



Connecticut SIM SHIP steering committee meeting

Discussion document
May 20, 2012

May 20 SHIP Steering Committee Meeting: Key points for review and decision-making

Review



- Where we are in the Connecticut SIM design effort
- Key takeaways from NGA summit
- Care delivery work group's early discussions on care delivery model and sources of value
- Payment and HIT work groups' next steps
- Synthesis of vision for CT SIM design efforts
- How peer states have communicated their visions

Align and finalize



- Feedback for care delivery work group on care delivery model and sources of value
- Guidance for payment and HIT work groups as they consider payment and HIT design decisions



May 20 SHIP Steering Committee Meeting: Where we are today (1 of 2)

ESTIMATED

April - September

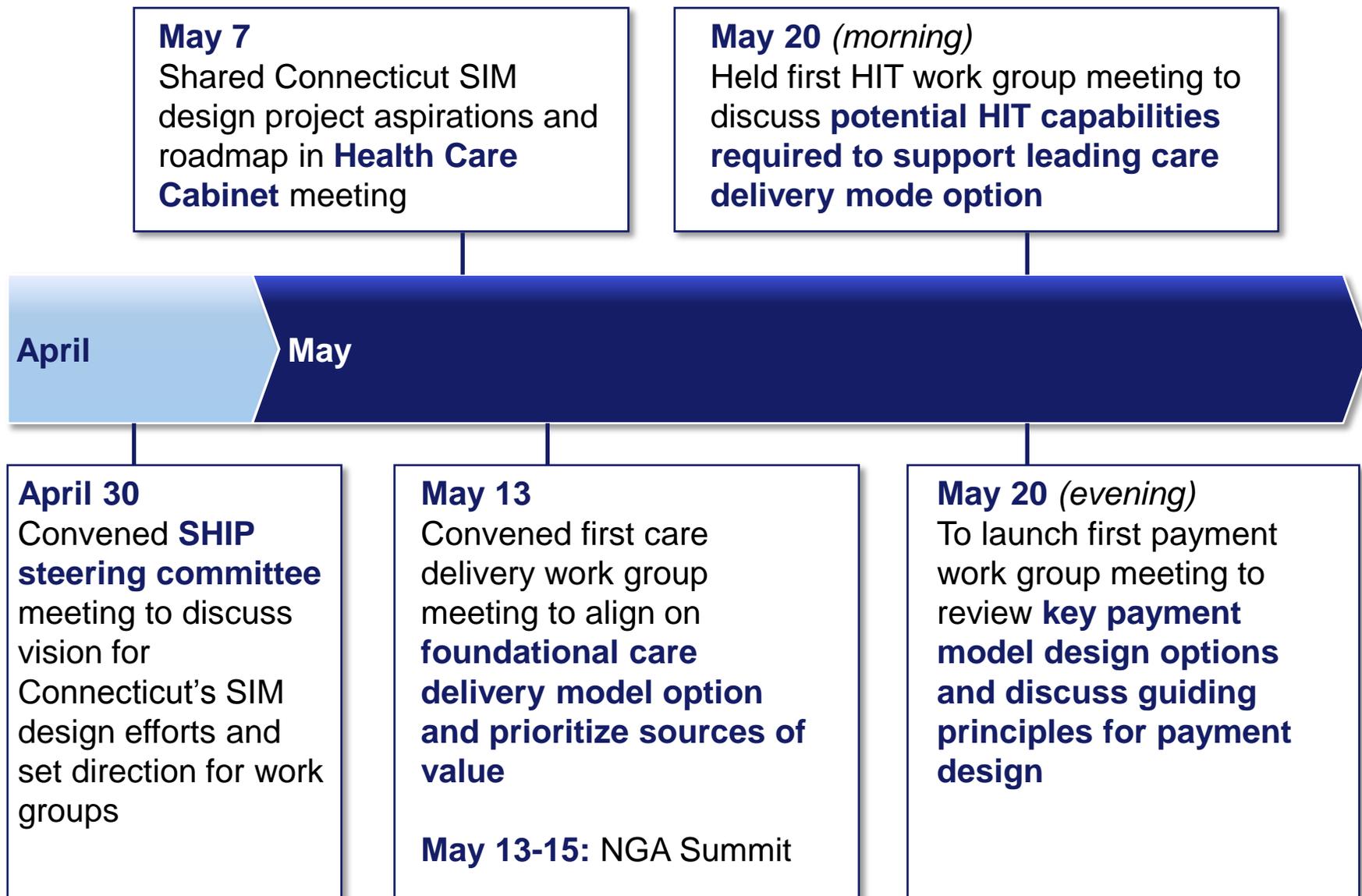
October to early 2014

Mid-2014 to 2017



April	May	June	August	September
Project set-up	Options and hypotheses	Design and planning	Syndication	Finalization
<ul style="list-style-type: none"> Understand current state Establish vision 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Design detailed health care delivery system and payment model Develop implementation and roll-out plan Align on key quality metrics 	<ul style="list-style-type: none"> Draft testing proposal Syndicate with key stakeholders 	<ul style="list-style-type: none"> Refine and submit testing proposal

May 20 SHIP Steering Committee Meeting: Where we are today (2 of 2)

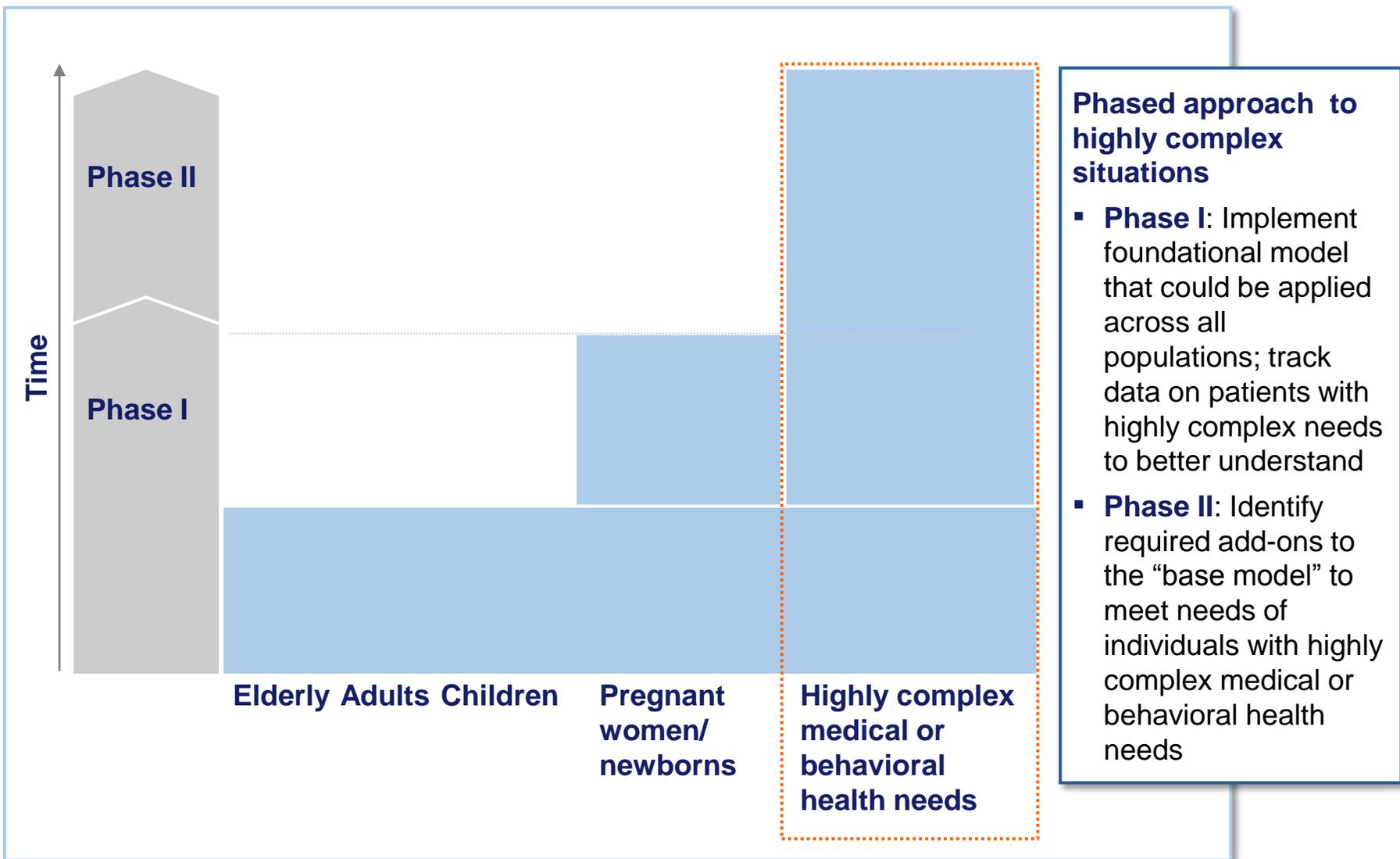


Key takeaways from April 30 SHIP steering committee discussion on vision for Connecticut SIM design efforts



- Vision will take into account CMMI guidance for SIM design states (e.g., total cost of care accountability, impact on 80% of lives across Connecticut, multi-payer effort)
- Care delivery and payment innovation needs to meaningfully curb health care expenditures over the next 3-5 years while maintaining health and quality
- Addressing health inequities will be a critical component of the vision for care delivery and payment model innovation
- 3-5 year goal for addressing health inequities could be to successfully implement structures and processes that enable the state to address health inequity over time
 - “Every provider accepts Medicaid patients“
 - “Two major urban hubs have seen significant improvement on the ground in health equity”
 - “We've developed a plan to provide all with access to a regular source of care”

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



For discussion: What is the best approach to designing a model that meets the unique needs of patients with highly complex needs?

- Which populations have highly complex medical or behavioral health needs that require the design of add-ons beyond the foundational model that will be developed in the next four months?
- How should add-ons for those highly complex populations be phased in?
- How can we incorporate existing efforts around those populations (e.g., ICI, SPMI health homes) to complement or be integrated into the new care delivery and payment model in later phases?

What is the high-level vision we want to put into place for the Connecticut SIM design effort?



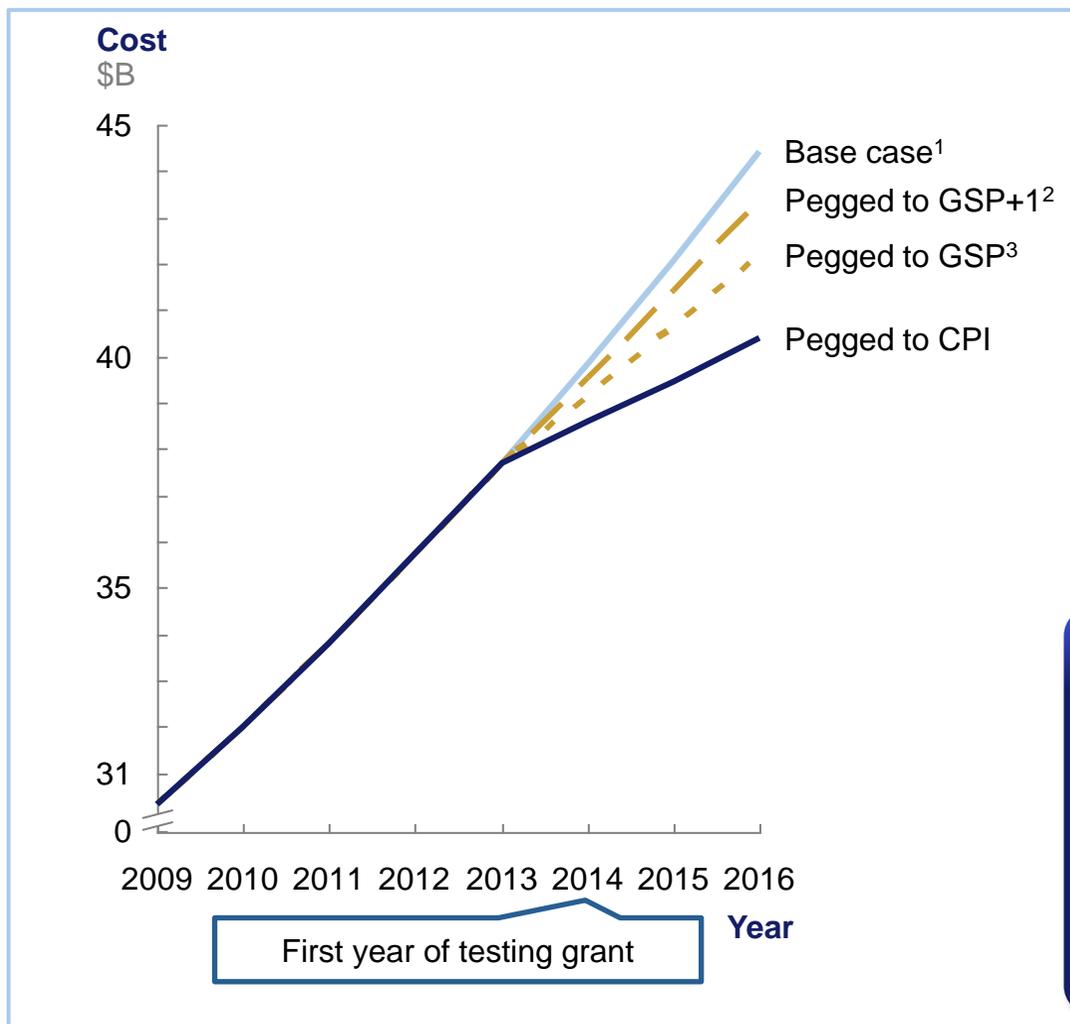
Strawman vision for discussion

Establish a person-centered healthcare system that preserves affordability and reduces health inequities for all of Connecticut

- Integration of primary care, behavioral health, population health, consumer engagement, and community support
- Shared accountability for the total cost and quality of healthcare
- Migration to 21st-century health information technology and healthcare workforce
- Supported by Medicaid, Medicare, and private health plans alike



For discussion: How will Connecticut set its target for meaningfully curbing health care costs in the next 3-5 years?



Trend	Growth rate (2014-2016 CAGR)	Savings relative to base case in 2016	Cumulative savings relative to base case (2014-2016)
Base case	5.6%	-	-
GSP+1	4.8%	2%	\$2B
GSP	3.8%	5%	\$4.4B
CPI	2.3%	9%	\$7.9B

Initial target setting will set aspiration that will guide care delivery, payment model, and HIT design decisions

Initial target will be validated and refined based on estimation of actual impact once model is designed

1 Projection based on five year historical trend (2005-2009) projected into future years
 2 Projection based on three year historical trend (2009-2011) projected into future years
 3 Projection based on three year historical trend (2010-2012) projected into future years

Peer state review: Setting measurable cost impact targets

NON-EXHAUSTIVE



State	Cost impact targets (3-year)	How target is communicated
Maine	<ul style="list-style-type: none"> ▪ \$1.3B 	<ul style="list-style-type: none"> ▪ 2-8% reduction in paid PMPM, varying by sub-population (e.g., adult, child, dual)
Oregon	<ul style="list-style-type: none"> ▪ \$372 	<ul style="list-style-type: none"> ▪ Reduction in Medicaid and state employee PMPM trend by two percentage points by 2014
Massachusetts	<ul style="list-style-type: none"> ▪ Not specified 	<ul style="list-style-type: none"> ▪ Health care expenditure growth in line with projected gross state product (PGSP) until 2017, then PGSP minus .5 percentage points
Arkansas	<ul style="list-style-type: none"> ▪ \$1.1B 	<ul style="list-style-type: none"> ▪ Percent reductions in cost from eliminating inefficiencies, reducing medical inflation, and re-investing savings
Minnesota	<ul style="list-style-type: none"> ▪ \$111M 	<ul style="list-style-type: none"> ▪ Assume \$90.3M in savings from the Medicaid program, with net cost savings at \$61.4M for Medicaid
Vermont	<ul style="list-style-type: none"> ▪ Not specified 	<ul style="list-style-type: none"> ▪ Not specified

Four predominant types of metrics have been utilized by testing grant states to measure quality

NON-EXHAUSTIVE



■ Frequent focus of testing grant states

Metric type	Definition	Illustrative examples
Process	<ul style="list-style-type: none"> Execution of specific actions and/or clinical processes that are perceived to improve outcomes 	<ul style="list-style-type: none"> Vermont: rate of execution of specific clinical processes, rate of well-child visits, several cancer screening measures Massachusetts: follow-up after hospitalization, disease screening, prenatal and postpartum care
Appropriate utilization	<ul style="list-style-type: none"> Measures of utilization of appropriate care settings and types of care 	<ul style="list-style-type: none"> Maine, Oregon, Massachusetts, Minnesota: ED utilization Oregon, Arkansas: ambulatory care sensitive hospital admissions
Patient experience	<ul style="list-style-type: none"> Measure of patient satisfaction with quality of care and experience within health system 	<ul style="list-style-type: none"> Vermont: Improved patient experience with care coordination Minnesota: Improved patient experience measured through CAHPS
Outcomes (quality or population health status)	<ul style="list-style-type: none"> Measures of quality outcomes and indicators of patient and/or population health 	<ul style="list-style-type: none"> Maine, Oregon, Massachusetts, Minnesota: avoidable readmissions Oregon: tobacco use, obesity metrics, self-perceived health status Arkansas: decreased disease progression (e.g., diabetes, CHF, hypertension)

Note: Other metrics that were not at the core of SIM testing grants can be considered (e.g., access, provider experience)

What metrics will Connecticut track to assess its ability to maintain performance on leading health and quality indicators?

Select testing grant states focus on impacting measures of health inequity



NON-EXHAUSTIVE

	Oregon	Vermont	Minnesota
Process	Medication reconciliation post-discharge		
Appropriate utilization	ED visits, ambulatory care-sensitive admissions		
Access		Adults' access to preventive/ambulatory services	
Patient experience	Member patient experience		
Outcomes (quality or population health status)	Health and functional status, obesity, rate of tobacco use	Target conditions (e.g., diabetes, heart disease and stroke, asthma)	Health indicators (e.g., pap smears, mammograms, diabetes)

Massachusetts, Arkansas, and Maine do not have explicit focus on health equity in their testing grant application

How will Connecticut measure its ability to address health inequity?



Care delivery work group discussed three potential care delivery models

	Description	Examples
<p>Population health</p>	<p>Provider(s) responsible for the overall health of a population of patients over a set period of time and often targets highest cost group of patients with high touch care management</p>	<p> Relationships with CT physician groups to support practice of evidence-based medicine and coordinated care, particularly for patients with chronic conditions</p> <p> Patient centered primary care program which supports access to primary care and enhances care coordination</p> <p> Connecticut state PCMH pilot for self-funded employees and Medicaid enrollees that seeks to enhance the quality and capacity of primary care practices for state employees and youth</p>
<p>Episodes of care</p>	<p>Provider(s) with direct or indirect control over majority of care delivery for a defined acute procedure or condition are responsible for all care associated with the procedure or condition (e.g., CABG)</p>	<p> Best practices created for discrete episodes based on national or local guidelines and enforced standard clinical protocols</p> <p></p>
<p>Discrete encounters</p>	<p>Specialty or service specific providers with direct control over discrete components of care delivery</p>	<p> Dedicated specialty hospital treats discrete eye procedures at lower costs and higher quality than in US</p>



... and reached alignment on a working hypothesis for the care delivery model

Leading hypothesis and rationale

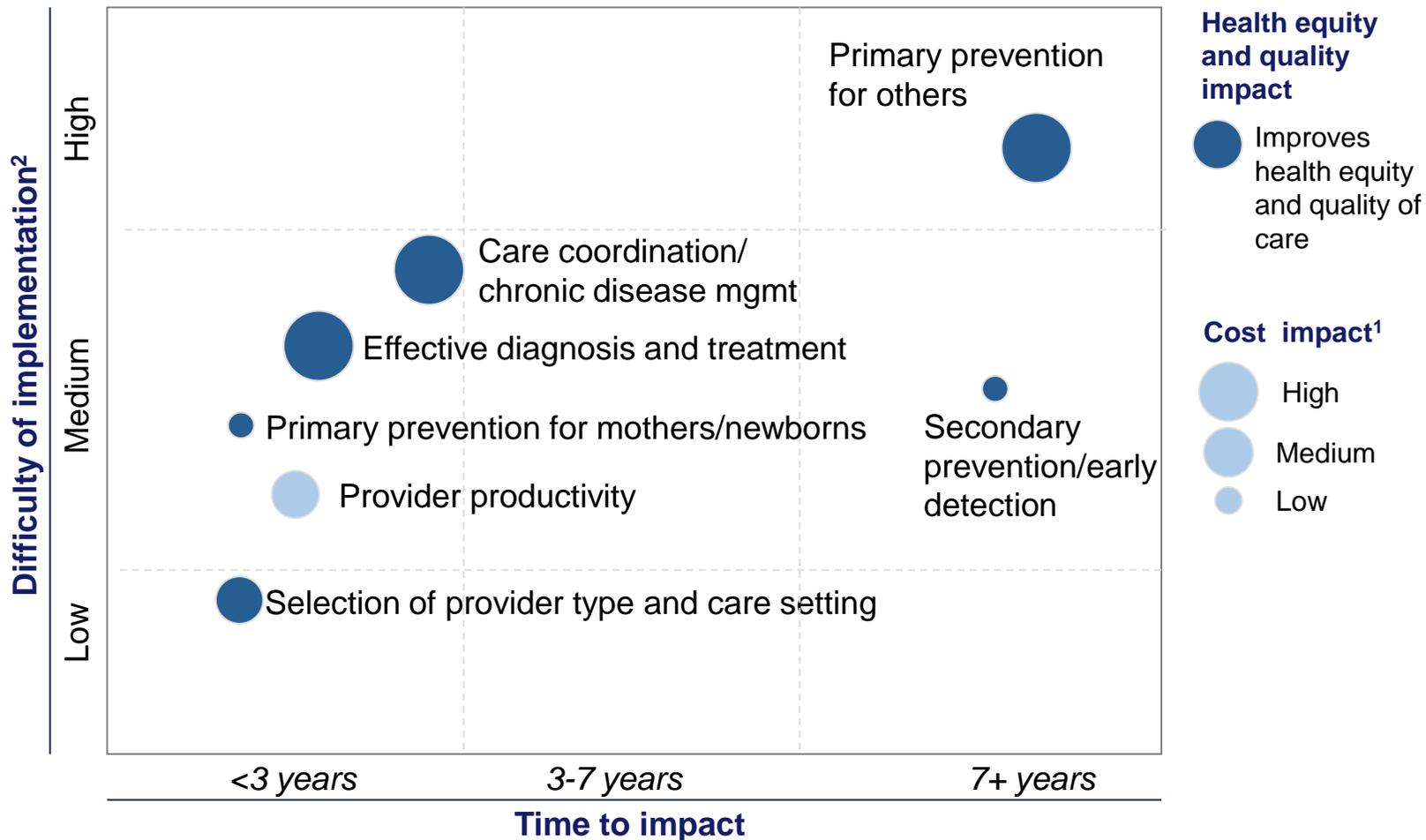
- **Lay foundational care delivery model that is population-health and total cost of care based**
 - Builds on ongoing efforts in state (e.g., Anthem PCMH, Cigna ACO)
 - Is in-line with CMMI guidelines of reaching 80% of the population within 5 years
 - Addresses health access inequities by encouraging comprehensive care
- **Consider whether to layer on episodes to target high opportunity procedures/ conditions**
 - Episodes represent targeted, near-term cost saving opportunity but require significant investment of time and effort to scale
 - Each individual episode requires significant episode-specific effort to design
 - Requires significant coordination and buy-in of specialists
 - Potential exists to consider select high opportunity episodes as supplementary to a population-health model, but ability to meet high resource and investment requirements of episode-design will need to be weighed

Next steps

- Consider ability to meet resourcing and investment needs required to design episodes alongside population-health model



Care delivery model work group assessed sources of value to focus on within the design of the care delivery model



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

SOURCE: See appendix for supporting evidence

What feedback does the SHIP steering committee meeting have for the care delivery work group?



- What considerations should the care delivery work group keep in mind when assessing benefits and limitations of layering episodes onto foundational population health model?
- How should the care delivery work group consider opportunities to improve discrete encounters of care on top of the foundational population health model?
- What cost impact targets should the care delivery work group keep in mind when considering the types of care delivery innovations (e.g., population health, episodes) that should be developed within the next 3-5 years?



Payment work group is considering set of strategic design considerations (1 of 2)

■ Led by care delivery work group

Strategic design considerations

Illustrative examples of options

1 Metrics

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ What will be the scope of accountability for cost and quality? ▪ What are the sources of value we hope to promote with the payment model? | <ul style="list-style-type: none"> ▪ Population health, episodes of care, discrete encounters ▪ Effective diagnosis and treatment, selection of provider and care setting, chronic disease management |
| <ul style="list-style-type: none"> ▪ What metrics will be used for eligibility for participation and eligibility for payment? | <ul style="list-style-type: none"> ▪ Structure (e.g., EMR adoption), processes (e.g., create a care plan), outcomes (e.g., lower costs, complications) |

2 Payment

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ What is the reward structure? ▪ How do we define the level of performance we wish to reward? ▪ What are the targets, pricing, and risk corridors? | <ul style="list-style-type: none"> ▪ Global payment, gain/risk sharing, P4P, conditional care coordination fees, conditional FFS enhancements ▪ Absolute, relative, improvement ▪ Quality targets, care coordination fees and/or bonus payment amount, benchmark trend, minimum savings, risk sharing splits, stop loss, gain sharing limits |
|---|---|

**THOUGHT
STARTER**

Across each of these design decisions, how important is it for state and commercial payers to be aligned?



Payment work group is considering set of strategic design considerations (2 of 2)

Strategic design considerations

Illustrative examples of options

3 Attribution

- What will be the rule for attribution?
 - At what level will performance be aggregated for measurement and rewards?
 - What exclusions and adjustments will be applied for fairness and consistency?
- Prospective member selection, plan auto-assignment, retrospective attribution
 - By physician, practice, virtual pod, or ACO/joint venture
 - Risk adjustment and/or exclusions by: beneficiary, clinical, outlier, provider-option, and/or actuarial minimums

4 Rollout

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

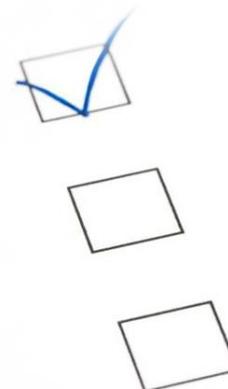
**THOUGHT
STARTER**

Across each of these design decisions, how important is it for state and commercial payers to be aligned?

What guidance does the SHIP steering committee meeting have for the payment work group?

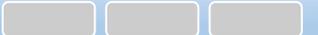


- What considerations should the payment work group be aware of as they set the guiding principles for strategic and technical design decisions (e.g., rewarding absolute performance or improvement, ultimately exposing providers to upside and downside risk)?
- What is the steering committee's guidance on the level of standardization across payers and providers that the work group should seek across each of these design decisions?





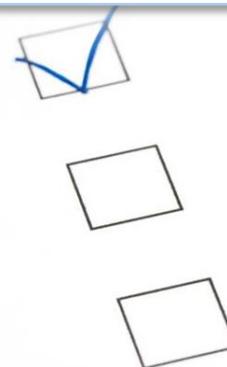
HIT work group will be assessing the optimal level of standardization in the HIT infrastructure

Option	Description	Rationale
 <p>Mostly consolidated across payors</p>	<p>All payors using/sharing same infrastructure and technology</p>	<ul style="list-style-type: none"> ▪ Cost synergies from scales across multiple payors ▪ Reduced operational complexity and confusion for the users (e.g., provider portal) ▪ Foundational requirements for state-wide initiatives (e.g., HIE)
 <p>Standardized but not consolidated</p>	<p>Standardized output agreed-upon by all payors with independent execution and delivery</p>	<ul style="list-style-type: none"> ▪ Output consistency (e.g., payment calculation, quality metrics, provider reports) required for state-wide roll out ▪ Stakeholder complexities associated with shared infrastructure
 <p>Not standardized or consolidated</p>	<p>No standardization of output; no technology/ infrastructure sharing or consolidation</p>	<ul style="list-style-type: none"> ▪ Cross-payor variation does not impact solution consistency ▪ Payors unable/unwilling to standardize

What guidance does the SHIP steering committee meeting have for the HIT work group?



- What is the optimal level of standardization of the HIT model?
 - Standardized outputs only (e.g., report formats)
 - Common provider-facing technology (e.g., shared provider portal)
 - Shared data analytics (e.g., all-payer claims database and analytics)
- What is the appetite for transparency on provider performance?
 - Physicians: performance metrics shared between providers
 - Consumers: patient has access to performance metrics specific to his/her network
 - Public: annual reports on provider performance are shared broadly

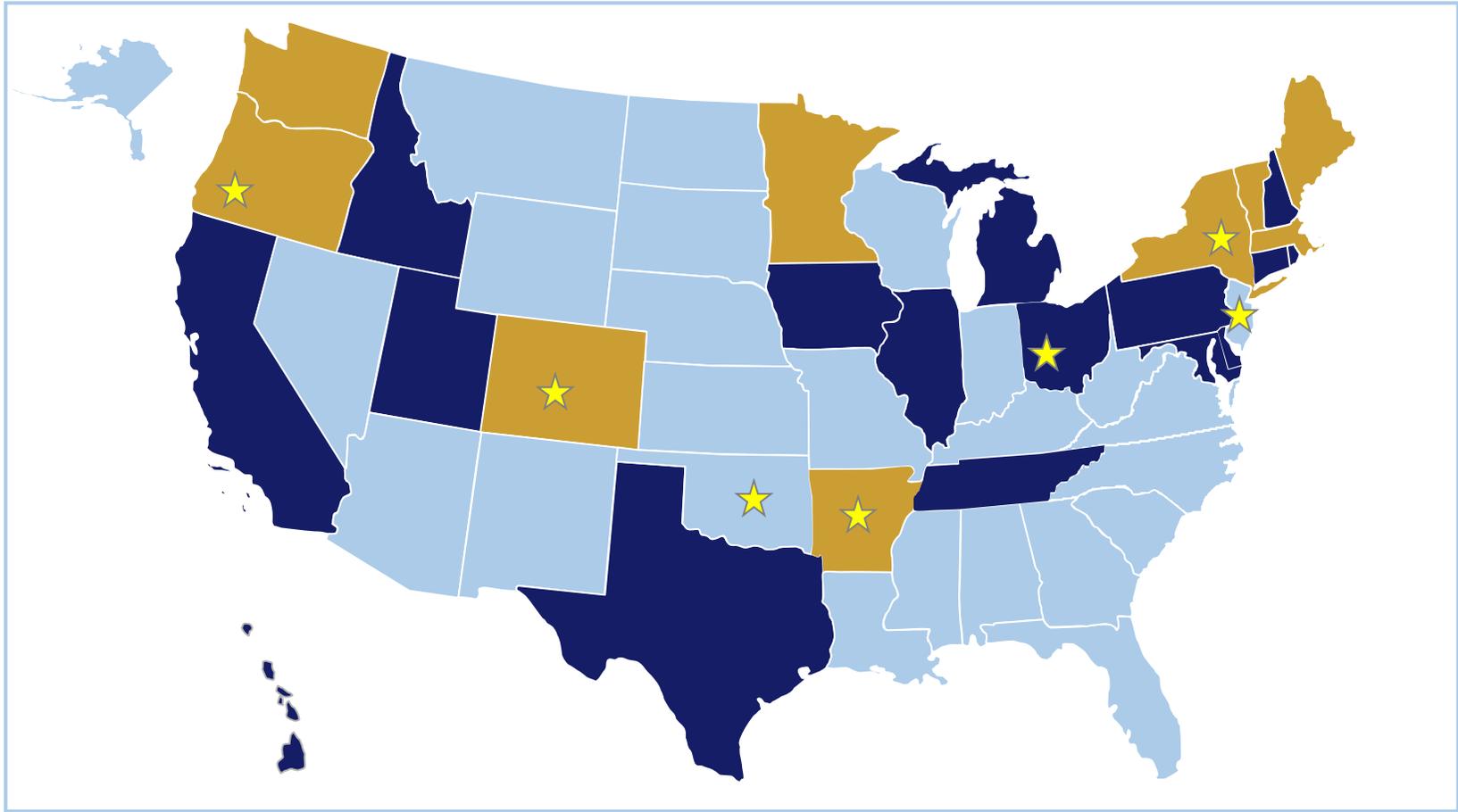


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- Share additional guidance for work groups with the core team co-chairs: Vicki Veltri (payment), Michael Michaud (HIT), Mark Schaefer (care delivery) for incorporation into work group thinking
 - Reconvene on June 10 to review care delivery, HIT, and payment work group recommendations for model design

APPENDIX

16 states were awarded Model Design grants and 6 received testing grants (3 pre-testing)

 SIM Testing or Pre-Testing  SIM Design  CPCI¹ Testing



1 Comprehensive Primary Care Initiative

The 6 testing states are using SIM to drive innovation at scale (1 of 2)

Brief description of approach

Arkansas

- **Population-health model:** PCMH for majority of Arkansans by 2016
- **Episodes:** episodes designed for all acute and complex chronic conditions (50-70% of spend) over 3-5 years

Maine

- **Population health model:** Formation of multi-payer Accountable Care Organizations (ACOs)
- Alignment of benefits from MaineCare (the state's Medicaid program) with benefits from Medicare and commercial payers to achieve and sustain lower costs for the Medicaid, Medicare and CHIP populations

Massachusetts

- **Population health model:** Support for primary care practices to transform into PCMHs
- **Discrete encounters:** Shared savings / shared risk payments for primary care with quality incentives based on a statewide set of quality metrics

Minnesota

- **Population health model:** ACOs with expanded scope of care to include long-term social services and behavioral health services
 - Created linkages between the ACOs and Medicare, Medicaid, and commercial insurers to align payments to provide better care coordination
 - Established “Accountable Communities for Health” to integrate care with behavioral health, public health, social services, etc., and to share accountability

The 6 testing states are using SIM to drive innovation at scale (2 of 2)

Brief description of approach

Oregon

- **Population health model:** System of Coordinated Care Organizations (CCOs), which are risk-bearing, community-based entities governed by a partnership among providers, the community, and entities taking financial risk for the cost of health care
- CCO model will begin with Medicaid and be spread to additional populations and payers, including Medicare and state employee plans

Vermont

- **Population health:** Shared-savings ACO model that involves integration of payment and services across an entire delivery system
- **Episodes:** Bundled payment model that involve integration of payment and services across multiple independent providers
- **Discrete encounters:** pay-for-performance model aimed at improving the quality, performance, and efficiency of individual providers Formation of multi-payer ACOs