



Connecticut SIM: Payment model work group meeting #3

Discussion Document
June 17, 2013

Agenda

Continue last week's discussion on the optimal reward structure for Connecticut's payment model *30 min*

Discuss metrics that can be used to hold providers accountable *75 min*

Review decisions from today's meeting and preview next steps *15 min*

Today, we will continue to address the strategic design questions that will form our payment model recommendation

Sequence of decisions that will be made over our next three meetings



1 Metrics/Payment

- What is the reward structure?
- What metrics will be used for eligibility for participation and eligibility for payment?

2 Metrics/Payment

- How do we define the level of performance we wish to reward?
- *How will consumers be incented?¹*
- *What are the targets, pricings, and risk corridors²*

3 Attribution

- What will be the rule for attribution?
- At what level will performance be aggregated for rewards?
- What exclusions and adjustments will be applied for fairness and consistency?

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 be phased in?
- How will payers and providers be enabled to adopt the new payment model?

1 Care delivery and payment work groups will define how consumers can be optimally involved in the population health based model on an ongoing basis, and each individual payer will ultimately make their own decisions

2 May or may not be addressed prior to submission of testing grant, depending on timing, data availability, and resources; may be decided by each individual payer

Based on current level of provider readiness, should we should adopt a one-track or two-track approach to reach the end-state reward structure?

Options

- 1 One-track aspirational: gain or risk sharing for those able to accept it
- 2 One-track progressing: all providers start in P4P and move in lock-step toward gain or risk sharing
- 3 Two-track converging over time: those able to accept gain/risk sharing today can do so; others starting in P4P and progress to gain/risk sharing over time
- 4 Two-tracks indefinitelys: those able to accept gain/risk sharing today can do so; others able to persist in P4P indefinitely

The care delivery work group has begun to outline a set of interventions to promote within Connecticut's care delivery and payment model

■ Focus for today

During this work group and the next, we will review the care delivery work group's working hypothesis on interventions to promote and:

- Assess ability to promote those interventions using the base set of **core measures suggested by CMMI** (i.e., what modifications or additions are required to the core measures?)
- Consider **approach** to holding providers accountable for those metrics (e.g., condition for participation, payment contingency)
- Discuss what **level of performance** we will reward (i.e., absolute/relative, or both)
- Align on how balance between core measure will shift across structure, process, outcomes, care experience, and cost/ resource use metrics **over time**

We must decide if these core measures are sufficient to track the interventions of care delivery model, or if any metrics must be added

Guiding principles for defining additional metrics

- 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
 - As needed, new metrics that have a material effect for providers and map to interventions specified in care delivery model work group 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 performance?
- Are there any other key guiding principles we should consider?

Discussion in breakout groups

Breakout exercise instructions

- **Group discussion:** Discuss the types of metrics required to hold providers accountable for specific interventions of care delivery model *(20 min)*
- **Breakout:** Breakout into 3 groups to discuss options for metrics that can be used to track provider performance given new care delivery system interventions *(30 min)*
 - Review CMMI’s proposed set of metrics summarized on posters (also in reference materials pp.11-16)
 - Determine if there are additional types of metrics that should be tracked alongside CMMI core measures (consider reference materials pp. 27-41)
 - Prioritize metrics
 - Discuss how metrics will evolve as providers transition to new payment model
- **Group debrief:** Each group to report out synthesis for full team discussion *(25 min)*
 - Were there any major gaps in CMMI core measures being tracked?
 - Which metrics did you prioritize, and why?
 - How will providers be held accountable for these metrics?

METRICS

For reference during breakout: CMMI has defined a set of core measures to be used in innovative reforms

| | Definition | Illustrative examples ¹ |
|------------------------------|---|---|
| Structures | <ul style="list-style-type: none"> Features of a healthcare organization or clinician relevant to the capacity to provide healthcare. This may include, but is not limited to, measures that address HIT, provider capacity, systems and other healthcare infrastructure supports | <ul style="list-style-type: none"> Adoption of Medication e-prescribing Adoption of HIT Provider ability to receive HIT data electronically into their EHR system |
| Processes | <ul style="list-style-type: none"> A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus | <ul style="list-style-type: none"> Preventive care (e.g., vaccination, well-child visits, screening) Clinical care (e.g., eye exams for diabetes patients, treatment for those with drug dependence) |
| Outcomes | <ul style="list-style-type: none"> The health state of a patient (or change in health status) resulting from healthcare –desirable or adverse | <ul style="list-style-type: none"> Mortality (e.g., 30 day rate, risk adjusted) Morbidity (e.g., healthy term newborn) Functional and health status changes (e.g., CARE tool) Safety (e.g., surgical site infection) |
| Care experience | <ul style="list-style-type: none"> Patient and their care givers' experience of care | <ul style="list-style-type: none"> CAHPS surveys Family evaluation of hospice |
| Cost and resource use | <ul style="list-style-type: none"> Counting the frequency of units of defined health system services or resources; some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use (i.e., monetize the health service or resource use units) | <ul style="list-style-type: none"> Cost of care (e.g., total cost of care for Medicare patients) Readmissions (e.g., hospital all-caused non-planned readmissions, risk adjusted) Ambulatory care sensitive (ACSC) admissions ER/ED utilization |

¹ Full list of metrics provided in background materials

SOURCE: CMMI

NEXT STEPS

Next steps

- Today: work group to spend 15 minutes to synthesize recommendations on reward structure and metrics from today's meeting

- Core team to synthesize working hypothesis on reward structure and on priority metrics for review at our next meeting

- Participants to share views on how metrics will be used to hold providers accountable (e.g., condition for participation) and on implied balance of metrics with the work group at our next meeting on July 1st