



# Connecticut SIM

## *SHIP Steering Committee*

Discussion document  
July 29, 2013

# Agenda

- Review recommendations from care delivery, payment, and HIT work groups ▪ 50 min
- Discuss targets to measure program success ▪ 30 min
- Align on plan for syndication/finalization ▪ 10 min

# 1 Who are the target populations?

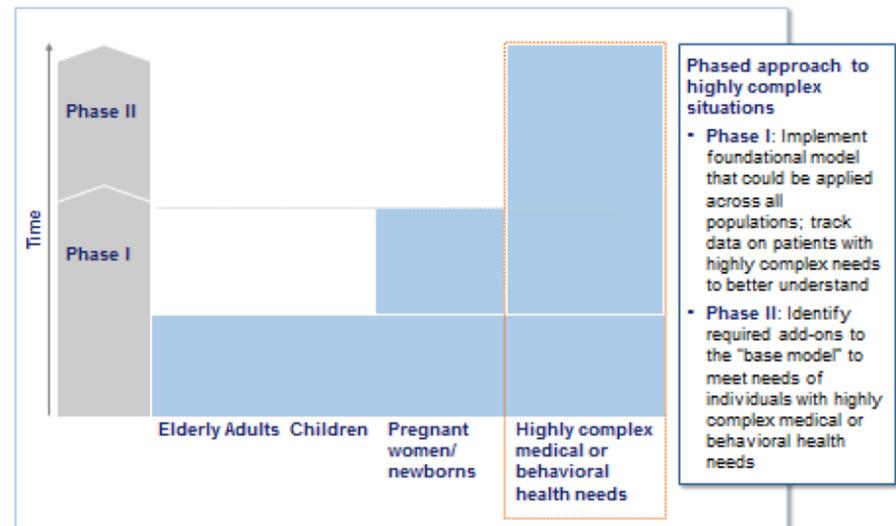
Connecticut will target the **foundational needs** of Connecticut's population with its new care delivery and payment model

Individuals with highly complex medical or behavioral health needs may require **additional layers of care-delivery innovation** to address their unique needs

Connecticut's foundational **medical home model** will make it possible for these "add-ons" to be layered on in later stages

This implies that patients currently receiving the majority of their care in **behavioral health homes** will remain there

We discussed designing a model that could be foundational across populations, with phasing in of add-ons to account for complexity



## 2 What are the key sources of value to address?

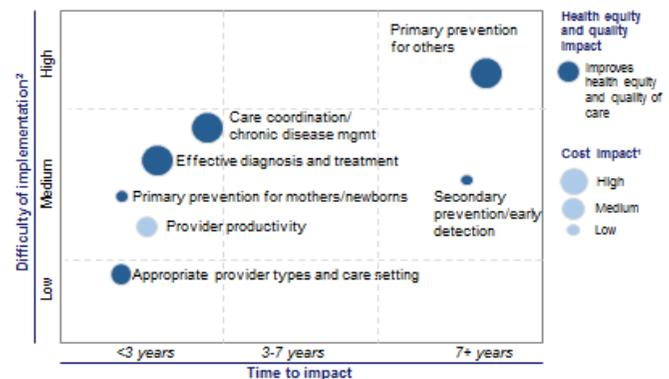
Connecticut’s population health, medical home model enables it to target multiple sources of value which represent **opportunities to remove waste and improve sub-par care in the current system**

**Appropriate provider types and care setting, effective diagnosis and treatment selection, and care coordination/chronic disease management**, will be prioritized due to their ability to **achieve cost, quality and health equity impact** within a short period of time (e.g., the time frame of the SIM testing grant) and be targeted with interventions broadly across the state; **for mothers and newborns, primary prevention will be prioritized**

### Sources of value

	Description	Examples
Primary prevention	• Prevention of disease by removing root causes	• Smoking cessation • Diet and exercise
Secondary prevention/ early detection	• Early detection of disease while asymptomatic to prevent disease progression	• Cervical cancer screening • Identification and management of patients at high risk for heart disease
Appropriate provider types and care setting	• Utilizing highest value provider types and care settings	• Choice of care setting for immunization administration • Optimized utilization of physician extenders
Effective diagnosis and treatment selection	• Evidence-informed choice of treatment method/intensity	• Enforcement of evidence-based inpatient clinical pathways
Provider productivity	• Reducing waste at provider center	• Improve flow in OR to increase number of surgeries performed daily • Streamline emergency room triaging
Care coordination / chronic disease management	• Ensuring patients effectively navigate the health system and adhere to treatment protocols	• Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)

### Prioritization matrix of sources of value



1 Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics  
2 Includes assessment of historical success rates and execution risk

### ③ What barriers need to be overcome?

Connecticut's model will **overcome barriers** which arise at multiple stages of a consumer's health - well-state, diagnosis, treatment for either a chronic condition or acute condition, post treatment care

- Lack of **whole person-centered care** and population health management
- **Restricted access** to appropriate care
- **No team-based** coordinated comprehensive **approach** to care
- **Limited consumer engagement**
- **Insufficient use of evidence-informed** clinical decision making
- **Inadequate performance management**

#### Barriers identified fall into 6 categories (1 of 2)

	Barriers
① Lack of whole-person-centered care and population health management	<ul style="list-style-type: none"> <li>• Lack of understanding of whole-person context (social, cultural, behavioral)</li> <li>• Limited access to whole-person data at point of care to promote more accurate diagnosis and treatment planning</li> <li>• Lack of infrastructure to risk-stratify consumers and prevent disease onset in high-risk consumers</li> </ul>
② Restricted access to appropriate care	<ul style="list-style-type: none"> <li>• Limited capacity (e.g., limited time, inefficient use of time) of providers</li> <li>• Lack of consumer access to appropriate care (e.g., primary, specialty, behavioral)</li> <li>• Cost of treatment prevents adoption</li> <li>• Limited availability of culturally/ linguistically accessible care</li> </ul>
③ No team-based, coordinated, comprehensive approach to care	<ul style="list-style-type: none"> <li>• No single point of accountability for consumer's total care</li> <li>• Limited incentives for provider for admission, transfer, and discharge planning</li> <li>• Suboptimal or no triage process to direct consumers to right site of care</li> <li>• Providers do not interact with the consumer's community</li> <li>• Providers (e.g., specialists) have limited vision to own sphere of influence</li> <li>• Limited use and multiple formats of HIT systems across providers and care settings lead to medical errors/ redundancies</li> <li>• No comprehensive treatment plan developed for consumers</li> <li>• Poor relationships and communication among providers</li> </ul>

#### Barriers identified fall into 6 categories (2 of 2)

	Barriers
④ Limited consumer engagement	<ul style="list-style-type: none"> <li>• Consumers lack incentives and are not enabled to be involved in self-diagnosis, self-care, and healthy behaviors</li> <li>• Consumers are not aware of available health care resources</li> <li>• Consumers do not understand educational materials</li> <li>• Consumers do not have quality and cost data to inform decisions (e.g., visit highest value provider)</li> <li>• Consumers have difficulty being compliant with treatment/rehab plans</li> <li>• Wellness resources are not readily accessible by consumers</li> <li>• Lack, or limited distribution, of health literacy (including screening education) programs</li> <li>• Policies and funding not in place to promote healthy behaviors</li> <li>• Limited communication channels/processes among consumer and other providers involved in care</li> </ul>
⑤ Insufficient use of evidence-informed clinical decision making	<ul style="list-style-type: none"> <li>• Best clinical practices not standardized</li> <li>• Limited health IT infrastructure to support clinical decision making</li> <li>• FFS reimbursement rewards overtreatment</li> </ul>
⑥ Inadequate performance management	<ul style="list-style-type: none"> <li>• Limited quality and cost transparency data</li> <li>• Multiple formats of information systems</li> </ul>

## 4 What interventions and changes in behaviors/ processes, and structures are required to capture sources of value?

Connecticut's **state-wide population-health model** directly addresses barriers to high quality, high value care. The **medical home approach**, in which a primary care provider helps coordinate the entirety of a person's care, sits at the **cornerstone of the model**. This model will overcome barriers to access sources of value and **achieve high quality, low cost care**. The population-health model has six key components:

- Whole person centered care and population health management
- Enhanced access to care (structural and cultural)
- Team-based, coordinated, comprehensive care
- Consumer engagement
- Evidence-informed clinical decision making
- Performance management

### Prioritized list of interventions (1 of 2)

#### Prioritized interventions

- |  |  |
|--|--|
| <p>1 Whole-person-centered care and population health management</p> | <ul style="list-style-type: none"> <li>• Identify consumers with high-risk or complex care needs</li> <li>• Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors<sup>1</sup>, behavioral health and other co-occurring conditions, and ability to self-manage care</li> </ul>   |
| <p>2 Enhanced access to care (structural and cultural)</p>           | <ul style="list-style-type: none"> <li>• Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication</li> <li>• Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers</li> <li>• Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours)</li> </ul> |
| <p>3 Team-based, coordinated, comprehensive care</p>                 | <ul style="list-style-type: none"> <li>• Provide team-based care from a prepared, proactive team</li> <li>• Integrate behavioral and primary care with "warm hand-offs" between behavioral health and primary care practitioners (on-site if possible)</li> <li>• Develop and execute against a whole-person-centered treatment plan</li> <li>• Coordinate across all elements of a consumer's care</li> </ul>   |

<sup>1</sup> Including history of trauma, housing instability, access to preventive oral health services

### Prioritized list of interventions (2 of 2)

#### Prioritized interventions

- |   |  |
|---|--|
| <p>4 Consumer engagement</p>                        | <ul style="list-style-type: none"> <li>• Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice</li> <li>• Use person centered care planning methods to develop and support implementation of self-management care plan</li> <li>• Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal</li> </ul> |
| <p>5 Evidence-informed clinical decision making</p> | <ul style="list-style-type: none"> <li>• Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice—ensure data is actionable and timely</li> <li>• Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression)</li> <li>• Maintain disease registry</li> <li>• Implement evidence-based guidelines</li> </ul>  |
| <p>6 Performance management</p>                     | <ul style="list-style-type: none"> <li>• Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks</li> <li>• Use performance and consumer experience data to continuously improve whole person centeredness</li> <li>• Establish learning collaboratives to disseminate best practices</li> </ul>  |

## 5 What roles will need to be fulfilled to implement these interventions?

Connecticut's model will require a care team of **traditional and non-traditional health workers** providing a **whole person centered approach**. It will particularly leverage **community health workers** across Connecticut's diverse population. It will encourage various individuals to collaborate across primary, acute, specialist, community, and social care. It will particularly require **collaboration between primary care and behavioral health providers**.

While it necessitates a team approach and collaboration across multiple provider types, Connecticut's **model is flexible** in that it does not define the leader, or composition, of care teams. Care teams should have a set of "**core providers**" who provide primary care (e.g., **PCPs, APRNs**) but the model does not impose any other limitations on the structure or exact composition of the care team, e.g.

- **Specialists, behavioral health providers, and physician extenders** can be included on the care team as the entity deems necessary
- The "leader" of the care team can be selected by each entity; **leadership may be fluid** and vary with consumer's health needs

# ⑥ What entities are optimally positioned to fulfill these roles and which will be primary?

Connecticut's model is **not prescriptive on the structure of participating provider entities** as it is designed to meet providers where they are and **support them in their transformation** towards managing the care of a population and achieving the triple aim. Providers will need to have a **sufficient volume of patients** in aggregate to achieve statistical significance when measuring performance.

**Connecticut will define practice standards**, phased over time, which encourage practices to **transform towards managing total cost of care**. These standards will be largely drawn from NCQA, AAAHC, URAC, Joint Commission, CMMI and other national standards which will be tied to practice transformation support. The models' initial **barrier to entry will be low** (e.g., self-assessment and statement of commitment) for initial period of program. Standards will **become increasingly rigorous and outcome based** over time to guide practices on their path towards managing the total cost of care. Practices which are already nationally accredited will **not have to duplicate accreditation**, but rather may have to meet a few additional standards.

As long as entities have lead provider and meet pre-qualification criteria we outlined, we are not prescriptive about required levels of integration

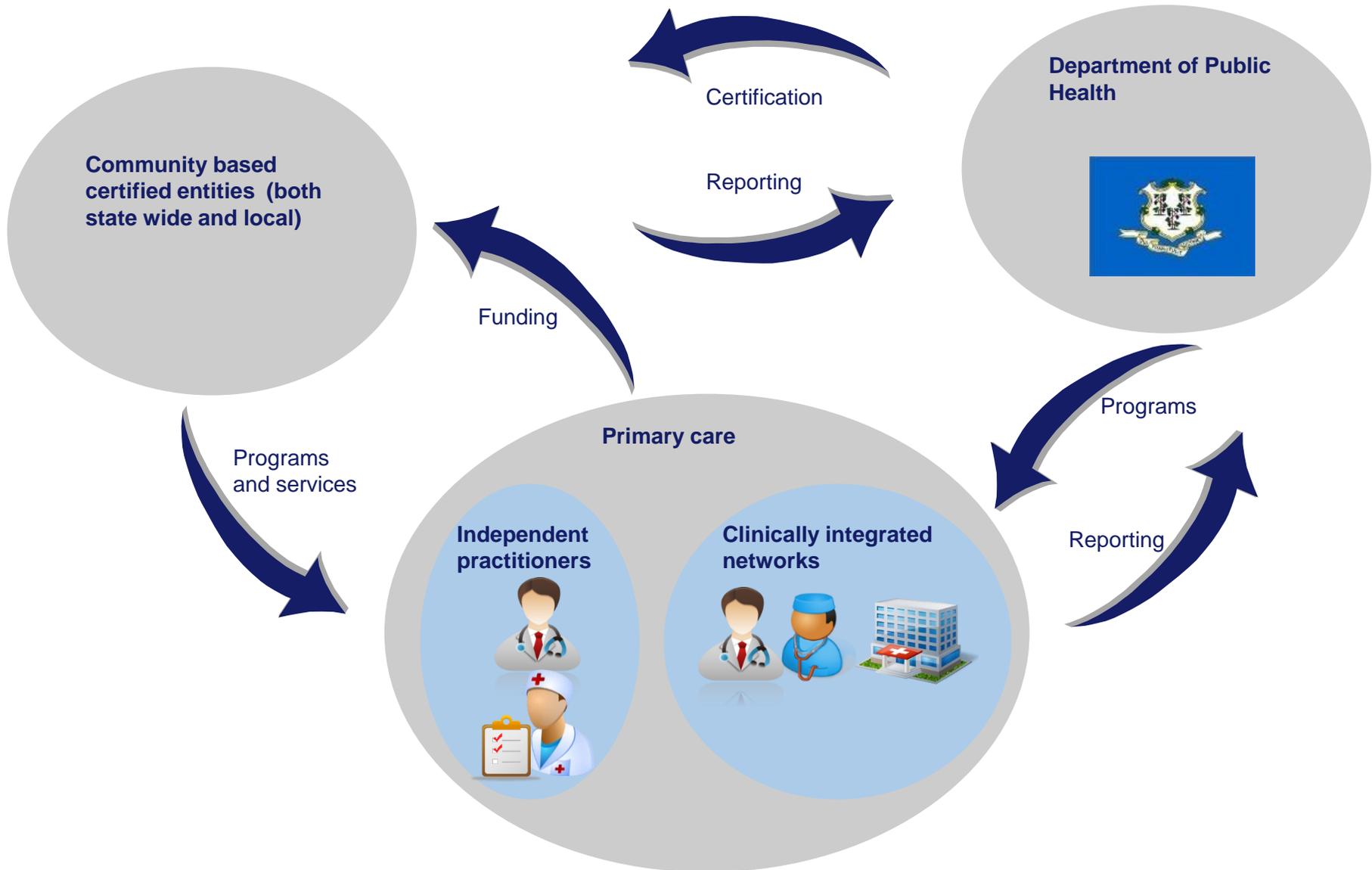
	Advanced primary care model			Integrated delivery network		
	Single PCP	PCP practices	Geo-centric risk pool of PCPs/ practices	Integrated groups of PCPs/ practices	+ Specialists/ behavioral health	+ Hospitals + Community orgs
Clinical integration						
Shared infrastructure (e.g., HIT)						
Financial integration (ability to bear risk, scope of accountability)						

Differences in level of clinical/financial integration and data sharing have implications on how care is delivered and total cost of care is optimized

	Advanced primary care model			Integrated delivery network		
	Single PCP	PCP practices	Geo-centric risk pool of PCPs/ practices	Integrated groups of PCPs/ practices	+ Specialists/ behavioral health	+ Hospitals + Community orgs
Optimized referrals						
Negotiation of provider fees						
Improved coordination/standardization						
Optimized HIT and provider support tools						

Optimal for market with high level of provider variability
Optimal for market with less provider variability

# ⑥ Primary care practices will be able to draw on support from certified community based support organizations

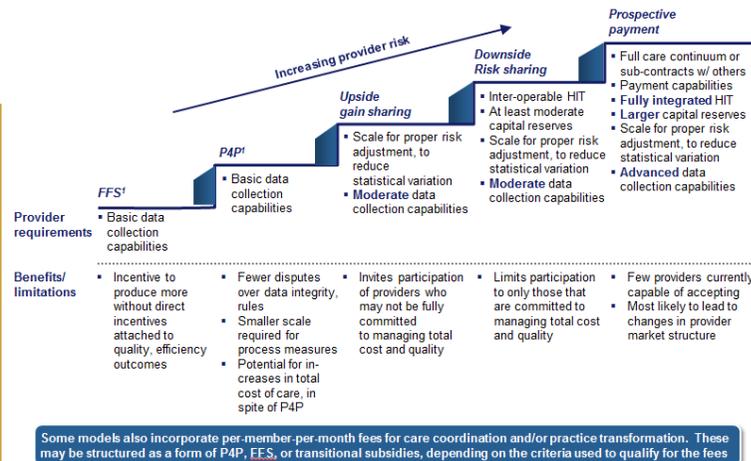


# 1 Reward structure recommendation

- The reward structure will reward providers for managing the health quality and costs for a panel of patients
  - Key aim of reward structure is total cost of care accountability; payers will determine on a payer-by-payer basis the extent to which risk and savings will be shared with providers
  - A transitional pay-for-performance model will be put in place in Year 1 to help enable smaller providers to ultimately manage total cost of care
- In both models, providers will be rewarded for both absolute performance and performance improvement
- Performance and shared savings payments will be contingent on meeting minimum quality standards

REWARD STRUCTURE

There are a range of reward structures that can be used to hold providers accountable...



REWARD STRUCTURE

We will hold providers accountable for both absolute performance and performance improvement

Options

- 1 Absolute performance
- 2 Performance improvement
- 3 Both absolute performance and improvement (e.g., progressive rewards)
- 4 Another option

Considerations for selecting absolute/relative

Absolute

- Rewards distinctive performers
- Targets held constant for several years
- Additional cost to payer

Relative

- Provides incentives to all providers regardless of starting point
- Facilitates performance improvement through setting flexible targets
- Budget neutral to payer

# 2 Metrics recommendation

- In year 1 of the pay for performance track, providers should be eligible for rewards for quality alone; in subsequent years, rewards should be contingent on both quality and cost savings
- Both the total cost of care and pay for performance tracks will be tied to a common scorecard for the Triple Aim
  - This scorecard will be accompanied by a set of practice standards that are required for initial and ongoing participation in the care delivery and payment models, with a low barrier to initial entry
  - It will also differentiate whether metrics will be used to determine eligibility of payment and level of payment in Year 1. Metrics that are selected but cannot, for various reasons, be used to hold providers accountable in Year 1 will be reporting only for that year
  - We will define a Version 1.0 of that scorecard through the metrics taskforce, to be refined following submission of the grant application

METRICS

We reviewed a core set of CMMI measures and suggested some Connecticut-specific additions

Illustrative CMMI core measures	Work group additions
<b>1 Whole-person-centered care and population health mgmt.</b> <ul style="list-style-type: none"> <li>Follow-up hospitalization after mental illness</li> <li>Tobacco use assessment and tobacco cessation intervention</li> <li>CAHPS surveys</li> </ul>	<ul style="list-style-type: none"> <li>Completion of wellness assessments and treatment plans</li> <li>Primary care quality measures, incl. quality indices</li> <li>Total medical cost per member</li> <li>Care plan/learning collaborative</li> </ul>
<b>2 Enhanced access to care (structural and cultural)</b> <ul style="list-style-type: none"> <li>Well-child visits in the first 15 months of life</li> <li>Hospital ED visit rate that did not result in hospital admission, by condition</li> </ul>	<ul style="list-style-type: none"> <li>Patient portal, provider website, and e-consults</li> <li>Availability &gt; normal business hours</li> <li>Time of discharge until next visit</li> <li>Translation services</li> <li>Patient surveys</li> <li>Ambulatory sensitive admissions</li> </ul>
<b>3 Team-based, coordinated, comprehensive care</b> <ul style="list-style-type: none"> <li>Post-discharge continuing care plan transmitted to next level of care provider upon discharge</li> <li>Care transition record transmitted to health care professional</li> <li>Medication reconciliation</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>4 Consumer engagement</b> <ul style="list-style-type: none"> <li>Transition record with specified elements received by discharged patients</li> <li>CAHPS Surveys</li> <li>CARE-F and CARE-C tools</li> <li>Clinical care measures (e.g., chronic disease testing and care, mental health)</li> </ul>	<ul style="list-style-type: none"> <li>Addition of select NQF metrics (e.g., individual engagement measure derived from individual engagement domain of C-CAT)</li> <li>Standard clinical pathways</li> <li>Bidirectional sharing of information</li> <li>Ongoing review and validation of current standards</li> <li>Medication interaction</li> <li>Appropriate use of procedures</li> </ul>
<b>5 Evidence-informed clinical decision making</b> <ul style="list-style-type: none"> <li>Medication reconciliation</li> <li>Admission statistics by chronic condition (e.g., COPD)</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>6 Performance management</b> <ul style="list-style-type: none"> <li>Adoption of medication e-prescribing</li> <li>Adoption of HIT</li> <li>Ability for providers with HIT to receive laboratory data electronically</li> <li>ED visit rate that did not result in hospital admission</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>

METRICS

Our "Version 0.1" medical home scorecard to be refined in coming weeks

Population health aspect	Measure title	Population health aspect	Measure title
Whole-person-centered care and pop. health mgmt.	Assessment completion rate <sup>1</sup>	Team-based, coordinated, care (cont.)	3-item care transition measure
	Risk stratification of consumer panel conducted		Demonstrated use of intensive case mgmt. tools
Enhanced access to care (structural and cultural)	Access to care outside normal business hours	Consumer engagement	Assessment of consumer progress towards treatment and follow-up when necessary
	E-consult capability		Patient portal
	Transition services		Demonstrated use of "Choosing Wisely" campaign to raise awareness at the point of care
Team-based, coordinated, care	Convenient availability including same day access	Evidence informed clinical decision making	Provision of quality cost information at point of care
	Availability of non-visit based options (e.g. telehealth through telephone, email, text, video)		Periodic review to ensure self-management care plan takes into account targeted considerations
	Care planning infrastructure		Quality index <sup>2</sup>
	Follow-up after hospitalization for mental illness		Adoption of HIT infrastructure
	Medication reconciliation		Ability for providers with HIT to receive lab data
	Demonstrated infrastructure to coordinate with community resources, including behavioral health practitioners and community-based sites of care		Maintenance of disease registry
Adoption of Medication e-prescribing	Ensure use of actionable data (e.g., disease registry)		
Post-discharge continuing care plan created	Evidence-based, standardized care pathways		
Post-discharge continuing care plan transmitted to next level of care provider upon discharge	Bi-directional provider information sharing (e.g., HIE)		
Care transition record transmitted to Health Care professional	Demonstrated implementation and periodic review of evidence-based guidelines		
Transition record with specified elements received by discharged by patients	Total medical cost per member		
	Utilization index <sup>3</sup>		
	Participation in learning collaborative		
	CAHPS and other patient surveys collected		
	Completion of performance review based on practice data to improve whole center/hood		

1 Based on claims data 2 Either based on clinical data that is already being measured, but is not reported today or a one-time measurement  
 3 Clinical data that is not being measured today 4 Completion of whole person assessments that consider consumer/family, risk, and behavioral health factors and ability to self-manage care 5 Detail on subsequent pages; utilization index for reporting purposes only  
 Note: Italicized measures indicate CT specific additions (both by the payment work group and to meet specific care delivery work group intervention)

### 3 Attribution recommendation

- *[Placeholder for today's discussion on consumer attribution strategies]*
- For robust performance measurement, aggregation will be recommended across purchasers at a minimum
  - This recommendation will allow for nearly all providers in Connecticut to participate in the P4P model
- Additional aggregation will be required for smaller providers to participate in the total cost of care model
  - Providers will be encouraged to aggregate through joining (or forming) corporate entities or other formal legally and financially integrated structures or to participate in a form of geo-centric aggregation, with resources and support provided by a public utility

CONSUMER ATTRIBUTION

Minimum scale is required for meaningful quality measurements

Triple Aim goals	Types of metrics	Minimum patient population <sup>1</sup>
Health	<ul style="list-style-type: none"> <li>▪ Health risk factors (e.g. obesity)</li> <li>▪ Prevalence of illness and injury</li> </ul>	<ul style="list-style-type: none"> <li>▪ Moderate (100-1,000)</li> </ul>
Health care	<ul style="list-style-type: none"> <li>▪ Patient satisfaction</li> <li>▪ Quality of care                             <ul style="list-style-type: none"> <li>— Structure</li> <li>— Process</li> <li>— Outcomes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Low to moderate (&lt;1,000)</li> <li>▪ Depends on specific metrics                             <ul style="list-style-type: none"> <li>— Low (&lt;100)</li> <li>— Moderate (100-1,000)</li> <li>— High (5,000+)</li> </ul> </li> </ul>
Costs	<ul style="list-style-type: none"> <li>▪ Total cost of care</li> <li>▪ Resource utilization, e.g.,                             <ul style="list-style-type: none"> <li>— Hospital days per 1,000</li> <li>— Emergency room visits per 1,000</li> <li>— Generic prescribing rates</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ High (5,000+)</li> <li>▪ Depends on specific metrics                             <ul style="list-style-type: none"> <li>— Moderate (100-1,000)</li> <li>— Moderate (100-1,000)</li> <li>— Low (&lt;100)</li> </ul> </li> </ul>

**Implications**

- Moderate scale required for P4P likely to require aggregation across payers or across providers
- High scale required for Total Costs to require aggregation across payers and across providers

<sup>1</sup> Rule of thumb, to be validated for each metric based on relevant population

PERFORMANCE AGGREGATION

Potential models for aggregating provider performance

Options	Description
<p>1 Corporate Entities</p> <ul style="list-style-type: none"> <li>▪ Medical group practice</li> <li>▪ Hospital system with employed physician</li> </ul>	<ul style="list-style-type: none"> <li>▪ Legally and financially integrated physicians</li> <li>▪ Level of shared clinical infrastructure may vary</li> <li>▪ Potential to distribute bonuses/gains through employment agreements</li> </ul>
<p>2 Formal "Joint Ventures"</p> <ul style="list-style-type: none"> <li>▪ Accountable Care Org</li> <li>▪ Physician-Hospital Org</li> <li>▪ Independent Practice Association</li> </ul>	<ul style="list-style-type: none"> <li>▪ Joint venture or other formal contractual relationship among otherwise independent providers</li> <li>▪ Provides legal/financial framework for co-investment in clinical infrastructure and/or distribution of bonuses/gains</li> </ul>
<p>3 Virtual Panels</p>	<ul style="list-style-type: none"> <li>▪ Informal relationship of independent providers who self-select to aggregate performance</li> <li>▪ Agreement to accept rewards from payor(s) based on aggregate performance</li> <li>▪ Distribution of bonuses/gains based on pre-determined formula established with payer</li> <li>▪ Potential for coordinated procurement of technology/services from the same vendor(s)</li> <li>▪ No legal/financial framework for co-investment</li> </ul>
<p>4 Geographic risk pools</p>	<ul style="list-style-type: none"> <li>▪ Performance aggregated among providers in a region</li> <li>▪ Rewards distributed based on pre-determined formula</li> <li>▪ Potential to share technology/services provided by payer(s)</li> <li>▪ No legal/financial framework for co-investment</li> </ul>

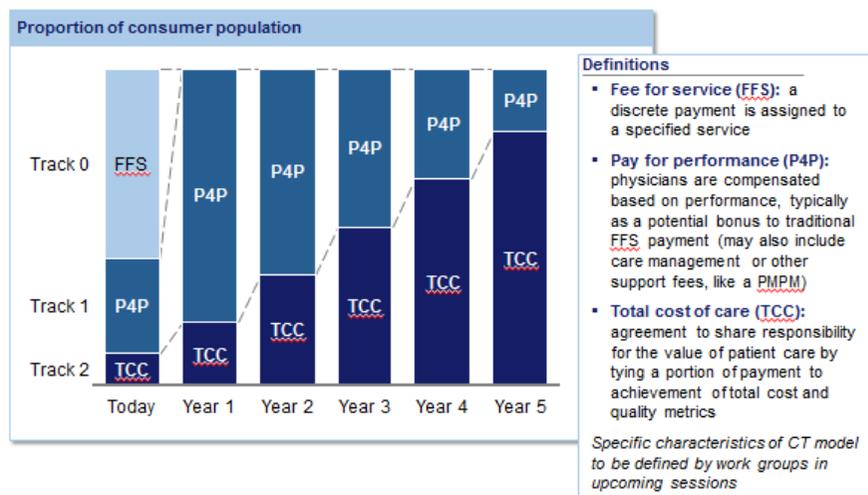
**Disclaimer:** the core team is currently seeking further counsel on the permissibility of above options to ensure compliance with anti-trust regulations and Federal Trade Commission (FTC) rulings

## 4 Rollout recommendation

- Establish a two-track approach to reward providers for effective management of a population of patients
  - Track 1 will offer pay-for-performance payments to support providers currently unable to manage a panel of patients to do so by year 5
  - Track 2 will be a total cost of care model for providers able to manage the health and overall costs of a panel of patients in year 1
- Roll-out is staged with the goal that 80% of all consumers in Connecticut will be accounted for in a total cost of care accountability model by year five of testing the model

### ROLLOUT

We aligned on a two-track approach to enable providers to adopt innovative reforms ILLUSTRATIVE



# 1 What capabilities are required across key stakeholders to implement the target care delivery and payment model?

Category	Strawman answer	Typical tech pathway
<p><b>Payer analytics</b> complemented by <b>provider analytics</b></p>	<ul style="list-style-type: none"> <li>Tools for payers to analyze claims to produce payment-related analytics, including metrics for outcome, quality and cost</li> <li>Complemented by provider analytics based on clinical data</li> </ul>	<ul style="list-style-type: none"> <li>Heavy <b>upfront development/sourcing</b> followed by incremental enhancement</li> </ul>
<p><b>Provider-payer-patient connectivity</b></p>	<ul style="list-style-type: none"> <li>Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models</li> </ul>	<ul style="list-style-type: none"> <li>Start <b>with basic or low tech solutions</b> to allow time for development or sourcing of tech-enabled enhancement</li> </ul>
<p><b>Provider-patient care mgmt. tools</b></p>	<ul style="list-style-type: none"> <li>Provider tools (e.g., workflow, event management, analytics) to coordinate the medical services for a patient</li> </ul>	<ul style="list-style-type: none"> <li>Dependent on state-specific <b>starting point</b> and <b>strategy in place</b></li> </ul>
<p><b>Provider-provider connectivity</b></p>	<ul style="list-style-type: none"> <li>Integrated clinical data exchange among doctors, hospitals, and other health care providers through a secure, electronic network</li> </ul>	

SOURCE: HIT workgroup discussions

## 2 What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?

Category	Strawman answer
<p><b>Payer analytics</b> complemented by <b>provider analytics</b></p>	<ul style="list-style-type: none"> <li>▪ Existing payer risk adjustment, performance analytics tools deployed as part of <b>PCMH/ACO pilots</b></li> <li>▪ All payers claims database efforts (<b>APCD</b>) led by AccessHealth CT (potential when established)</li> <li>▪ Tools to analyze <b>clinical data</b> among some providers (e.g. ACOs)</li> </ul>
<p><b>Provider-payer-patient connectivity</b></p>	<ul style="list-style-type: none"> <li>▪ Payers' existing portals:               <ul style="list-style-type: none"> <li>– <b>Provider portals</b> that connect providers, health plans and practice management systems (e.g. Availity for Anthem)</li> <li>– <b>Patient portals</b> that allows enrollees to track claims and account activity, find doctors and services, access health advice and get answers to coverage questions (e.g., myCigna for Cigna)</li> </ul> </li> <li>▪ <b>AccessHealth CT</b> developing a patient portal to give comparison information for consumers on the Health Insurance Exchange</li> </ul>
<p><b>Provider-patient care mgmt. tools</b></p>	<ul style="list-style-type: none"> <li>▪ <b>DMHAS</b> managing a system of care for behavioral health populations that includes care management tools</li> </ul>
<p><b>Provider-provider connectivity</b></p>	<ul style="list-style-type: none"> <li>▪ <b>HITE-CT</b> promoting adoption of point-to-point connectivity tools (via direct messaging) for exchange of information between providers</li> <li>▪ Large provider systems (e.g. Hartford Healthcare, Yale) with <b>localized health information exchange</b> solutions</li> </ul>

### 3 What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, portal)?

Category	Strawman answer
<p><b>Payer Analytics</b> (complemented by <b>provider analytics</b>)</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Standardized but not consolidated</b></p> <ul style="list-style-type: none"> <li>Highly <b>standardized</b> metrics/analytics/reports created by payers' <b>independent</b> infrastructure</li> <li>Potential to leverage All Payer Claims Database (<b>APCD</b>) when established</li> <li>Claims-based analytics complemented by <b>provider analysis of clinical data</b> to better manage quality of care delivery and outcomes</li> <li>For provider analytics, leverage <b>existing metrics</b> (e.g., meaningful use) to minimize operational complexity/disruption and allow for comparisons across systems</li> </ul>
<p><b>Provider-payer-patient connectivity</b></p>	<p><input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Mostly consolidated across payers</b></p> <ul style="list-style-type: none"> <li>Need for <b>a single portal</b> for providers to access information from and submit metrics to <b>multiple payers</b> thus reducing operational complexity and user confusion</li> </ul>
<p><b>Provider-patient care mgmt. tools</b></p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Following common guidelines but not consolidated</b></p> <ul style="list-style-type: none"> <li>Providers <b>committed</b> to adopting care management process/technology but having <b>flexibility</b> to select vendors/solutions independently</li> <li>Potential options:             <ul style="list-style-type: none"> <li>Develop population health <b>how-to manual</b> and/or <b>training</b> that includes application of HIT capabilities (e.g. using excel to risk stratify the population)</li> <li>Provide <b>minimum set of technology</b> to enable provider care management</li> <li><b>Pre-qualify vendors</b> or develop a <b>shared services model</b> to simplify the evaluation and procurement process while giving providers access to enhanced care management tools</li> </ul> </li> </ul>
<p><b>Provider-provider connectivity</b></p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Standardized but not consolidated</b></p> <ul style="list-style-type: none"> <li>Exchange of health information between providers is a <b>key enabler</b> of a population health model</li> <li><b>SHIP/SIM</b> needs to stay connected with <b>HITE-CT</b> as it facilitates provider-provider connectivity:             <ul style="list-style-type: none"> <li>Focus currently on accelerating adoption of <b>direct messaging</b> that will enable point-to-point exchange of health data</li> <li>Eventual goal to transition to a clearing house model for health information exchange between provider groups (<b>HIE</b>)</li> </ul> </li> </ul>

## 4 What is the best strategy to develop the required HIT capabilities?

Category	Strawman answer
<p><b>Payer analytics</b> complemented by <b>provider analytics</b></p>	<ul style="list-style-type: none"> <li>▪ Begin with building on <b>payer's own population health analytics</b> and continue to establish the full set of tools required in the end state</li> <li>▪ In the longer term, look to <b>leverage APCD</b> to provide system level analytics that informs public health policy and consumer facing analytics that allows for cost/quality comparison across payers/providers</li> </ul>
<p><b>Provider-payer-patient connectivity</b></p>	<ul style="list-style-type: none"> <li>▪ <b>Select and scale a single existing provider portal</b> for use across multiple payers</li> <li>▪ Leverage AccessHealth CT and APCD patient portal to promote <b>consumer engagement</b> efforts</li> <li>▪ Potentially develop state relationships with 3<sup>rd</sup> party patient engagement tool vendors (e.g. Castlight, Truven Health Analytics etc.)</li> </ul>
<p><b>Provider-patient care mgmt. tools</b></p>	<ul style="list-style-type: none"> <li>▪ <b>Educate and inform</b> (near term): Set adoption requirements and provide information/coaching to adopt technology and/or source services</li> <li>▪ <b>Create marketplace</b> (potential option for medium term): Pre-qualify vendors and pre-negotiate discounted pricing</li> <li>▪ <b>Develop shared services</b> (potential option for long term): Create a state-wide solution for all providers in the state to 'plug-in' to</li> </ul>
<p><b>Provider-provider connectivity</b></p>	<ul style="list-style-type: none"> <li>▪ <b>Follow HITE-CT strategy:</b> evolution from adoption of point-to-point connectivity tools (via direct messaging) towards health information exchange via a clearing house model (HIE)</li> </ul>

SOURCE: HIT workgroup discussions

# 5 What will be the pace of roll-out of the required capabilities throughout the state?

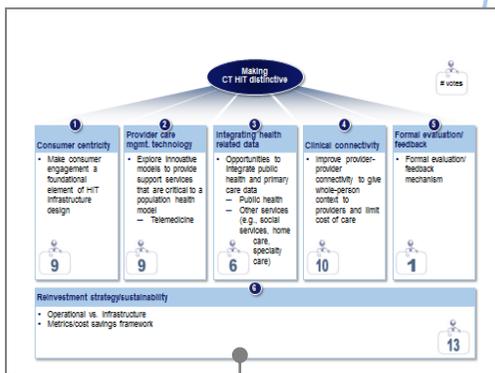
Category	SIM Timeframe		Beyond SIM
	Stage 1 (1 year)	Stage 2 (2-3 yrs)	Stage 3 (3+ yrs)
<b>Payer analytics</b> complemented by <b>provider analytics</b>	Reporting based on foundational analytics (patient attribution, risk stratification, risk adjusted cost comparison, quality/utilization metrics)	Enhanced analytics that identify high priority patients for targeted intervention (care gaps analyses, alert generation)	System level public health/epidemic analyses; patient 360° view enabled by integration of claims and clinical data
<b>Provider-payer-patient connectivity</b>	Multi-payer online portal for providers to receive static reports; basic patient portal to allow consumers to enter quality metric data	Bi-directional provider-payer portal with data visualization; patient engagement/transparency tools	HIE-enabled bidirectional communication and data exchange
<b>Provider-patient care mgmt. tools</b>	Define provider workflow changes required to improve care coordination; provide manual/education that details options and applications for supporting technology	<ul style="list-style-type: none"> <li>Pre-qualify vendors and health information service providers with pre-negotiated, discounted pricing</li> <li>Potentially develop a shared-service model that providers can plug-into to avail of enhanced care management tools</li> </ul>	
<b>Provider-provider connectivity</b>	Promote point-to-point connectivity via scalable protocol such as direct messaging	Facilitate interoperability between local implementations of health information exchange <sup>1</sup> solutions	Potentially integrate state-wide Health Information Exchange <sup>1</sup>

<sup>1</sup> HITE-CT will drive adoption of provider-provider connectivity tools and eventual creation of a state-wide health information exchange

# 6 How can we create distinctiveness?

Focus in near term

NOT MUTUALLY EXCLUSIVE



## Aspects

Clinical connectivity

Provider care mgmt. technology

Consumer centricity

Integrating health-related data

## Description

Ensure necessary financial and technical assistance are in place to **promote technology adoption** and providers' exchange of health information

Accelerate provider groups' adoption of care management technology

Leverage technology to **make consumers a member of their own care team** – educated on healthy behaviors and on high quality, cost efficient care decisions

Enable providers to **better manage their populations** by leveraging tailored health related data (e.g., population home care, social)

## How to be distinctive

Support existing efforts in state to **accelerate EHR adoption**, promote meaningful use, and enable clinical connectivity

**Increase adoption of care mgmt. technology** by educating providers, establishing a marketplace with pre-qualified vendors, or developing a shared service

**Leverage existing CT infrastructure**, proprietary tools developed by payers or specialized technology vendors to increase consumer centricity

Connect with DPH's ongoing initiatives to **integrate public health databases**

Share information between **primary care and public health** once infrastructure is established

- We also identified **developing a sustainable reinvestment strategy as a top priority**
- This question will be addressed by the **SHIP and a cross-work group co-chair team**

# Agenda

- Review recommendations from care delivery, payment, and HIT work groups ▪ 50 min
- Discuss targets to measure program success ▪ 30 min
- Align on plan for syndication/finalization ▪ 10 min

## Connecticut SIM programmatic success can be measured along a set of targets that are aligned to the Triple Aim

### Triple Aim

#### Health

- Prevention and reduced severity of disease (e.g., diabetes, asthma, hypertension)

#### Quality

- Percentage of consumers being managed by providers in Track 1 and Track 2
- Track 1 and Track 2 providers meeting targets for quality at the aggregate level and for underserved populations
- Improvement in consumer experience scores

#### Costs

- Reduction in total health care cost and trend

### Targets

# These programmatic targets will be aligned with metrics tracked at the provider level within the provider scorecard

ILLUSTRATIVE

## Illustrative measures

### Quality

#### ***Whole-person-centered care and population-health management***

- Completion of whole-person-centered assessment
- Development of whole-person-centered treatment plan
- Demonstrated use of risk stratification

#### ***Enhanced access to care***

- Access to preventative care (e.g., screenings)
- 24/7 availability of a live voice
- Availability of non-visit based options (e.g., ability to deliver care remotely: email, text, e-consults)
- Practice adherence to NCLAS standards

#### ***Team-based coordinated care***

- Track, follow-up on, and coordinate tests, referrals, and care at other facilities
- Demonstrated infrastructure to coordinate with community resources, including behavioral health practitioners and community-based sites of care
- Post-discharge planning

#### ***Consumer engagement***

- Availability of shared decision making tools

#### ***Evidence-informed clinical decision-making***

- HIT adoption
- Maintenance of disease registry
- Adult weight screening and follow-up
- Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention

#### ***Performance management***

- Demonstrated completion of regular performance reviews
- Provider performance along quality index covering clinical process and outcomes measures (e.g., immunizations, preventive screening, optimal chronic disease management)

#### ***Consumer experience***

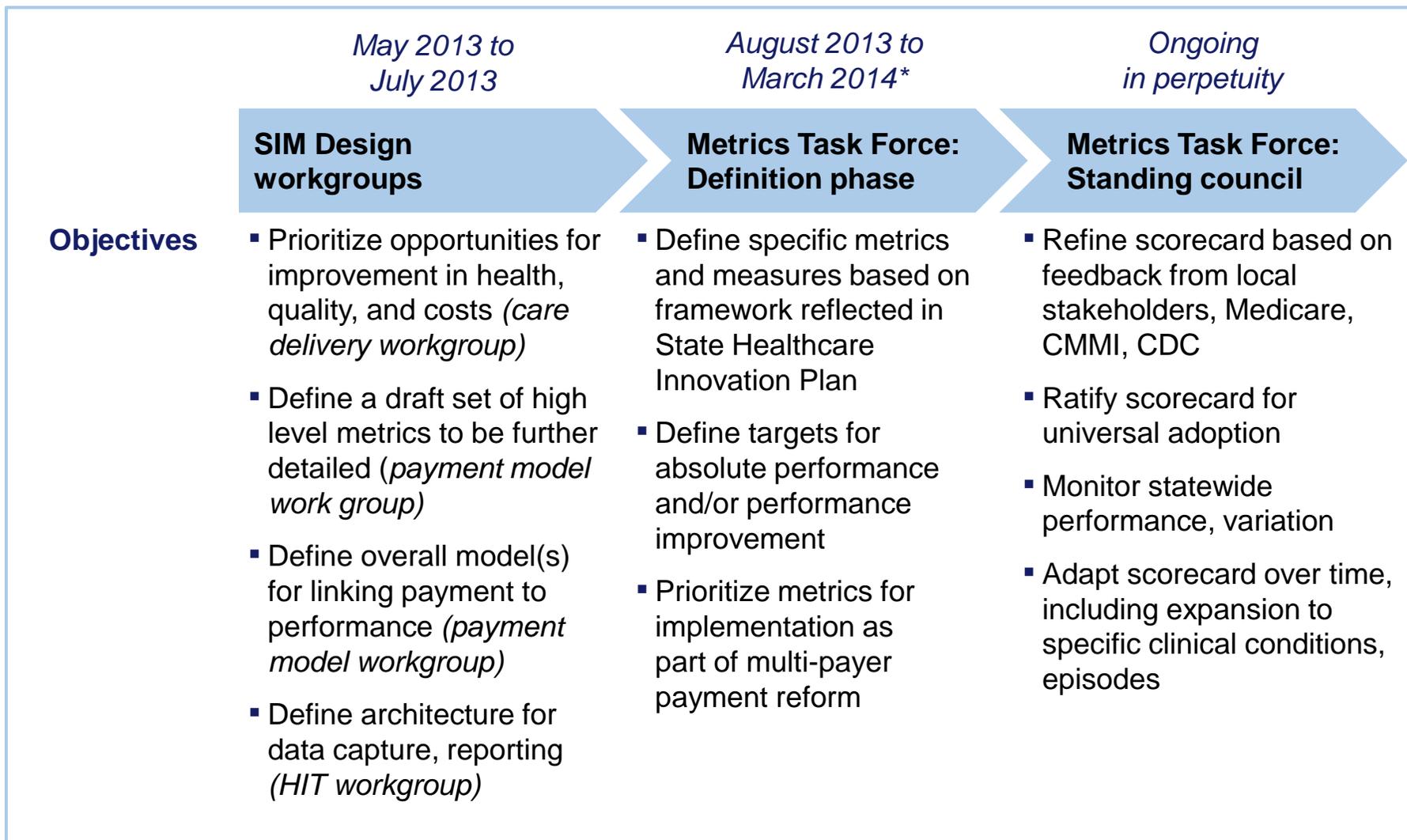
- HCAHPS or other consumer experience survey

### Costs

- Potentially avoidable complications
- Hospitalization rate
- Emergency room utilization
- Generic prescribing rate

- Total cost of care per capita
- Trend in cost of care
- Use of high- vs. low-cost providers
- Use of high- vs. low-cost site of care

# Metrics for evaluation will continue to be refined in a metrics task force



\*March 2014 reflects anticipated timeframe for submission of SIM Testing Grant application to CMMI

## Steering committee discussion on metrics task force composition as input into final decision

### Stakeholder groups for inclusion

- Consumers / advocates
- Primary care providers
- Specialist physicians
- Behavioral health providers
- Hospitals/systems
- Medicare
- Medicaid
- Private insurers
- Employer purchasers
- State agencies (e.g., DPH, DSS)

### Questions for steering committee input

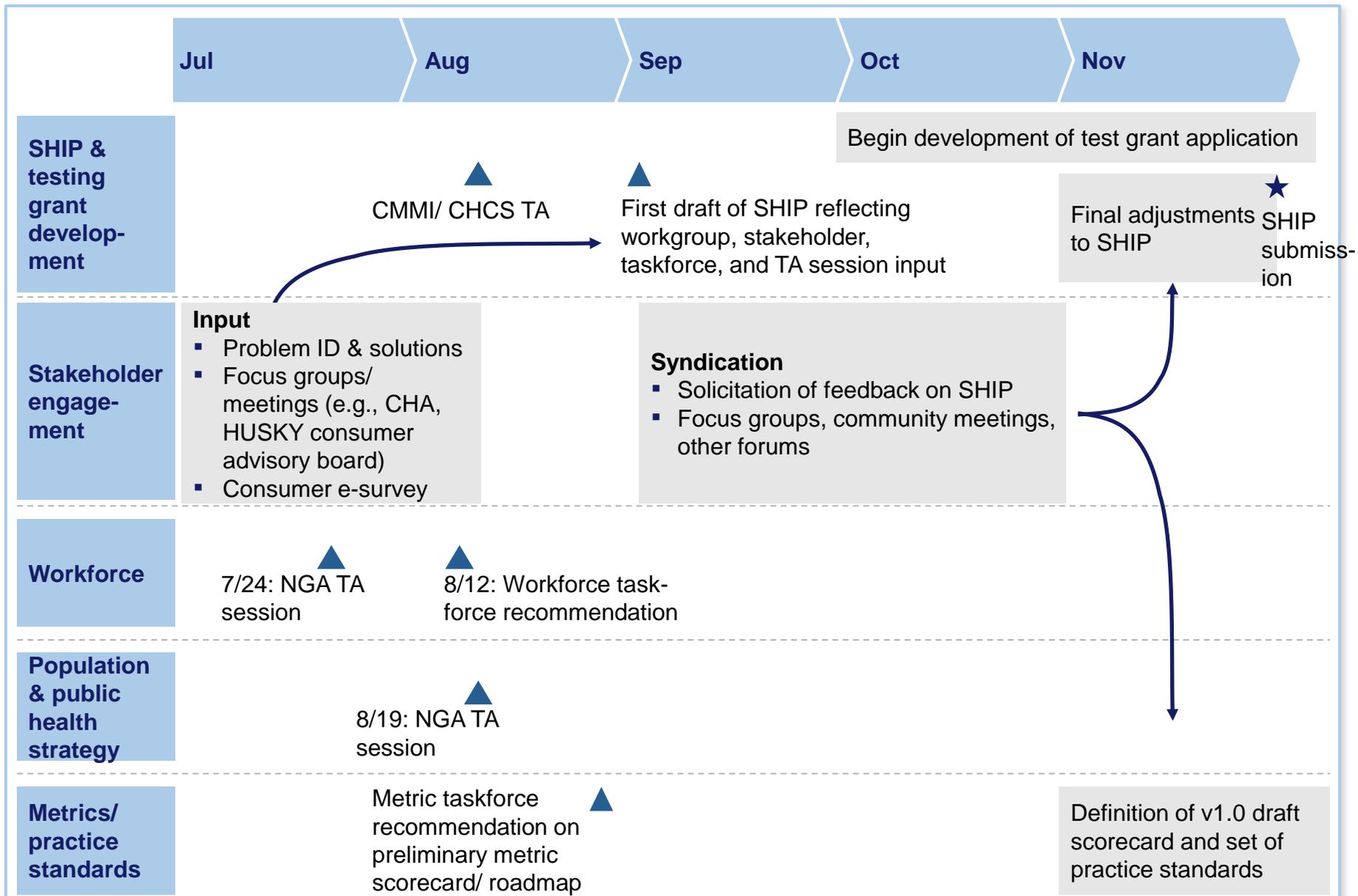
- Are these the right groups?
- How many formal representatives of each stakeholder group?
- How will members be appointed?
- What will be the time commitment?

Note: Providers may include MDs or non-MDs

# Agenda

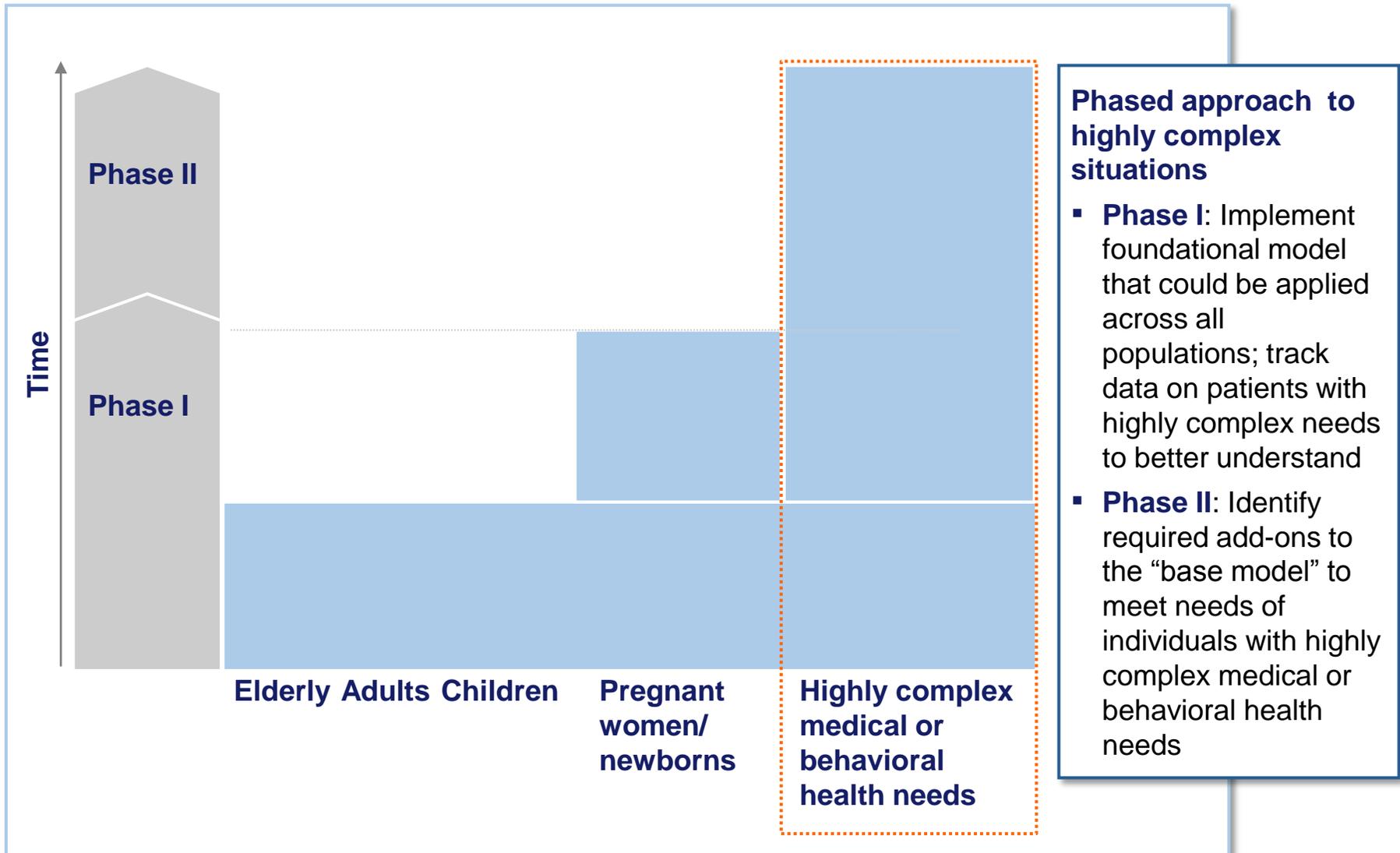
- Review work-in-progress content of State Healthcare Innovation Plan ▪ 50 min
- Discuss targets to measure program success ▪ 30 min
- Align on plan for syndication/finalization ▪ 10 min

# Overview: Plan for syndication/finalization



# APPENDIX

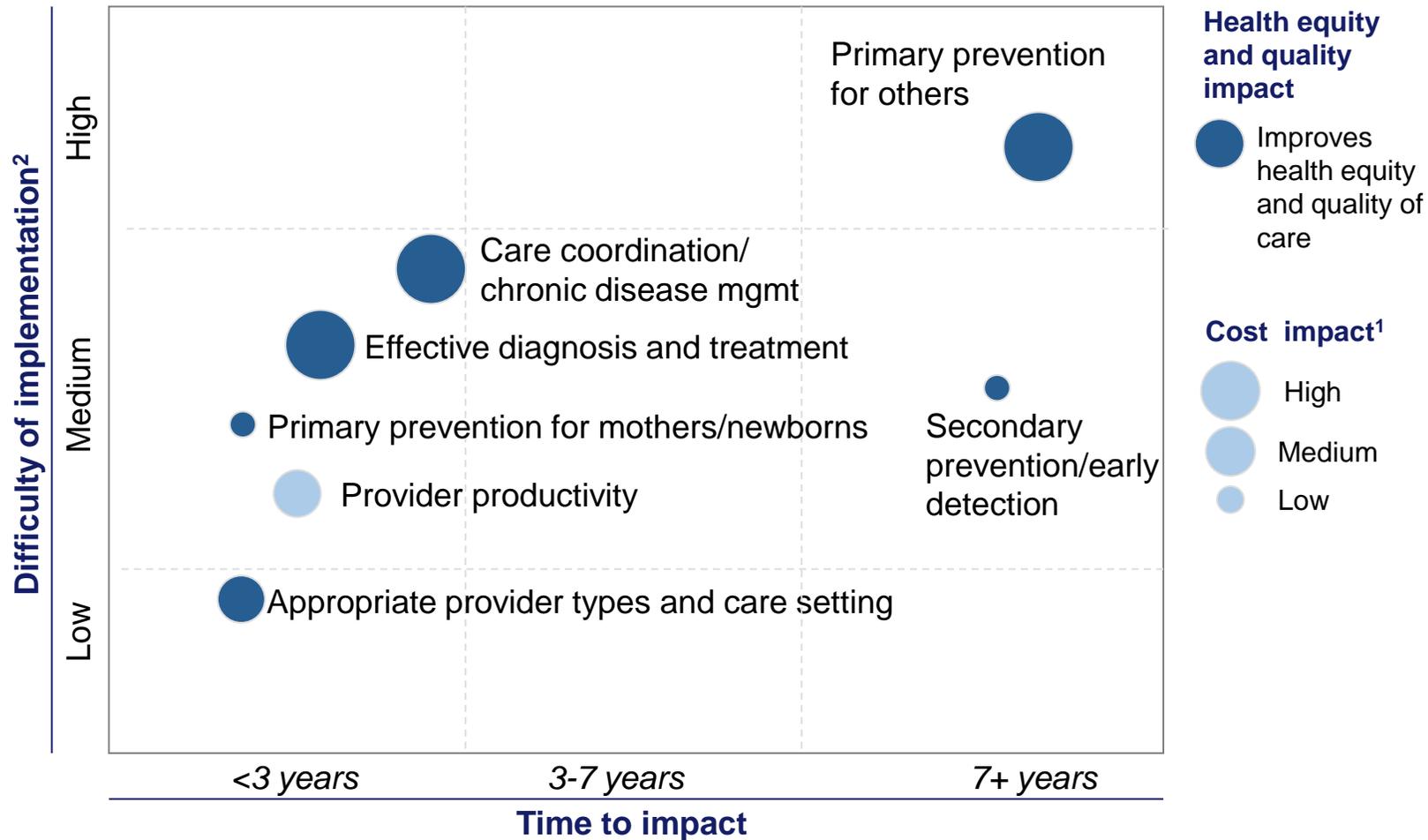
# 1 We discussed designing a model that could be foundational across populations, with phasing in of add-ons to account for complexity



## 2 Sources of value

	Description	Examples
<b>Primary prevention</b>	<ul style="list-style-type: none"> <li>Prevention of disease by removing root causes</li> </ul>	<ul style="list-style-type: none"> <li>Smoking cessation</li> <li>Diet and exercise</li> </ul>
<b>Secondary prevention/ early detection</b>	<ul style="list-style-type: none"> <li>Early detection of disease while asymptomatic to prevent disease progression</li> </ul>	<ul style="list-style-type: none"> <li>Cervical cancer screening</li> <li>Identification and management of patients at high risk for heart disease</li> </ul>
<b>Appropriate provider types and care setting</b>	<ul style="list-style-type: none"> <li>Utilizing highest value provider types and care settings</li> </ul>	<ul style="list-style-type: none"> <li>Choice of care setting for immunization administration</li> <li>Optimized utilization of physician extenders</li> </ul>
<b>Effective diagnosis and treatment selection</b>	<ul style="list-style-type: none"> <li>Evidence-informed choice of treatment method/intensity</li> </ul>	<ul style="list-style-type: none"> <li>Enforcement of evidence-based inpatient clinical pathways</li> </ul>
<b>Provider productivity</b>	<ul style="list-style-type: none"> <li>Reducing waste at provider center</li> </ul>	<ul style="list-style-type: none"> <li>Improve flow in OR to increase number of surgeries performed daily</li> <li>Streamline emergency room triaging</li> </ul>
<b>Care coordination / chronic disease management</b>	<ul style="list-style-type: none"> <li>Ensuring patients effectively navigate the health system and adhere to treatment protocols</li> </ul>	<ul style="list-style-type: none"> <li>Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)</li> </ul>

### 3 Prioritization matrix of sources of value



<sup>1</sup> Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics

<sup>2</sup> Includes assessment of historical success rates and execution risk

### 3 Barriers identified fall into 6 categories (1 of 2)

1 Lack of whole-person-centered care and population health management

2 Restricted access to appropriate care

3 No team-based, coordinated, comprehensive approach to care

#### Barriers

- Lack of understanding of whole-person context (social, cultural, behavioral)
  - Limited access to whole-person data at point of care to promote more accurate diagnosis and treatment planning
  - Lack of infrastructure to risk-stratify consumers and prevent disease onset in high-risk consumers
- 
- Limited capacity (e.g., limited time, inefficient use of time) of providers
  - Lack of consumer access to appropriate care (e.g., primary, specialty, behavioral)
  - Cost of treatment prevents adoption
  - Limited availability of culturally/ linguistically accessible care
- 
- No single point of accountability for consumer's total care
  - Limited incentives for provider for admission, transfer, and discharge planning
  - Suboptimal or no triage process to direct consumers to right site of care
  - Providers do not interact with the consumer's community
  - Providers (e.g., specialists) have limited vision to own sphere of influence
  - Limited use and multiple formats of HIT systems across providers and care settings lead to medical errors/ redundancies
  - No comprehensive treatment plan developed for consumers
  - Poor relationships and communication among providers

### 3 Barriers identified fall into 6 categories (2 of 2)

#### 4 Limited consumer engagement

##### Barriers

- Consumers lack incentives and are not enabled to be involved in self-diagnosis, self-care, and healthy behaviors
- Consumers are not aware of available health care resources
- Consumers do not understand educational materials
- Consumers do not have quality and cost data to inform decisions (e.g., visit highest value provider)
- Consumers have difficulty being compliant with treatment/rehab plans
- Wellness resources are not readily accessible by consumers
- Lack, or limited distribution, of health literacy (including screening education) programs
- Policies and funding not in place to promote healthy behaviors
- Limited communication channels/processes among consumer and other providers involved in care

#### 5 Insufficient use of evidence-informed clinical decision making

- Best clinical practices not standardized
- Limited health IT infrastructure to support clinical decision making
- FFS reimbursement rewards overtreatment

#### 6 Inadequate performance management

- Limited quality and cost transparency data
- Multiple formats of information systems

## 4 Prioritized list of interventions (1 of 2)

### Prioritized interventions

#### 1 Whole-person-centered care and population health management

- Identify consumers with high-risk or complex care needs
- Conduct whole person assessments that identify consumer/family strengths and capacities, risk factors<sup>1</sup>, behavioral health and other co-occurring conditions, and ability to self-manage care

#### 2 Enhanced access to care (structural and cultural)

- Improve access to primary care through a) extended hours (evenings/weekends), b) convenient, timely appointment availability including same day (advanced) access, c) providing non-visit-based options for consumers including telephone, email, text, and video communication
- Enhance access to specialty care through non-visit-based consultations: eConsults between specialists and primary care providers
- Provide information on where consumers should go to meet their care needs (e.g., appropriate physician locations and hours)

#### 3 Team-based, coordinated, comprehensive care

- Provide team-based care from a prepared, proactive team
- Integrate behavioral and primary care with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)
- Develop and execute against a whole-person-centered treatment plan
- Coordinate across all elements of a consumer’s care

<sup>1</sup> Including history of trauma, housing instability, access to preventive oral health services

## 4 Prioritized list of interventions (2 of 2)

### Prioritized interventions

#### 4 Consumer engagement

- Raise consumer awareness about health care decision making and provide information—broad based, targeted, and at the point of care to foster informed choice
- Use person centered care planning methods to develop and support implementation of self-management care plan
- Support consumer general health education, ease of access to personal health information, communication with care delivery team, wellness management and illness self-management with a patient health care portal

#### 5 Evidence-informed clinical decision making

- Use multi-layer, diverse team to enable data synthesis, reconciliation, and use by practice – ensure data is actionable and timely
- Use consumer risk stratifiers to enable targeted effort based on evidence (e.g., chronic disease progression)
- Maintain disease registry
- Implement evidence-based guidelines

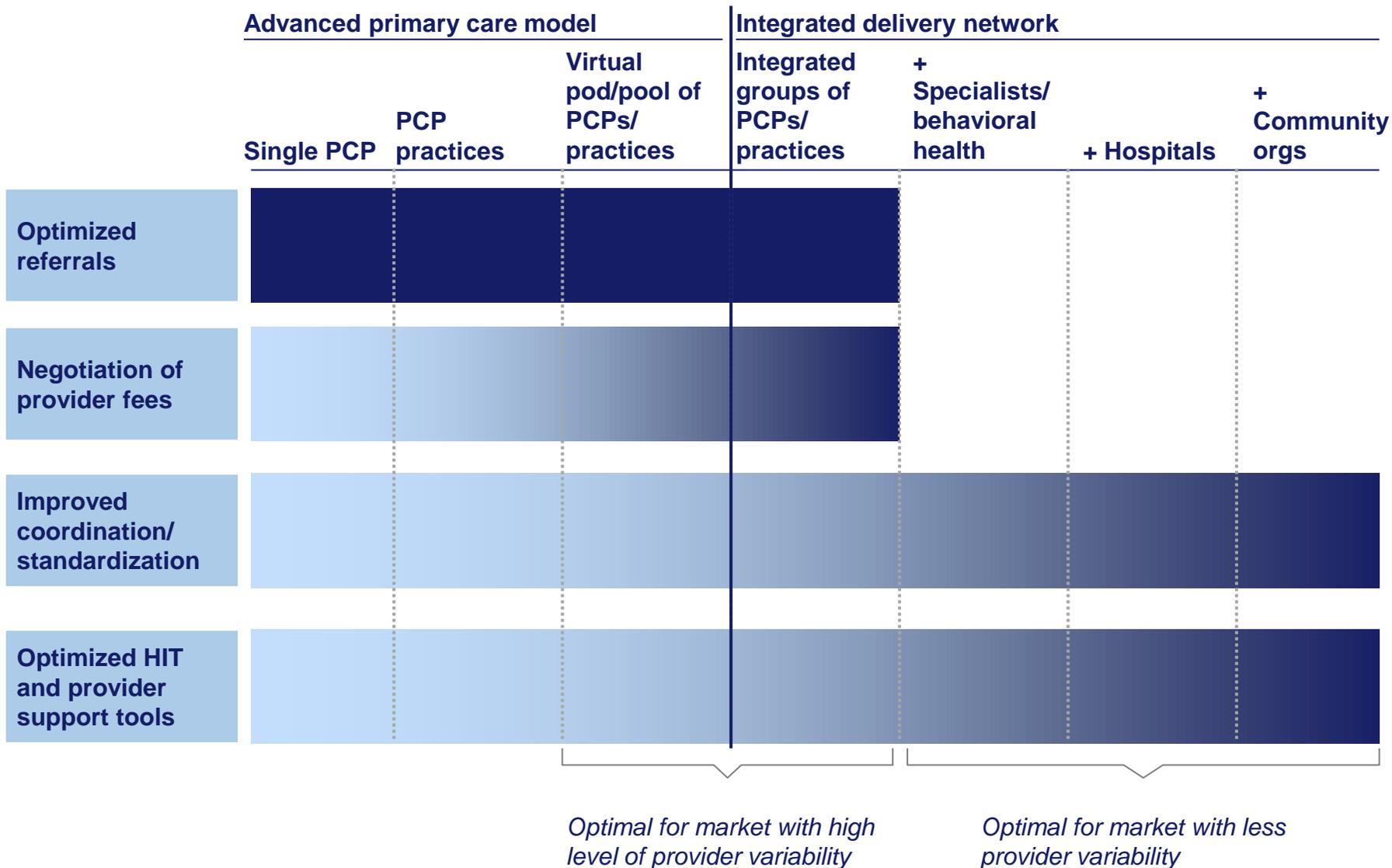
#### 6 Performance management

- Track utilization measures (e.g., rates of hospitalizations and ER visits) and drivers (e.g., after hours visits) and compare to external benchmarks
- Use performance and consumer experience data to continuously improve whole person centeredness
- Establish learning collaboratives to disseminate best practices

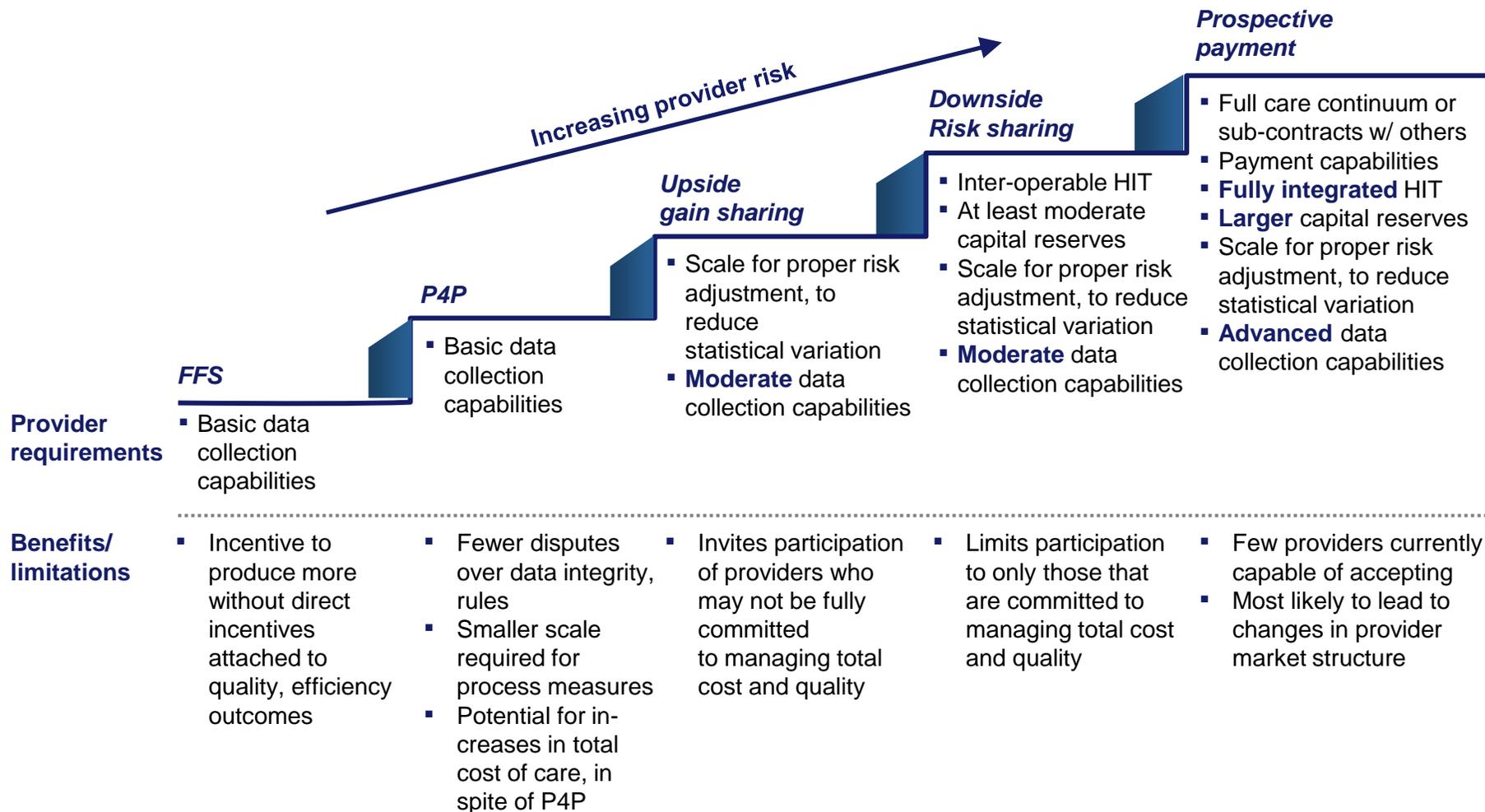
**6** As long as entities meet pre-qualification criteria we outlined, we are not prescriptive about required levels of integration

	Advanced primary care model			Integrated delivery network			
	Single PCP	PCP practices	Virtual pod/pool of PCPs/practices	Integrated groups of PCPs/practices	+ Specialists/behavioral health	+ Hospitals	+ Community orgs
Clinical integration							
Shared infrastructure (e.g., HIT)							
Financial integration (ability to bear risk, scope of accountability)							

# 6 Differences in clinical/financial integration and data sharing have implications on care delivery and management of total cost of care



# 1 There are a range of reward structures that can be used to hold providers accountable



Some models also incorporate per-member-per-month fees for care coordination and/or practice transformation. These may be structured as a form of P4P, FFS, or transitional subsidies, depending on the criteria used to qualify for the fees

# 1 Providers will be rewarded for both absolute performance and performance improvement

## Recommendation

### Options

- 1 Absolute performance
- 2 Performance improvement
- 3 Both absolute performance and improvement (e.g., progressive rewards)
- 4 Another option

## Considerations for selecting absolute/relative

### Absolute

- Rewards distinctive performers
- Targets held constant for several years
- Additional cost to payer

### Relative

- Provides incentives to all providers regardless of starting point
- Facilitates performance improvement through setting flexible targets
- Budget neutral to payer

## 2 We reviewed a core set of CMMI measures and suggested some Connecticut-specific additions

	Illustrative CMMI core measures	Work group additions
1 Whole-person-centered care and population health mgmt.	<ul style="list-style-type: none"> <li>Follow-up hospitalization after mental illness</li> <li>Tobacco use assessment and tobacco cessation intervention</li> <li>CAHPS surveys</li> </ul>	<ul style="list-style-type: none"> <li>Completion of wellness assessments and treatment plans</li> <li>Primary care quality measures, incl. quality indices</li> <li>Total medical cost per member</li> <li>Care plan/learning collaborative</li> </ul>
2 Enhanced access to care (structural and cultural)	<ul style="list-style-type: none"> <li>Well-child visits in the first 15 months of life</li> <li>Hospital ED visit rate that did not result in hospital admission, by condition</li> </ul>	<ul style="list-style-type: none"> <li>Patient portal, provider website, and e-consults</li> <li>Availability &gt; normal business hours</li> <li>Time of discharge until next visit</li> <li>Translation services</li> <li>Patient surveys</li> <li>Ambulatory sensitive admissions</li> </ul>
3 Team-based, coordinated, comprehensive care	<ul style="list-style-type: none"> <li>Post-discharge continuing plan transmitted to next level of care provider upon discharge</li> <li>Care transition record transmitted to health care professional</li> <li>Medication reconciliation</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
4 Consumer engagement	<ul style="list-style-type: none"> <li>Transition record with specified elements received by discharged patients</li> <li>CAHPS Surveys</li> <li>CARE-F and CARE-C tools</li> </ul>	<ul style="list-style-type: none"> <li>Addition of select NQF metrics (e.g., individual engagement measure derived from individual engagement domain of C-CAT)</li> </ul>
5 Evidence-informed clinical decision making	<ul style="list-style-type: none"> <li>Clinical care measures (e.g., chronic disease testing and care, mental health)</li> <li>Medication reconciliation</li> <li>Admission statistics by chronic condition (e.g., COPD)</li> </ul>	<ul style="list-style-type: none"> <li>Standard clinical pathways</li> <li>Bidirectional sharing of information</li> <li>Ongoing review and validation of current standards</li> <li>Medication interactions</li> <li>Appropriate use of procedures</li> </ul>
6 Performance management	<ul style="list-style-type: none"> <li>Adoption of medication e-prescribing</li> <li>Adoption of HIT</li> <li>Ability for providers with HIT to receive laboratory data electronically</li> <li>ED visit rate that did not result in hospital admission</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>

## 2 Our “Version 0.1” medical home scorecard to be refined

Population health aspect      Measure title      Population health aspect      Measure title

● Low difficulty<sup>1</sup>      ● High difficulty<sup>3</sup>  
 ● Medium difficulty<sup>2</sup>

<b>Whole-person-centered care and pop. health mgmt.</b>	● <i>Assessment completion rates<sup>4</sup></i>
	● <i>Risk-stratification of consumer panel conducted</i>
	● <i>Whole-person-centered treatment plan</i>

<b>Enhanced access to care (structural and cultural)</b>	● <i>Access to care outside normal business hours</i>
	● <i>E-consult capability</i>
	● <i>Translation services</i>
	● <i>Convenient availability including same day access</i>
	● <i>Availability of non-visit based options (e.g., telehealth through telephone, email, text, video)</i>

<b>Team-based, coordinated, care</b>	● <i>Care planning infrastructure</i>
	● <i>Follow-up after hospitalization for mental health</i>
	● <i>Medication reconciliation</i>
	● <i>Demonstrated infrastructure to coordinate with community resources, including behavioral health practitioners and community health sites of care</i>
	● <i>Adoption of Medication e-prescribing</i>
	● <i>Post-discharge continuing care plan created</i>
	● <i>Post-discharge continuing care plan transmitted to next level of care provider upon discharge</i>
	● <i>Care transition record transmitted to Health Care professional</i>
	● <i>Transition record with specified elements received by discharged by patients</i>

<b>Team-based, coordinated, care (cont.)</b>	● <i>3-item care transition measure</i>
	● <i>Demonstrated use of intensive case mgmt. tools</i>
	● <i>Assessment of consumer progress towards treatment and follow-up when necessary</i>

<b>Consumer engagement</b>	● <i>Patient portal</i>
	● <i>Demonstrated use of “Choosing Wisely” campaign to raise awareness at the point of care</i>
	● <i>Provision of quality /cost information at point of care</i>
	● <i>Periodic review to ensure self-management care plan takes into account targeted considerations</i>
	● <i>Quality index<sup>5</sup></i>

<b>Evidence informed clinical decision making</b>	● <i>Adoption of HIT infrastructure</i>
	● <i>Ability for providers with HIT to receive lab data</i>
	● <i>Maintenance of disease registry</i>
	● <i>Ensure use of actionable data (e.g., disease registry)</i>
	● <i>Evidence-based, standardized care pathways</i>
	● <i>Bi-directional provider information sharing (e.g., HIE)</i>
	● <i>Demonstrated implementation and periodic review of evidence-based guidelines</i>

<b>Performance management</b>	● <i>Total medical cost per member</i>
	● <i>Utilization index<sup>5</sup></i>
	● <i>Participation in learning collaborative</i>
	● <i>CAHPS and other patient surveys collected</i>
	● <i>Completion of performance review based on practice data to improve whole centeredness</i>

1 Based on claims data      2 Either based on clinical data that is already being measured, but is not reported today or a one-time measurement  
 3 Clinical data that is not being measured today      4 Completion of whole person assessments that consider consumer/family, risk, and behavioral health factors and ability to self-manage care      5 Detail on subsequent pages; utilization index for reporting purposes only  
 Note: *Italicized measures indicate CT specific additions (both by the payment work group and to meet specific care delivery work group intervention)*

### 3 Minimum scale is required for meaningful quality measurements

Triple Aim goals	Types of metrics	Minimum patient population <sup>1</sup>
Health	<ul style="list-style-type: none"> <li>Health risk factors (e.g. obesity)</li> <li>Prevalence of illness and injury</li> </ul>	<ul style="list-style-type: none"> <li>Moderate (100-1,000)</li> </ul>
Health care	<ul style="list-style-type: none"> <li>Patient satisfaction</li> <li>Quality of care                             <ul style="list-style-type: none"> <li>Structure</li> <li>Process</li> <li>Outcomes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Low to moderate (&lt;1,000)</li> <li>Depends on specific metrics                             <ul style="list-style-type: none"> <li>Low (&lt;100)</li> <li>Moderate (100-1,000)</li> <li>High (5,000+)</li> </ul> </li> </ul>
Costs	<ul style="list-style-type: none"> <li>Total cost of care</li> <li>Resource utilization, e.g.,                             <ul style="list-style-type: none"> <li>Hospital days per 1,000</li> <li>Emergency room visits per 1,000</li> <li>Generic prescribing rates</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>High (5,000+)</li> <li>Depends on specific metrics                             <ul style="list-style-type: none"> <li>Moderate (100-1,000)</li> <li>Moderate (100-1,000)</li> <li>Low (&lt;100)</li> </ul> </li> </ul>

**Implications**

- Moderate scale required for P4P likely to require aggregation across payers or across providers
- High scale required for Total Costs to require aggregation across payers and across providers

<sup>1</sup> Rule of thumb, to be validated for each metric based on relevant population

### 3 Potential models for aggregating provider performance

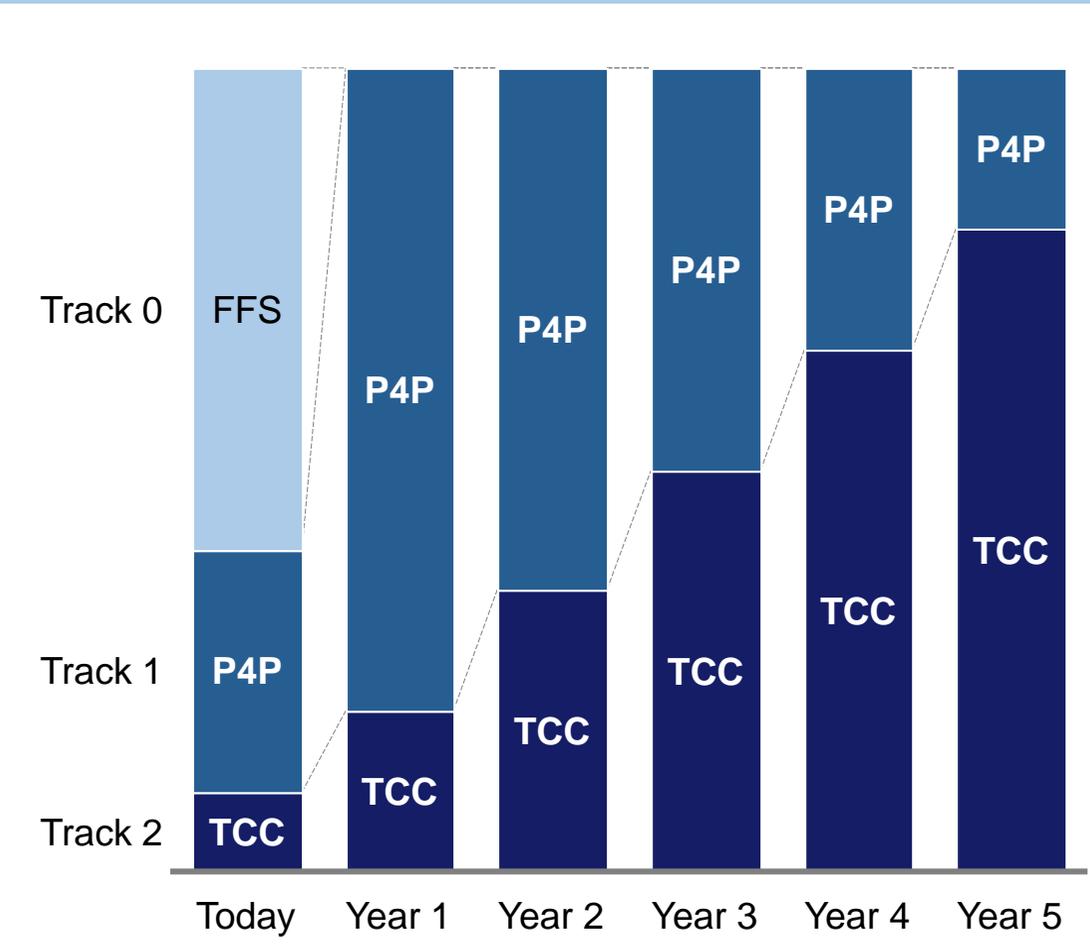
Options	Description
<p><b>1 Corporate Entities</b></p> <ul style="list-style-type: none"> <li>▪ Medical group practice</li> <li>▪ Hospital system with employed physician</li> </ul>	<ul style="list-style-type: none"> <li>▪ Legally and financially integrated physicians</li> <li>▪ Level of shared clinical infrastructure may vary</li> <li>▪ Potential to distribute bonuses/gains through employment agreements</li> </ul>
<p><b>2 Formal “Joint Ventures”</b></p> <ul style="list-style-type: none"> <li>▪ Accountable Care Org</li> <li>▪ Physician-Hospital Org</li> <li>▪ Independent Practice Association</li> </ul>	<ul style="list-style-type: none"> <li>▪ Joint venture or other formal contractual relationship among otherwise independent providers</li> <li>▪ Provides legal/financial framework for co-investment in clinical infrastructure and/or distribution of bonuses/gains</li> </ul>
<p><b>3 Virtual Panels</b></p>	<ul style="list-style-type: none"> <li>▪ Informal relationship of independent providers who self-select to aggregate performance</li> <li>▪ Agreement to accept rewards from payor(s) based on aggregate performance</li> <li>▪ Distribution of bonuses/gains based on pre-determined formula established with payer</li> <li>▪ Potential for coordinated procurement of technology/services from the same vendor(s)</li> <li>▪ No legal/financial framework for co-investment</li> </ul>
<p><b>4 Geographic risk pools</b></p>	<ul style="list-style-type: none"> <li>▪ Performance aggregated among providers in a region</li> <li>▪ Rewards distributed based on pre-determined formula</li> <li>▪ Potential to share technology/services provided by payer(s)</li> <li>▪ No legal/financial framework for co-investment</li> </ul>

**Disclaimer:** the core team is currently seeking further counsel on the permissibility of above options to ensure compliance with anti-trust regulations and Federal Trade Commission (FTC) rulings

# 4 We aligned on a two track approach to enable providers to adopt innovative reforms

ILLUSTRATIVE

Proportion of consumer population



### Definitions

- **Fee for service (FFS):** a discrete payment is assigned to a specified service
- **Pay for performance (P4P):** physicians are compensated based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)
- **Total cost of care (TCC):** agreement to share responsibility for the value of patient care by tying a portion of payment to achievement of total cost and quality metrics

Note: Total Cost of Care model (TCC) may include upside gain sharing, full risk sharing, and/or capitation