Reinventing Health Care: Health System Transformation

Aspen Institute

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September 25, 2013
• Our Goals and Early Results
• Value-based purchasing and quality improvement programs
• Center for Medicare and Medicaid Innovation
• Quality Measurement to Drive Improvement
• Future and Opportunities for collaboration
Size and Scope of CMS Responsibilities

• CMS is the largest purchaser of health care in the world (approx $900B per year)

• Combined, Medicare and Medicaid pay approximately one-third of national health expenditures.

• CMS programs currently provide health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP (Children’s Health Insurance Program); or roughly 1 in every 3 Americans.

• The Medicare program alone pays out over $1.5 billion in benefit payments per day.

• CMS answers about 75 million inquiries annually.

• Millions of consumers will receive health care coverage through new health insurance programs authorized in the Affordable Care Act.
We need delivery system and payment transformation

**Current State** – Producer-Centered
- Volume Driven
- Unsustainable
- Fragmented Care Systems
- FFS Payment Systems

**Future State** – People-Centered
- Outcomes Driven
- Sustainable
- Coordinated Care Systems

**New Payment Systems**
- Value-based purchasing
- ACOs Shared Savings
- Episode-based payments
- Care Management Fees
- Data Transparency
The “3T’s” Road Map to Transforming U.S. Health Care

Key T1 activity to test what care works
Clinical efficacy research

Clinical efficacy knowledge

Key T2 activities to test who benefits from promising care
Outcomes research
Comparative effectiveness research
Health services research

Clinical effectiveness knowledge

Key T3 activities to test how to deliver high-quality care reliably and in all settings
Quality Measurement and Improvement
Implementation of Interventions and health care system redesign
Scaling and spread of effective interventions
Research in above domains

Basic biomedical science

Improved health care quality & value & population health

Transformation of Health Care at the Front Line

• At least six components
  – Quality measurement
  – Aligned payment incentives
  – Comparative effectiveness and evidence available
  – Health information technology
  – Quality improvement collaboratives and learning networks
  – Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5
Early Example Results

- Cost growth leveling off - actuaries and multiple studies indicated partially due to “delivery system changes”
- But cost and quality still variable
- Moving the needle on some national metrics, e.g.,
  - Readmissions
  - Line Infections
- Increasing value-based payment and accountable care models
- Expanding coverage with insurance marketplaces gearing up for 2014
Results: Medicare Per-Capita Spending Growth at Historic Low

Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget
Wide Variation in Spending Across the Country: CT Scans

CT Scans Per Capita Spending* (2011)

Fort Myers, FL
$117 per capita

Honolulu, HI
$49 per capita

National Average = $76

Ratio to the national average

*includes institutional and professional spending
Medicare All Cause, 30 Day Hospital Readmission Rate

Source: Office of Information Products and Data Analytics, CMS
Over 1,000 ICUs achieved an average 41% decline in CLABSI over 6 quarters (18 months), from 1.915 to 1.133 CLABSI per 1,000 central line days.
Discussion

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The Six Goals of the National Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable
CMS has a variety of quality reporting and performance programs, many led by CCSQ

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality Reporting</th>
<th>PAC and Other Setting Quality Reporting</th>
<th>Payment Model Reporting</th>
<th>“Population” Quality Reporting</th>
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<tbody>
<tr>
<td>• Medicare and Medicaid EHR Incentive Program</td>
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<td>• Inpatient Rehabilitation Facility</td>
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<td>• PPS-Exempt Cancer Hospitals</td>
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<td>• Inpatient Psychiatric Facilities</td>
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<td>• Inpatient Quality Reporting</td>
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<td>• HAC payment reduction program</td>
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<td>• Readmission reduction program</td>
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<td>• Home Health Quality Reporting</td>
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CMS framework for measurement maps to the six national priorities

**Greatest commonality of measure concepts across domains**

- Measures should be patient-centered and outcome-oriented whenever possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

### Clinical quality of care
- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

### Person- and Caregiver-centered experience and engagement
- CAHPS or equivalent measures for each setting
- Shared decision-making

### Care coordination
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

### Population/ community health
- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

### Efficiency and cost reduction
- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

### Safety
- Healthcare Acquired Infections
- Healthcare acquired conditions
- Harm

### Preventive Quality of Care
Quality can be measured and improved at multiple levels

- Measure concepts should “roll up” to align quality improvement objectives at all levels

- Patient-centric, outcomes oriented measures preferred at all three levels

- The six NQS domains can be measured at each of the three levels

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**Community**
- Population-based denominator
- Multiple ways to define denominator, e.g., county, HRR
- Applicable to all providers

**Practice setting**
- Denominator based on practice setting, e.g., hospital, group practice

**Individual clinician and patient**
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician’s total performance

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Increasing individual accountability

Increasing commonality among providers
Value-Based Purchasing

• Goal is to reward providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

• Hospital value-based purchasing program shifts approximately $1 billion based on performance

• Five Principles
  - Define the end goal, not the process for achieving it
  - All providers’ incentives must be aligned
  - Right measure must be developed and implemented in rapid cycle
  - CMS must actively support quality improvement
  - Clinical community and patients must be actively engaged

VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012
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The CMS Innovation Center

Identify, Test, Evaluate, Scale

The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

- The Affordable Care Act
CMS Innovations Portfolio: Testing New Models to Improve Quality

**Accountable Care Organizations (ACOs)**
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

**Primary Care Transformation**
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

**Bundled Payment for Care Improvement**
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

**Capacity to Spread Innovation**
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

**Health Care Innovation Awards**

**State Innovation Models Initiative**

**Initiatives Focused on the Medicaid Population**
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

**Medicare-Medicaid Enrollees**
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
Innovation is happening broadly across the country
Accountable Care Organizations (ACOs) Vision

• An ACO promotes seamless coordinated care
  – Puts the beneficiary and family at the center
  – Attends carefully to care transitions
  – Manages populations of patients
  – Evaluates data to improve care and patient outcomes
  – Innovates around better health, better care and lower growth in costs through improvement
  – Invests in team-based care, workforce, and quality infrastructure
4 million Medicare beneficiaries having care coordinated by 220 SSP and 32 Pioneers ACOs
(Geographic Distribution of ACO Population)
State Innovation Models

GOALS:

• Partner with states to develop broad-based State Health Care Innovation Plans
• 6 Implementation and 19 Design/Pre-testing States
• Plan, Design, Test and Support of new payment and service and delivery models
• Utilize the tools and policy levers available to states
• Engage a broad group of stakeholders in health system transformation
• Coordinate multiple strategies, payers, and providers into a plan for health system improvement
GOAL: Test new innovative service delivery and payment models that will deliver better care and lower costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) enrollees.

• Test models in four categories:
  1. Reduce Medicare, Medicaid and/or CHIP expenditures in *outpatient and/or post-acute settings*
  2. Improve care for *populations with specialized needs*
  3. Transform the *financial and clinical models for specific types of providers and suppliers*
  4. Improve the *health of populations*
Partnership for Patients: Hospitals Continue to Generate Increases in Reporting, Improvement and Achievement on More Harm Areas

- Reporting on 5 or More HACs
- Improving on 5 or More HACs
- Showing Benchmark Status on 5 or More HACs
Innovation Center
2013 Looking Forward

We’re Focused On

• Implementation of Models
• Monitoring & Optimization of Results
• Evaluation and Scaling
• Integrating Innovation across CMS
• Portfolio analysis and launch new models to round out portfolio
Possible Model Concepts

• Outpatient specialty models
• Practice Transformation Support
• Health Plan Innovation
• Consumer Incentives
• ACOs version 2.0
• Home Health
• SNF
• More.....
Cost trends are down, Outcomes are Improving & Adverse Events are Falling

- Total U.S. health spending grew only 3.9 percent in 2011
- Medicare trend over 3 years at historic lows - +.4% in 2012
- Medicaid spending per beneficiary has decreased over last two years - .9% and .6% in 2011 and 2010
- Pioneer model with early promising results, Partnership for Patients
- Expanding coverage with insurance marketplaces gearing up for 2014
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The Future of Quality Measurement for Improvement and Accountability

- Meaningful quality measures increasingly need to transition away from setting-specific, narrow snapshots
- Reorient and align measures around patient-centered outcomes that span across settings
- Measures based on patient-centered episodes of care
- Capture measurement at 3 main levels (i.e., individual clinician, group/facility, population/community)
- Why do we measure?
  - Improvement

Source: Conway PH, Mostashari F, Clancy C. The Future of Quality Measurement for Improvement and Accountability. JAMA 2013 June 5; Vol 309, No. 21 2215 - 2216
Opportunities and Challenges of a Lifelong Health System

• Goal of system to optimize health outcomes and lower costs over much longer time horizons
• Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time
• Health trajectories modifiable and compounded over time
• Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368, 17: 1569-1571
Financial Instruments and models that might incentivize lifelong health management

- Horizontally integrated health, education, and social services that promote health in all policies, places, and daily activities
- Consumer incentives (value-based insurance design)
- “Warranties” on specific services
- Bundled payment for suite of services over longer period
- Measuring health outcomes and rewarding plans for improvement in health over time
- Community health investments
- ACOs could evolve toward community accountable health systems that have a greater stake in long-term population health outcomes
Contact Information

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