Innovation and Health System Transformation

AHQA Annual Meeting

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Director, Center for Medicare and Medicaid innovation
Director, Center for Clinical Standards and Quality

September 10, 2014
Discussion

- Our Goals and Early Results
- Value-based purchasing and quality improvement programs
- Quality Measurement to Drive Improvement
- Future and Opportunities for collaboration
Delivery system and payment transformation

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

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

New Payment Systems and Policies (and more)
- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency
<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Quality</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td><strong>Description</strong></td>
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<tr>
<td>Payments are based on volume of services and</td>
<td>At least a portion of payments vary based</td>
<td>• Some payment is linked to the effective management of a</td>
<td>• Payment is not directly</td>
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<tr>
<td>not linked to quality or efficiency</td>
<td>on the quality or efficiency of health</td>
<td>population or an episode of care</td>
<td>triggered by service delivery so</td>
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<tr>
<td></td>
<td>care delivery</td>
<td>• Payments still triggered by delivery of services, but,</td>
<td>volume is not linked to payment</td>
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<td></td>
<td></td>
<td>opportunities for shared savings or 2-sided risk</td>
<td>• Clinicians and organizations</td>
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<td></td>
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<td>are paid and responsible for</td>
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<td></td>
<td></td>
<td></td>
<td>the care of a beneficiary for a</td>
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<td></td>
<td></td>
<td></td>
<td>long period (eg, &gt;1 yr)</td>
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<tr>
<td><strong>Examples</strong></td>
<td><strong>Examples</strong></td>
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<tr>
<td><strong>Medicare</strong></td>
<td><strong>Medicare</strong></td>
<td><strong>Medicare</strong></td>
<td><strong>Medicare</strong></td>
</tr>
<tr>
<td>• Limited in Medicare fee-for-service</td>
<td>• Hospital value-based purchasing</td>
<td>• Accountable Care Organizations</td>
<td>• Eligible Pioneer accountable</td>
</tr>
<tr>
<td>• Majority of Medicare payments now are</td>
<td>• Physician Value-Based Modifier</td>
<td>• Medical Homes</td>
<td>care organizations in years 3 – 5</td>
</tr>
<tr>
<td>linked to quality</td>
<td>• Readmissions/Hospital Acquired Condition</td>
<td>• Bundled Payments</td>
<td>• Some Medicare Advantage plan</td>
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<tr>
<td></td>
<td>Reduction Program</td>
<td></td>
<td>payments to clinicians and</td>
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<td></td>
<td></td>
<td></td>
<td>organizations</td>
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<tr>
<td><strong>Medicaid</strong></td>
<td><strong>Medicaid</strong></td>
<td><strong>Medicaid</strong></td>
<td><strong>Medicaid</strong></td>
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<tr>
<td>Varies by state</td>
<td>• Primary Care Case Management</td>
<td>• Integrated care models under fee for service</td>
<td>• Some Medicaid managed care</td>
</tr>
<tr>
<td></td>
<td>• Some managed care models</td>
<td>• Managed fee-for-service models for Medicare-Medicaid</td>
<td>plan payments to clinicians and</td>
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<td></td>
<td></td>
<td>beneficiaries</td>
<td>organizations</td>
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<tr>
<td></td>
<td></td>
<td>• Medicaid Health Homes</td>
<td>• Some Medicare-Medicaid (duals)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicaid shared savings models</td>
<td>plan payments to clinicians and</td>
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<td></td>
<td></td>
<td>organizations</td>
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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
Results: Medicare Per Capita Spending Growth at Historic Lows

*Medicare Part D prescription drug benefit implementation, Jan 2006

Source: CMS Office of the Actuary
Medicare Spending Slowing

Growth in Medicare Spending Per Beneficiary, 2000 - 2013

- 2000 - 2008: 6.3%
- 2009 - 2012: 2.0%
- 2013: 0.1%
Medicare All Cause, 30 Day Hospital Readmission Rate

Source: Office of Information Products and Data Analytics, CMS
Hospital Acquired Condition (HAC) Rates Show Improvement

- 2010 – 2012 - Preliminary data show a 9% reduction in HACs across all measures
- Represents 15K lives saved, 520K injuries, infections, and adverse events avoided, and over $4 billion in cost savings
- Many areas of harm dropping dramatically (2010 to 2013 for these leading indicators)

<table>
<thead>
<tr>
<th>Ventilator-Associated Pneumonia (VAP)</th>
<th>Early Elective Delivery (EED)</th>
<th>Obstetric Trauma Rate (OB)</th>
<th>Venous thromboembolic complications (VTE)</th>
<th>Falls and Trauma</th>
<th>Pressure Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>55.3% ↓</td>
<td>52.3% ↓</td>
<td>12.3% ↓</td>
<td>12.0% ↓</td>
<td>11.2% ↓</td>
<td>11.2% ↓</td>
</tr>
</tbody>
</table>
Beneficiaries Moving to MA Plans with High Quality Scores

Medicare Advantage (MA) Enrollment Rating Distribution

<table>
<thead>
<tr>
<th>Year</th>
<th>2-Star</th>
<th>3-Star</th>
<th>4-Star</th>
<th>5-Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>14%</td>
<td>70%</td>
<td>16%</td>
<td>9%</td>
</tr>
<tr>
<td>2012</td>
<td>9%</td>
<td>59%</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>2013</td>
<td>5%</td>
<td>56%</td>
<td>28%</td>
<td>9%</td>
</tr>
<tr>
<td>2014</td>
<td>1%</td>
<td>43%</td>
<td>43%</td>
<td>9%</td>
</tr>
</tbody>
</table>

4 or 5 Stars
- 2009: 16%
- 2012: 29%
- 2013: 37%
- 2014: 55%

2 or 3 Stars
- 2009: 84%
- 2012: 71%
- 2013: 63%
- 2014: 45%
Discussion

• Our Goals and Early Results
• Value-based purchasing and quality improvement programs
• Quality Measurement to Drive Improvement
• Future and Opportunities for collaboration
Value-Based Purchasing

• Hospital:
  • Value-based purchasing, readmissions, healthcare acquired conditions, EHR Incentive Program and Inpatient Quality Reporting

• Physician/clinician
  • Physician value-based modifier, physician quality reporting system, EHR incentive program

• End stage renal disease bundle and quality incentive program
CMS is increasingly linking Fee-for-service payment to value

### Hospitals, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>Performance period 2014 (payment FY16)</th>
<th>Performance period 2015 (FY17)</th>
<th>Performance period 2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVB (Hospital Value-based Purchasing)</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>6.75</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

### Physician / Clinician, % of FFS payment at risk

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VBM (Value-Based modifier)¹</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)²</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

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1 Physician VBM for 2014 Performance period is being phased in as follows: Physicians in groups of 10+ EPs only for 2014 performance period; all physicians, groups and EPs starting in 2015 performance period. For the 2015 performance period, 4% is proposed maximum downward VBM adjustment. For 2016 performance period, amount at risk to be proposed in next year’s rulemaking and will depend in part on the final value for 2015 performance period.

2 For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75%, then the amount at risk would go up to 4%.

3 Proposed rule for 2016 performance year will be written in 2015. No cap on percent at risk for physician value-based modifier but unclear what the proposed rule will contain.
Discussion

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Foundational Principles of the CMS Quality Strategy

- Eliminate disparities
- Strengthen infrastructure and data systems
- Enable local innovations
- Foster learning organizations
10th SOW Successes

- Improving Transitions of Care
  - Nearly $1 billion in cost savings

- Improving Health for Populations and Communities
  - 1,826 professionals recruited/assisted with PQRS EHR 2012 reporting potentially impacting 4.1 million Medicare beneficiaries

- Reducing Health Care Associated Infections
  - 85,149 fewer days with urinary catheters for Medicare beneficiaries

- Reducing Potential for Adverse Drug Events
  - 44,640 potential adverse drug events were prevented

- Preventing or Healing Pressure Ulcers in Nursing Homes
  - 3,374 pressure ulcers prevented or healed in 797 nursing homes

- Minimizing the Use of Physical Restraints in Nursing Homes
  - 6,250 Medicare beneficiaries in 981 nursing homes are now restraint-free

- Partnering with More Nursing Homes
  - 5,021 nursing homes recruited to participate in national collaborative

- Improving the Lives of People with Diabetes
  - 20% absolute rate of improvement in controlling blood sugar levels among participants screened

QIO PROGRAM
2011-2014
Keeping the Patient at the Center
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
# A Decade of Progress

| Public reporting of quality data | • Began in 2005 with the IQR Program  
|                                 | • Encourages hospitals to focus on providing quality care by publicly reporting hospital performance |
| Paying for quality, not volume  | • ESRD QIP (2008)  
|                                 | • Hospital VBP Program (2011) |
| Measuring quality in many care settings | • For example, ambulatory surgical centers, inpatient psychiatric facilities, cancer hospitals, outpatient facilities, inpatient rehab hospitals |
| Developing a specific strategy for CMS’s Quality Programs | • The CMS Quality Strategy, spearheaded by the Quality Improvement Council |
| Beginning to “report once” from EHRs for multiple programs | • 2014 eCQM policy alignment between the Medicare EHR Incentive Program for EHs and the IQR Program |
Vision for Quality Moving Forward
## Future State Vision from CCSQ Leadership

<table>
<thead>
<tr>
<th>Select Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains:</strong> 3 to 5 measures per domain ideal for each program covering all six domains of the National Quality Strategy / six goals of the CMS Quality Strategy</td>
</tr>
<tr>
<td><strong>Episode of Care:</strong> Assess quality improvement via measures across an episode of care</td>
</tr>
<tr>
<td><strong>Population Health:</strong> Identify the right population health measures, measure gaps, and frame of attribution</td>
</tr>
<tr>
<td><strong>Patient-Centered Measures:</strong> Increase patient accountability, engagement and improve/ lessen the quality measurement gap</td>
</tr>
<tr>
<td><strong>Registry reporting and Electronic Health Record (EHR) reporting should be expanded, as appropriate</strong></td>
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<tr>
<td><strong>CMS ensures the contractors are in place to retool or create new electronic measures</strong></td>
</tr>
<tr>
<td><strong>A healthcare system that is coordinated, organized, cares about patient experience, integrated across settings, and increasingly focused on quality and value of care</strong></td>
</tr>
<tr>
<td><strong>Every program articulates their vision and determines what is needed to realize the long-term vision</strong></td>
</tr>
<tr>
<td><strong>Agile IT systems that accommodate evolving measurement and reporting needs; regular transfer of patient data between programs</strong></td>
</tr>
<tr>
<td><strong>The ecosystem of measurement systems, providing data and feedback to providers and patients to improve care and the health of individuals</strong></td>
</tr>
<tr>
<td><strong>Interagency work is leveraged and data is shared in a targeted way</strong></td>
</tr>
<tr>
<td><strong>Future changes to the quality reporting programs clearly communicated via rulemaking</strong></td>
</tr>
<tr>
<td><strong>HHS Secretary and CMS Administrator dashboard or scorecard for the “health of the nation” snapshot</strong></td>
</tr>
<tr>
<td><strong>Track trends in quality improvement based on intended and unintended consequences</strong></td>
</tr>
</tbody>
</table>
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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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