Transforming Health Care Delivery in the Home and Community

Home and Community-based Health Services Leadership Summit
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Thank You

• For the care you are providing every day
• For the hard work you are doing to improve your care systems every day
• For your commitment to health care reform, innovation and transformation
• Our Goals and Early Results
• Center for Medicare and Medicaid Innovation
• Home and Community-Based Care
• Future and Opportunities for collaboration
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
National Bloodstream Infection Rate

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
• Our Goals and Early Results
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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
Our Strategy: Conduct many model tests to find out what works

The Innovation Center portfolio of models will address a wide variety of patient populations, providers, and innovative approaches to care and payment.
CMS Measures of Success

• **Better care and lowers costs:**
  Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

• **Improved Prevention and population health:**
  All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

• **Expanded Health Care Coverage:**
  All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.
CMS Innovations Portfolio

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 Program
- Million Hearts

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

Medicare-Medicaid Enrollees (Dual eligible)
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

State Innovation Models (SIM) Initiative

Health Care Innovation Awards
Rapid-Cycle Evaluation

• **“Be part of the solution”**: Gather information and leverage our claims data to promote and support continuous quality improvement in the marketplace.

• **Speed**: Improve our data systems and our ability to use data so that we can frequently and rapidly assess effectiveness and provide feedback to providers.

• **Rigor**: Use advanced epidemiologic methods to measure effectiveness to meet a high standard of evidence and allow for certification.
Learning and Diffusion

Integral part of every model team

(1) Applying rigorous methods for rapidly studying and improving performance.

(2) Applying innovative approaches to harvest, refine and spread what works

(3) Bringing people together to learn from one another to accelerate the pace of change

Activities tailored for each initiative

- ACO Accelerated Development Learning Sessions
- Learning Infrastructure for Partnership for Patients
Innovation is happening broadly across the country
Accountable Care Organizations

• Encourage and support physicians, hospitals, and other providers to lower costs by providing better quality care and rewarding success by allowing providers to share in the resulting savings.

• Goals for ACOs:
  – Give providers incentives to achieve savings and tools to help coordinate and improve care, while assuring quality of care.
  – Assure patients get coordinated care, without overly burdensome regulations.
  – Promote better coordination between primary care providers and specialists.
Quality Measurement & Performance for ACOs

- Quality measures (33) are separated into the following four key domains:
  - Better Care
    1. Patient/Caregiver Experience
    2. Care Coordination/Patient Safety
  - Better Health
    3. Preventative Health
    4. At-Risk Population

- Must meet quality targets to share in savings and amount of savings shared depends on quality performance
Bundled Payments for Care Improvement

**GOAL:** Test payment models that link payments for multiple services patients receive during an episode of care for effectiveness in promoting coordination across services and reducing the cost of care.

**Four models:**

1. Acute care hospital stay only
2. Acute care hospital stay plus post-acute care
3. Post-acute care only
4. Prospective payment of all services during inpatient stay
Independence at Home

**GOAL:** Testing the effectiveness of providing chronically ill beneficiaries with home-based primary care.

- Medical practices provide chronically ill beneficiaries with home-based primary care.
- Practices must serve 200 targeted beneficiaries living with multiple chronic diseases to be eligible
  - Beneficiaries must be living with multiple chronic diseases
- Incentive payments for practices successful in:
  - meeting quality standards; and
  - reducing total expenditures
- 15 independent practices and 3 consortia participating
Partnership For Patients: Improving Patient Safety

GOAL: Decrease preventable hospital-acquired conditions by 40% in 3 years.

- Design intensive programs to teach and support hospitals in making care safer
- Share best practices
- Provide technical assistance for hospitals and care providers
- Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
- Engage patients and families
- 26 Hospital Engagement Networks
Patient Safety Improving

• 2010 – 2012 - Preliminary data show a 9% reduction in HACs across all measures

• Represents 15K lives saved, 540K 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>
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<td>55.3% ↓</td>
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GOALS: Test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries

• Open to community-based organizations partnered with hospitals

• Currently 102 participants

• $300 million in total funding

• Participants in all 10 CMS Regions
State Innovation Models (SIM)

- 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
- Utilize the tools and policy levers available to states
- Engage a broad group of stakeholders in health system transformation
State Innovation Models

Round One

• 6 Implementation and 19 Design/Pre-testing States

Round Two

• Second Round published on May 22, 2014
• Up to 12 new test states and up to 15 design states in round 2 and almost 40 states submitted letter-of-intent to apply
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Examples of Home and Community-based Services

**Strong Start**
- Strategy 1: Decrease Early Elective Deliveries
- Strategy 2: Enhance prenatal care to decrease prematurity

**Partnerships for Patients**
- 26 Hospital Engagement Networks (HENs)
- Ohio Children’s Hospitals’ Solutions for Patient Safety
  - includes over 80 children’s hospitals

**Health Care Innovation Awards**
- Models that produce better care, better health, and reduced cost through improvement
- Round 2 targeted children with high cost, special needs
Health Care Innovation Awards (HCIA)

- Awarded 108 projects to broad range of innovators
- Goal: Identify models that produce better care, better health, and reduced cost through improvement 3 year test period
- Awards range $1m to $30m
- Seeks to identify new models of workforce development and deployment and related training
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 priority categories:
  1. Reduce Medicare, Medicaid and/or CHIP expenditures in outpatient and/or post-acute settings
  2. Improve care for populations with specialized needs
     - Including high-cost pediatric populations, children in foster care, and children at high risk for dental disease, adolescents in crisis, and pediatric providers who provide services to children with complex medical issues.
  3. Transform the financial and clinical models for specific types of providers and suppliers
  4. Improve the health of populations
Award Examples

• Courage Center: Minneapolis, MN
  – Medical home for Adults with disability
  – Independent Living Skills
• CAPABLE: Baltimore, MD
  – Team based care for frail elders to improve functional status and stay at home
  – Team includes a handyman!
• The Michigan Public Health Institute (MPHI)
  – Hub and spoke
  – CHWs help chronically ill patients access wide variety of health and social service needs
  – Developing payment model
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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
Thank You

innovation.cms.gov

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