



# State Innovation Model: Payment model work group kickoff

STATE OF CONNECTICUT

Discussion Document  
May 20, 2013

# Objectives for today's discussion

## Review



- Connecticut SIM design aspirations and roadmap

## Align and finalize



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



# Welcome to the SIM design payment model work group

■ Co-chairs

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*Department of Social Services*

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*Office of the State Comptroller*

Lori Pasqualini  
*Connecticut Business Group on Health*

Note: Aetna to be included in future work groups



# Working group norms - expectations for how we will work together

## Objectives

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

## Presence

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

## Mindset

- Respond promptly to email and phone requests
- Leave day job at the door, think of best interest of Connecticut
- Seek consensus amongst working group

## Action

- Build momentum and excitement in your respective communities
- Champion this effort broadly
- Shape the future of health care delivery in Connecticut





## Connecticut has a unique opportunity to address quality, access, and cost challenges today

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

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

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

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

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

**The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration**



# CT has support from CMMI to innovate care delivery and payment model reforms and has high aspirations for what it can achieve

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

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

## . . . helped shape Connecticut's targeted aspirations

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

# The SIM Design phase extends from April through September

ESTIMATED

April - September

October to early 2014

Mid-2014 to 2017

Design phase

Testing grant application  
review and selection

Testing phase

April

May

June

August

September

Project set-up

Options and  
hypothesesDesign and  
planning

Syndication

Finalization

- Understand current state
- Establish vision

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

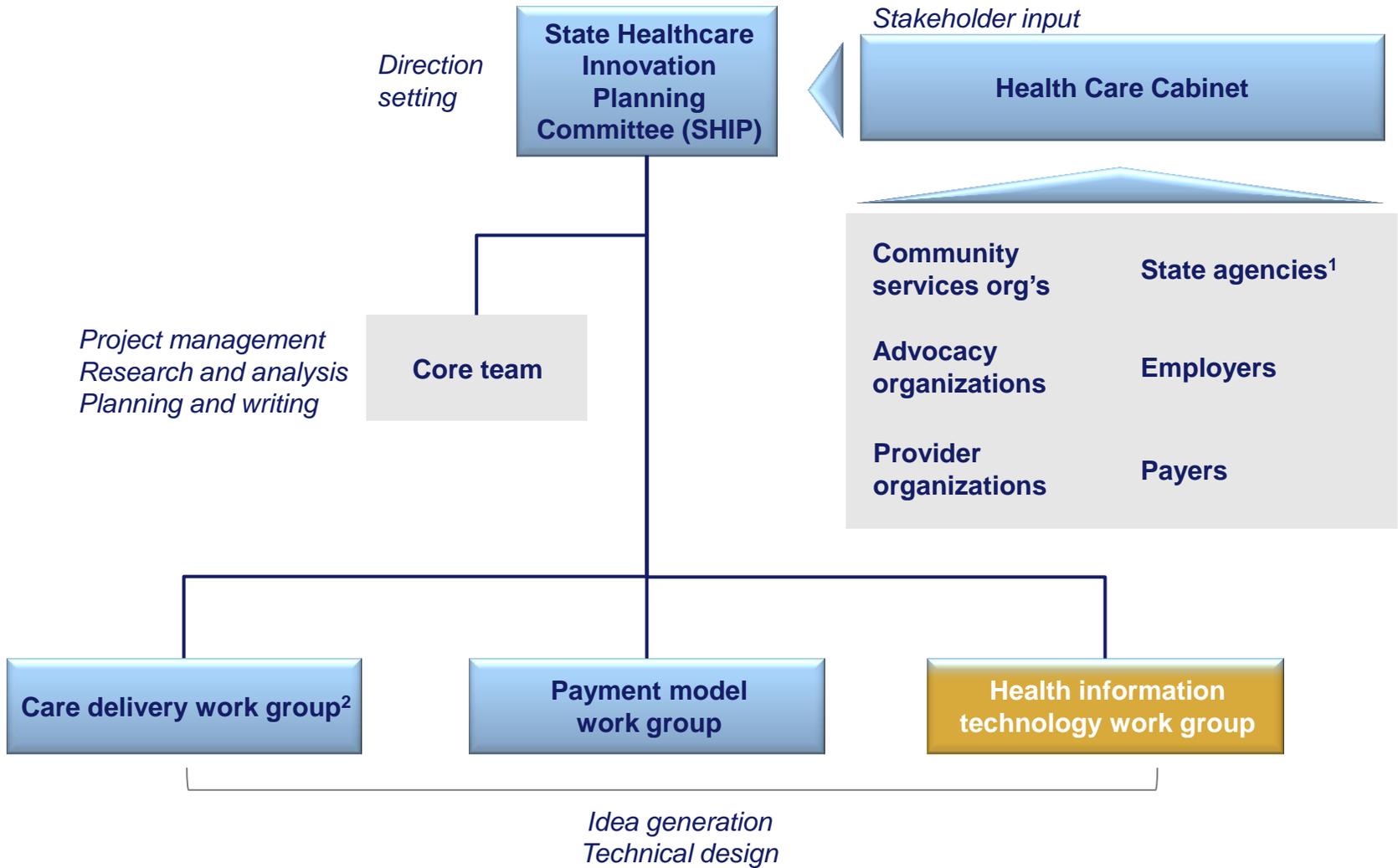
- Design detailed health care delivery system and payment model
- Develop implementation and roll-out plan
- Align on key quality metrics

- Draft testing proposal
- Syndicate with key stakeholders

- Refine and submit testing proposal



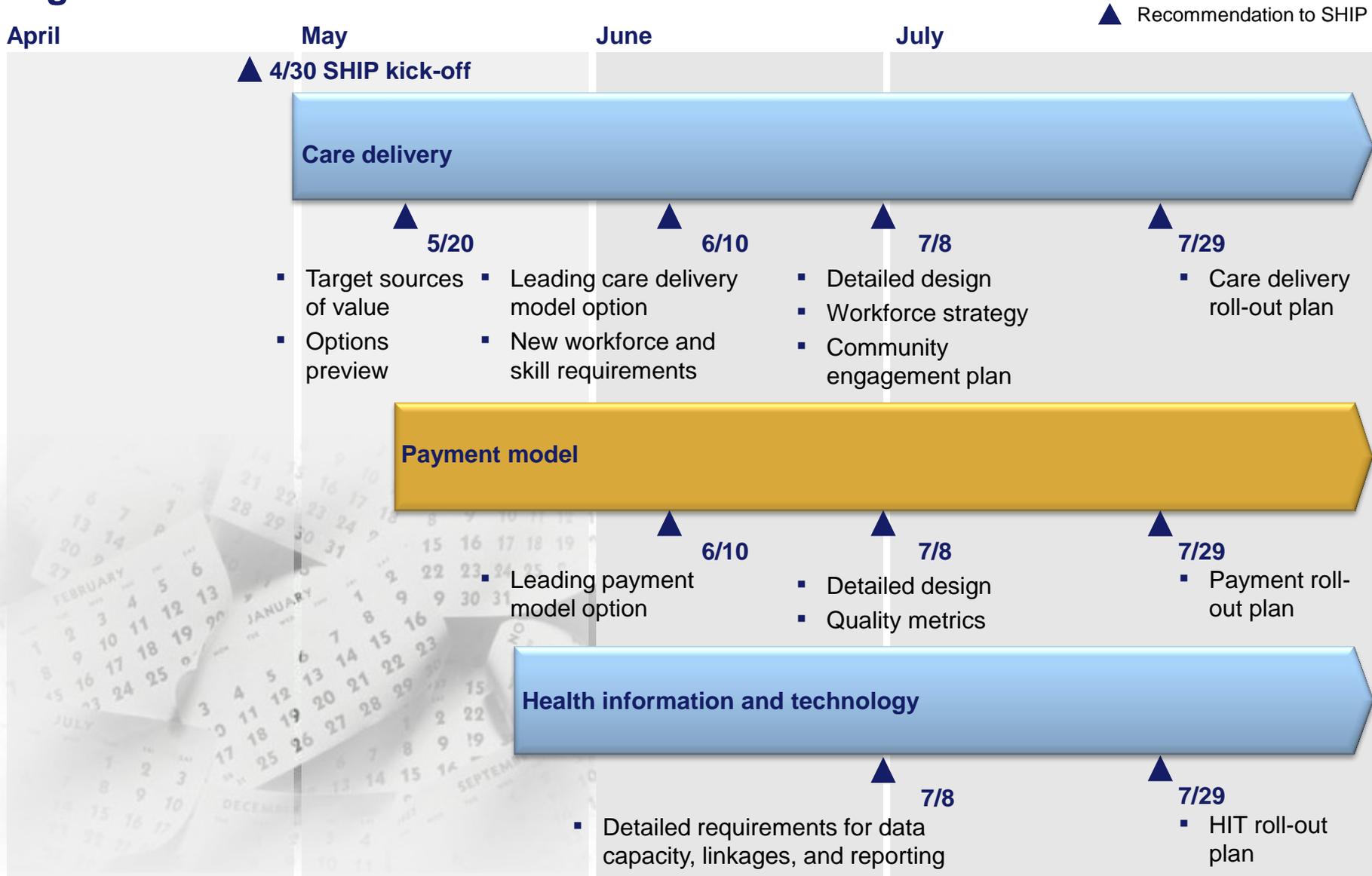
# The HIT work group will provide recommendations to SHIP, the primary decision-making body



1 Planners: OSC, DMHAS, DSS, UCHC, DPH  
 2 Parallel process: DCF, DPH/UCHC, DMHAS



# The payment work group will make recommendations to the SHIP at regular intervals



## We will now break into small groups as a way of starting to pull everyone into the discussion

### Purpose

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

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

- **5 minutes:** Reflect individually and write down thoughts
- **5 minutes:** Share in your small group of 3-4
- **5 minutes:** Report back to the full workgroup

# The payment work group will be defining in the near-term a set of principles to guide payment design decisions



ILLUSTRATIVE

## Example guiding principles

- Providers should be rewarded for effective behaviors (quality and cost)
  - If successful, providers will be held accountable for elements within the scope of provider control
  - Payment model must be financially sustainable
  - Payment model should help improve – not detract from – patient access and health equity
  - Payment model should complement and enable the care delivery model
- Which of these align with your beliefs about payment?
  - What else should guide payment model design?

# Several strategic design considerations will be relevant for payment innovation (1/2)



■ Led by care delivery work group

## Strategic design considerations

## Illustrative examples of options

### 1 Metrics

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

### 2 Payment

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

THOUGHT  
STARTER

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

# Several strategic design considerations will be relevant for payment innovation (2/2)



## Strategic design considerations

## 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?**



# This will be the first in a series of workshops to design a new payment model along the key dimensions of a payment model

5/20



Overview and guiding principles

6/3



Strategic payment model design decisions

6/17



Defining cost of care, exclusions, adjustments

7/1



Balancing financial stewardship and behavioral change

7/15



Operationalizing the payment model



# Five workshops will span six to eight weeks with analysis and prep work in between

## Workshop title

## Description

**May 20:** Overview and guiding principles

- Review vision for care delivery and payment innovation
- Align on guiding principles for payment innovation
- Understand scope of payment model options and design parameters
- Discuss strategic payment model design considerations

**June 3:** Strategic payment model design decisions

- Review synthesis of strategic payment model design decisions
- Discuss data around industry/ provider landscape (e.g., fragmentation)
- Discuss member attribution and implications on patient panel sizes
- Discuss structures, processes, and/or outcomes to measure under new payment model (e.g., metrics)

**June 17:** Defining cost of care, exclusions, adjustments

- Align on metrics and plan for staging accountability for metrics
- Discuss how providers will be supported to participate in care delivery and payment model (e.g., in-kind support)
- Understand rationale for using different tools to mitigate volatility (MSRs, virtual pooling, accruals, joint venture, etc.)
- Discuss required risk adjustors, exclusions, and adjustments to mitigate risk

**July 1:** Balancing financial stewardship and behavioral change

- Review base case, total reward to providers, and yearly payouts
- Discuss tradeoffs of financial sustainability and motivating change
- Suggest refinements to incorporate

**July 15:** Operationalizing the payment model

- Align on payment implementation plan with phasing, including plan to support provider transition
- Develop communication plan vis-à-vis providers

## Next steps

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