

# Reinventing Health Care: Health System Transformation



*Aspen Institute*

*Patrick Conway, M.D., MSc  
CMS Chief Medical Officer  
Director, Center for Clinical Standards  
and Quality*

*Acting Director, Center for Medicare and  
Medicaid Innovation*

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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.**

# We need delivery system and payment transformation

## ***Current State –***

**Producer-Centered**

**Volume Driven**

**Unsustainable**

**Fragmented Care  
Systems**

**FFS Payment Systems**

**PRIVATE  
SECTOR**

The diagram features two large, light blue arrows pointing from the 'Current State' on the left to the 'Future State' on the right. The top arrow is labeled 'PRIVATE SECTOR' and the bottom arrow is labeled 'PUBLIC SECTOR'. The arrows are stacked vertically, with the top arrow starting at the 'Current State' and the bottom arrow starting at the 'Future State'.

## ***Future State –***

**People-Centered**

**Outcomes Driven**

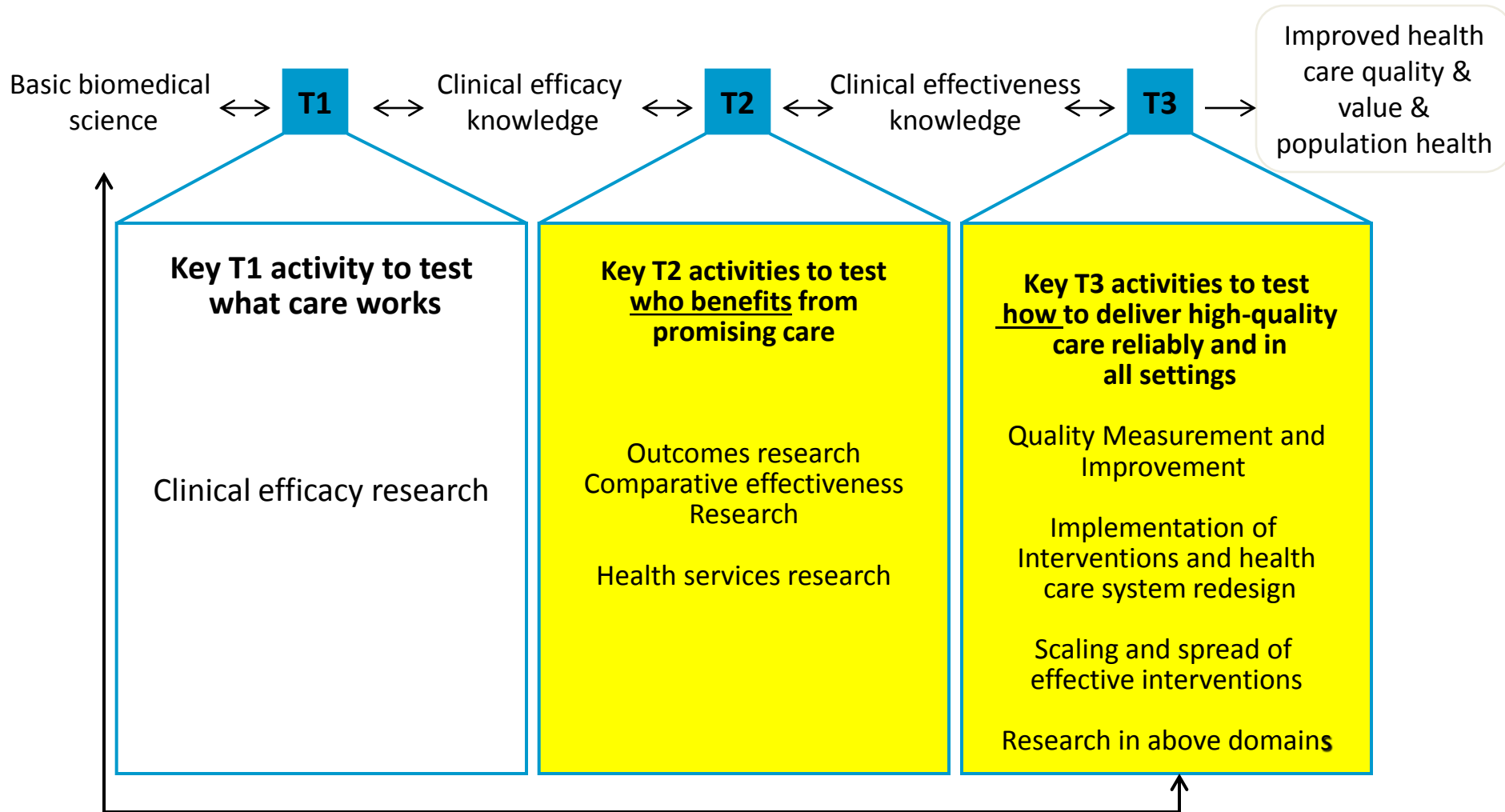
**Sustainable**

**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



Source: JAMA, May 21, 2008: D. Dougherty and P.H. Conway, pp. 2319-2321. The “3T’s Roadmap to Transform U.S. Health Care: The ‘How’ of High-Quality Care.”

# **Transformation of Health Care at the Front Line**

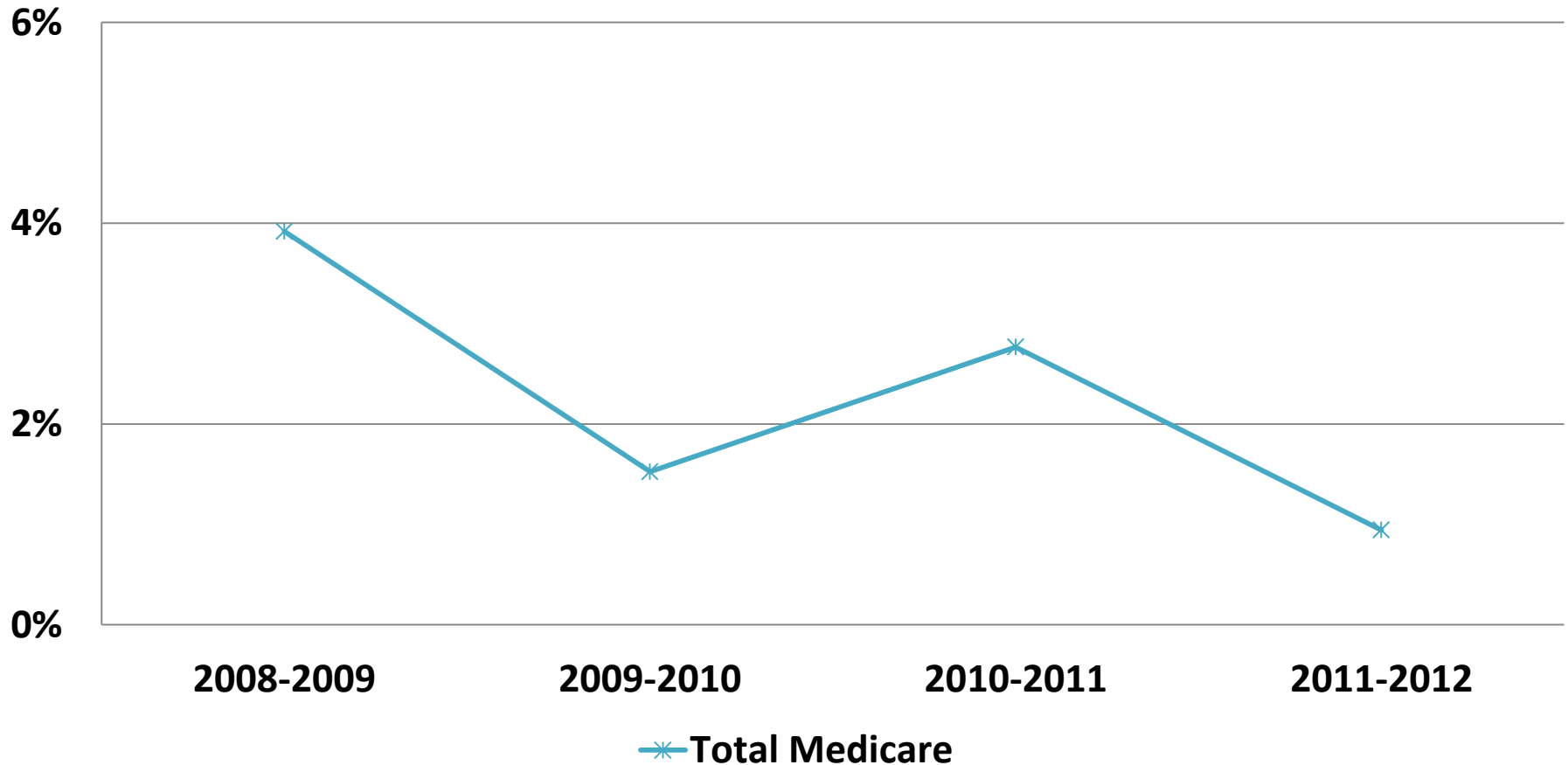
- **At least six components**
  - **Quality measurement**
  - **Aligned payment incentives**
  - **Comparative effectiveness and evidence available**
  - **Health information technology**
  - **Quality improvement collaboratives and learning networks**
  - **Training of clinicians and multi-disciplinary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

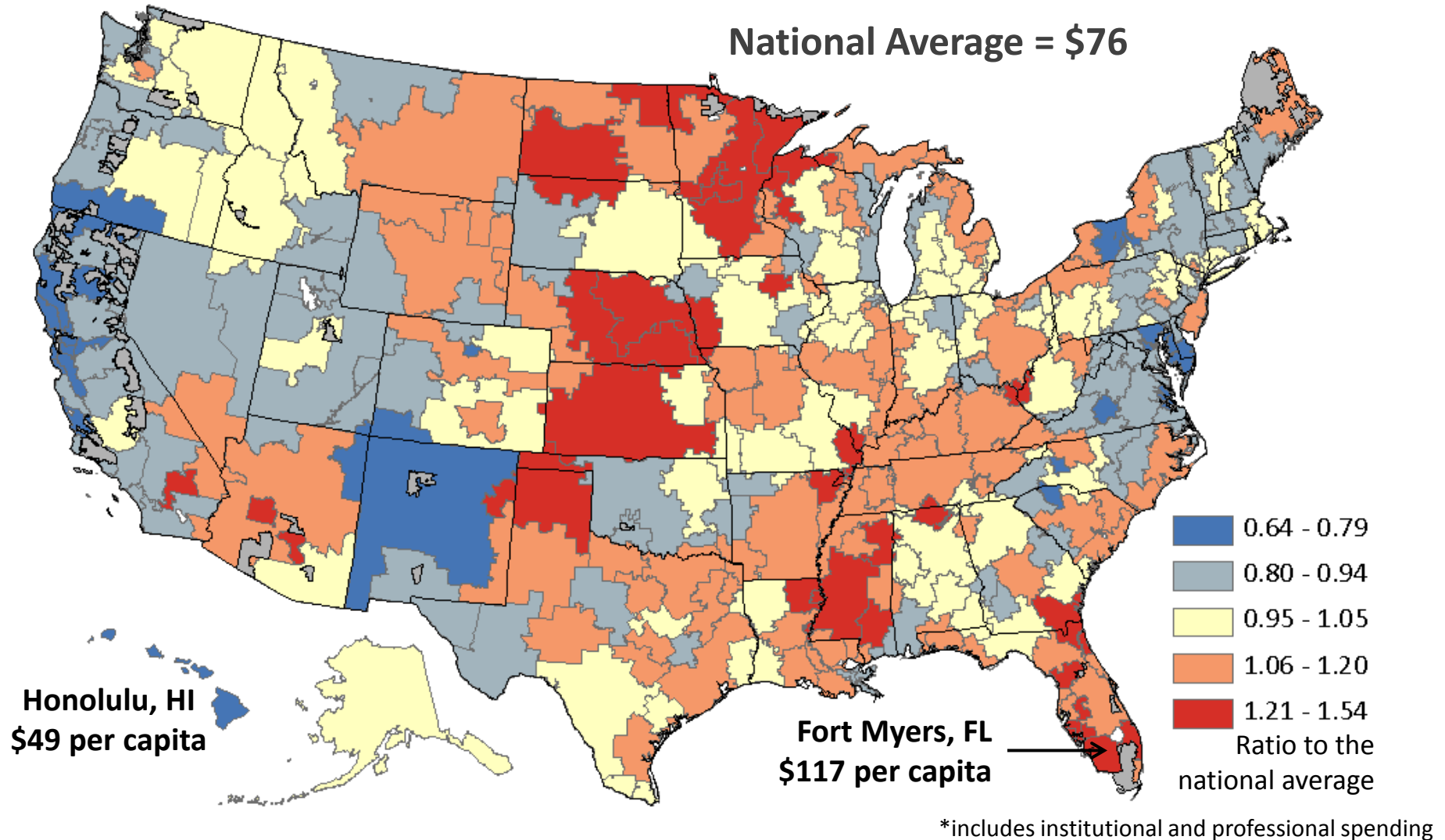
# Results: Medicare Per-Capita Spending Growth at Historic Low



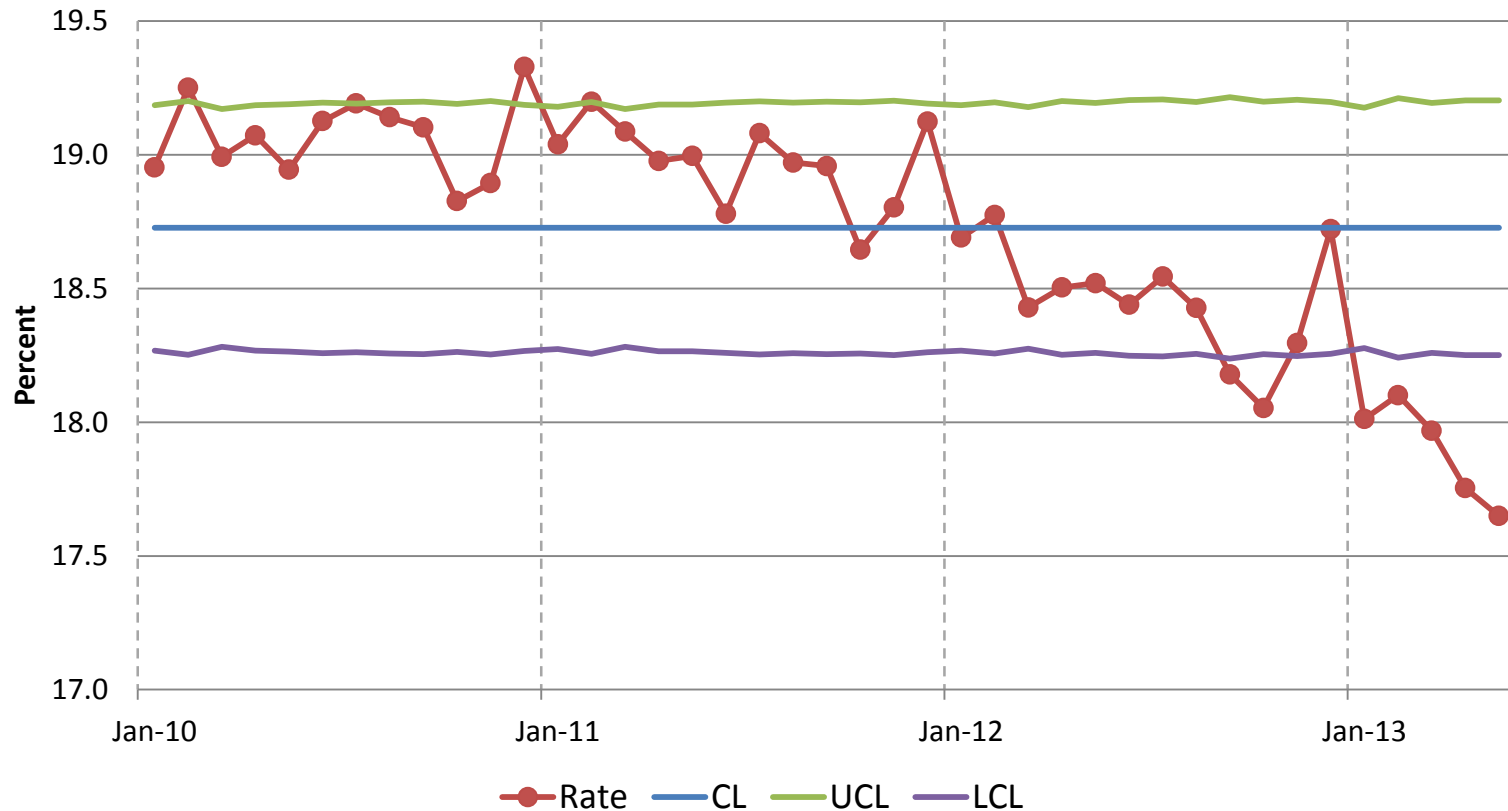
Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget



# Wide Variation in Spending Across the Country: CT Scans

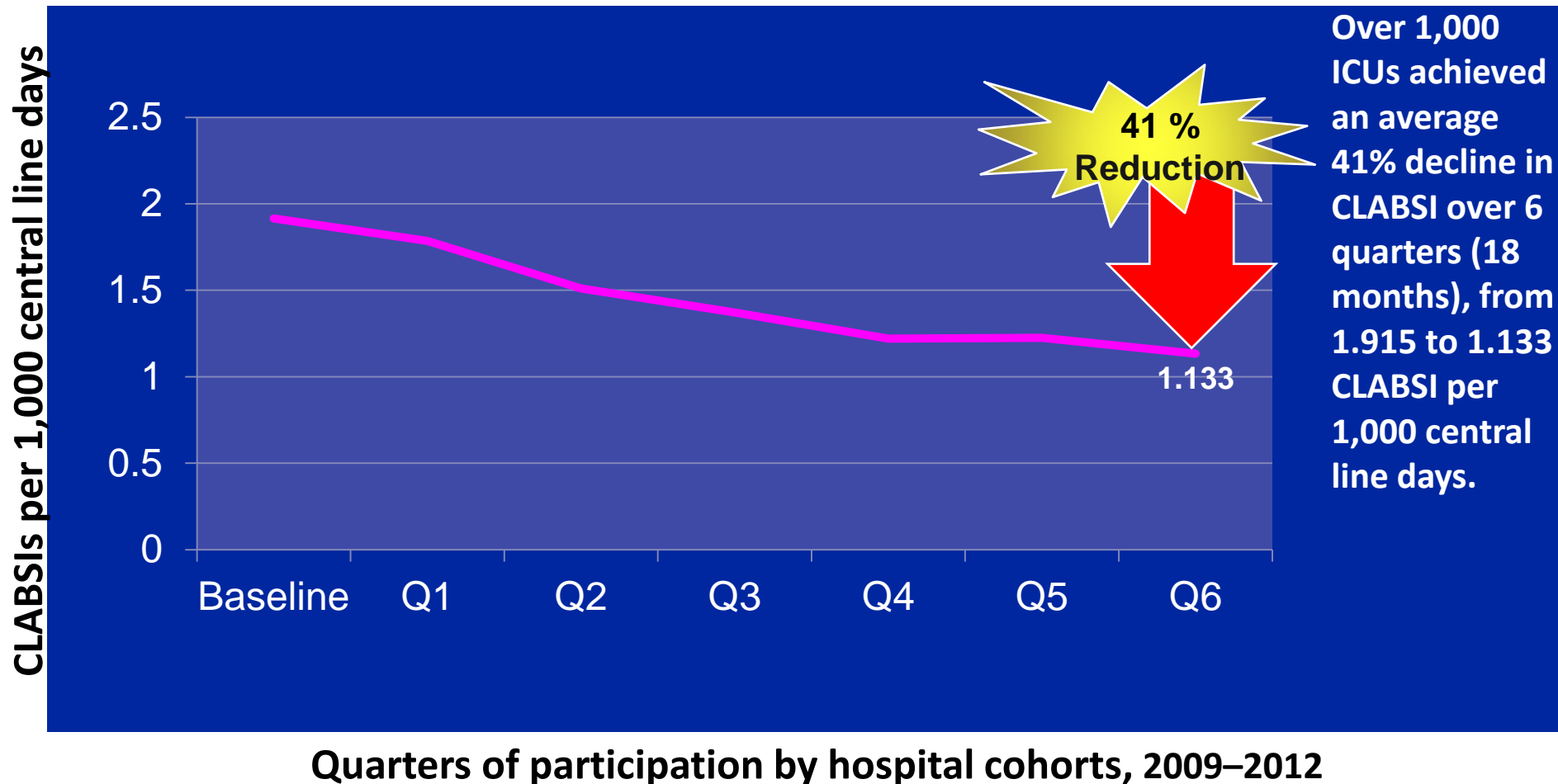


# Medicare All Cause, 30 Day Hospital Readmission Rate



Source: Office of Information Products and Data Analytics, CMS

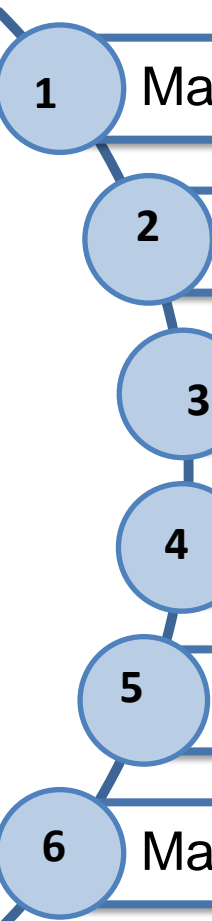
# National Bloodstream Infection Rate



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# The Six Goals of the National Quality Strategy

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- 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

## Hospital Quality

- Medicare and Medicaid EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- HAC 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
- LTCH Quality Reporting
- ESRD QIP
- Hospice Quality Reporting
- Home Health Quality Reporting

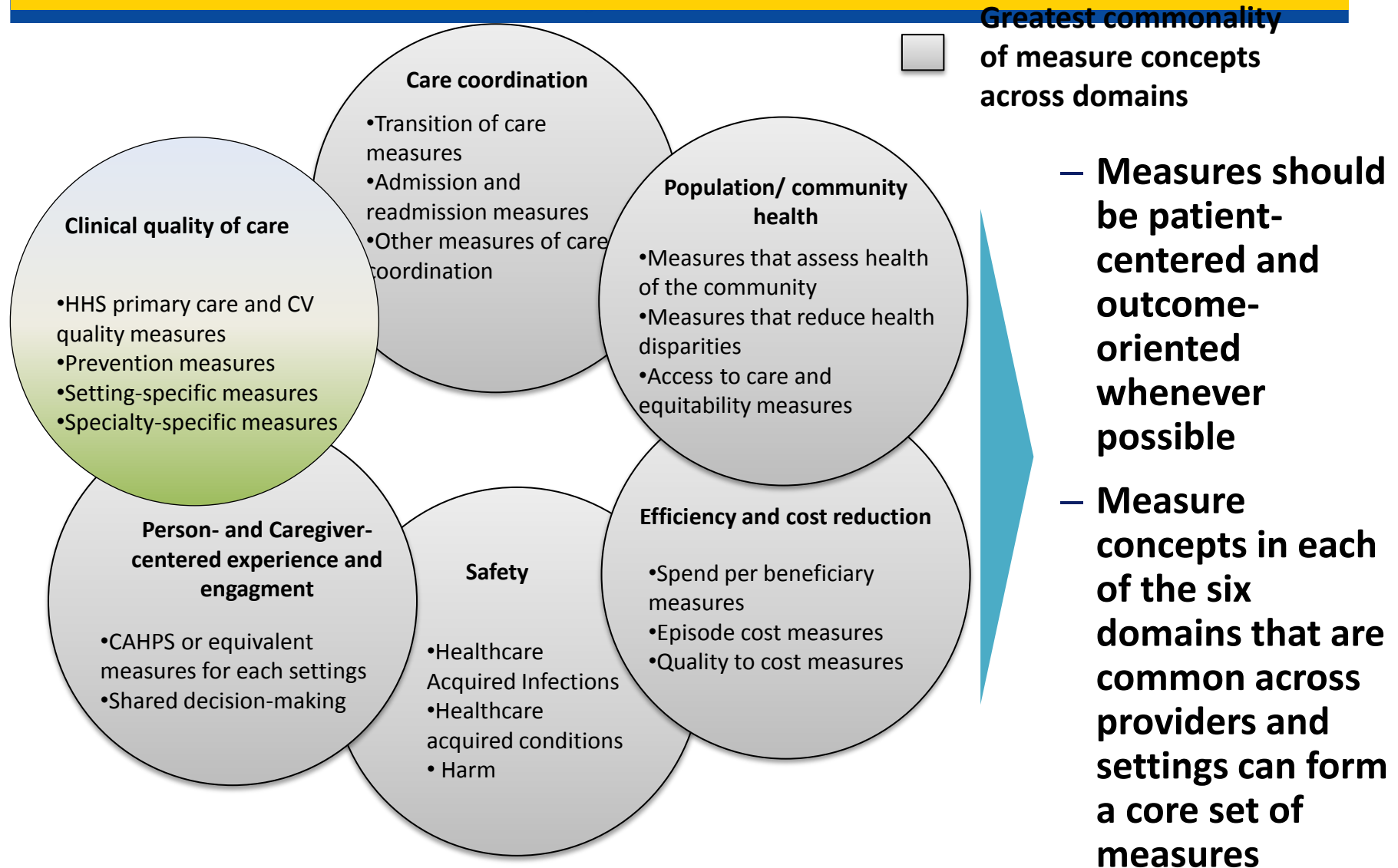
## Payment Model Reporting

- Medicare Shared Savings Program
- Hospital Value-based Purchasing
- Physician Feedback/Value-based Modifier

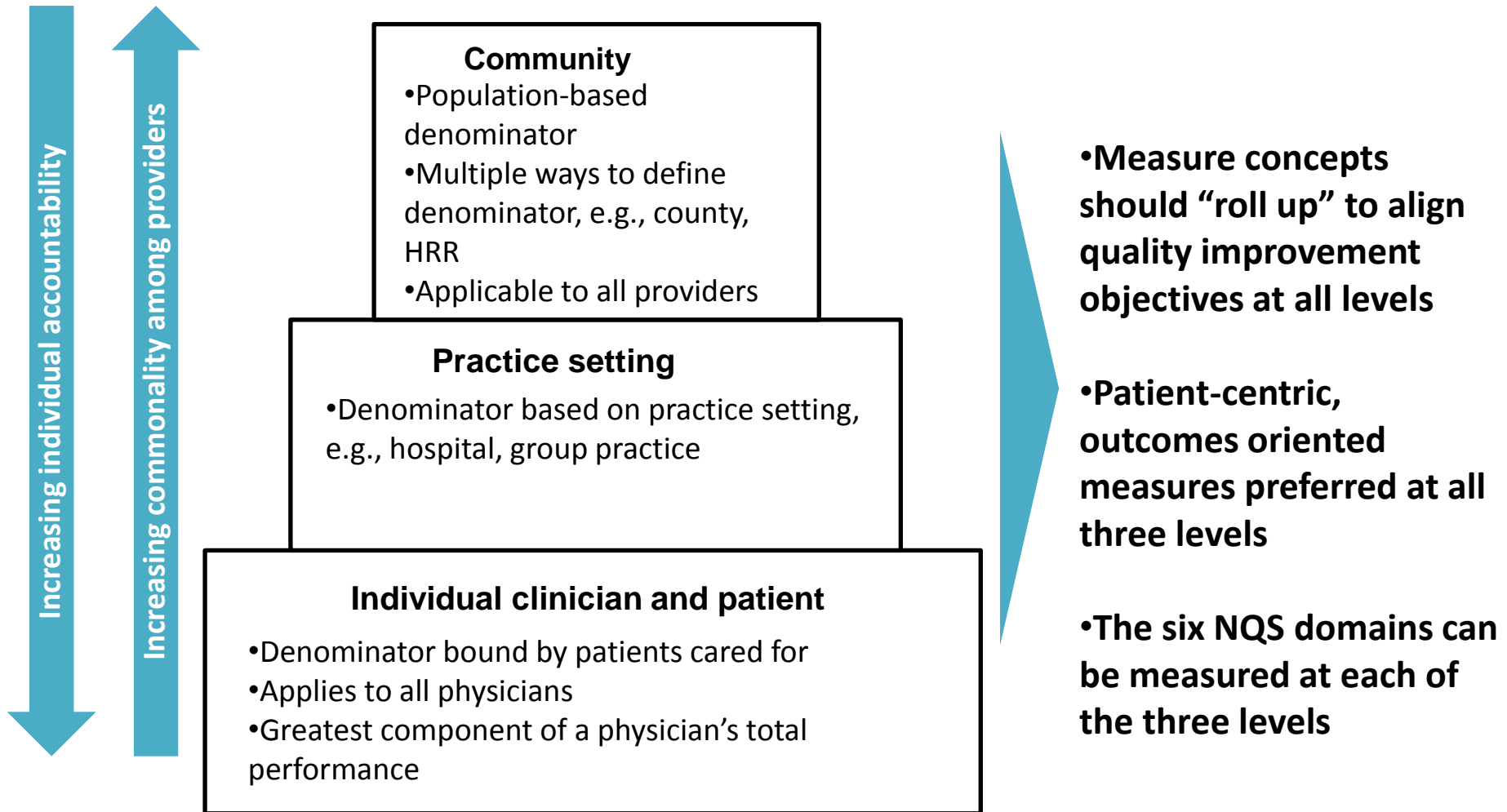
## “Population” Quality Reporting

- Medicaid Adult Quality Reporting
- CHIPRA Quality Reporting
- Health Insurance Exchange Quality Reporting
- Medicare Part C
- Medicare Part D

# CMS framework for measurement maps to the six national priorities



# Quality can be measured and improved at multiple levels





# 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**

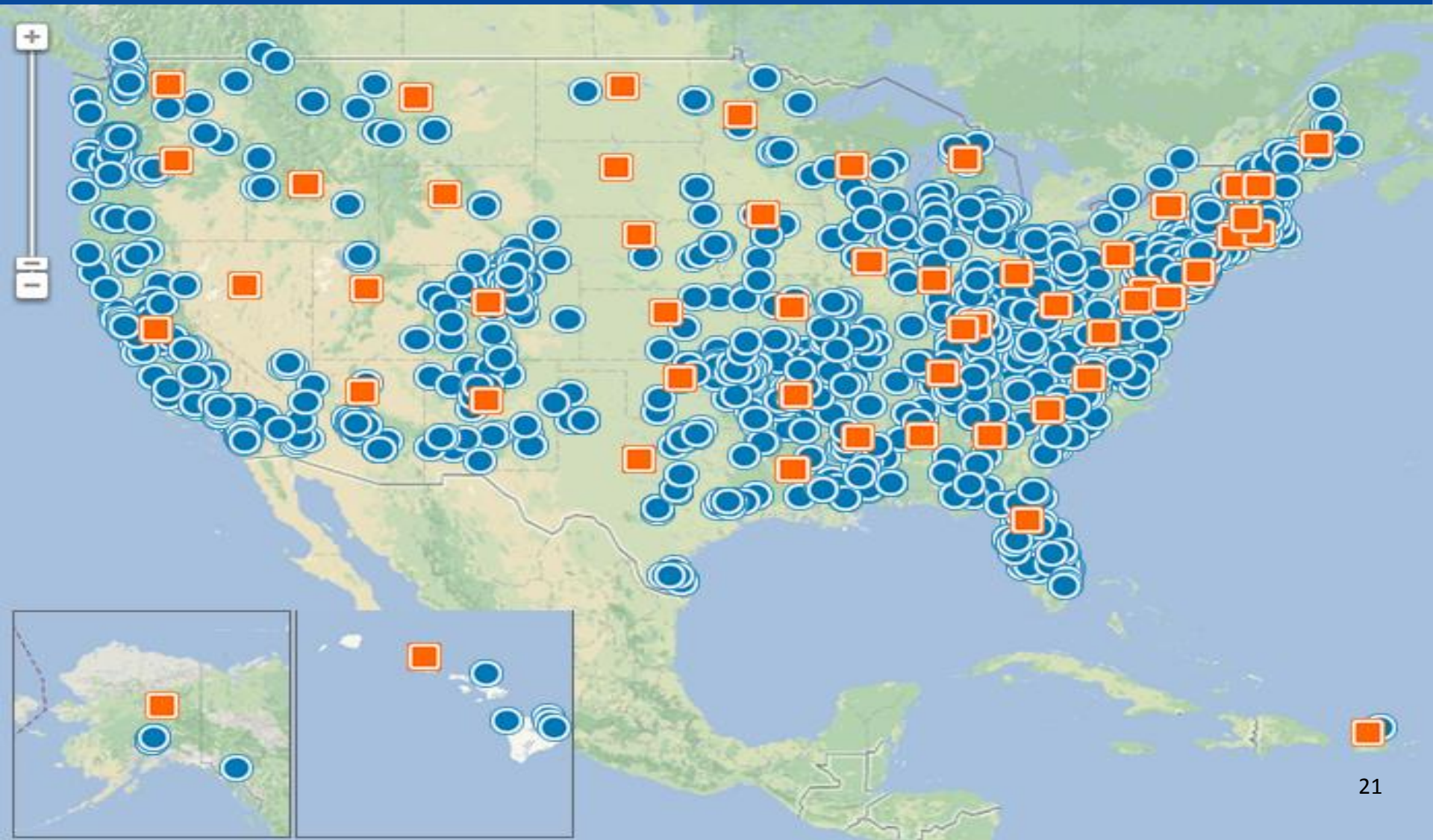
#### **Initiatives Focused on the Medicaid Population**

- 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

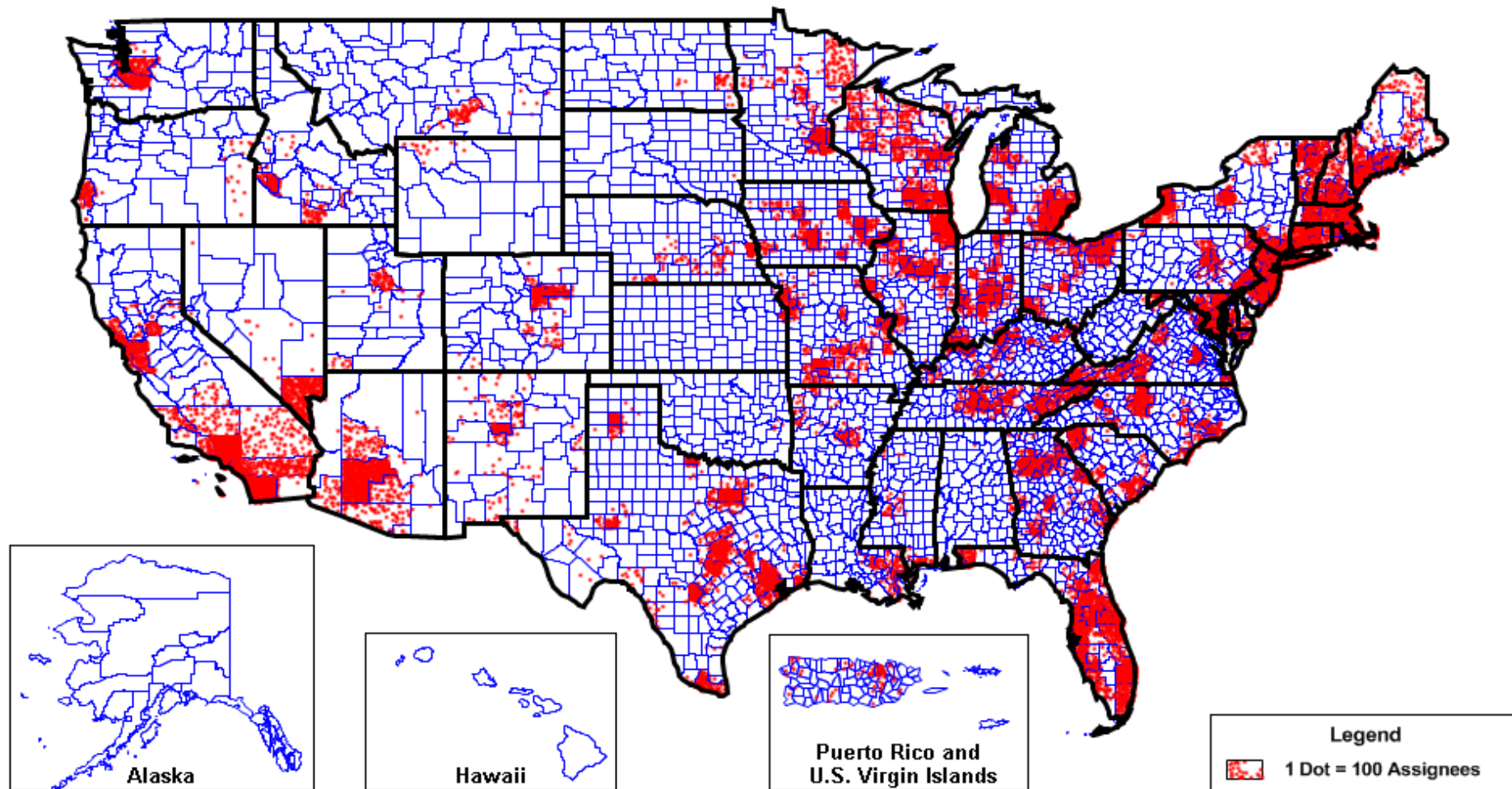


# Accountable Care Organizations (ACOs) Vision

- 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

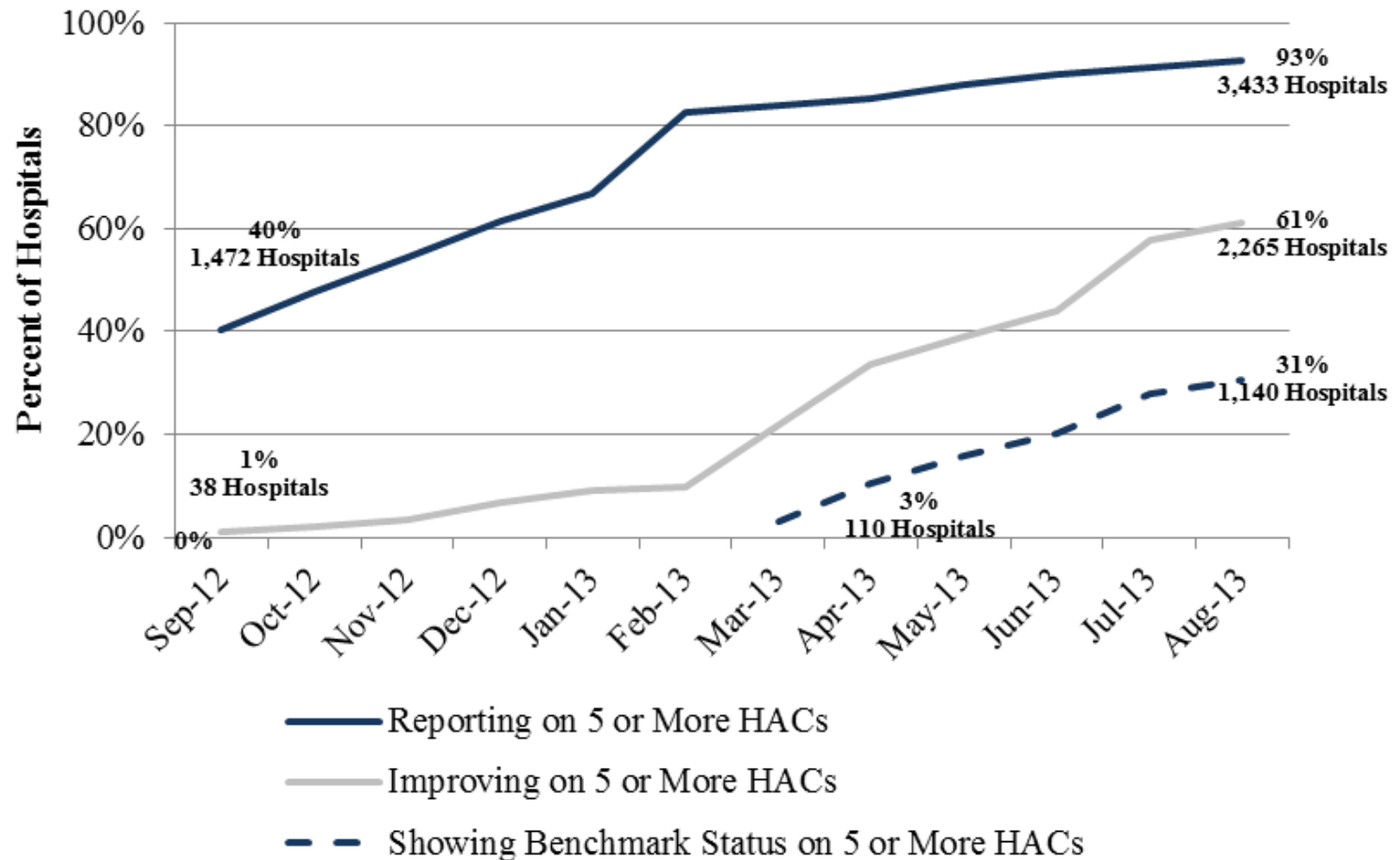


# Health Care Innovation Awards Round Two

**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



# **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.....

# **We are starting to see results nationally**

## **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**

**Dr. Patrick Conway, M.D., M.Sc.**

**CMS Chief Medical Officer**

**Director, Center for Clinical Standards and Quality**

**Acting Director, Center for Medicare and Medicaid Innovation**

**410-786-6841**

**[patrick.conway@cms.hhs.gov](mailto:patrick.conway@cms.hhs.gov)**