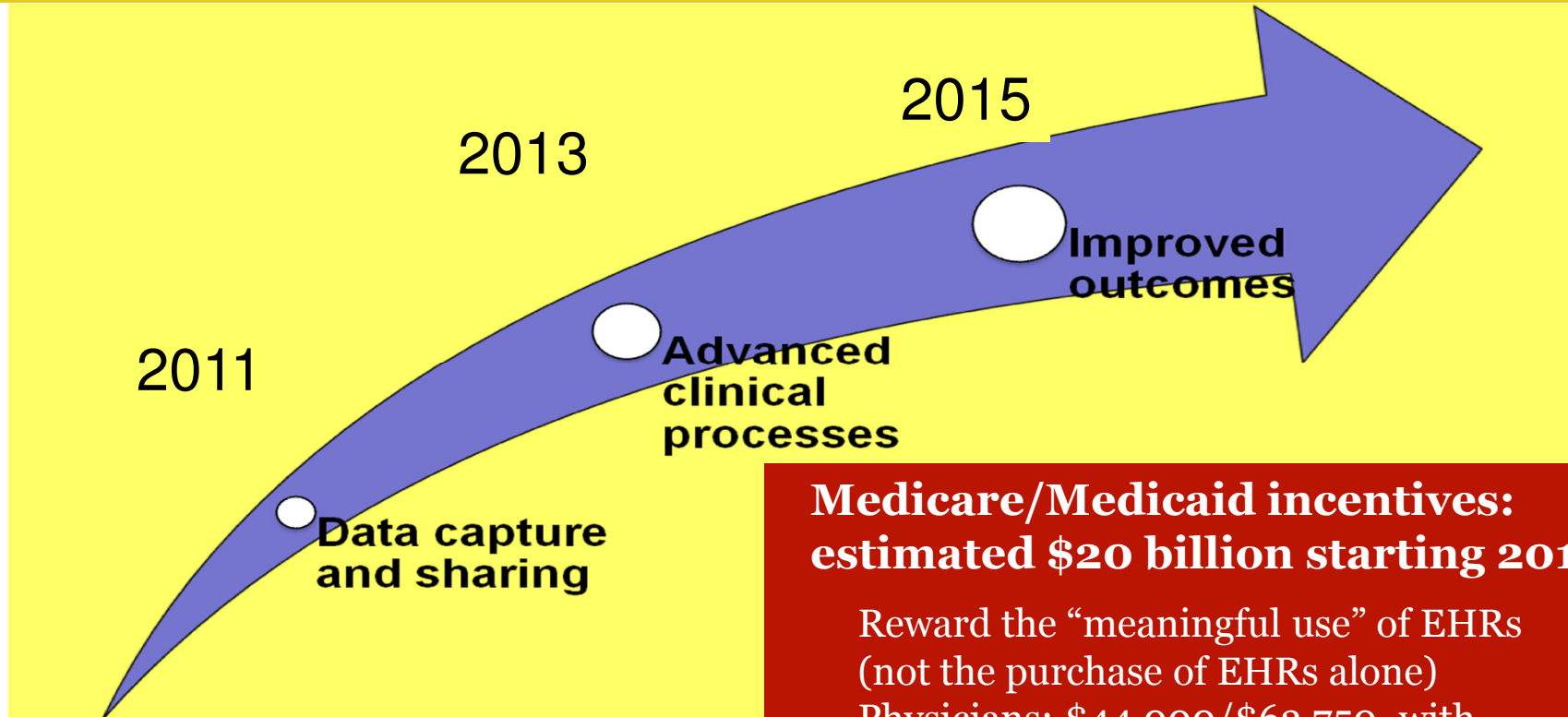
- **Affordable**
- **Accessible** – to care and to information
- **Seamless and Coordinated**
- **High Quality** – timely, equitable, safe
- **Person and Family-Centered**
- **Supportive of Clinicians** in serving their patients needs



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
- Better care will be, overall, less costly care

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

Innovation Will Transform American Health Care

Current State

Producer-Centered

- Fragmented delivery systems with variable quality
- Costs rising at twice the inflation rate
- 17 year lag between best practice discovery and widespread adoption
- Clinicians dissatisfied
- Patients often passive and unengaged

Current payments – part of the problem...

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

PRIVATE
SECTOR

PUBLIC
SECTOR

INNOVATION
CENTER

Future State

People-Centered

- All Americans receive the right care, in the right setting, at the right time, **all** the time
- Health dollars spent efficiently; rate of growth slowed significantly
- Clinical and delivery system best practices diffused rapidly

CMS part of the solution...

- Episode-based payments
- Value-based purchasing
- Accountable Care Organizations
- Patient Centered Medical Homes
- Resource Utilization Reporting
- **Innovation Center**

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

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.”

The Innovation Center Strategy: The Three I's

- **Incentives**

Test models that align payment and administrative approaches that support delivering three part aim outcomes

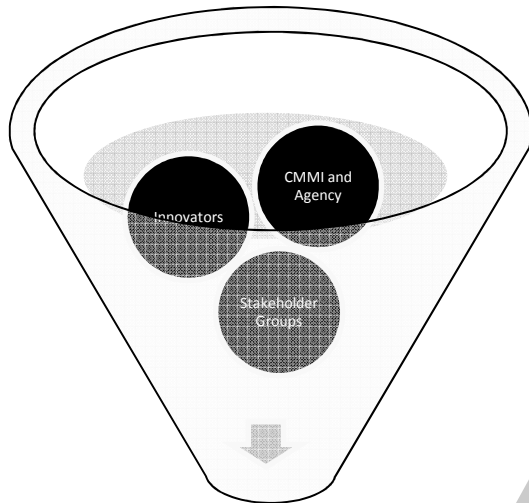
- **Improvement and Spread**

Support development and diffusion of three part aim knowledge, models and operational activities

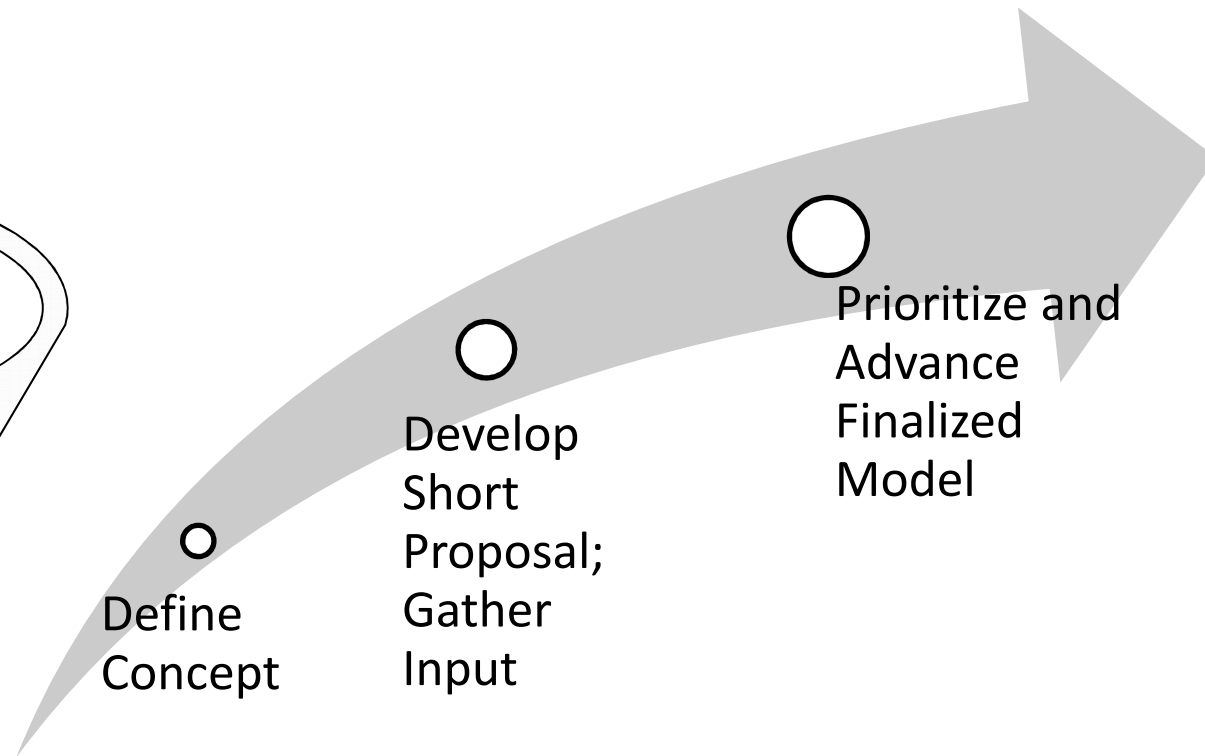
- **Ideas**

Drive development of new ways to deliver three part aim outcomes.

Innovation Center: Pipeline Development



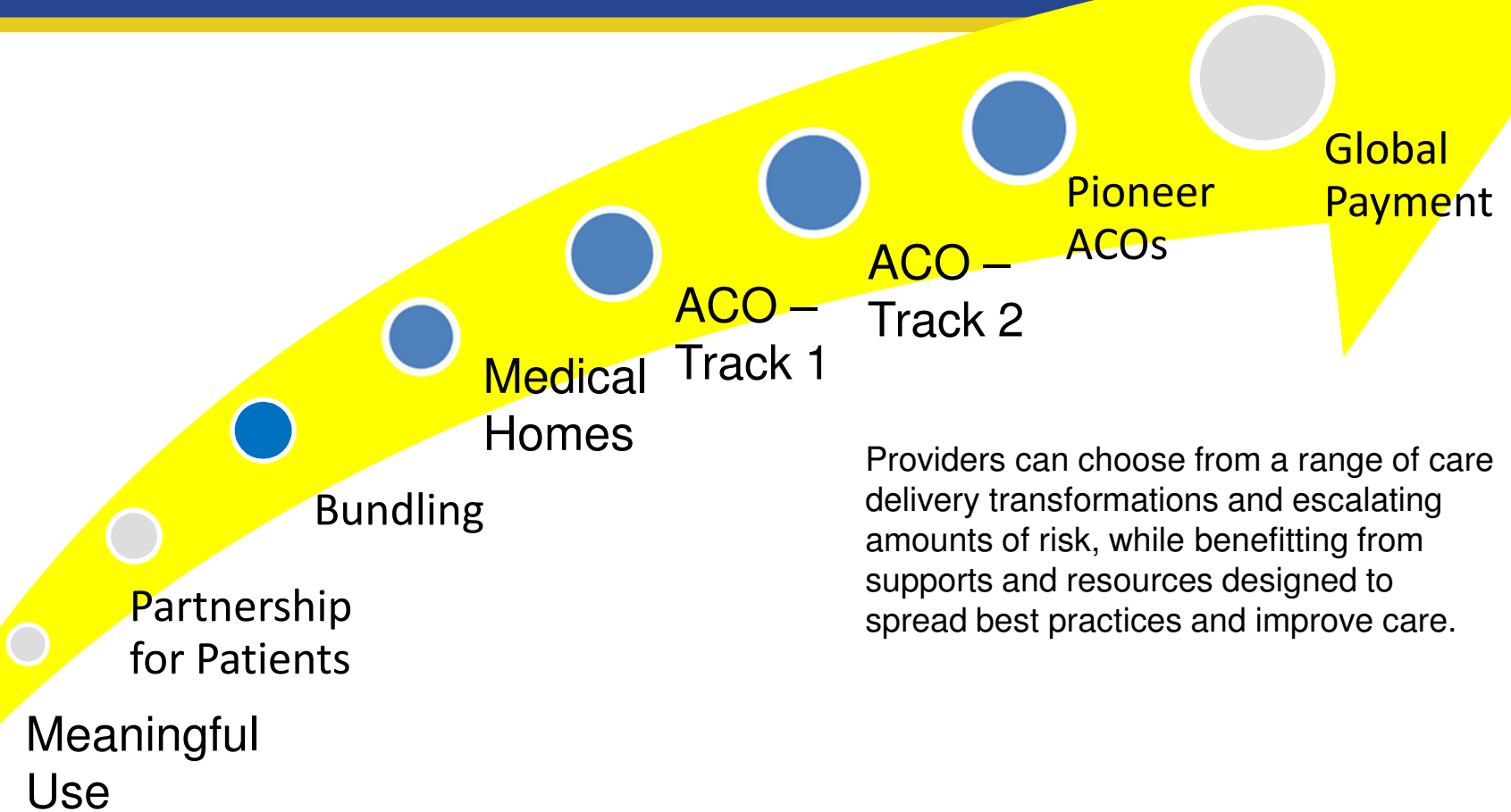
**Ideas for
Consideration**



Our Initial Work on Models

- Partnership for Patients: (1) Patient Safety and (2) Care Transitions
- Imaging Demonstration
- Medicaid Emergency Psychiatric Demonstration
- Bundled Payments for Care Improvement
- Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)
- ACO: Pioneer
- Comprehensive Primary Care Initiative
- Duals: Nursing Home Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.
- Physician Practice Group Demonstration Extension
- Million Hearts

Delivery Reform Continuum



Providers can choose from a range of care delivery transformations and escalating amounts of risk, while benefitting from supports and resources designed to spread best practices and improve care.

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

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 in Three Years**
- Over 2600 hospitals have signed the pledge

Improving Patient Safety and Care Transitions

- The Centers for Medicare and Medicaid Services has committed **up to \$500 million to help hospitals and health care organizations to improve patient care.**
 - Awards coming in the Fall
- The Community-based Care Transitions Program, mandated by section 3026 of the Affordable Care Act, provides the opportunity for community based organizations to partner 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
- Learn more: www.healthcare.gov/partnershipforpatients

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

Comprehensive Primary Care initiative (CPCi)

- CMS-led, multi-payer approach to improving and strengthening our primary care system
- Enhanced payment strategy to provide Primary Care Providers with resources to:
 - **Manage Care for Patients with High Health Care Needs**
 - **Ensure Access to Care**
 - **Deliver Preventive Care**
 - **Engage Patients and Caregivers**
 - **Coordinate Care Across the Medical Neighborhood**
- Medicare will pay approximately \$20 per beneficiary per month to start, then move towards smaller PBPM to be combined with shared savings opportunity

CMS ACO Initiatives

ACO Initiatives at CMS:

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

The Pioneer ACO Model

- Designed for organizations that
 - Are already well on their way to changing care delivery and business model
 - Interested in being the leading edge and 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 are currently under review
- First performance period starting in the beginning of 2012

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

Medication Management in Coordinated Care Systems

- We are seeking commitments and engagement to achieve the bold aims of our National Quality Strategy
 - The effective and safe use of medications is critical to achieving the 3-part aim (better care and improved health at lower expenditures)
 - A significant body of evidence describes the benefits of coordinated medication management
 - Comprehensive medication management is essential in designing a medication use system to help patients achieve intended goals of therapy and to resolve drug therapy problems impeding progress toward goals
 - Drug-related morbidity and mortality is a \$200 billion annual obstacle that needs to be reduced

Importance of Medication Management in HHS Programs and Initiatives

- Agency for Healthcare Research and Quality (AHRQ) – medication management evaluation
- Centers for Disease Control (CDC) – medication management project
- Health Resources and Services Administration (HRSA) – Patient Safety and Clinical Pharmacy Collaborative (PSPC)
- Part D MTM Program – 2011 MTM Fact Sheet
- Office of the National Coordinator (ONC) – Beacon Program communities
- Food & Drug Administration - FDA Safe Use Initiative

CMMI Initiatives that can Benefit from Medication Management

- Community-based Care Transitions (Sec. 3026) applications (go.cms.gov/caretransitions)
- Million Hearts initiative to measure improvements in the ABCS (aspirin, blood pressure, cholesterol, smoking)
- Medical homes benefit when patients use effective and safe medications as intended
- Accountable care organizations benefit from efficient and effective team-based medication management
- Partnership for Patients aims to reduce adverse drug events (hospital acquired conditions) and decrease readmissions

The Partnership is Coming to a Pharmacy Meeting Near You

- American College of Clinical Pharmacy – Pittsburgh (Dr. Don Berwick Address to Pharmacists & Students, Oct. 16th)
- Academy for Managed Care Pharmacy – Atlanta (October 14th: 7:00-8:00 a.m.)
- American Society of Consultant Pharmacists – Phoenix (November 17th: 10:15-11:30 a.m.)
- American Society of Health-System Pharmacists Midyear Meeting – New Orleans (Dec. 7th: 8:00-9:30 a.m.)
- Other exciting 2012 engagement experiences planned

Provide suggestions:



www.innovation.cms.gov

Care Innovations Summit

- January 26th 2012 in Washington DC
- Co-hosted by the Innovation Center, Office of the National Coordinator for Health IT, West Wireless Health Institute, and Health Affairs
 - Showcase care innovation projects that are enabling achievement of the three-part aim
 - Forty (40) or more innovators will be selected to present their work
 - Bring together leading innovators from inside and outside the healthcare industry to facilitate dialogue and drive action towards the three-part aim
- Learn more, including how to register and apply to present your work at the Summit: <http://hcidc.org/>

Partnership

- America needs a people centered, coordinated, sustainable and reliable health care system
- Join us in creating it

Collect Commitments, Offers and Insights

- Please provide us with your insights, suggestions, offers and commitments
- This is the time to step up and make a difference
- Please forward your medication management program suggestions and commitments to:
Brian.Isetts1@cms.hhs.gov 410-786-0110

Thank You

Questions?

Suggestions?

How can we work together?

<http://innovations.cms.gov>

