Delivery System Reform

National Advisory Committee
On Rural Health and Human Services

Objective and Measurement Approach for Delivery System Reform (DSR)

- In January, 2015, under Secretary Burwell's leadership, the Department has begun an effort to **accelerate improvements to our health care delivery system**.

- The overarching objective of the initiative is **improving care and spending our dollars more wisely** across the U.S. health care system.

- This objective will be realized through aggressive, coordinated management of three focus areas: **Incentives, Care Delivery, and Information**.

- As part of this effort, we have outlined **goals for delivery system reform**, an approach for **achieving and tracking progress** towards goals**,** and **policy levers critical to success.**

Three Focus Areas of Delivery System Reform (DSR)

Improving the way providers are paid, the way care is delivered, and the way information is distributed will get us to better care, smarter spending, and healthier people system-wide.

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

In the Secretary's own words….

- **If we find better ways to deliver care, pay providers, and distribute information, we can receive better care, spend our dollars more wisely, and have healthier communities, a healthier economy, and a healthier country.**
- To drive progress on the way care is provided, we're focused on:
  - Improving the **coordination and integration** of health care.
  - **Engaging patients** more deeply in decision-making.
  - Improving the **health of patients –** with a priority on prevention and wellness.
- To improve the ways providers are paid, **we are looking to reward value and care coordination – rather than volume and care duplication.** We want to pay providers for what works, whether it's something as complex as preventing or treating disease, or something as straightforward as making sure a patient has more than one way to communicate with the team of clinicians taking care of them.
- To improve the way information is distributed, we're working to create more **transparency on cost and quality information,** to bring **electronic health information** to more places**, and to bring the most recent scientific evidence to the point of care so we can bolster clinical decision-making.**
- To move these goals forward, **we're identifying grant and rulemaking opportunities within Medicare and Medicaid** and finding ways to use them appropriately to improve the quality of care that beneficiaries receive while spending dollars more wisely. Medicare and Medicaid are the two largest health insurance plans in the world. Together they cover roughly 1 in 3 Americans.

Payment Taxonomy Framework

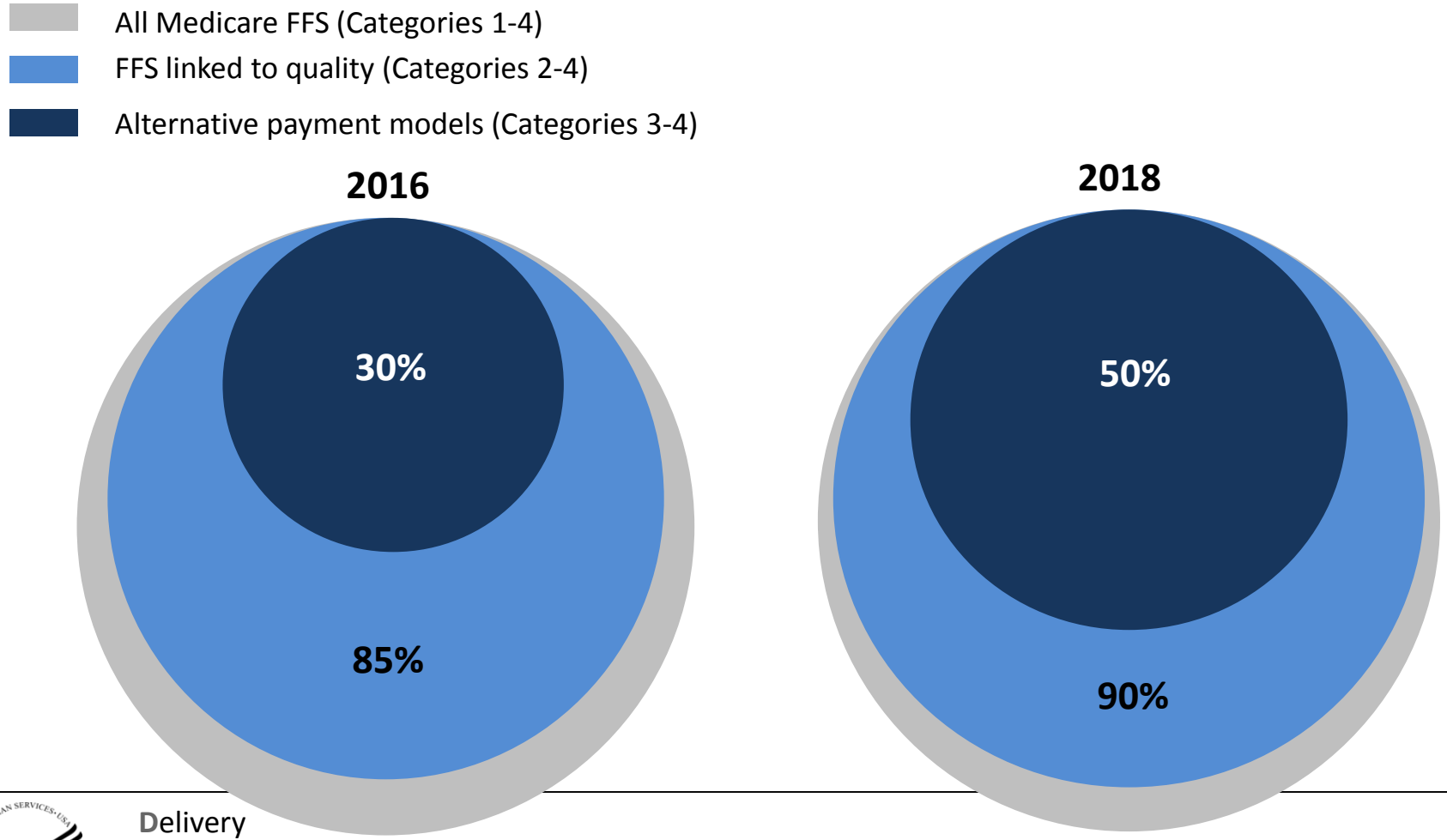
	Category 1: Fee for Service—No Link to Quality	Category 2: Fee for Service—Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

Goals: Focus Areas

Focus Areas	2016 Goal	2018 Goal
Incentives		
Promote value-based payment systems		
– Test new alternative payment models	**30%*** of Medicare payments in alternative payment models	**50%**
– Increase linkage of Medicaid, Medicare fee-for-service, and other payments to value	**85%** of remaining FFS Medicare payments linked to quality/value	**90%**
Bring proven payment models to scale*		
Care Delivery		
Integrate and coordinate care	**30%** of patients in primary care medical homes or physician groups accountable for both cost and quality	**50%**
Improve population health	**15** states implement comprehensive reform	**25** states
Promote patient engagement in decisions	**80%** of patients participate in shared-decision making	**85%**
Information		
Create transparency on cost and quality information	Establish websites for all FFS settings and health plan programs with quality info. and star ratings for consumers	Measure use
	Establish metrics on consumer access to out-of-pocket costs data	Measure use
Bring electronic health information to the point of care for meaningful use	**85%** of providers adopt certified EHR	**90%**
	30% of clinical visits have electronic health info. available when and where needed**	**50%**

*Same goal used for testing new models and bringing proven models to scale **Exact measure still under discussion

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



What does this all mean for rural health?

Session Goals and Outcomes

- Convey the direction and pace of health care delivery system reform and the implications and opportunities in rural America, for policymakers and for the field
- Support the Committee's ability to make recommendations to the Secretary regarding rural delivery system reform

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My Perspectives

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- Independent, nonprofit, community-based Minnesota organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Working at the intersection of research, policy, and practice
  - Develop and lead quality and safety projects and campaigns across care continuum
  - Rural health quality is organizational priority

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My Perspectives (cont.)

RUPRI Health Panel

- Established in 1993 to provide science-based, objective policy analysis to federal policy makers
  - 6 members from academia, research, practice
- Policy briefs, white papers, presentations, comments on proposed rules available at:
  - http://www.rupri.org/areas-of-work/health-policy/

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DSR in Context: RUPRI "Futures" Paper

- An aspirational vision
- Builds on IOM rural health report, the Commonwealth Commission report
- Intended to be a guide or roadmap during rapidly a changing policy and program environment
- Released in September 2011
  - http://www.rupri.org/panelandnetworkviewer.php?id=9

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What is the high performance health care system of the future?

The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health care system informed by the needs of each unique rural community will lead to greater community health and well-being.

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Foundations of a High Performance Rural Health System

1. Affordable
2. Accessible
3. Community-focused
4. High quality
5. Patient-centered

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DSR Implications and Opportunities for Rural Health

DSR Challenges in Rural

- Statutory exclusions
- Lack of appropriate measures which account for low volume and narrower service mix
- Limited capital and financial resources
- Workforce shortages – both numbers and types

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Significant action despite the challenges

- Public sector
  - New payment models (ACO/shared savings, total cost of care), patient-centered medical homes, SIM programs, community transformation grants, value-based purchasing, workforce initiatives
- Private sector
  - Payer-provider contracts for “accountable care,” patient-centered care teams, evolving systems that combine providers and provider types, use of telehealth

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Example: Lakewood Health System

- Lakewood Health System
  - An independent integrated rural health care system which includes a CAH and five primary care clinics. All clinics are certified a Health Care Homes (PCMH), they have an extensive care coordination program and proactive palliative care and hospice initiatives, and became a Medicaid ACO this year.

Preview Example: Southern Prairie

- Southern Prairie Community Care
  - A collaboration of 12 rural Minnesota counties which joined together to become a Medicaid ACO and a SIM Accountable Community for Health, focused on improving population health through integrating health care, behavioral health, and human services. They are using an e-Health grant to develop a Health Information Exchange for their network.

Transitioning from Volume to Value: A Resource

- *Rural Health Value* project (RUPRI, Stratis Health) has gathered and developed a comprehensive set of tools to support the transformation from volume to value
  - *Just released* - Value-Based Care Strategic Planning Tool (VBC Tool) assesses 121 different value-based care capacities in eight categories, which results in a customized Value-Based Care Readiness Report

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Synthesis and Dialogue

Synthesis of emerging rural DSR opportunities

- Significant momentum behind the transformation from volume to value
- Care delivery redesign is necessary and opportunities abound
- New governance approaches are needed but difficult

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From Volume to Value

- Measurement is paramount to assuring and demonstrating value
  - Not a new message, but measurement has increased prominence
- Payment models are changing for rural
  - While rural has been somewhat sheltered, value-based purchasing and alternative payment models are here
  - Impact will occur directly and indirectly

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Care Delivery ReDesign

- Effective care coordination is essential for success, both for patient care and for new payment models
  - Not just a care coordinator, but a comprehensive approach
- End-of-life care needs and impact are substantial in rural
  - Establishing palliative care programs and services, securing hospice care, promoting advance care planning

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New Governance Approaches

- To address population health
  - Population health means both patient panels *and* the health of the community
  - Across health and non-health care organizations
- To participate effectively in alternative payment programs and models
- To leverage negotiating and purchasing power
  - Managed care contracts, HIT tools and support, ACO/ alternative payment programs

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Rural Stakeholders are Taking Action

- HHS's Federal Office of Rural Health Policy (see next slide)
- Plus public and private sector efforts through NRHA, AHA and state hospital associations, and others

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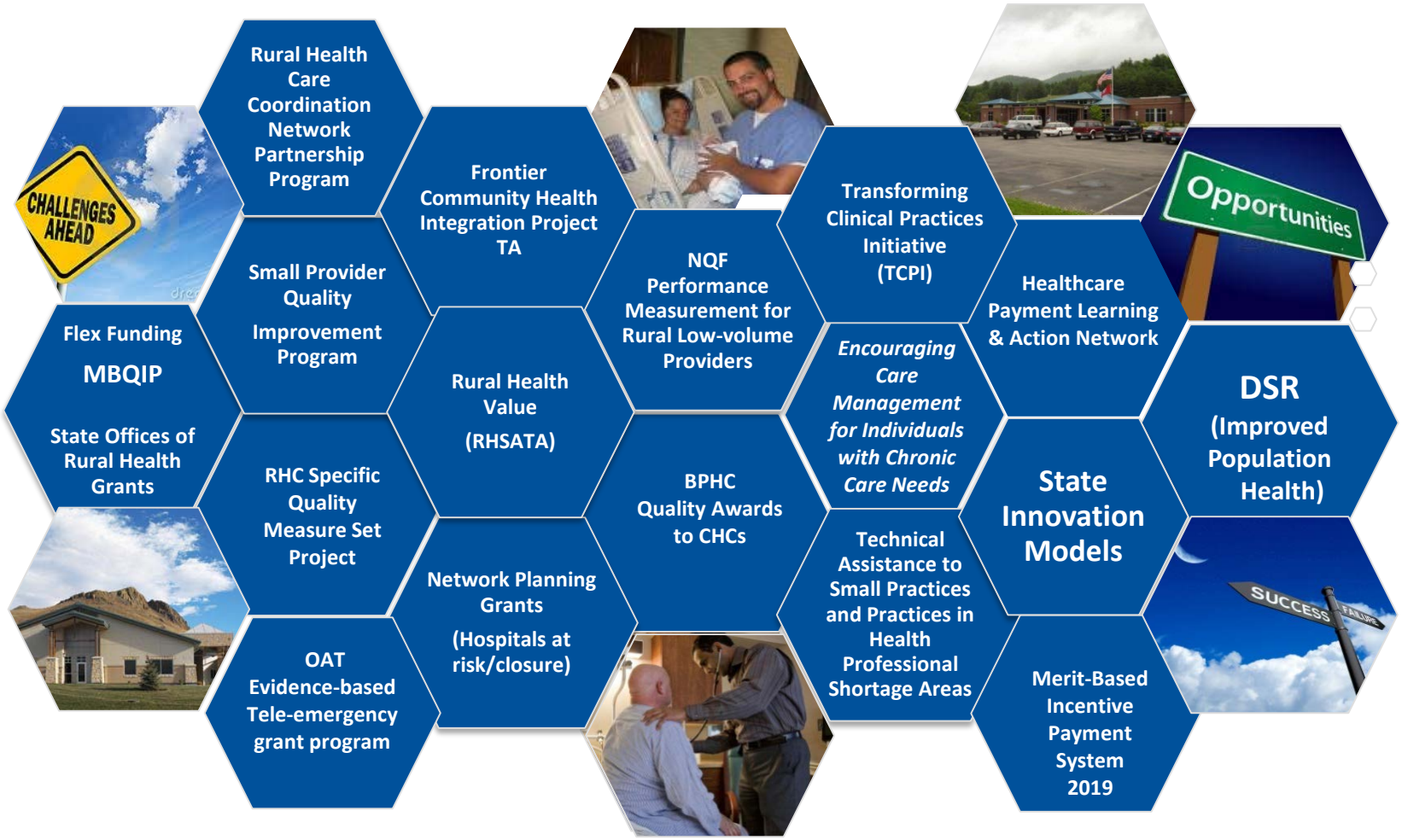
Leveraging Programs for the Future



NQF Rural Health Project

NQF gives guidance on how rural measurement should occur

- 20-member rural expert committee convened to provide recommendations to HHS regarding performance measurement issues for rural and low-volume providers.
- *Performance Measurement for Rural Low-Volume Providers* draft for public comment issued on June 1, 2015.

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NQF Rural Health Project (cont.)

14 recommendations, including:

- Make participation in CMS quality improvement programs mandatory for all rural providers…but a phased approach
- Fund development of rural-relevant measures:
  - patient hand-offs and transitions
  - alcohol/drug treatment
  - telehealth/telemedicine
  - access to care and timeliness of care
  - cost
  - population health at the geographic level
  - advance directives/end-of-life
- Encourage voluntary groupings of rural providers for payment incentive purposes

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RUPRI Health Panel

RUPRI helps make policies and programs actionable for rural communities

- *Advancing the Transition to a High Performance Rural Health System* white paper issued November 2014.
- Focused on strategies and options for creating a pathway to a transformed, high performing rural health system.
  - Builds on the RUPRI Health Panel's earlier paper that conceptually defined the core elements of a high performance rural health system

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RUPRI Health Panel (cont.)

- Illustrations, public policy considerations, and demonstrations to trial in four areas:
  - Community-appropriate health system development and workforce design
  - Governance and integration approaches
  - Flexibility in facility or program designation to care for patients in new ways
  - Financing models that promote investment in delivery system reform

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For NAC Consideration

- What should policymakers be doing?
- What should rural care delivery leaders and organizations be doing?
- What should Committee members keep their eye out for during their upcoming site visits and panel presentations?

Key Policy Questions

1. How should rural providers be incorporated into value-based payment and quality?

measurement from which they are often precluded due to statutory payment exclusions?

2. What kinds of protections should be added to value-based programs to protect rural?

providers from excessive financial risk while encouraging improved care delivery?

3. How can HHS design complementary, equally rigorous quality reporting and value-based programs to facilitate participation from rural providers omitted from DSR initiatives?

Key Policy Questions

4. What should HHS do to ensure that quality measures are relevant to and attainable for rural providers given their lower patient volume and other unique circumstances?

5. How should the Secretary structure MACRA-authorized technical assistance to best help small and rural providers transition to alternative payment models?

6. How can HHS facilitate meaningful rural participation in its existing technical assistance programs for care delivery reform (e.g., Health Care Payment Learning and Action Network, Transforming Clinical Practice Initiative)?

Key Policy Questions

7. What methods, techniques, or messages should the Secretary apply in the MACRA authorized education and outreach campaign for chronic care management to most effectively reach rural populations?

8. How should the Secretary support rural providers to build needed infrastructure and capacity for meaningful use of EHR and health IT?

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Committee Discussion

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