Connecticut SIM: Payment model work group meeting #2

Discussion Document

June 3, 2013

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

Today's points for review and decision-making

Review

- **SHIP's vision** for care delivery, payment and HIT innovation
- Progress of care delivery and HIT work groups to date
- **Synthesis of first work group** discussion
  - Strategic payment model design decisions
  - Guiding principles for payment reform
- Data around the provider/industry landscape

Align and finalize

- **Initial hypotheses on** reward structure and member attribution strategy
- **Initial hypotheses on metrics** (e.g., structures, processes, and/or outcomes metrics) to measure under the new payment model

The SHIP has discussed a vision for Connecticut's care delivery, payment and HIT models

Establish a whole person-centered healthcare system that improves affordability, promotes value over volume, and reduces health inequities for all of Connecticut

- Understanding and consideration of the needs of a whole-person that impact health
- Integration of primary care, behavioral health, population health, consumer engagement, and community support
- Shared accountability for the total cost and quality of healthcare
- Increased access to the right care in the right setting at the right time
- Migration to 21st-century healthcare workforce and health information technology that promotes usability at the point of care
- Supported by Medicaid, Medicare, and private health plans alike

Care delivery, payment, and HIT work groups' design decisions will be brought together to provide an integrated recommendation

Prioritize sources of value → **Identify barriers to sources of value** → **Identify changes to behaviors and processes required** → **Define desired results and outcomes**

Enablers

Care delivery

Workforce strategy
- *Define roles and responsibilities*
- *Conduct capabilities assessment*
- *Define strategies to fulfill capability/ capacity gaps*

→ **Community outreach, education, engagement**
- *Define how consumers and communities will be incorporated into new care delivery model*

→ **Roll-out**
- *Define 3-5 year roll-out plan and pace*

Payment

Metrics
- *Define metrics and scope of accountability*

→ **Payment**
- *Define incentives/ reward structure*

→ **Attribution**
- *Define rule for attribution*

→ **Roll-out**
- *Define 3-5 year roll-out plan and pace*

HIT

Identify relevant current HIT capabilities
- *Leverage existing assets*

→ **Standardize across stakeholders**
- *Apply integrated approach as possible*

→ **Roll-out**
- *Define 3-5 year roll-out plan and pace*

The care delivery work group is defining elements of a population health model that address barriers and capture sources of value

PRELIMINARY

	Description
1 **Whole patient centered care and population health management**	▪ Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a patient's health ▪ Assess and document patient risk factors to identify high risk patients
2 **Enhanced access to care (structural and cultural)**	▪ Provide patients access to culturally and linguistically appropriate routine/urgent care and clinical and mental health advice during and after office hours, whether in-person, by phone, remotely, and/or electronically (e.g., video-conferencing, email, website, community/ home-based services)
3 **Team-based, coordinated, comprehensive care**	▪ Leverage multi-disciplinary teams and improved data sharing to improve care planning, diagnosis, treatment, and patient coaching to ensure adherence and manage care transitions across care settings and care disciplines
4 **Patient engagement**	▪ Appropriately educate and encourage patients to engage in healthy behaviors, reduce risky behaviors, provide self-care, and to partner with the provider to follow-through on care plans
5 **Evidence-informed clinical decision making**	▪ Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness
6 **Performance management**	▪ Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care ▪ Use performance and patient experience data to identify opportunities to improve and compare performance with other providers

SOURCE: National Committee for Quality Assurance (NCQA) standards for ACO accreditation and PCMH recognition, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

We discussed during the last meeting a set of principles that will guide our payment design decisions

Guiding principles for payment reform

- Variation in payment model should be based on the needs of the whole-person, not the needs of the health system
- Payment model should complement and enable the care delivery model
- 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 – consumer access and health equity
- The payment model should leverage and be complementary to ongoing initiatives in Connecticut
- Payment model should be aligned across payers

Are there any reservations with this set of guiding principles, or any additional principles we should include?

We aligned on a set of key questions that will be answered in the work group's final recommendation (1 of 2)

Today's topics of discussion

Strategic design considerations	Illustrative examples of options
1 Metrics	
▪ What will be the scope of accountability for cost and quality?	▪ Population health, episodes of care, discrete encounters
▪ What are the sources of value we hope to promote with the payment model?	▪ Effective diagnosis and treatment, selection of provider and care setting, chronic disease management
▪ What metrics will be used for eligibility for participation and eligibility for payment?	▪ Structure (e.g., EMR adoption), processes (e.g., create a care plan), outcomes (e.g., lower costs, complications)
2 Payment	
▪ What is the reward structure?	▪ Global payment, gain/risk sharing, P4P, conditional care coordination fees, conditional FFS enhancements
▪ How do we define the level of performance we wish to reward?	▪ Absolute, relative, improvement
▪ How will consumers be incented?	▪ Top down (e.g., state programs) or bottoms-up (e.g., at employer level)
▪ What are the targets, pricing, and risk corridors?	▪ Quality targets, care coordination fees and/or bonus payment amount, benchmark trend, minimum savings, risk sharing splits, stop loss, gain sharing limits

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

We aligned on a set of key questions that will be answered in the work group's final recommendation (2 of 2)

Today's topics of discussion

Strategic design considerations	Illustrative examples of options
3 Attribution	
▪ What will be the rule for attribution?	▪ Prospective member selection, plan auto-assignment, retrospective attribution
▪ At what level will performance be aggregated for measurement and rewards?	▪ By physician, practice, virtual pod, or ACO/joint venture
▪ What exclusions and adjustments will be applied for fairness and consistency?	▪ 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?	▪ Mandatory and universal, staged by geography or other criteria, voluntary
▪ At what pace should accountability and payment type for participating providers be phased in?	▪ Baseline reporting period, transitional payment model (e.g., P4P), direct to end state (e.g., risk sharing)
▪ How will payers and providers be enabled to adopt the new payment model?	▪ Up-front investment, in-kind support, PMPM fees

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

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

Increasing provider risk

	FFS[1]	*P4P*[1]	*Upside gain sharing*	*Downside Risk sharing*	*Prospective payment*
Provider requirements	▪ Basic data collection capabilities	▪ Basic data collection capabilities	▪ Scale for proper risk adjustment, to reduce statistical variation ▪ **Moderate** data collection capabilities	▪ Inter-operable HIT ▪ At least moderate capital reserves ▪ Scale for proper risk adjustment, to reduce statistical variation ▪ **Moderate** data collection capabilities	▪ Full care continuum or sub-contracts w/ others ▪ Payment capabilities ▪ **Fully integrated** HIT ▪ **Larger** capital reserves ▪ Scale for proper risk adjustment, to reduce statistical variation ▪ **Advanced** data collection capabilities
Benefits/ limitations	▪ Incentive to produce more without direct incentives attached to quality, efficiency outcomes	▪ Fewer disputes over data integrity, rules ▪ Smaller scale required for process measures ▪ Potential for in-creases in total cost of care, in spite of P4P	▪ Invites participation of providers who may not be fully committed to managing total cost and quality	▪ Limits participation to only those that are committed to managing total cost and quality	▪ Few providers currently capable of accepting ▪ Most likely to lead to changes in provider market structure

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

A set of strategic considerations can inform the decision of a reward structure for payment model reform

ILLUSTRATIVE

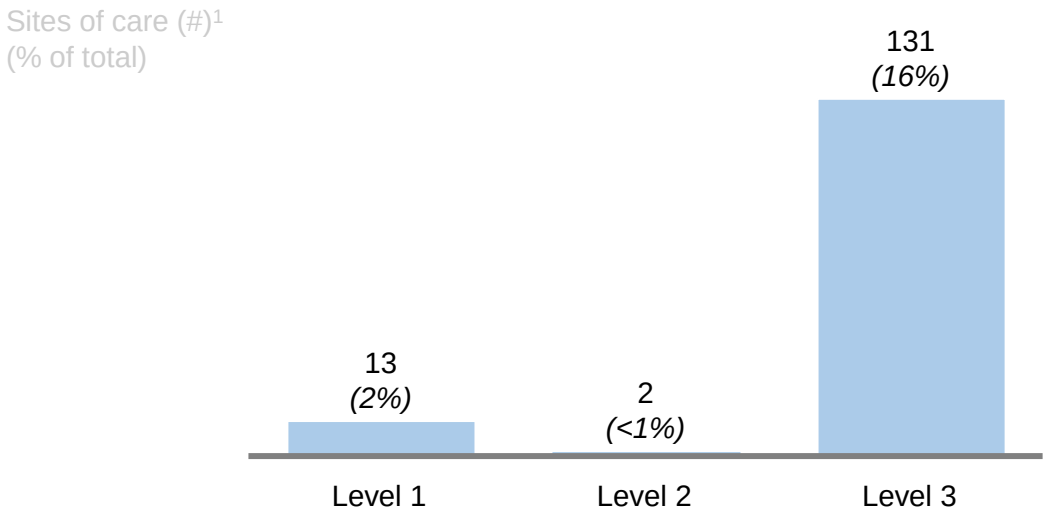
Key considerations for choosing a reward structure

- Will the rewards drive a set of changes in behaviors that address the needs of the whole-person and improve health outcomes?
- Are rewards sufficiently material and of the right type to motivate changes in behavior?
- How receptive are stakeholders to the reward structure (e.g., are stakeholders open to accepting downside risk)?
- How feasible is the reward structure (e.g., are panels at sufficient scale to mitigate volatility, can providers sustain financial risk)?
- Does necessary infrastructure exist for the reward structure (e.g., technological capabilities, data collection)?
- How quickly can the reward structure be rolled-out to meet sufficient scale for impact?
- How capable are stakeholders of managing total cost of care accountability, and how might that affect the ramp-up to end-state payment model (e.g., P4P evolving into upside gain sharing by year 3)
- How important is payer alignment on the reward structure to ultimate reward structure design?

Landscape of current care delivery and payment innovation capabilities in Connecticut

NON-EXHAUSTIVE

NCQA Physician Practice Connections – PCMH 2008 Recognition



	Level 1	Level 2	Level 3
Number of clinicians	74	5	649
Illustrative Examples	▪ Western Connecticut Medical Group	▪ Saint Francis HealthCare Partners	▪ ProHealth, Hartford Medical Group
PCMH 2011 Recognition	▪ None	▪ Avon Health, Tritown Family Practice	▪ CONNCare, Staywell Health Care

Additional capabilities

- **CMS** has recognized several ACOs in Connecticut under Medicare Shared Savings (e.g., Hartford HealthCare, ProHealth Physicians, Saint Francis HealthCare Partners, Primed LLC) and its Advanced Payment ACO program (e.g., MPS ACO Physicians, Primed LLC)
- **Commercial payers** are also participating in innovation: Anthem (e.g., episodes pilot, PCMH pilot), CIGNA (e.g., accountable care initiatives with Day Kimball, New Haven Community Group, ProHealth), and Aetna (e.g., coordinated care collaboration with ProHealth)
- The **State of Connecticut** has also launched a number of innovative initiatives including the State employee/Medicaid PCMH pilot, the ICI Duals initiative, HEP, and SPMI health homes
- Roughly 40% of Connecticut physicians have transitioned to **electronic medical records**

1 ~800 sites of care in Connecticut that have at least one PCP
Note: NCQA PPC-PCMH 2008 standards revised in PCMH2011 standards. New applications will be subjected to PCMH2011 standards
SOURCE: NCQA, 2012 Health Leaders InterStudy Report, CMS, 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)

Guiding principles for selecting consumer attribution methodology

ILLUSTRATIVE

Key considerations for selecting a consumer attribution strategy

- Leverage consumer attribution methodology to promote equality of access to a PCP across patients from range of payer populations
- Consider implications of consumer attribution methodology on resultant risk profiles of consumer panels across PCPs (i.e., balance risk across providers or promote specialization)
- Promote consumer choice to select providers who meet their needs
- Consider needs of Connecticut's desired reward structure and its implications on the minimum consumer panel sizes required for providers to participate
- Promote clear sense of accountability and ownership of providers over consumers on their panel
- Consider complexity and feasibility of implementation for desired approach
- Determine importance of payer consistency across consumer attribution methodologies
- Timing and frequency (e.g., monthly, quarterly) of informing providers about consumers attributed to them

- Do these align with your beliefs regarding consumer attribution?
- Are there any other key considerations we should consider?

Consumers can potentially be attributed to a range of provider types

Provider types	Potential rationale
▪ Primary care physicians (e.g., internal medicine, family practice physician, pediatrician)	▪ Have broadest level of insight and control over primary care needs of individual consumers ▪ Able to provide clinical expertise on how care for specified individual needs to be coordinated across providers
▪ OB/GYN, Nurse midwives	▪ Optimally positioned to support consumers on women's health related issues
▪ Other physicians (e.g., geriatrics, endocrinologist, cardiologist, psychiatrist)	▪ Have deep insight into needs of patient sub-populations with specific set of comorbidities/ existing conditions
▪ Nurse practitioners, APRNs, PAs	▪ Have potential to relieve access issues based on PCP shortage ▪ Will require some level of clinical oversight from a licensed physician ▪ Potentially requires changes to licensure/ scope of practice
▪ FQHC, CHC	▪ Aware of consumer's broader context that impact health and health outcomes

What is your ingoing hypothesis on which providers should have consumers attributed to them?

There are several standard methodologies for consumer attribution

	Description
Prospective consumer selection	▪ Allows consumers to select the provider responsible for their care in advance of a defined evaluation period (e.g., 12 months)
Prospective auto-assignment	▪ Uses historical claims data to assign a consumer to a providers' consumer roster prior to the start of a defined evaluation period (typically used when a consumer does not select a provider within a specified period of time)
Retrospective claims based attribution	▪ Assigns consumers to providers based on historical claims data at the end of a defined evaluation period after the consumer has received care from their accountable provider

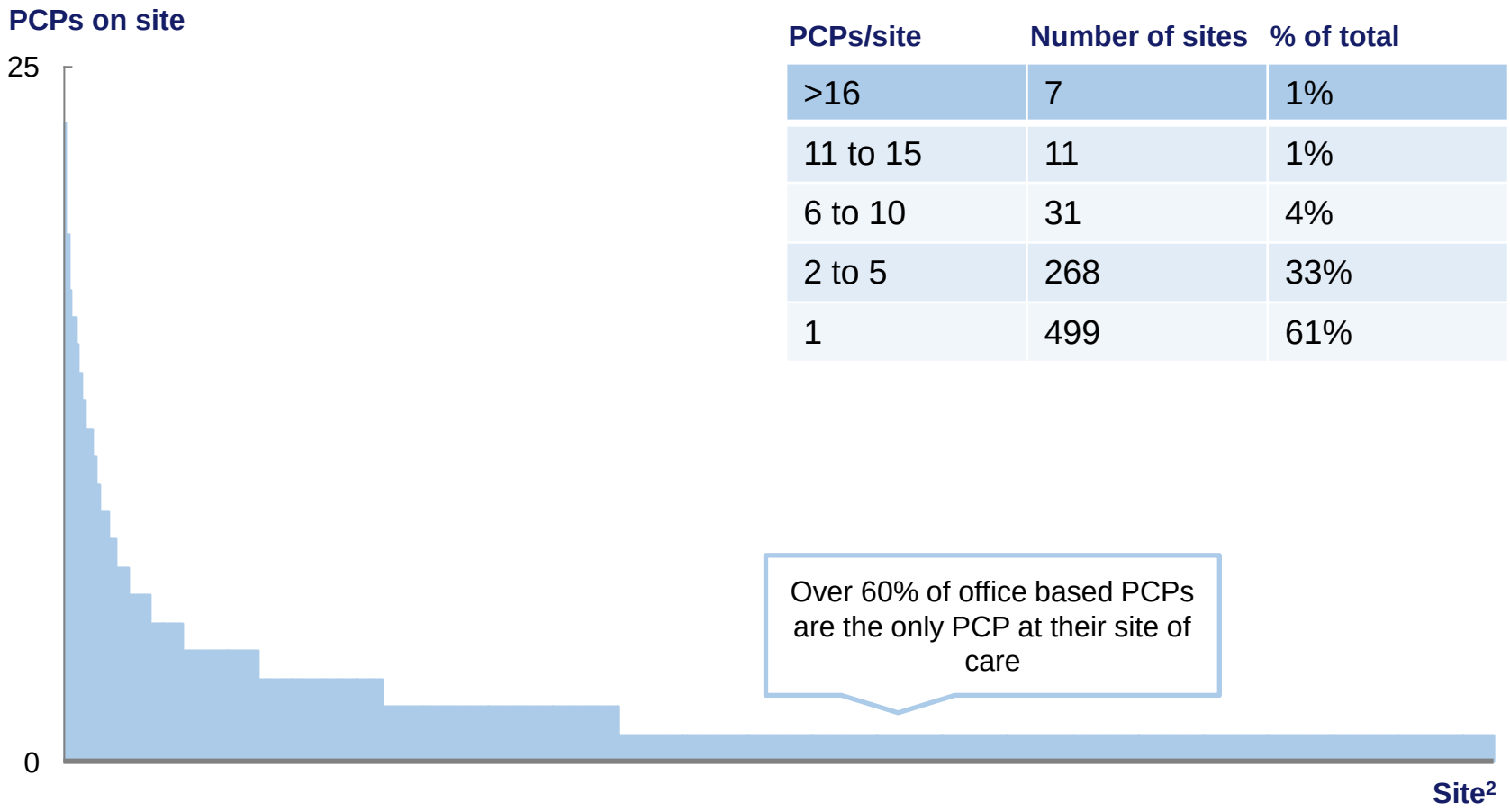
Illustrative example: Technical questions to be answered if a retrospective claims-based attribution methodology is selected

- What will be the administrative rule for assigning an individual to a provider based on utilization (e.g., plurality of visits, paid claims, allowed claims, charges)?
- Will E&M codes be in-scope?
- What will be the timeframe over which frequency of utilization will be considered to attribute a patient to a provider?
- Is there a minimum number of visits within the specified timeframe?
- If a patient does not meet the selected attribution criteria, is there an alternative, more flexible attribution rule that is used?

Long tail of sites of care with a single PCP

PCP fragmentation[1]

PCPs per site in Connecticut (n=~800 sites, ~1740 PCPs)



PCPs/site	Number of sites	% of total
>16	7	1%
11 to 15	11	1%
6 to 10	31	4%
2 to 5	268	33%
1	499	61%

1 PCPs include family practitioners, general practitioners, internal medicine/pediatrics, and internists
2 Total number of sites = ~800sites in Connecticut with at least one PCP
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

Performance pools

	Options
Provider aggregation	▪ Individual physician ▪ Physician practice or corporation ▪ ACO or other joint venture ▪ Virtual panel or pod ▪ Geographic region
Purchaser aggregation	▪ Risk-bearing purchaser (e.g. fully insured, ASO) ▪ Health plan across all lines of business ▪ Multi-payer performance pool

A set of guiding principles can be used for defining metrics to hold providers accountable within the reward structure

Guiding principles for defining metrics to hold providers accountable

- Selected metrics should be evidence-based and nationally recognized
- Selected metrics should be meaningful indicators of value that capture both the improvements in quality/patient experience as well as decrease in costs
- Metrics that can be acquired through existing data sources and systems should be prioritized over metrics not currently tracked
  - Metrics that are not currently tracked but can be gathered from existing data sources should be prioritized over metrics that are neither currently tracked, nor collected in existing data sources
  - As needed, new metrics that have a material affect for providers and map to interventions specified in care delivery should be introduced
- If new metrics must be created, claims-based, clinical oriented metrics are preferable to non-clinical metrics (e.g., chart review)
- Payers should be aligned around selected metrics

- How do these align with your beliefs about measuring perfor-mance?
- Are there any other key guiding principles we should consider?

Providers can potentially be held accountable to set of structural, procedural, and/or outcomes-based metrics

ILLUSTRATIVE

	Definition	Benefits	Illustrative examples
Structures	▪ The establishment of resources and infrastructure that are required to achieve the desired results and outcomes of the care delivery and payment model	▪ Creates the incentive for providers to invest time and resources into infrastructure development ▪ Is relatively clearer to measure ▪ Provides tangible set of metrics that can be tracked for sources of value with longer time to impact	▪ Adults' Access to Preventive/Ambulatory Health Services ▪ Availability of care during evenings, weekends, or holidays
Processes	▪ Execution of a set of actions or a series of actions required to achieve specific outcomes	▪ Provides actionable steps to guide providers towards desired outcomes of care delivery model ▪ Creates clear association between desired behaviors and payment ▪ Is relatively clearer to measure	▪ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ▪ Well-Child Visits in the First 15 months of Life
Outcomes	▪ Demonstrated impact on **quality, patient experience**, **utilization,** and **costs** under the new care delivery and payment model	▪ Ties provider performance/rewards directly to our system goals ▪ Enables providers to apply judgment on optimal structures/processes	▪ **Quality/ patient experience**: Patient satisfaction with health system experience ▪ **Utilization**: Re-admits/1000, ER/1000 ▪ **Costs:** Overall cost index to peers, PMPM ▪ **Clinical outcomes:** Controlling chronic disease (e.g., hypertension, diabetes)

There are a range of approaches that can be used to hold individuals accountable to a defined set of metrics

ILLUSTRATIVE

Approaches	Description	Examples
Reporting	▪ Capturing and reporting of metrics to patients, other providers, and/or to the broader community	▪ Provider report cards
Condition for participation	▪ Limitation of provider participation in care delivery and payment models to the adoption of or adherence to specific structures, processes and outcomes	▪ EMRs that meet meaningful use as a pre-requisite to participate in payment model ▪ Participation in coordinated care team
Contingency for reward	▪ Specifies an outcome or action that is required to receive a specific reimbursement (e.g., a PMPM, fee for service enhancements, P4P bonus)	▪ Quality baseline to participate in gain-sharing
Consideration when setting reward level	▪ Determines the size of reimbursement (e.g., percent of shared savings, level of PMPM, size of P4P bonus)	▪ PMPM based on risk-adjusted characteristics of patient panel ▪ P4P bonus pegged to scale of quality or efficiency metrics

Next meeting, we will align on target metrics used to measure performance and discuss several technical design considerations

Focus for next meeting

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 (provider and consumer) ▪ 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 recommendation on guiding principles for payment model design and initial hypotheses on consumer attribution and metrics to hold individuals accountable
- Participants to provide specific structural, procedural, or outcomes metrics that can be used to track performance
- All to convene in next work group on June 17 to further discussion on strategic and technical design decisions for payment model reform

Legend

- Care delivery/HIT will strongly impact payment work group

- Payment work group will strongly impact care delivery/HIT