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Connecticut SIM: Payment model discussion document

Work group #4
July 1, 2013

Agenda

Review working hypothesis on reward structure from our last meeting *10 min*

Continue last meeting's discussion on quality measurement in Connecticut's payment model *30 min*

Discuss the level of performance we wish to reward *30 min*

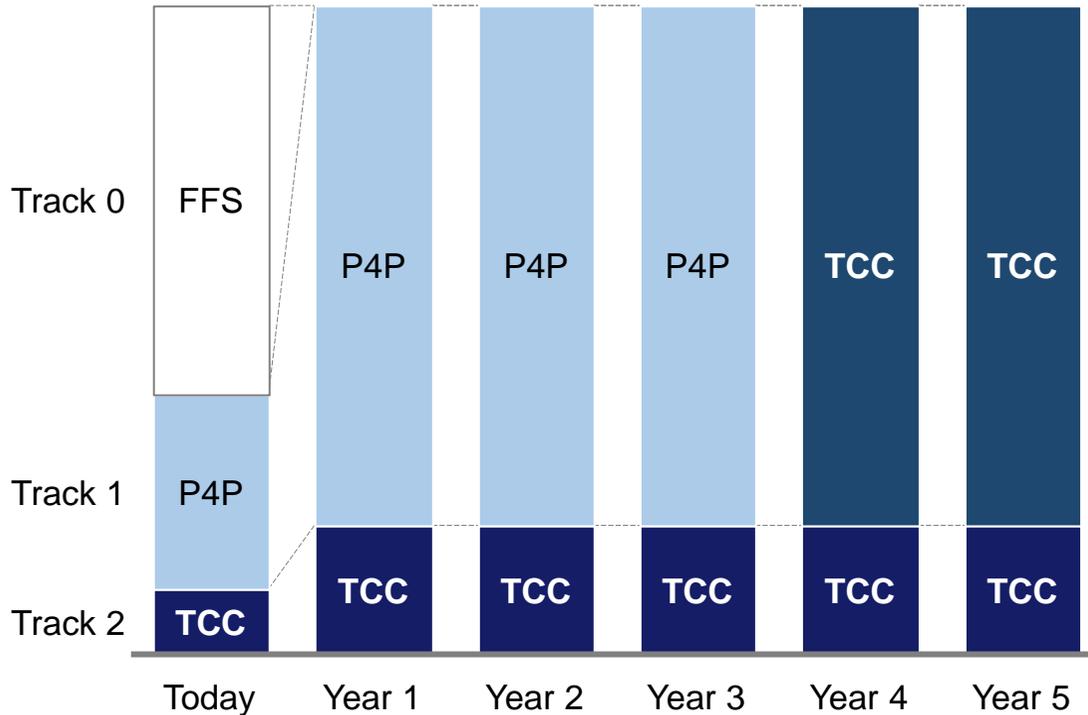
Discuss provider/payer fragmentation in Connecticut *30 min*

Review decisions made in our meeting and next steps *10 min*

At our last meeting, we aligned on a two-track approach to enable providers to adopt innovative reforms

ILLUSTRATIVE

Proportion of consumer population



Definitions

- **Fee for service (FFS):** a discrete payment is assigned to a specified service
- **Pay for performance (P4P):** physicians are compensated based on performance, typically as a potential bonus to traditional FFS payment (may also include care management or other support fees, like a PMPM)
- **Total cost of care (TCC):** agreement to share responsibility for the value of patient care by tying a portion of payment to achievement of total cost and quality metrics

Specific characteristics of CT model to be defined by work groups in upcoming sessions

Work group to define necessary milestones (e.g., provider adoption, legislative action to facilitate transformation) over 3-5 years of testing grant in upcoming sessions

We also discussed the goal of creating a common multi-payer scorecard of performance metrics organized around the Triple Aim

Triple Aim	Types of metrics	Proposed guiding principles
Health	<ul style="list-style-type: none"> ▪ Health risk factors (e.g. obesity) ▪ Prevalence of illness and injury 	
Health care	<ul style="list-style-type: none"> ▪ Consumer experience (e.g., engagement, satisfaction) ▪ Quality of care <ul style="list-style-type: none"> – Structure – Process – Outcomes – Care coordination 	
Costs	<ul style="list-style-type: none"> ▪ Total cost of care ▪ Resource utilization, e.g., <ul style="list-style-type: none"> – Hospital days per 1,000 – Emergency room visits per 1,000 – Generic prescribing rates 	

We reviewed a core set of CMMI measures and suggested some Connecticut-specific additions

	Illustrative CMMI core measures	Work group additions
1 Whole-person-centered care and population health mgmt.	<ul style="list-style-type: none"> Follow-up hospitalization after mental illness Tobacco use assessment and tobacco cessation intervention CAHPS surveys 	<ul style="list-style-type: none"> Completion of wellness assessments and treatment plans Primary care quality measures, incl. quality indices Total medical cost per member Care plan/learning collaborative
2 Enhanced access to care (structural and cultural)	<ul style="list-style-type: none"> Well-child visits in the first 15 months of life Hospital ED visit rate that did not result in hospital admission, by condition 	<ul style="list-style-type: none"> Patient portal, provider website, and e-consults Availability > normal business hours Time of discharge until next visit Translation services Patient surveys Ambulatory sensitive admissions
3 Team-based, coordinated, comprehensive care	<ul style="list-style-type: none"> Post-discharge continuing plan transmitted to next level of care provider upon discharge Care transition record transmitted to health care professional Medication reconciliation 	<ul style="list-style-type: none"> None
4 Consumer engagement	<ul style="list-style-type: none"> Transition record with specified elements received by discharged patients CAHPS Surveys CARE-F and CARE-C tools 	<ul style="list-style-type: none"> Addition of select NQF metrics (e.g., individual engagement measure derived from individual engagement domain of C-CAT)
5 Evidence-informed clinical decision making	<ul style="list-style-type: none"> Clinical care measures (e.g., chronic disease testing and care, mental health) Medication reconciliation Admission statistics by chronic condition (e.g., COPD) 	<ul style="list-style-type: none"> Standard clinical pathways Bidirectional sharing of information Ongoing review and validation of current standards Medication interactions Appropriate use of procedures
6 Performance management	<ul style="list-style-type: none"> Adoption of medication e-prescribing Adoption of HIT Ability for providers with HIT to receive laboratory data electronically ED visit rate that did not result in hospital admission 	<ul style="list-style-type: none"> None

Today, we want to consider how the same metrics might be applied differently to our P4P and Total Cost of Care models

	Track #1: Pay-for-performance	Track #2: Total cost of care
Basis for estimating savings	<ul style="list-style-type: none"> Resource utilization (e.g., hospital days/1,000, ER visits/1,000, generic prescribing rate) 	<ul style="list-style-type: none"> Total cost per member per year (including IP Facility, Professional, OP pharmacy, Behavioral Health, other)¹
Basis for qualifying for payouts	<ul style="list-style-type: none"> Consumer experience Quality of care (e.g., structure, process, outcome, care coordination measures) 	<ul style="list-style-type: none"> Consumer experience Quality of care (e.g., structure, process, outcome, care coordination measures)
Basis for risk-adjustment	<ul style="list-style-type: none"> Health risk factors Prevalence of illness and injury 	<ul style="list-style-type: none"> Health risk factors Prevalence of illness and injury
Informational purposes	<ul style="list-style-type: none"> Total cost per member per year (including IP Facility, Professional, OP pharmacy, Behavioral Health, other)¹ 	<ul style="list-style-type: none"> Resource utilization (e.g., hospital days/1,000, ER visits/1,000, generic prescribing rate)

¹ Total cost of care inclusive of all payer and member liabilities

What criteria should be met in order to qualify for rewards?

- ① Providers should be rewarded for improving quality, and experience independent of impact on cost/utilization
- ② Providers should be rewarded for creating savings for the system, independent of impact on quality/experience
- ③ Provider must create savings for the system and achieve standards for quality/experience to earn rewards
- ④ Providers may receive rewards for quality alone in year one, but must achieve quality and savings in future years
- ⑤ Another option

What level of performance should we reward?

Options

- ① Absolute performance
- ② Performance improvement
- ③ Both absolute performance and improvement (e.g., progressive rewards)
- ④ Another option

Considerations for selecting absolute/relative

Absolute

- Rewards distinctive performers
- Targets held constant for several years
- Additional cost to payer

Relative

- Provides incentives to all providers regardless of starting point
- Facilitates performance improvement through setting flexible targets
- Budget neutral to payer

Minimum scale is required for meaningful quality measurements

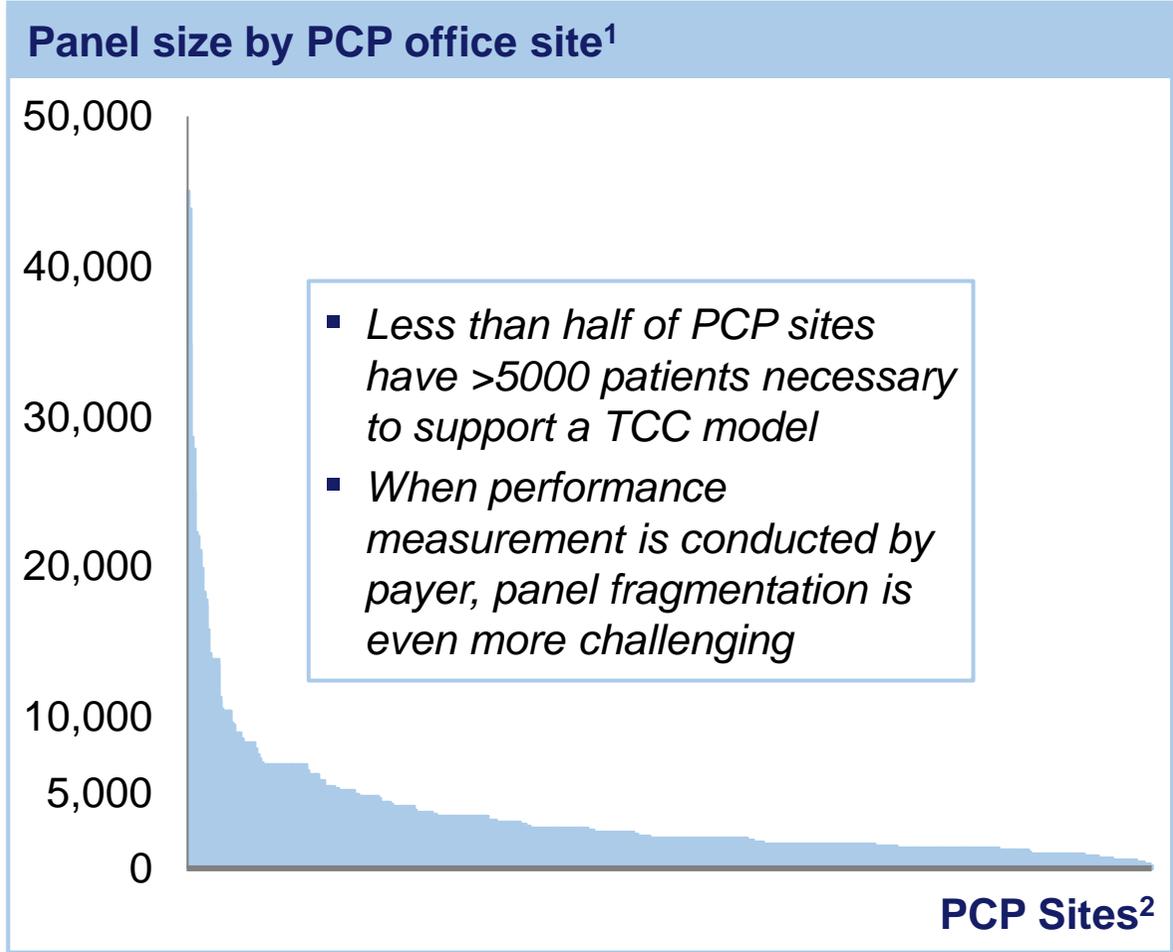
Triple Aim goals	Types of metrics	Minimum patient population ¹
Health	<ul style="list-style-type: none"> ▪ Health risk factors (e.g. obesity) ▪ Prevalence of illness and injury 	<ul style="list-style-type: none"> ▪ Moderate (100-1,000)
Health care	<ul style="list-style-type: none"> ▪ Patient satisfaction ▪ Quality of care <ul style="list-style-type: none"> – Structure – Process – Outcomes 	<ul style="list-style-type: none"> ▪ Low to moderate (<1,000) ▪ Depends on specific metrics <ul style="list-style-type: none"> – Low (<100) – Moderate (100-1,000) – High (5,000+)
Costs	<ul style="list-style-type: none"> ▪ Total cost of care ▪ Resource utilization, e.g., <ul style="list-style-type: none"> – Hospital days per 1,000 – Emergency room visits per 1,000 – Generic prescribing rates 	<ul style="list-style-type: none"> ▪ High (5,000+) ▪ Depends on specific metrics <ul style="list-style-type: none"> – Moderate (100-1,000) – Moderate (100-1,000) – Low (<100)

Implications

- Moderate scale required for P4P likely to require aggregation across payers or across providers
- High scale required for Total Costs to require aggregation across payers and across providers

¹ Rule of thumb, to be validated for each metric based on relevant population

PCP and payer fragmentation lead to small patient panel sizes



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

How should performance be aggregated to achieve scale necessary for robust performance measurement?

Purchaser aggregation

Options

- ASO accounts with fully insured
- Health plan across lines of business
- Multi-payer performance pool

Provider aggregation

-
- Geographic region
 - ACO or other joint venture
 - Virtual panel or pod

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 metrics
- Participants to consider requirements for provider progression in reward structure in advance of our meeting on July 15

