Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

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Improving the quality and affordability of care received by Americans is, alongside increasing access to it, a core pillar of the Affordable Care Act. The Administration is working to ensure that Americans receive better care; that we spend our health care dollars more wisely; and that we have healthier communities, a healthier economy, and ultimately, a healthier country. This means finding better ways to deliver care, pay providers, and share and utilize information.

The Affordable Care Act offers many tools to improve the way providers are paid to reward quality and value instead of quantity, to strengthen care delivery by better integrating and coordinating care for patients, and to make information more readily available to consumers and providers. Doing so will improve the coordination and integration of health care, engage patients more deeply in decision-making and improve the health of patients – with a priority on prevention and wellness.

It is our role and responsibility to lead this change, and we will lead. At the same time, we understand the importance of engaging partners who are also committed to improving our health care system. Patients, physicians and other providers, government, and businesses all have a stake in this effort.

Significant progress has already been made, thanks to the Affordable Care Act, and other efforts are underway.

Health care cost growth has slowed

The United States is in the midst of a sustained, historic slowdown in the growth of health care costs. The years 2011, 2012, and 2013 saw the slowest growth in real per capita national health expenditures on record, spurred by slow growth in per-beneficiary spending throughout our health care system, including Medicare, Medicaid, and private insurance. Slow growth in the cost of health care continued in 2014, even as millions gained coverage. The average premium for employer-based family coverage increased just 3 percent in 2014, according to the Kaiser Family Foundation, tied for the smallest increase since the Kaiser survey began in 1999. Medicare spending per beneficiary was approximately flat in fiscal year 2014, and from 2010 to 2014, Medicare spending per beneficiary grew at a rate that was 2 percentage points per year less than growth in GDP per capita. Looking forward, due primarily to
the persistent slowdown in health care costs, the Congressional Budget Office now estimates that Federal spending on Medicare and Medicaid in 2020 will be $188 billion below what it projected as recently as August 2010.

**Health outcomes are improving and adverse events are decreasing**

Since 2011, patient safety has improved dramatically, thanks in part to the Partnership for Patients (see below). Patient harm has fallen by 17%, saving 50,000 lives and billions of dollars. As one example, clinicians at some hospitals have reduced their early elective deliveries to close to zero, meaning fewer at-risk newborns and fewer admissions to the neonatal intensive care units.

In 2012, we implemented an Affordable Care Act program that ties Medicare payment for hospitals to readmission rates for certain conditions, i.e. the percentage of patients that have to return to the hospital within 30 days of being discharged. After holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has further decreased to approximately 17.5 percent in 2013. This translates into an 8 percent reduction in the rate and an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.

**Providers are engaged**

The Innovation Center is charged with testing innovative payment and service delivery models to reduce expenditures in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), and at the same time, preserving or enhancing quality of care. Already the Innovation Center is engaged in projects with more than 60,000 health care providers to improve care, and an estimated 2.5 million Medicare, Medicaid and CHIP beneficiaries are receiving care through the Innovation Center’s payment and service delivery models.

For example, in 2012, Medicare Accountable Care Organizations (ACOs) began participating in the Medicare Shared Savings Program and the Pioneer ACO. These programs encourage providers to invest in redesigning care for higher quality and more efficient service delivery, without restricting patients’ freedom to go to the Medicare provider of their choice.

There are 424 organizations currently participating in the Medicare ACOs, serving over 7.8 million Medicare beneficiaries. As existing ACOs choose to add providers and more organizations join the Shared Savings Program, participation in ACOs is expected to grow. Medicare ACOs participating in the Shared Savings Program and the Pioneer ACO Model combined generated over $417 million in savings for Medicare.

**Medicare beneficiaries are shopping for coverage according to quality**

The Affordable Care Act ties payment to private Medicare Advantage plans to the quality ratings of the coverage they offer. Since those payment changes have been in effect, more seniors are able to choose from a broader range of higher quality Medicare Advantage plans, and more seniors have enrolled in these higher quality plans as well.
Approximately 40 percent of Medicare Advantage contracts received four or more stars in 2015, which is an increase from 6 percent in 2013. About 60 percent of Medicare Advantage enrollees are currently enrolled in plans with four or more stars for 2015, an increase of approximately 31 percentage points compared to the percentage in four or five star plans for the 2012 ratings.

Below are specific examples of reforms and investments that help build a health care delivery system that better serves all Americans.

**INCENTIVES: PAYING FOR VALUE:**

* **Hospitals.** Two important programs that reward hospitals based on the quality of care they provide to patients began in 2012, and a third was initiated in 2014.

  * **Hospital Value-Based Purchasing Program.** This program links a portion of hospitals’ Medicare payments for inpatient acute care to their performance on important quality measures. Examples of measures include whether a patient received an antibiotic before surgery, and how well doctors and nurses communicate with patients. For FY 2015, as directed by the law, CMS increased the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, from 1.25 to 1.5 percent of the base operating DRG payment amounts to all participating hospitals.

  * **Hospital Readmissions Reduction Program.** This program reduces Medicare payments to hospitals with excess readmissions beginning October 2012 to encourage patient safety and care quality. In FY 2015, the maximum reduction in payments under the Hospital Readmissions Reduction Program increased from 2 to 3 percent of base discharge amounts, as required by law. CMS will assess hospitals’ readmissions penalties using five readmissions measures endorsed by the National Quality Forum.

  * **Hospital-Acquired Condition Reduction Program.** This program, authorized by the Affordable Care Act, began in October 2014 and reduces Medicare payments for some hospitals that rank in the worst performing quartile with respect to hospital-acquired conditions (HACs), which is determined based on the hospital’s performance on three quality measures (Patient Safety Indicator 90 composite, central-line associated bloodstream infection and catheter associated urinary tract infection). Additional safety measures for measures such as surgical site infections and methicillin resistant staph aureus infections have been added for future years.

* **Dialysis Facilities.** The End-Stage Renal Disease (ESRD) Quality Incentive Program ties Medicare payments directly to facility performance on quality measures, resulting in better care at lower cost for over 503,000 Medicare beneficiaries with end stage renal disease. In addition, a new comprehensive care model announced in January 2013 will test a new payment and service delivery approach to improve care for ESRD beneficiaries, by coordinating primary care with care for their special health needs.

* **Testing New Payment Models:** The Innovation Center is testing innovative payment and service delivery models that are already seeing results.
**Pioneer Accountable Care Organization Model.** Nineteen ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Preliminary results from the independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of $147 million in their first year. During the second performance year, Pioneer ACOs generated estimated total model savings of over $96 million and savings to the Medicare Trust Funds of approximately $41 million. Pioneer ACOs also outperformed published quality benchmarks in year one and improved in almost all quality and patient experience measures in year two. When combined with ACOs in the Medicare Shared Savings Program, there are 424 organizations currently participating in the Medicare ACOs, and these two programs combined generated over $417 million in savings for Medicare since 2012.

**Bundled Payments for Care Improvement initiative.** The initiative currently has 105 Awardees in Phase 2 (risk-bearing), including 38 conveners of health care organizations, representing 243 Medicare organizational providers. Additionally within Phase 1 of the initiative are 870 participants, including 138 conveners of health care organizations, representing 6,424 Medicare organizational providers. They are testing how bundling payments for episodes of care can result in more coordinated care for Medicare beneficiaries and lower costs for Medicare. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged.

**Health Care Innovation Awards.** The Health Care Innovation Awards Round One are funding up to $1 billion in awards to 107 organizations across the country that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP. The Health Care Innovation Awards Round Two are funding up to $360 million to 39 organizations to test new payment and service delivery models.

**CARE DELIVERY: PROMOTING BETTER CARE AND PROTECTING PATIENT SAFETY:**

**Comprehensive Primary Care Initiative.** The Innovation Center is currently testing the Comprehensive Primary Care Initiative (CPC), which is a multi-payer partnership between Medicare, Medicaid private health care payers, and primary care practices in four states (Arkansas, Colorado, New Jersey and Oregon) and three regions (New York’s Capital District and Hudson Valley, Ohio and Kentucky’s Cincinnati-Dayton region, and Oklahoma’s Greater Tulsa region). This initiative includes providing care management for those at greatest risk; improving health care access; tracking patient experience; coordinating care with hospitals and specialists; and using health information technology to support population health. Practices receive non-visit based care management fees from the participating payers, and the opportunity to share in savings. Results from the first year suggest that CPC has generated nearly enough savings in Medicare health expenditures to offset care management fees paid by CMS, with hospital admissions decreasing by 2% and emergency department visits by 3%. Results should be interpreted cautiously as effects are emerging earlier than anticipated, and additional research is needed to assess how the initiative affects cost and quality of care beyond the first year.
• **Multi-Payer Advanced Primary Care Initiative.** The Innovation Center is currently testing the Multi-Payer Advanced Primary Care Practice (MAPCP), which is a multi-payer initiative in which Medicare is participating with Medicaid and private health care payers in eight advanced primary care initiatives in Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. Under this demonstration, participating practices and other auxiliary supports (e.g., community health teams) receive monthly care management fees from the participating payers and additional support (e.g., data feedback, learning collaboratives, practice coaching). More than 3,800 providers, 700 practices, and 400,000 Medicare beneficiaries participated in the first year. Unlike CPC, the eight states participating in MAPCP convene the participants and administer the initiatives rather than CMS. During the first year, the demonstration produced an estimated $4.2 million in savings. Also, the rate of growth in Medicare FFS health care expenditures was reduced in Vermont and Michigan, driven largely by reduced growth in inpatient expenditures.

• **Partnership for Patients.** The nationwide Partnership for Patients initiative, launched in April 2011 with funds provided by the Affordable Care Act, aims to save 60,000 lives by averting millions of hospital acquired conditions over three years by reducing complications and readmissions and improving the transition from one care setting to another. At the core of this initiative are 26 Hospital Engagement Networks, which work with 3,700 hospitals (representing 80% of the American population), working with health care providers and institutions, to identify best practices and solutions to reducing hospital acquired conditions and readmissions. As of December 2014, an HHS report shows an estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. Preliminary estimates show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

• **Supporting practice transformation.** In October 2014, CMS announced the Transforming Clinical Practice Initiative (TCPI), which is designed to help clinicians achieve large-scale health transformation through an over $800 million investment. Specifically, the initiative is designed to support 150,000 clinician practices over the next four years in sharing, adapting and further developing comprehensive quality improvement strategies. TCPI is one of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation.

• **Healthy infants.** The Strong Start for Mothers and Newborns initiative, announced in February 2012, aims to reduce early elective deliveries as well as test models to decrease preterm births among high-risk pregnant women in Medicaid and the Children’s Health Insurance Program (CHIP). The initiative builds on the work of the Partnership for Patients, testing ways to support providers in reducing early elective deliveries. It also provides over $11.7 million to 27 awardees to test enhanced prenatal care interventions to lower the risk of preterm birth among pregnant women with Medicaid or CHIP. As part of this initiative, clinicians at some hospitals have reduced their early elective deliveries to close to zero, meaning fewer at-risk newborns and fewer admissions to the neonatal intensive care unit. From 2010 to 2013, there was a reduction of 64.5 percent in early elective deliveries, reflecting the collaborative efforts of providers, private sector organizations, and government toward the shared goal of improved birth outcomes.
• **Better coordination of care for beneficiaries with multiple chronic conditions.** Under this year’s rulemaking, the Medicare Physician Fee Schedule will include a new chronic care management fee beginning next year. This separate payment for chronic care management will support physician practices in their efforts to coordinate care for Medicare beneficiaries with multiple chronic conditions. This helps improve the way care is provided by supporting clinicians coordinating care for patients, including outside of regular office visits.

• **Providing states with additional flexibility and resources to enhance care.** The State Innovation Models Initiative aims to help states deliver high-quality health care, lower costs, and improve their health system performance. Together with awards released in early 2013, over half of states (34 states and 3 territories and the District of Columbia), representing nearly two-thirds of the population are participating in efforts to support comprehensive state-based innovation in health system transformation aimed at finding new and innovative ways to improve quality and lower costs. Seventeen states are currently implementing comprehensive state-wide health transformation plans (Arkansas, Colorado, Connecticut, Delaware, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New York, Ohio, Oregon, Rhode Island, Tennessee, Vermont and Washington).

• **Integrating care for individuals enrolled in Medicare and Medicaid.** Many of the ten million Medicare-Medicaid enrollees suffer from multiple or severe chronic conditions. Total annual spending for their care is approximately $300 billion. Twelve states (California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia and Washington) have entered into agreements with CMS to integrate care for Medicare-Medicaid enrollees. Enrollees participating in the Financial Alignment Initiative may have access to coordinated services, and some states offer services that were not available outside of this demonstration, like dental, vision, and community-based behavioral health services. These demonstrations are designed to provide enrollees with person-centered, integrated care that provides a more easily navigable and seamless path to accessing and using services covered by Medicare and Medicaid.

• **Greater independence for Americans with disabilities and long-term care needs.** The Affordable Care Act includes a number of policies to promote non-institutional long-term care programs that will help keep people at home and out of institutions:

  • **Money Follows the Person Program.** The Money Follows the Person Program helps states rebalance their long-term care systems in part by transitioning Medicaid beneficiaries from institutions to the community. As of December 2013, over 40,650 individuals with chronic conditions and disabilities have transitioned from institutions back into the community through Money Follows the Person Program. The 44 participating States and DC have proposed to transition an additional 25,816 individuals out of institutional settings through 2016.

  • **Balancing Incentive Program.** Nineteen states are participating in the Balancing Incentive Program, which gives states incentives to increase access to non-institutional long-term services and supports and provides new ways to serve more Medicaid beneficiaries in home and community-based settings.
• **Health Home State Plan Amendments.** Sixteen states have approved Health Home State Plan Amendments to integrate and coordinate primary, acute, behavioral health, and long term services and supports for Medicaid beneficiaries.

• **Promoting care at home.** An Affordable Care Act demonstration, Independence at Home, tests whether providing chronically ill beneficiaries with primary care in the home will help them stay healthy and out of the hospital. Fourteen primary care practices and three consortia of physician practices are participating in the Independence at Home Demonstration.

**INFORMATION: IMPROVING THE AVAILABILITY OF INFORMATION TO GUIDE DECISION-MAKING**

• **Electronic Health Records (EHRs).** Adoption of electronic health records continues to increase among physicians, hospitals, and others serving Medicare and Medicaid beneficiaries helping to evaluate patients’ medical status, coordinate care, eliminate redundant procedures, and provide high-quality care. The proportion of U.S. physicians using EHRs increased from 18% to 78% between 2001 and 2013, and 94% of hospitals now report use of certified EHRs. Electronic health records likely will help speed the adoption of many other delivery system reforms, by making it easier for hospitals and doctors to better coordinate care and achieve improvements in quality.

• **Access to Cost, Charge, and Quality Data:** Cost and charge data for hundreds of services (inpatient, outpatient, and physician services) and quality scores for hundreds of thousands of hospitals, physicians, nursing homes, and other providers are now available on the Medicare website. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

• **Physician Compare.** Physician Compare, a website created by the Affordable Care Act, helps consumers make informed choices about the health care they receive from Medicare physicians and other health care professionals. Currently, users have the ability to compare the general information for up to three group practices on Physician Compare. This includes names, addresses, distance from the search location, specialty, Medicare assignment, and affiliated health care professionals. The first quality measures were added to Physician Compare in February 2014, and since then, the number of groups reporting quality data through the Physician Quality Reporting System (PQRS) has doubled. In 2015, CMS plans to expand Physician Compare to include quality performance results for all physician groups.

• **Hospital Compare.** Hospital Compare helps consumers make informed choices about the health care they receive from hospitals. Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals- across the country and includes measures such as access to timely and effective care, readmissions, and patient experience, among many others. Beneficiaries also can now find information on the incidence of serious hospital-acquired conditions in individual hospitals. In FY 2015, hospitals with high rates of hospital-acquired conditions will see their Medicare payments reduced.

• **Charge Data for Hospital and Physician Services.** In May 2013, HHS released for the first time new data showing variation across the country and within communities on what hospitals charge
for common inpatient services. The data posted on CMS’s website include information comparing the charges for services that may be provided during the 100 most common Medicare inpatient stays. Hospitals determine what they will charge for items and services provided to patients and these “charges” are the amount the hospital generally bills for an item or service. The website also includes data on outpatient charges. In April 2014, CMS updated the hospital data and released for the first time comprehensive data on physician utilization and charges in the Medicare program.

• Qualified Entity Program. The Qualified Entity (QE) Program, created by the Affordable Care Act, allows organizations approved as qualified entities (QEs) access to Medicare data to produce public performance reports on physicians, hospitals, and other providers. These reports combine private sector and/or Medicaid claims data with the Medicare data to identify which hospitals and doctors provide the highest quality, cost-effective care. QEs must protect the privacy and security of the Medicare claims data and may use it only for purposes of the QE Program. To date, CMS has certified 12 regional QEs and one national QE. Two of the regional QEs, Q-Corp and Health Insight, released public reports using the combined Medicare and other payer data in 2014.

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