Health System Transformation

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Discussion

• 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.

Our Aims

- Better Health for the Population
- Better Care for Individuals
- Lower Cost Through Improvement
How do we ensure quality care?

- Improvement as a Strategy
- Customer-Mindedness
- Outcomes Focus
- Statistical Thinking
- Continual Improvement (PDSA)
- Leadership

How Will Change Actually Happen?

- There is no “silver bullet”
- We must apply many incentives
- We must show successful alternatives
- We must offer intensive supports
  - Help providers with the painstaking work of improvement
- We must learn how to scale and spread successful interventions
The “3T’s” Road Map to Transforming U.S. Health Care

Key T1 activity to test what care works
Clinical efficacy research

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

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

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

![Graph showing Medicare Per-Capita Spending Growth](chart.png)
Wide Variation in Spending Across the Country

CT Scans Per Capita Spending* (2011)

National Average = $76

Honolulu, HI
$49 per capita

Fort Myers, FL
$117 per capita

*includes institutional and professional spending

Wide Variation in Spending Across the Country

Heart Failure and Shock with Complications MS-DRG 291

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Ratio to Nat’l Avg

- NJ-Ridgewood: 1.49
- FL-Hudson: 1.15
- PA-Lancaster: 1.00
- NC-Raleigh: 0.85
- KY-Owensboro: 0.71

Source: CMS Office of Information Products and Data Analysis, Medicare Claims Analysis - 2010
Medicare All Cause, 30 Day Hospital Readmission Rate

![Graph showing Medicare All Cause, 30 Day Hospital Readmission Rate with data from Jan-10 to Jan-13. The graph indicates a downward trend in readmission rates over time.](image)

Central Line Infections National Project

![Graph showing Central Line Infections National Project with data from Q1 to Q6. The graph indicates a significant reduction in CLABSI rates from Baseline to Q6.](image)

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.

Quarters of participation by hospital cohorts, 2009–2012

Source: Office of Information Products and Data Analytics, CMS
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The Six Goals of the CMS 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
Value-Based Purchasing

• 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

FY 2014 Hospital VBP domains

- FY 15 adding efficiency domain (20%) with total cost per beneficiary for admissions; increase outcomes to 30%, decrease process to 20%
- FY16 and 17 – more outcomes weighting and safety measures, align with NQS domains
Other Payment adjustment programs

• Starting in Oct 2012, hospitals with excess risk adjusted Medicare readmissions had payments reduced (5 conditions finalized for FY15)

• Payment reductions for hospitals in bottom quartile of healthcare acquired conditions starting Oct 2014
  – Finalized to start with 2 domains weighted 65/35% each: healthcare acquired infections and healthcare acquired conditions
  – Need to move beyond claims-based HAC measures over time

Physician Reporting Programs

• Principle of report once and receive credit for all programs: Physician Quality Reporting System, Physician Value-Based Modifier, EHR Incentive Meaningful Use, and ACO if applicable

• Focus on registry reporting and EHR based reporting, both of which can be all payer

• Group reporting growth, including for ACOs

• Physician value modifier starts in 2013 (groups of 100 or more), proposed down to groups of 10 or more for 2014 and by 2017 adjusting all Medicare payments to physicians based on quality and cost
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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
Delivery System 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 key to an improved health system
A transformed mind-set by ALL

Every clinician and health care administrative person starts every day believing that **success** – whether it’s the success of the patient, the doctor, or the organization – is directly related to their ability to **achieve better outcomes and lower costs by improving care for their population** and that they have the **knowledge and tools** to do it.
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

**Health Care Innovation Awards**
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

**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
Providers are Driving Transformation

- More than 50,000 providers are or will be providing care to beneficiaries as part of the Innovation Center’s current initiatives
- Millions of beneficiaries are served by Innovation Center models aimed at achieving better health outcomes at lower costs

Accountable Care Organizations (ACOs)

- An ACO promotes seamless coordinated care
  - Puts the beneficiary and family at the center
  - Attends carefully to care transitions
  - Proactively manages the beneficiary’s care
  - 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 and workforce
4 million Medicare beneficiaries having care coordinated by 220 SSP and 32 Pioneers ACOs (Geographic Distribution of ACO Population)

State Innovation Models

• Partner with states to develop broad-based State Health Care Innovation Plans
• Plan, Design, Test and Support of new payment and service and delivery models in the context of larger health system transformation
• Engage a broad group of stakeholders in health system transformation – goals better health, better care, and lower costs
• Coordinate multiple strategies into a plan for health system improvement
• 6 Implementation states and 19 design states currently
Health Care Innovation Awards Round Two

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

We are starting to see results nationally

Cost trends are down, Outcomes are Improving & Adverse Events are Falling

- 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
  - Generated shared savings and low cost growth
  - Outperformed published benchmarks on 15/15 clinical quality measures and 4/4 patient experience measures
Partnership for Patients: Over 3000 Hospitals Reducing Harm and Improvement Accelerating

Innovation Center Looking Forward

- Implementation
- Monitoring & Optimization of Results
- Evaluation – Adopt, Adapt, Abandon
- Improving and Expanding CMS Capabilities
- Additional Model Tests
Possible New Model Concepts

- Outpatient specialty models
- Practice Transformation Support
- ACOs version 2.0
- Health Plan Innovation
- Consumer Incentives
- Home Health
- SNF
- More.....

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CMS has a variety of quality reporting and performance programs, many led by CCSQ

**Hospital Quality**
- Medicare and Medicaid EHR Incentive Program
- PPS Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- PAC payment reduction program
- Readmission reduction program
- Outpatient Quality Reporting
- Ambulatory Surgical Centers

**Physician Quality Reporting**
- Medicare and Medicaid EHR Incentive Program
- PQRS
- eRx quality reporting

**PAC and Other Setting Quality Reporting**
- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTC Quality Reporting
- ESRD QIP
- Hospice Quality Reporting
- Home Health Quality Reporting

**Payment Model Reporting**
- Medicare Shared Savings Program
- Hospital Value-based Purchasing
- Physician Feedback/Value-based Modifier
- Medicare Part C
- Medicare Part D

CMS framework for measurement maps to the six national priorities

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

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

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

- **Population/ community health**
  - Measures that assess health of the community
  - Measures that reduce health disparities
  - Access to care and equityability 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 settings
  - Shared decision-making

**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
Quality can be measured and improved at multiple levels

- **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

- **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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- **Future and Opportunities for collaboration**
Vision for the Future

• Measures Drive Improvement
  – Real-time
  – Local ownership with benchmarking
  – Linked to decision support and patient dashboards
• Measures Drive Value-Based Purchasing
  – Reliable
  – Accurate
  – Outcomes-based
• Measures Inform Consumers
  – Meaningful
  – Transparent

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
What can you do?

- Eliminate patient harm
- Engage patients and families in transformation
- Teach others and continuously learn
- Test new ideas
- Strive to build the best possible quality improvement infrastructure
- Relentless pursuit of improving health outcomes
- You are a Major Force for Delivery System Transformation

Questions and Comments

- How can we work together to reduce and attempt to eliminate patient harm in all settings?
- How can we work together to accelerate the pace of improvement in the health system?
- How can CMS support your efforts?
- How can we drive improvement in all settings and shift towards payment based on value and accountable, coordinated care?
- How do we scale and spread success?
- How can we best lead transformation of the delivery system?
Contact Information

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