Delivery System Reform and the Health Care Payment Learning and Action Network

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Centers for Medicare and Medicaid Services
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Systems and Policies**
- Fee-For-Service Payment Systems

**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information.

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Medicare Fee-for-Service

**GOAL 1:**
30%
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:**
85%
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

**NEXT STEPS:**
Testing of new models and expansion of existing models will be critical to reaching incentive goals
Creation of a Health Care Payment Learning and Action Network to align incentives for payers

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

Set internal goals for HHS
Invite private sector payers to match or exceed HHS goals
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- **Alternative payment models (Categories 3-4)**
- **FFS linked to quality (Categories 2-4)**
- **All Medicare FFS (Categories 1-4)**

### Historical Performance
- **2011**: ~0% FFS linked to quality, 0% alternative payment models
- **2014**: ~20% FFS linked to quality, >80% alternative payment models

### Goals
- **2016**: 30% FFS linked to quality, 85% alternative payment models
- **2018**: 50% FFS linked to quality, 90% alternative payment models
The Health Care Payment Learning and Action Network will accelerate the transition to alternative payment models

- Medicare alone cannot drive sustained progress towards alternative payment models (APM)

- Success depends upon a critical mass of partners adopting new models

- The network will
  
  - Convene payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  
  - Identify areas of agreement around movement to APMs
  
  - Collaborate to generate evidence, shared approaches, and remove barriers
  
  - Develop common approaches to core issues such as beneficiary attribution
  
  - Create implementation guides for payers and purchasers

Network Objectives

- Match or exceed Medicare alternative payment model goals across the US health system
  
  - 30% in APM by 2016
  
  - 50% in APM by 2018

- Shift momentum from CMS to private payer/purchaser and state communities

- Align on core aspects of alternative payment design
Guiding Committee Recommended Focus Areas

- **Define terms and concepts** associated with alternative payments in a way that non-experts can understand (e.g. value, types of APMs and components);

- **Seek alignment** in areas such as patient-reported outcomes and experience, attribution, components of implementing APMs, clinically relevant data sharing, and transparency of data;

- **Make the business case** for building and implementing practical solutions for small and medium practice providers and ensure that as we incentivize movement from fee-for-service to APMs, early adopters are not penalized;

- **Remain cognizant** how the movement toward APMs will impact low income and vulnerable populations; and

- **Share best practices, early results and learning, and information** that informs the transition process across all stakeholder groups.
LAN Structure

The Guiding Committee shapes Work Groups and outreach/learning strategies

4K Network Participants

- States Affinity Group*
- Health Plans Affinity Group
- Consumers/Patients Affinity Group
- Provider Affinity Group
- Employer / Purchaser Affinity Group

Guiding Committee

WG 1  WG 2  WG 3  WG 4

Note: Affinity groups are notional

*in coordination with State Innovation Model (SIM) work
Pulling the Pieces Together

Darren DeWalt, MD
Dennis Wagner, MPA
Paul McGann, MD
Questions to Run On...

Rick Potter’s Question: What would make QIOs & the QIO network the immediate, instinctive, “go-to place” for CMS to get solutions and results?

How are we currently growing and planning to grow the 11th Scope of Work?

What can QIOs do to further align with and advance work and results on CMS priorities?
Investing in Quality Improvement

- Embrace a Results-Focused Return on Investment (ROI)
- Team with CMS in Growing the Investment in Healthcare QI and the QIO Program
- QIOs to Lead on Integration & Teaming with Influential Partners
An Answer to Rick Potter’s Question
-- Contracting and Results --

“We’re focused on going far beyond contract minimums – this is about using CMS resources to achieve as many results as we can possibly achieve for the patients we serve.”

-- Ann Hendrich
Ascension Health
Nursing Home Recruitment is Exceeding Current Contract Targets

### National Cumulative Monthly Recruitment

<table>
<thead>
<tr>
<th>Month</th>
<th>Recruitment Target No.</th>
<th>Star Category Target No.</th>
<th>Target</th>
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<tbody>
<tr>
<td>Oct 2014</td>
<td>16.4%</td>
<td>23.50%</td>
<td>6%</td>
</tr>
<tr>
<td>Nov 2014</td>
<td>26.2%</td>
<td>37.30%</td>
<td>12%</td>
</tr>
<tr>
<td>Dec 2014</td>
<td>34.0%</td>
<td>46.80%</td>
<td>18%</td>
</tr>
<tr>
<td>Jan 2015</td>
<td>41.6%</td>
<td>55.20%</td>
<td>24%</td>
</tr>
<tr>
<td>Feb 2015</td>
<td>47.2%</td>
<td>62.20%</td>
<td>30%</td>
</tr>
<tr>
<td>Mar 2015</td>
<td>56.2%</td>
<td>72.10%</td>
<td>35%</td>
</tr>
</tbody>
</table>
Large Numbers of Beneficiaries Impacted in Communities Recruited for C.3 Care Coordination Work

- **1st Cohort**
  - Nearly 7,000,000 beneficiaries impacted through participating communities (18% of FFS Medicare beneficiaries in the country)
    - Over 2,000,000 are rural beneficiaries (28%)

- **Leading QIN-QIOs**
  - CA – 532,619 impacted beneficiaries (16%)
  - TX – 442,916 impacted beneficiaries (18%)
  - FL – 402,217 impacted beneficiaries (16%)
Focusing More and More on the “What” -- Program Results & Outcomes --

**WHAT**
- Military Model: Tight
- Bureaucracy: Flexible
- Anarchy: Flexible
- Flexible, Mission-Driven: Tight

**HOW**
- Tight
- Tight
- Flexible
- Flexible
Embrace a Results Focus and Return on Investment (ROI)

The CMS healthcare delivery system reform work endeavors to reward value and care coordination over volume and duplication.

Choose to establish and aim for higher targets.

Seize opportunities to use aggressive target setting and innovation to increase value, influence and impact. For example, ramp up recruiting of pharmacies and action on ADE work.

Focus on generating program outcomes and results.
As CMS proposes new work and expanded resources for CMMI test models and the QIO program, it will be critically important for QIOs to be in closer working partnerships with influential partners: HENs (hospital associations & systems), PTNs and SANs (medical societies, clinician leadership organizations, others), Regional Health Collaboratives, RECs and others. 

Help propel initiatives to grow nation’s investment in quality improvement.

Join with CMS in viewing other organizations and initiatives as resources and partners – not competition.

Be open to resourcing or being resourced by these partners. *We are all in this together.*
Lead on Integration & Teaming with Influential Partners

Position QIN-QIOs as natural health system integrators -- with ties to all the key provider organization types (hospitals, clinical practices, long-term care organizations, home health and others).

Help us flip our collective mindset:

from “using CMS QIO resources to have QIOs do all the work”

to “leveraging CMS QIO resources to position QIOs to lead on and team in resourcing and integrating the work of influential and trusted healthcare partners.”

Embrace partnering and the active resourcing of partner relationships to achieve goals.
Currently Growing the 11th SOW through Phase II Work

- Immunizations
- Behavioral Health
- Special Innovation Projects
- Transforming Clinical Practice Initiative
Anticipated Potential Additional Work to Further Grow QIO Program

- MACRA Implementation on Merit-Based Incentive Payment System
- Expanded Teaming with Regional Extension Centers on HIT & MIPS
- More Special Innovation Projects
- Potential Value & Efficiency Project(s) to Address Emerging Needs
- Patient & Family Engagement Support & Outcomes
- Drive National Harm Rate Below 121 Harms per 1000 Discharges
Some Key CMS Priorities

• Improvement in quality of care for individuals
• Promotion of alternative payment models
• Management of medical costs
• Advancement of work on health disparities/rural models
• Foster simplicity for consumers and industry
• Improvement in consumer/beneficiary experience
• Data Transparency
• New Legislation Implementation
Questions to Run On...

Rick Potter’s Question: What would make QIOs & the QIO network the immediate, instinctive, “go-to place” for CMS to get solutions and results?

How are we currently growing and planning to grow the 11th Scope of Work?

What can QIOs do to further align with and advance work and results on CMS priorities?
SAN

What does this mean to you?
How will your understanding evolve over time?

Dennis Wagner, MPA
Paul McGann, MD
Darren DeWalt, MD
Secretary Burwell

“We all have a stake in achieving these goals and delivering for patients, providers, and taxpayers alike.”
SAN: a “formalized” beginning
Support and Alignment Network

http://innovation.cms.gov/Files/x/TCPI-FOA-SAN.pdf

How will we create and evaluate impact?

How will we generate ROI?
**Practice Transformation in Action**

*Transforming Clinical Practice will employ a three-prong approach to national technical assistance*

This technical assistance will enable large-scale transformation of more than 150,000 clinicians’ practices to deliver better care and result in better health outcomes at lower costs.

**Aligned Federal and State programs with support contractor resources**

QIO/TCPI 11th SoW D1 TO

**Practice Transformation Networks (PTNs) to provide on the ground support to practices**

**Support and Alignment Networks (SANs) to achieve alignment with medical education, maintenance of certification, more**

- Communities
- Ambulatory and Post-Acute Care
- Primary and Specialty Care Clinicians and Practices
- Hospitals and Healthcare Systems
- Public Health Services
Who Might Be a…

**Practice Transformation Network**

- Health Systems
- State Organizations
- Regional Extension Centers
- Quality Improvement Organizations
- Primary Care and/or Specialty Care Practices
- Small/Rural/Medically Underserved Practices
- And more!

**Support and Alignment Network**

- Medical Associations
- Professional Societies
- Foundations
- Patient and Consumer Advocacy Organizations
- University Consortiums
- And more!

Any entities with existing federal contracts, grants, or cooperative agreements would need to satisfy both conflict of interest and duplication of effort specifications.
Transforming Clinical Practice Goals

- Support more than 150,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing and procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled
Transforming Clinical Practice Initiative
Phases of Transformation

Set Aims
Use Data to Drive Care
Achieve Progress on Aims
Achieve Benchmark Status
Thrive as a Business via Pay-for-Value Approaches
Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

**FOCUS AREAS**

- Pay Providers
- Deliver Care
- Distribute Information

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**NEXT STEPS:**
Testing of new models and expansion of existing models will be critical to reaching incentive goals.

Creation of a Health Care Payment Learning and Action Network to align incentives for payers.
The Partnership for Patients is focused on two breakthrough aims.

**GOALS:**

40% Reduction in Preventable Hospital-Acquired Conditions
1.8 Million Fewer Injuries | 60,000 Lives Saved

20% Reduction in 30-Day Readmissions
1.6 Million Patients Recover without Readmission
Public-private partnerships generate major national results.
Early elective deliveries are dangerous to both mother and baby.

According to March of Dimes and the evidence, non-medically indicated deliveries before 39 weeks of gestation can result in:

- Underdeveloped vital organs such as the lungs and brain;
- Long-term effects, such as difficulty breathing;
- Increased risk of cerebral palsy; and
- Increased potential for learning disabilities.

The March of Dimes says that if a pregnancy is healthy and there are no complications that require an early delivery, women should wait until labor begins on its own, or until at least 39 weeks of pregnancy.
National collaboration by Partnership for Patients, OB-GYN doctors, March of Dimes and others prevented 34,315 early elective deliveries of babies between 2010 and 2014.

Source: HEN-reported data submitted October 2014.
Note: Baseline and current period rates are rounded for presentation, while the percent improvement is calculated using unrounded data.
HEN baseline and current periods vary. Of the 24 HENs, 1 HEN baseline period is in 2010, 7 begin in 2011, 10 are in 2012, and 10 are in 2013. Most of the baseline periods are quarters, 5 are annual, one is more than a year, and the remaining use less than a full year but at least 3 months. Twenty HENs’ current periods end in Q1 2014 or later, 7 end in 2013, and one ends in Q4 2012; all current periods are 3 months.
4 Examples of Many HEN-Wide Results in Reduction of Early Elective Deliveries

**Carolinias Health Care System**

- Percentage of EEDs
- Year and Month: Aug 10 to Jun 14
- Data points: 9.60%, 2.48%

**New York State**

- Rate of Scheduled Delivery of a Baby
- Year and Month: Jul 12 to Mar 14
- Data points: 11.85%, 2.72%

**Iowa Healthcare Collaborative**

- EED Rate per 100
- Year and Month: Dec 11 to Mar 14
- Data points: 7.55, 1.31

**NoCVA**

- Percent of EED
- Year and Month: Jul 12 to Mar 14
- Data points: 3.5%, 0.8%

Source: HENs Monthly Reports, June 2014.
Potentially Preventable Readmissions (PPR) Data

HEN participating average rate of Potentially Preventable Readmissions
113 (99%) of 114 Minnesota HEN hospitals reporting a 19% decrease
(Q4 2010 - Q4 2013)

19% decrease
# Improving the Distribution of Information

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<tr>
<th>Focus Area</th>
<th>Health IT Feature</th>
<th>Impact</th>
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<tbody>
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<td><strong>Surveillance</strong></td>
<td>Electronic Data Transmission</td>
<td>Real-time Data</td>
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<td>Reduced burden</td>
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<td>Improved patient access</td>
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<td><strong>Prevention</strong></td>
<td>Clinical Decision Support</td>
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<td>Pt Panels / clinical guidelines</td>
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<td>Sharing best practices</td>
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<td><strong>Incentives</strong></td>
<td>EHRs</td>
<td>Progressive MU</td>
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<td><strong>Research</strong></td>
<td>Data Repositories &amp; Registries</td>
<td>Answer research questions</td>
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<td>Identify best practices</td>
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<td>Develop new research questions</td>
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From: National Action Plan for ADE Prevention. DHHS (2014) Table 1, p.19
State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, February, 2015

NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; WA received approval for both demonstrations, but subsequently withdrew its capitated model; NY withdrew its managed FFS proposal. All other states proposed capitated models.

SIM Participation

State Innovation Model Participants
Effective 3/15

- **Test States**
- **Design States**
- **States with Active AF4Q Alliances**

- American Samoa, Northern Mariana Islands, Puerto Rico
Important Transforming Clinical Practice Initiative Web Links


Panelists for Today: “Putting the Pieces Together”

- Dennis Wagner
  - Director, Quality Improvement Innovation Group (QIIG), CMS/CCSQ
  - Co-Director, Partnership for Patients
  - Co-Director, Transforming Clinical Practice Initiative

- Darren DeWalt, MD
  - Director, Learning and Diffusion Group (LDG), CMS/CMMI

- Jennifer Lundblad, PhD, MBA
  - President & CEO, Stratis Health (Minnesota)

- Cally Vinz
  - Institute for Clinical Systems Improvement (Minnesota)
Questions you have processed already:

1. “SAN”: What does this mean to you?
2. “SAN”: How will your understanding evolve over time?
3. How will we create and evaluate impact?
4. How will we generate ROI?
Question 5: Rapid Changes in Health Care and the need for Sensemaking for Providers

• Health care reform is difficult for everyone. The changes are both broad (affecting everything) and deep (profoundly impacting individual programs and providers). Just look at what was covered in this meeting!
• What strategies and approaches can be used by QIOs in this rapidly changing environment?
• What support from CMS would be helpful?
Question 6: Reform calls for thinking and acting in new ways—even with partnerships

- QIN-QIOs have a long tradition of partnering with many organizations. Hospital associations, medical societies, and LTC associations are just a few examples.
- We are in a new era, surrounded by hundreds of new programs and payment models.
- What new partnership opportunities are emerging now, beyond the “traditional” partnerships?
- What might these new types of partnerships look like?
Question 7: Back to the Future--
The power of examples

• Do you find examples of high performance helpful?
• Examples from MN!
• Examples from you!
• How can we generate more examples, faster?