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Connecticut SIM: Payment model reference materials

Reference materials
July 29, 2013

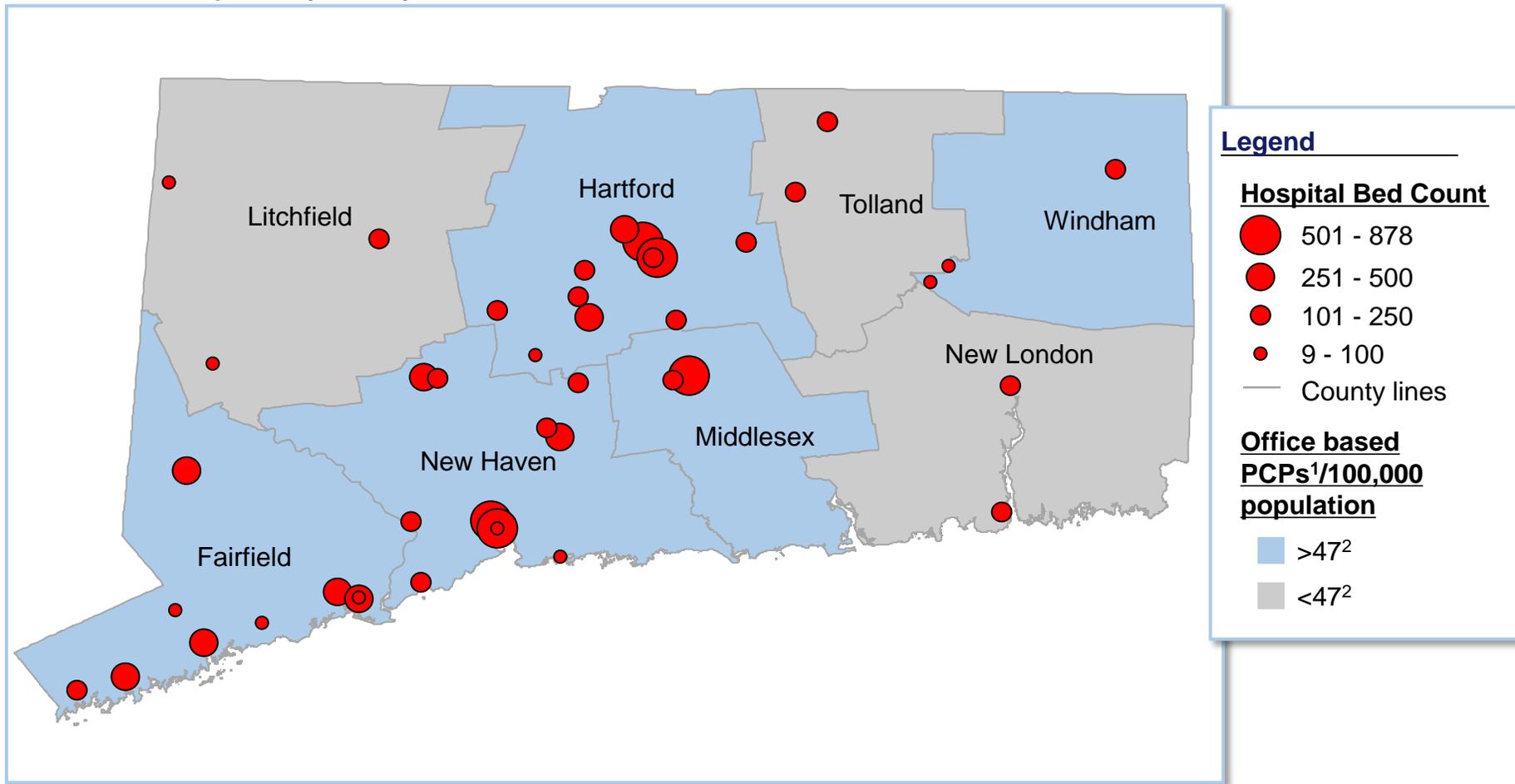
Background on performance aggregation and attribution

“ACO-like” Model: Bangor Beacon ACO

“Geocentric” Model: Community Care of North Carolina

Connecticut hospitals mapped by size with overlay of PCP concentration by county

Connecticut hospitals by county

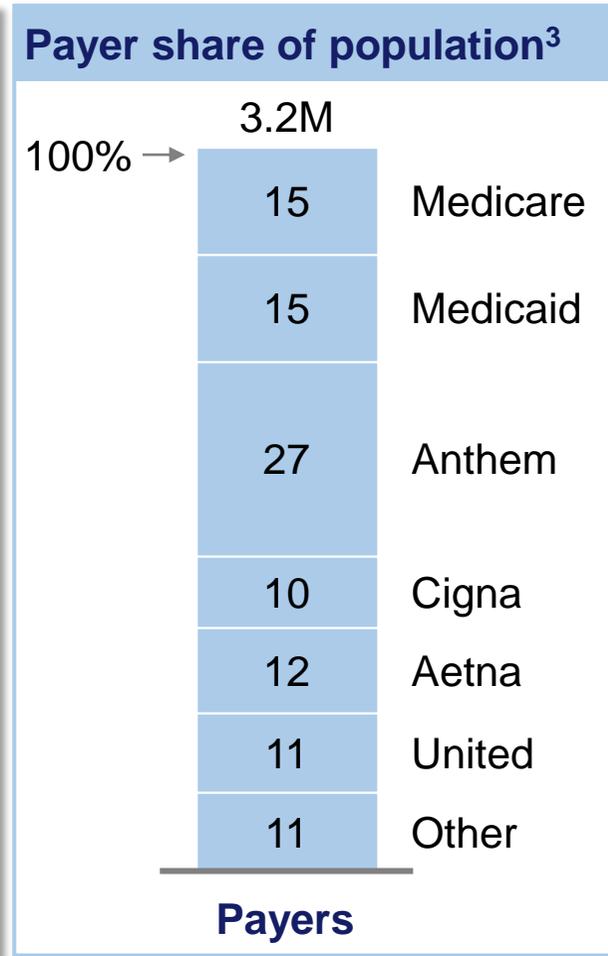
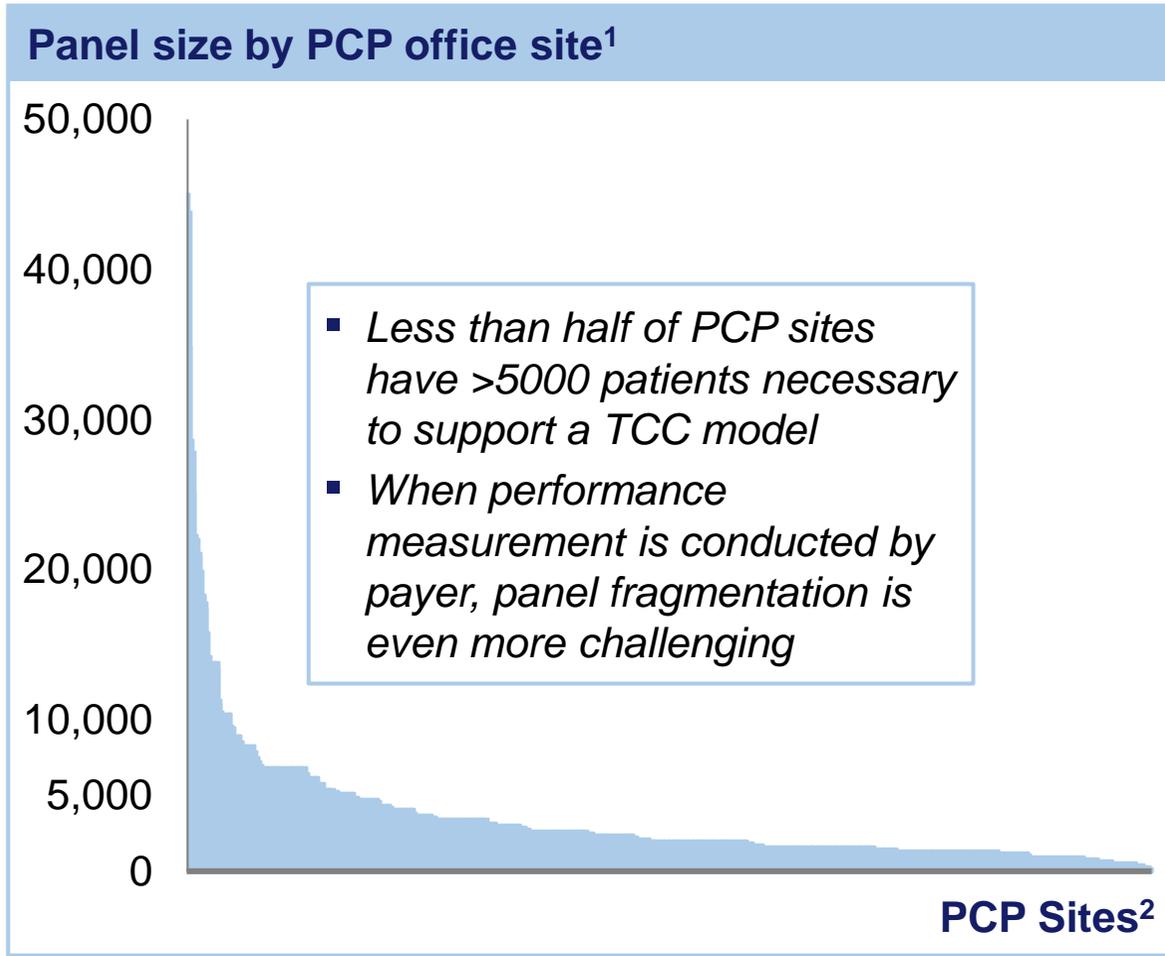


1 Includes family practitioners, general practitioners, internal medicine/pediatrics, internists

2 National average for specialties listed above

SOURCE: AHD 2013, AMA Census of Physicians 2011. SK&A data. Methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians

The group referred to the level of provider fragmentation in CT (1/2)



1 PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists; panel sizes are pooled across payers

2 Total number of sites = ~800 sites in Connecticut with at least one PCP. Excludes sites without patient visit data (50 sites total), and does not separate sites of care owned by same parent company

3 Does not include uninsured population (~300k); figures represented at insurer level (does not include self-insured employers, e.g., state employees)

SOURCE: SK&A data (~800 sites captured). Methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians; Kaiser State Health Facts, Health Leaders Interstudy data

Potential elements of clinical integration

Elements of clinical integration

Common patient population

Aligned financial incentives

Common governance

Exchange of health information

Shared clinical pathways

Common care coordination

Evaluation and remediation

Physician engagement

Broadly, there are three potential models through which small providers could be enabled to take on total cost of care accountability

Option

Description

“ACO-like” model

- Small providers aggregate into ACOs
 - ACO has strong central governance to manage continuum of care for a patient population, support performance management, and to internally distributed shared savings
 - Model requires contractual financial relationships among providers and is self-funding
-

“Virtual” model

- Small providers virtually pool their volume to create a pool of patients that are actuarially sound for performance measurement
 - No formal governance structure or legal/financial relationship among providers; performance aggregated for performance measurement only
 - Provision of financial support required
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“Geocentric” model

- Small providers within a geography pool their patient volume for performance measurement
- Practice transformation and care coordination support provided through community-based public utilities
- Providers within each region share this common set of resources

Background on performance aggregation and attribution

“ACO-like” Model: Bangor Beacon ACO

“Geocentric” Model: Community Care of North Carolina

Overview: Bangor Beacon Community Pioneer ACO

Why was a change in care delivery considered?

- **Eastern Maine Healthcare Systems (EMHS)** led applications for both ONC grant and CMS Pioneer ACO designation
- **Bangor Beacon Community (BBC) program** aimed to promote cost-effective care through care coordination and patient self-management by leveraging existing and establishing new health information technology infrastructure
- **Beacon LLC Pioneer ACO** builds on the BBC care delivery model by incentivizing financial sustainability

What was the scope of the care model?

- **BBC program** targets patients with chronic conditions, with clinical transformations affecting greater Bangor region
- **Beacon LLC ACO** covers ~22K Medicare beneficiaries
- **Quality outcomes and cost savings** were used to measure program success

What were the changes made?

- **Nurse care managers** were added to each primary care practice to design care plans and coordinate care on behalf of patients
- **High level of healthcare technology** enabled model

How was the care model put in place?

- **EMHS** was the lead organization behind both the BBC program and Beacon LLC
- **ONC grant** was received in May 2010
- Necessary health IT and clinical interventions were operation by **September 2010**
- Beacon LLC was designed a Pioneer ACO in **October 2011**

How did payment reform support care model?

- **All 9 participating hospitals** are responsible for delivering savings to the Medical program
- **Pioneer ACOs** operate over 3-year period
 - Y1: upside-only
 - Y2: increased upside- and down-side risk
 - Y3: capitation and shared revenue from risk sharing contract

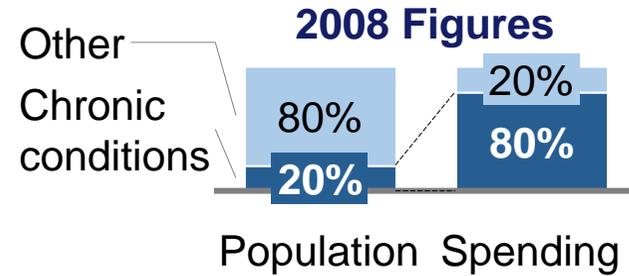
What was the impact in terms of quality and costs?

- **Improved outcomes** in diabetes (45% decrease % patient with HbA1C >9) and chronic health failure patients (9% increase in % patients with BP <130/80)
- **Reduced healthcare utilization:** both ED visits and hospital admissions decreased ~40% 12 months after intervention
- Beacon LLC achieved **3% cost savings** in its first three quarters as a Pioneer ACO, outperforming 25/32 peer providers

1 Why was a new care delivery model considered?

What was the overall context? Why was this initiated?

- Bangor, ME region saw a **high rate of patients with chronic disease** compared to state and national averages, with a small portion of the population accounting for nearly all healthcare expenditure in the region



Who was involved in initiating the change?

- **EMHS** leads both Bangor Beacon Community program and Pioneer ACO
- **12 engaged partners** include: Eastern Maine Medical Center, Penobscot Community Health Care, St. Joseph Healthcare, the Acadia Hospital, HealthInfoNet, Eastern Maine Community College, Eastern Maine HomeCare, Community Health and Counseling Services, Ross Manor, and Stillwater Health

How were people brought together? What circumstances helped facilitate that?

- EMHS received a 3-year \$12.7m grant from the **Office of the National Coordinator for Health Information Technology** to found the BBC program in May 2012
- **Center for Medicare and Medicaid Innovation** selected EMHS to be a Pioneer ACO in January 2012



2 What was the scope of new care delivery model?

Description

Size of population targeted

- Bangor Beacon Community program affected **53.7k patients**
 - **1,200 patients** enrolled initially in primary care management model
- Pioneer ACO will initially focus on **22k Medicare beneficiaries** but aim extend care delivery model to service all patient sub-populations

Geographic Scope

- Bangor hospital service area covers **Piscataquis, Hancock, Waldo, and Somerset counties** in Maine

Patient segments & pathways

- **Clinical focus areas** include diabetes, cardiovascular care, asthma, COPD, mental health, and immunizations
- **Nonclinical focus areas** include utilization and patient-report, measurement, disparities, and safety

Providers involved

- **Eastern Maine Healthcare Systems** is the lead grantee of the Bangor Beacon Community and initial applicant for CMS Pioneer ACO designation
- **3 hospital partners**, Eastern Maine Medical Center, Inland Hospital, and TAMC (all part of EMHS) are involved in initial BBC program
 - Beacon LLC expanded to include total of **9 hospitals** operating as Pioneer ACO
- **4 Federally Qualified Health Centers**

3 What were the goals of the new care delivery model?

	Description
Patients	<ul style="list-style-type: none">▪ To promote patient self-management and empower patients as a member of their care coordination team
Quality	<ul style="list-style-type: none">▪ To improve management of chronic conditions through information exchange, telemedicine, medical home model and patient safety
Costs	<ul style="list-style-type: none">▪ Reducing costs associated with hospital admissions and emergency department visits by increasing the quality of care for high-risk patients
Population health	<ul style="list-style-type: none">▪ To improve population health through proper immunization and sharing of immunization data among providers▪ Reduce variation in the delivery of evidence-based medicine and improve care quality for the community
Health IT	<ul style="list-style-type: none">▪ To leverage existing statewide health information exchange to build an integrated organization to test new payment models and be accountable for the care of their population▪ Increase meaningful users of HIT to 60% within the community
Sustain-ability	<ul style="list-style-type: none">▪ Project will focus on producing systematic changes with sustainable and positive results for the community

SOURCE: Eastern Maine Healthcare Systems Grants -- Award Summary,

4a Health information technology is a crucial enabler for extension of the primary care workforce

1. Enhancing health information technology infrastructure

- Broadening reach of **HealthInfoNet**, statewide health information exchange
- **Connecting major health systems**, behavioral health facilities, LTC facilities, homecare, FQHCs
- Adding **functionality to send notifications** to provider or care manager
- Integrating **behavioral health data** in HealthInfoNet

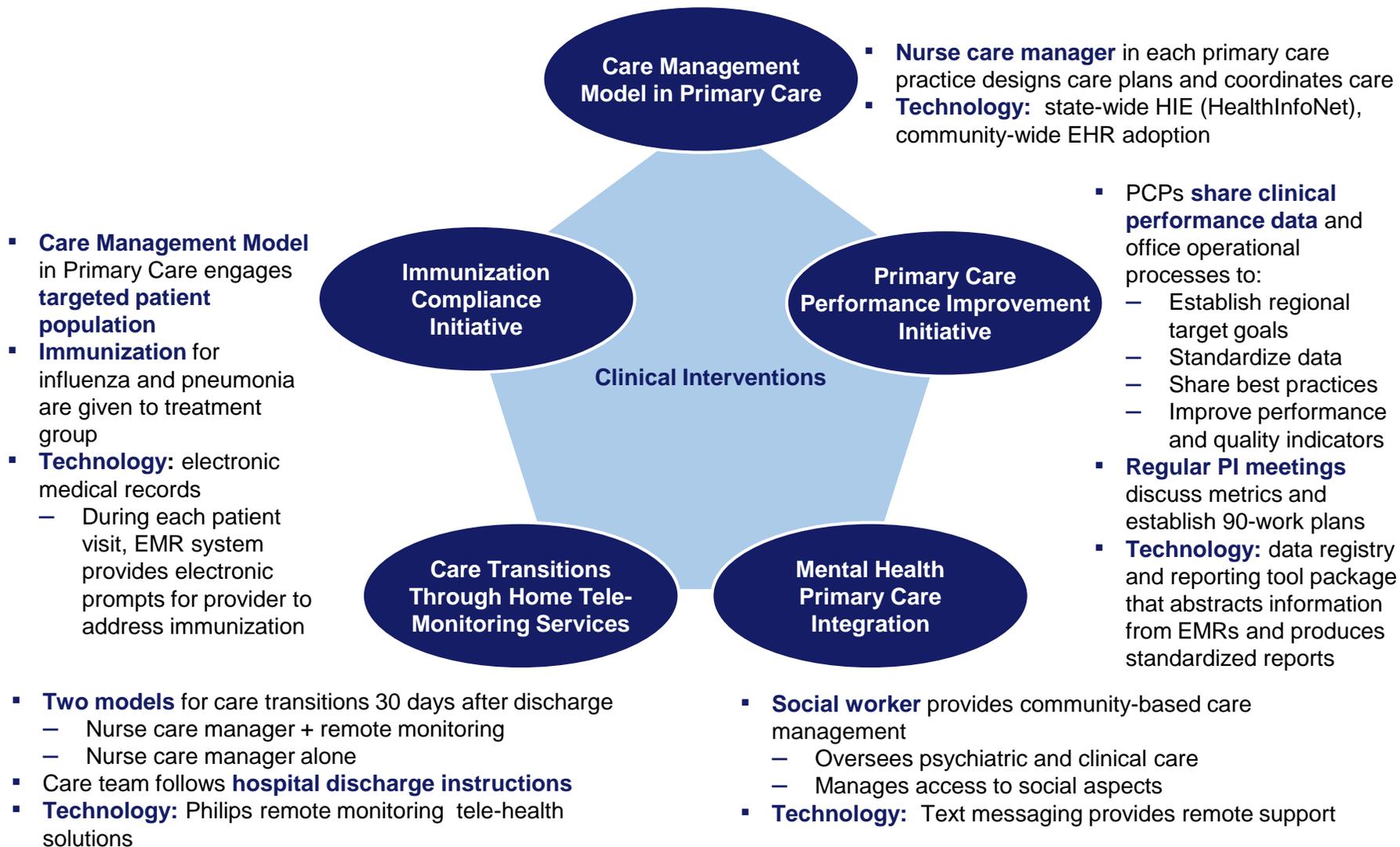
2. Care coordination through extension of PCP workforce

- Expanding reach of primary care through a network of technology-supported **nurse care managers**
- Managers utilize **electronic health records** to capture and access and track patient information and monitor patients via electronic home monitoring
- Enhancing **performance improvement efforts** of PCPs through sharing clinical performance data and office operational processes
 - Participants extract and share performance reports from practice EHR, which are stratified by region

3. Test mobile health innovation

- **mHealth**: Exploring ways to extent the reach of care coordinators to patients by using remote monitoring technology to monitor patients after release from hospital to reduce avoidable readmissions
 - Providing texting support to mental health patients
- **Telemonitoring project**: Care team tracks patient vitals on a daily basis through devices such as automated medication dispensers and other monitors
 - Homecare agencies and care coordinators collaborate to monitor patients at home and collaborate to identify warning signs
 - Care coordinators have been able to telephonically do medical reconciliation with the patients and homecare nurse

4b Clinical transformation takes place through five targeted initiatives, each supported by IT infrastructure



SOURCE: Office of the National Coordinator for Health Information Technology: Bangor Beacon Community, December, 7, 2012.

4c Care Management Model in Primary Care



Care delivery process

Patient ID/enrollment	Initial assessment	Care plan	Monitor/outreach	Ongoing care
<ul style="list-style-type: none">Identify high risk/high cost chronic conditions patients (diabetes, CHF, COPD, asthma) with:<ul style="list-style-type: none">At least one hospital admission, ED, non-urgent care/walk-in care visit due to condition in last 6 monthsOther disease-specific measures 	<ul style="list-style-type: none">PCP takes clinical leadUtilizes and updates state-wide health information exchange, HealthInfoNetNurse care manager assesses need to involve other clinical staff or care team 	<ul style="list-style-type: none">Nurse care manager develops care planCoordinates care team when necessary<ul style="list-style-type: none">Mental health care management teamHome health servicesInpatient care management teamIn-clinic patient education is provided by the nurse care manager 	<ul style="list-style-type: none">Telemedicine allows remote monitoring<ul style="list-style-type: none">Patients upload health vitals dailyAlerts are sent to nurse care managerNurse care manager provide telephone consultation and health coachingDispatches relevant care team when necessary 	<ul style="list-style-type: none">Patients are encouraged to self-manage chronic condition, as per in-clinic educationNurse care managers are available for telephone consultation when needed 

Technology integration

- Community-wide HIE** provides care transition infrastructure between hospitals and primary care practices, providing real-time information to care managers on admissions and emergency department visits
- EHR adoption across the region** includes standardized data collection through care manage encounter forms
- Secure e-mail** connects providers, nurse care managers, and patients

5 What were the operational changes in how care is delivered?

Primary care

- **Practice redesign and care coordination:** each primary care practice has the support of at least one **nurse care manager** who:
 - Develops care plan
 - Assesses the need to incorporate other staff members
 - Coordinates the transition of care for those patients
 - Provides patient education

Community care

- **Nurse care manager** oversees **at-home care**
 - Telephone consultation allows self-management of conditions
 - Involves PCP or other relevant care teams when necessary

Acute setting

- **Automated electronic alert** is sent to **nurse care managers** following ED visit or hospital admission
 - Provides clinical support
 - Coordinates care transition when timing is appropriate
- PCP is then notified by the nurse care manager



Addition of nurse care managers is the key operational change enabling care delivery model

6 How were key success factors addressed?



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- Nation-wide Beacon community programs share general design
 - EMHS was lead ONC grantee and the initial Bangor health system recognized as an CMS Pioneer ACO
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- Effective use of leadership groups
 - Care Manager Forums are held bi-weekly and address issues of communication, technology, and process barriers
 - Statewide Advisory Committee shares best practices
-
- Maine already used statewide health information exchange system, HealthInfoNet
 - Increased functionality of EHR, clinical data sharing capabilities, and telemedicine initiatives were enabled by ONC's \$12.7m grant
-
- No financial risk to BCC participants
 - ONC grant funded program activities
 - BBC program did not involve change in payment model
 - ACO structure is utilized to provide financial sustainability by holding provider accountable for total care costs
-
- Continuous patient engagement is ensured through in-clinic patient education, at-home consultations, and encouraged self-management
 - Bangor Beacon Patient Advisory Group provides

6 How does the payment model align incentives?

Relevant questions

Overview and guiding principles

- Initial BBC program did not include a payment-based element
- EMHS participation in CMS Pioneer ACO program began on January 1, 2012
- Renamed ACO Beacon LLC and extended ACO participation to other regional hospitals, including a total of six hospitals, as of January 2013

Aligning individual incentives

- Beacon LLC, the ACO entity, is held responsible
- Provider is accountable for total cost of care by Medicare beneficiaries
- Pioneer ACO sees increased accountability over 3 years:
 - Year 1: upside-only savings of 50%
 - Year 2: upside and downside savings/losses of 70%
 - Year 3: ACO migrates to capitation model and receive 50% revenue from risk share contracts

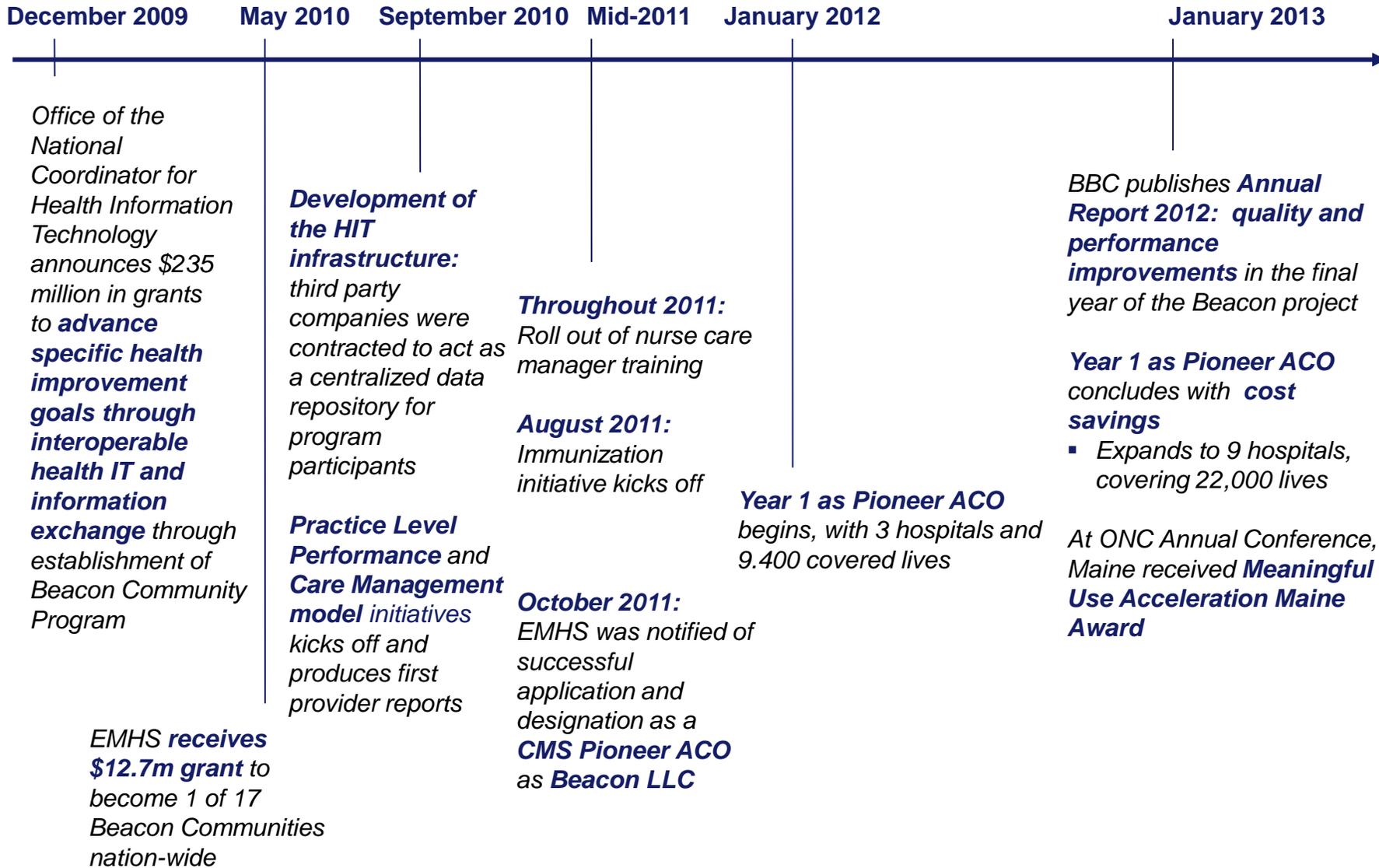
Mechanisms to mitigate volatility

- Accountability is increased incrementally over 3-year period
- First year of upside-only shared savings allows adjustment period, provided the ACO achieves savings rate of ~2.5%

Operationalizing the payment model

- EMHS applied for to be a Pioneer ACO in July 2011
- Received notice of Pioneer Designation in October 2011
- Began operating as Beacon LLC in January 2012

7 How was the care model put in place?



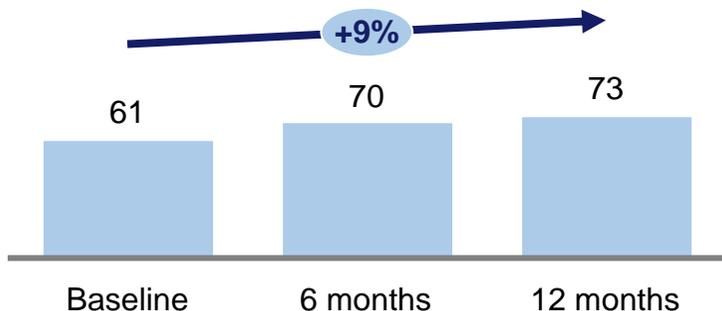
SOURCE: US Department of Health & Human Services: HealthITBuzz, ONC Beacon Communities, December 2, 2009, Bangor Beacon Community Program Annual Report 2012.

8 What was the impact in terms of quality and costs?

Improved chronic heart failure outcomes¹

Blood pressure control for CHF patients

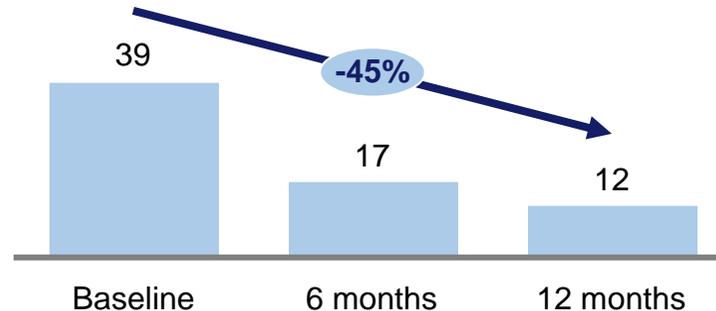
Percent of CHF patients with BP <130/80



Improved diabetes outcomes¹

HbA1C levels in diabetes patients

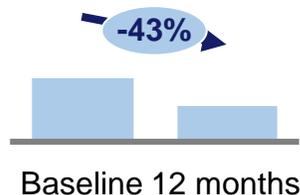
Percent of diabetes patients with HbA1C >9



Reduced healthcare utilization¹

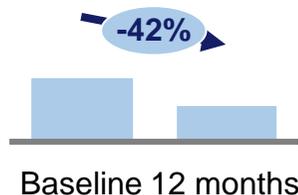
Emergency dept visits

Total ED visits



Hospitalizations

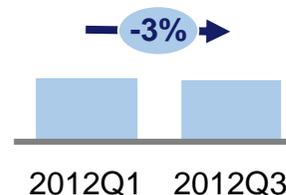
Total hospital admissions



Cost savings

Pioneer ACO cost savings

Percent reduction in costs



- 14 out of 32 ACOs managed to generate cost savings in the first three quarters
- Beacon LLC ranks 7th out of 32 participants by reduction in cost

¹ Results exclude patients loss to follow-up (16.3% of patients of total enrolled patients at six months; another ~22% at 12 months). Primary reasons for loss: death, unable to contact patient, patient discharged from practice for compliance issues, patient in skilled nursing facility, patient unable to comply with protocol

SOURCE: Eastern Maine Healthcare Systems' Annual Report, 2012, Office of the National Coordinator for Health Information Technology: Bangor Beacon Community.

9 What advice would you give to organizations who are designing a new care delivery model?

Do's



- Leverage existing healthcare information technology:
 - Increase adoption and usage of existing infrastructure
 - Supplement functionalities to enhance provider care coordination and patient engagement
- Incorporate non-physician providers and paraprofessional into care teams
- Establish robust forums and focus groups to ensure patient and clinical engagement

Dont's



- Restrict program enrolment eligibility by insurance coverage, as may affect provider buy-in
 - Other programs targeting Medicaid enrollees were challenged by negative provider attitudes

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CCNC: Elements of PCMH Strategy (1/3)

Care delivery Aspirations	Target patients and scope	<ul style="list-style-type: none"> CCNC targets 2/3 of the state Medicaid population (>1 million patients); enrollment is mandatory for most children and parents and disabled and elderly individuals who are not receiving Medicare (non-dual eligibles)
	Care delivery improvements e.g., <ul style="list-style-type: none"> Improved access Team-based care, including care coordination Patient engagement Population management 	<ul style="list-style-type: none"> Care managers work closely with physicians delivering care to a panel of 3-4,000 patients of which 150-200 may require active case management Specialized care transitions program to help reduce hospital admissions, with a care manager embedded in the hospital liaising with acute staff Care manager helps PCP with patient reviews, adherence to care plan and non-medical needs (e.g. housing, social support) CCNC is exploring new models including pharmacist care consultants
	Target sources of value	<ul style="list-style-type: none"> Program focuses of two sources of value: managing utilization and chronic disease management
Payment Model	Technical expectations/ Requirements	<ul style="list-style-type: none"> Networks qualify for the enhanced federal match under “Health Homes for Enrollees with Chronic Conditions” provision of PPACA 14 PCMH/delivery networks (>1,300 PCP practices) cover the entire state
	Attribution	<ul style="list-style-type: none"> Patients are assigned to a network, PCP and care manager on enrollment Minimum network panel size is 2,000 enrollees
	Quality metrics and performance evaluation	<ul style="list-style-type: none"> Performance measure agreements signed by each network
	Payment streams/ incentives	<ul style="list-style-type: none"> Distributed payment model with separate network and practice fees <ul style="list-style-type: none"> Practices receive FFS at 95% of Medicaid rates plus \$2.50 PMPM for women and children, and \$5 PMP for aged, blind and disabled Networks receive \$3 PMPM for women and children, and \$8 PMPM for aged, blind and disabled - part of which supports the central office Savings beyond an established threshold are shared with the network
	Patient benefits/ network	<ul style="list-style-type: none"> To be determined (no direct patient incentives identified)

1 ABD = aged, blind and disabled

CCNC: Elements of PCMH Strategy (2/3)

Infrastructure	PCMH infrastructure	<ul style="list-style-type: none"> Central Informatics center for data analytics and performance reporting Central support office deploys resources for launch, care manager hiring, access to technical and clinical consultants and other support functions
	Provider infrastructure	<ul style="list-style-type: none"> Care managers used online case management information system (CMIS) to coordinate care and transitions
	Payer / Provider infrastructure	<ul style="list-style-type: none"> Providers receive quarterly practice profile reports that include data on utilization, disease management metrics, costs and savings,
	Provider / Provider infrastructure	<ul style="list-style-type: none"> Local community networks are the basis of the system
	System infrastructure	<ul style="list-style-type: none"> Unknown
Scale-up and sustain practice performance	Clinical leadership / support	<ul style="list-style-type: none"> Each network has a board, steering committee and to maintain local leadership while contribution to centralized state-level governance: each network appoints a director to the state board of clinical directors
	Practice transformation support	<ul style="list-style-type: none"> Network QI teams employ rapid cycle quality improvement (model developed by IHI) and 3rd party randomized case reviews
	Workforce	<ul style="list-style-type: none"> Each practice has a physician champion CCNC is exploring new care management models including pharmacist consultants
	Legal / regulatory environment	<ul style="list-style-type: none"> Regulatory framework developed under “Health Homes for Enrollees with Chronic Conditions” provisions of PPACA

CCNC: Elements of PCMH Strategy (3/3)

Scale-up and sustain practice performance (cont.)

Network / contracting

- Unknown

ASO contracting

- Unknown

Multi-payer collaboration

- Single payor model (Medicaid), though may expand to Dual Eligibles

Performance transparency

- Data shared within network and across program: practice outcomes benchmarks; provider portal for all patient information
- Quality Measurement and Feedback Initiative used by board of clinical directors to determine performance targets

Evidence, pathways, and other research

- All care management programs defined and approved by physician and network leadership

Ongoing PCMH support

- Central support office support community development through employed community developers, network access to expert input and other tools