State Innovation Model: Payment model work group kickoff

STATE OF CONNECTICUT

Discussion Document
May 20, 2013
Objectives for today’s discussion

Review

- Connecticut SIM design aspirations and roadmap

Align and finalize

- Guiding principles for payment model reform
- Common terminology and understanding of strategic and technical payment design questions
- Scope of work in coming weeks
Welcome to the SIM design payment model work group

**INTRODUCTIONS AND YOUR EXPECTATIONS**

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<tr>
<th>Co-chairs</th>
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<tr>
<td>Thomas Raskauskas, MD</td>
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<td><em>President/CEO, St. Vincent’s Health Partners</em></td>
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<td>Vicki Veltri, JD, LLM</td>
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<td><em>Project Director, SIM</em></td>
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<td>Paul J. Di Leo, Deputy Commissioner</td>
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<td><em>Dept. of Mental Health and Addiction Services</em></td>
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<td>Robert Smanik</td>
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<td><em>Day Kimball Hospital</em></td>
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<td>Bernadette Kelleher</td>
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<td><em>Anthem BCBS</em></td>
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<td>Todd Staub, MD</td>
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<td><em>ProHealth</em></td>
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<td>Courtland Lewis, MD</td>
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<td><em>Physician specialist - orthopedist</em></td>
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<td>Susan Walkama</td>
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<td><em>Wheeler Clinic</em></td>
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<td>Kate McEvoy, JD</td>
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<td><em>Department of Social Services</em></td>
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<td>Thomas Woodruff, PhD</td>
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<td><em>Office of the State Comptroller</em></td>
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<td>Lori Pasqualini</td>
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<td><em>Connecticut Business Group on Health</em></td>
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Note: Aetna to be included in future work groups
ROADMAP

Working group norms - expectations for how we will work together

- **Objectives**
  - Develop recommendation on payment model design to incentivize providers to optimize quality and better manage costs

- **Presence**
  - Attend bi-weekly meetings with full group
  - Participate actively in discussions to jointly shape work group thinking
  - As needed, meet with facilitators one-on-one or in small groups in between workgroup meetings to move the answer forward
  - Respond promptly to email and phone requests

- **Mindset**
  - Leave day job at the door, think of best interest of Connecticut
  - Seek consensus amongst working group

- **Action**
  - Build momentum and excitement in your respective communities
  - Champion this effort broadly
  - Shape the future of health care delivery in Connecticut
Connecticut has a unique opportunity to address quality, access, and cost challenges today

Although Connecticut ranks at or above the national average on many indicators of health, there exists opportunity for improvement

- Connecticut is among the top five states with the lowest rates of smoking, premature deaths, and poor mental health days and the highest rates of immunization coverage; is among the top quartile of states with the lowest obesity rates; and is among the top 50% of states with the lowest rates of preventable hospitalizations, diabetes, infant mortality, cardiovascular deaths, and cancer deaths
- Health disparities, however, continue to exist across racial and ethnic groups, illustrated by the variability in the infant mortality rate of non-hispanic black infants that is 3x that of non-hispanic white infants
- Connecticut meets national average on select indicators of quality and patient experience, but quality varies significantly across regions

At the same time, Connecticut lacks a solution for the state to address the steep growth in state health expenditures

- Connecticut faces a potential ~$1B budget deficit in 2014 and 2015, driven in part by an increase in health care spending, which continues to grow at a rate higher than Connecticut’s gross state product
- Connecticut has the third highest per individual health care spend (including the highest per enrollee spend on Medicaid patients, 8th highest per enrollee spend on Medicare patients)
- Inefficiencies in health care utilization continue to exist today, illustrated by the significant utilization of high-cost care settings (e.g., emergency department) for non-urgent visits

While Connecticut has many payment and care delivery innovations underway, no common model is shared across Medicaid, Medicare, and Commercial insured populations

The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration
CT has support from CMMI to innovate care delivery and payment model reforms and has high aspirations for what it can achieve.

CMMI guidance for State Innovation Models (SIM) design states . . .

- Design care delivery and payment reform that touches **80% of state lives within 5 years**
- Roll-out across multiple payers’ populations in a truly **multi-payer approach**
- Describe how **“broad-based accountability for outcomes, including total cost of care** for Medicare, Medicaid, and CHIP beneficiaries, is created”
- Test innovative payment and service delivery models that have the potential to **“lower costs,” while “maintaining or improving quality of care”**

. . . helped shape Connecticut’s targeted aspirations

- Gain alignment around a common care delivery and payment model that is applicable across Medicare, Medicaid, and Commercial populations
- Define a solution that incorporates total cost of care accountability
- Maintain or improve leading indicators of health and patient experience under the new care delivery and payment model
- Establish timeline for rollout that will meaningfully curb health care spending growth within 3-5 years

SOURCE: CMMI Funding Opportunity Announcement, Connecticut SIM grant award letter
The SIM Design phase extends from April through September

April - September  

**Design phase**

- Understand current state
- Establish vision

**Options and hypotheses**

- Identify target populations and sources of value
- Develop health care delivery system hypothesis
- Pressure-test health care delivery system hypothesis
- Develop payment model hypothesis
- Align key stakeholders

**Design and planning**

- Design detailed health care delivery system and payment model
- Develop implementation and roll-out plan
- Align on key quality metrics

**Finalization**

- Draft testing proposal
- Syndicate with key stakeholders
- Refine and submit testing proposal

October to early 2014  

Mid-2014 to 2017  

**Testing grant application review and selection**

**Testing phase**

**ROADMAP**

**April**  

- Project set-up
  - Understand current state
  - Establish vision

**May**  

- Options and hypotheses
  - Identify target populations and sources of value
  - Develop health care delivery system hypothesis
  - Pressure-test health care delivery system hypothesis
  - Develop payment model hypothesis
  - Align key stakeholders

**June**  

- Design and planning
  - Design detailed health care delivery system and payment model
  - Develop implementation and roll-out plan
  - Align on key quality metrics

**August**  

- Syndication
  - Draft testing proposal
  - Syndicate with key stakeholders

**September**  

- Finalization
  - Refine and submit testing proposal

**ESTIMATED**

- Design detailed health care delivery system and payment model
- Develop implementation and roll-out plan
- Align on key quality metrics
The HIT work group will provide recommendations to SHIP, the primary decision-making body.
The payment work group will make recommendations to the SHIP at regular intervals

April

- 4/30 SHIP kick-off

May

- Target sources of value
- Options preview
- 5/20

June

- Leading care delivery model option
- New workforce and skill requirements
- 6/10

July

- Detailed design
- Workforce strategy
- Community engagement plan
- 7/8

- Care delivery roll-out plan
- 7/29

Payment model

- Leading payment model option
- 6/10

- Detailed design
- Quality metrics
- 7/8

- Payment roll-out plan
- 7/29

Health information and technology

- Detailed requirements for data capacity, linkages, and reporting
- 7/8

- HIT roll-out plan
- 7/29
We will now break into small groups as a way of starting to pull everyone into the discussion

**Purpose**

- Understand how improvements to the current fee-for-service payment model can promote value and improve health

**Approach**

- Break-out into groups of 3-4
- Share your personal experiences and expectations:
  - Personal experiences of failure of FFS payment
  - Expectations for how a new model would improve care
- Return to the larger group to share 3-5 examples of each based on your personal experience or expectations

**Timing**

- **5 minutes**: Reflect individually and write down thoughts
- **5 minutes**: Share in your small group of 3-4
- **5 minutes**: Report back to the full workgroup
The payment work group will be defining in the near-term a set of principles to guide payment design decisions.

Example guiding principles

▪ Providers should be rewarded for effective behaviors (quality and cost)
▪ If successful, providers will be held accountable for elements within the scope of provider control
▪ Payment model must be financially sustainable
▪ Payment model should help improve – not detract from – patient access and health equity
▪ Payment model should complement and enable the care delivery model

▪ Which of these align with your beliefs about payment?
▪ What else should guide payment model design?
Several strategic design considerations will be relevant for payment innovation (1/2)

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<tr>
<th>Strategic design considerations</th>
<th>Illustrative examples of options</th>
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<td><strong>1 Metrics</strong></td>
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<tr>
<td>▪ What will be the scope of accountability for cost and quality?</td>
<td>▪ Population health, episodes of care, discrete encounters</td>
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<td>▪ What are the sources of value we hope to promote with the payment model?</td>
<td>▪ Effective diagnosis and treatment, selection of provider and care setting, chronic disease management</td>
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<td>▪ What metrics will be used for eligibility for participation and eligibility for payment?</td>
<td>▪ Structure (e.g., EMR adoption), processes (e.g., create a care plan), outcomes (e.g., lower costs, complications)</td>
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<td><strong>2 Payment</strong></td>
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<td>▪ What is the reward structure?</td>
<td>▪ Global payment, gain/risk sharing, P4P, conditional care coordination fees, conditional FFS enhancements</td>
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<td>▪ How do we define the level of performance we wish to reward?</td>
<td>▪ Absolute, relative, improvement</td>
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<td>▪ What are the targets, pricing, and risk corridors?</td>
<td>▪ Quality targets, care coordination fees and/or bonus payment amount, benchmark trend, minimum savings, risk sharing splits, stop loss, gain sharing limits</td>
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Across each of these design decisions, how important is it for state and commercial payers to be aligned?
Several strategic design considerations will be relevant for payment innovation (2/2)

### Strategic design considerations

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<th>3 Attribution</th>
<th>Illustrative examples of options</th>
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<td>▪ What will be the rule for attribution?</td>
<td>▪ Prospective member selection, plan auto-assignment, retrospective attribution</td>
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<td>▪ At what level will performance be aggregated for measurement and rewards?</td>
<td>▪ By physician, practice, virtual pod, or ACO/joint venture</td>
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<td>▪ What exclusions and adjustments will be applied for fairness and consistency?</td>
<td>▪ Risk adjustment and/or exclusions by: beneficiary, clinical, outlier, provider-option, and/or actuarial minimums</td>
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### 4 Rollout

| ▪ What will be the pace of roll-out of the new payment model throughout the state? | ▪ Mandatory and universal, staged by geography or other criteria, voluntary |
| ▪ At what pace should accountability and payment type for participating providers be phased in? | ▪ Baseline reporting period, transitional payment model (e.g., P4P), direct to end state (e.g., risk sharing) |

Across each of these design decisions, how important is it for state and commercial payers to be aligned?
This will be the first in a series of workshops to design a new payment model along the key dimensions of a payment model.

- **Overview and guiding principles**
- **Defining cost of care, exclusions, adjustments**
- **Balancing financial stewardship and behavioral change**
- **Operationalizing the payment model**
- **Strategic payment model design decisions**
Five workshops will span six to eight weeks with analysis and prep work in between

<table>
<thead>
<tr>
<th>Workshop title</th>
<th>Description</th>
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| **May 20:** Overview and guiding principles | - Review vision for care delivery and payment innovation  
- Align on guiding principles for payment innovation  
- Understand scope of payment model options and design parameters  
- Discuss strategic payment model design considerations |
| **June 3:** Strategic payment model design decisions | - Review synthesis of strategic payment model design decisions  
- Discuss data around industry/provider landscape (e.g., fragmentation)  
- Discuss member attribution and implications on patient panel sizes  
- Discuss structures, processes, and/or outcomes to measure under new payment model (e.g., metrics) |
| **June 17:** Defining cost of care, exclusions, adjustments | - Align on metrics and plan for staging accountability for metrics  
- Discuss how providers will be supported to participate in care delivery and payment model (e.g., in-kind support)  
- Understand rationale for using different tools to mitigate volatility (MSRs, virtual pooling, accruals, joint venture, etc.)  
- Discuss required risk adjustors, exclusions, and adjustments to mitigate risk |
| **July 1:** Balancing financial stewardship and behavioral change | - Review base case, total reward to providers, and yearly payouts  
- Discuss tradeoffs of financial sustainability and motivating change  
- Suggest refinements to incorporate |
| **July 15:** Operationalizing the payment model | - Align on payment implementation plan with phasing, including plan to support provider transition  
- Develop communication plan vis-à-vis providers |
Next steps

- Core team to synthesize early discussion on guiding principles for payment model design
- Participants to inventory metrics being tracked within your organizations and prepare to share at the next work group meeting
- All to convene in next work group meeting the week of June 3 to begin to align around “straw man” for strategic design decisions