

A decorative graphic on the left side of the slide, consisting of a grid of overlapping diamond shapes in various shades of blue, creating a textured, geometric pattern.

Connecticut SIM: Payment model discussion document

Work group #5
July 15, 2013

Contents

Review updates from care delivery and HIT work groups	10 min
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Review working hypotheses on reward structure and metrics from our last meeting	40 min
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Discussion on open topics, including performance aggregation and consumer attribution	70 min
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Emerging care delivery work group recommendations

Target populations

- Establish a foundational model that meets the general needs of all patient populations; anticipate additional set of interventions to be developed in future years to meet specialized needs of sub-populations with complex care needs

Sources of value

- Address all sources of value, with emphasis on selection of provider types and care setting, effective diagnosis and treatment selection, and care coordination/chronic disease management; for pregnant women/newborns, special emphasis on primary prevention

Core components of new care delivery model

- Roll-out a whole-person-centered medical home model that promotes:
 - Whole-person-centered care and population health management
 - Enhanced access to care (structural and cultural)
 - Team-based, coordinated, comprehensive care
 - Consumer engagement
 - Evidence-informed clinical decision making
 - Performance management

Provider eligibility for participation

- Enable providers to determine for themselves their organizational structure as long as they have a core of primary care providers and are able to fulfill requirements of new care delivery/ payment model (e.g., must be able to take on total cost of care accountability by year 5)
- Encourage broad participation by setting the bar for entry low (e.g., self-assessment) but phase in CT-selected practice guidelines as requirements for continued support for any entity choosing to participate in the model

Emerging HIT work group recommendations

Capabilities required in new model

- Payer tools to analyze claims data to manage performance and payment
- Channels for patients and providers to access/submit health information
- Provider tools and analytics to coordinate medical services for patients
- Integrated clinical data exchange among providers via a secure, electronic network

Existing capabilities and initiatives that can be leveraged

- Existing payer/provider analytics and experiences as part of PCMH/ACO pilots
- Patient and provider portals currently hosted by payers
- DMHAS care mgmt. experience/tools used to manage behavioral health populations
- HITE-CT promoting point-to-point connectivity; localized HIE solutions, eHealthConnecticut
- State data assets and initiatives, e.g., DPH and DSS databases, CT Data Collaborative, APCD¹

Level of standardization

- Standardized metrics/analytics/reports created by payers' independent infrastructure
- Consolidated portal for consumers/patients and/or providers to access and share information²
- Standardized care mgmt guidelines with flexibility for providers to select own technology/tools
- Standardized but not consolidated provider connectivity tools (e.g. direct messaging)

Roll out

- Continue to build on existing payer and provider population health analytics to establish full set of tools required in end-state (near term and ongoing effort)
- Develop or select/scale a single provider portal for use across multiple payers (near term)
- Potentially develop state relationships with 3rd party patient engagement tool vendors
- Deploy a range of solutions to enable providers at different levels of technology maturity to create care management capabilities:
 - Educate providers on process changes and technology adoption (near term)
 - Simplify procurement through creating a marketplace or pre-qualifying vendors (medium term)
 - Host shared service for providers to access basic care management capabilities (long term)
- Ensure alignment with eHealthConnecticut and HITE-CT strategies to accelerate EHR adoption and enable connectivity between providers (ongoing effort)

¹ Potential when established - led by Access Health CT

² Patient portal, while consolidated, could give consumers access to their payer's proprietary engagement/education tools

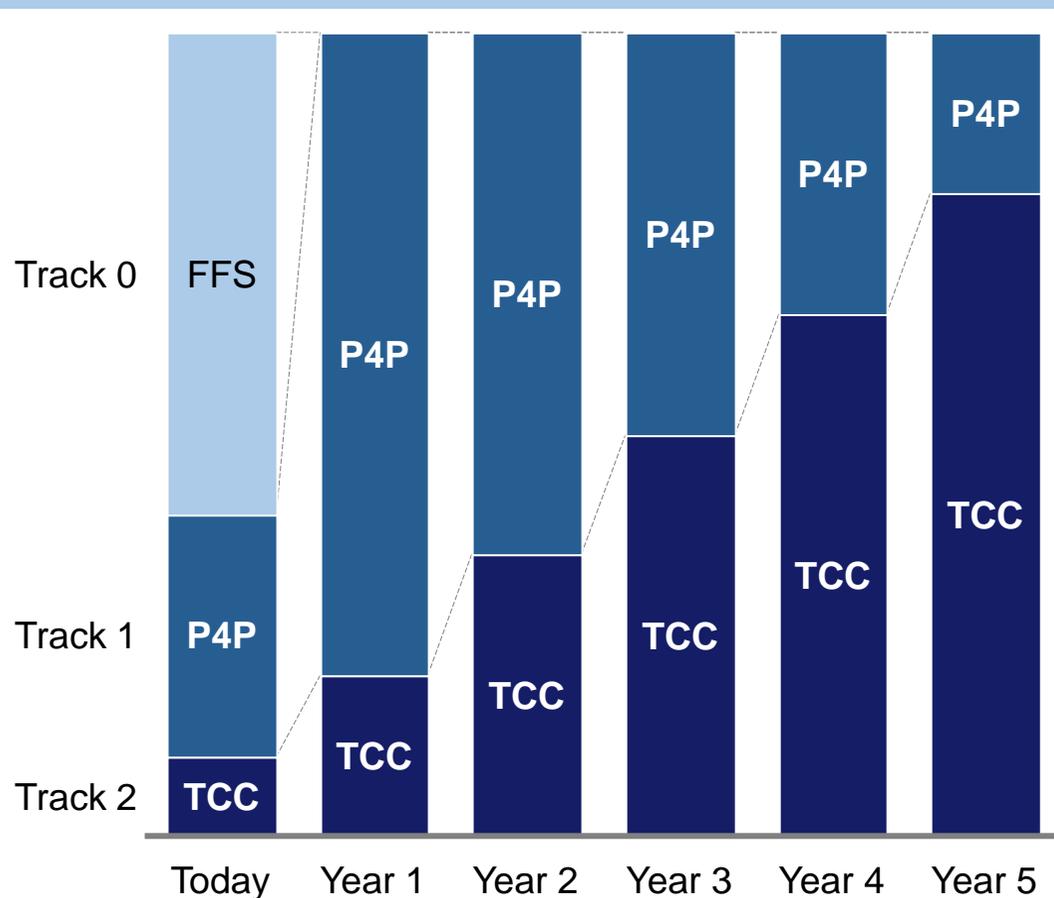
Consensus from prior payment model workgroup discussions

ILLUSTRATIVE

Summary Points of Consensus

1. We will establish a two-track approach to reward providers for effective management of a population of patients
2. Both tracks will be tied to a common scorecard for The Triple Aim; we will define v1.0 of that scorecard, to be refined following submission of the grant application
3. In year 1, providers should be eligible for rewards for quality alone; in subsequent years, rewards should be contingent on both quality and cost savings
4. Providers should be rewarded for both performance improvement and absolute performance
5. To the extent possible, performance should be aggregated across payers to improve reliability of measures

Proportion of consumer population



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

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 (may include upside gain sharing, full risk sharing, and/or capitation)

Potential elements of clinical and legal/financial integration

Elements of clinical integration

- Common patient population
- Aligned financial incentives
- Common governance
- Health information exchange
- Shared clinical pathways
- Common care coordination
- Evaluation and remediation
- Physician engagement



Levels of integration

- Common legal entity
- Joint venture
- Co-investment
- Employment agreement
- Vendor contract
- Credentialing/ privileging relationship
- Informal relationship

Potential models for aggregating provider performance

Options	Description
<p>1 Corporate Entities</p> <ul style="list-style-type: none"> ▪ Medical group practice ▪ Hospital system with employed physician 	<ul style="list-style-type: none"> ▪ Legally and financially integrated physicians ▪ Level of shared clinical infrastructure may vary ▪ Potential to distribute bonuses/gains through employment agreements
<p>2 Formal “Joint Ventures”</p> <ul style="list-style-type: none"> ▪ Accountable Care Org ▪ Physician-Hospital Org ▪ Independent Practice Association 	<ul style="list-style-type: none"> ▪ Joint venture or other formal contractual relationship among otherwise independent providers ▪ Provides legal/financial framework for co-investment in clinical infrastructure and/or distribution of bonuses/gains
<p>3 Virtual Panels</p>	<ul style="list-style-type: none"> ▪ Informal relationship of independent providers who self-select to aggregate performance ▪ Agreement to accept rewards from payor(s) based on aggregate performance ▪ Distribution of bonuses/gains based on pre-determined formula established with payer ▪ Potential for coordinated procurement of technology/services from the same vendor(s) ▪ No legal/financial framework for co-investment
<p>4 Geographic risk pools</p>	<ul style="list-style-type: none"> ▪ Performance aggregated among providers in a region ▪ Rewards distributed based on pre-determined formula ▪ Potential to share technology/services provided by payer(s) ▪ No legal/financial framework for co-investment

Disclaimer: the core team is currently seeking further counsel on the permissibility of above options to ensure compliance with anti-trust regulations and Federal Trade Commission (FTC) rulings

Gathering your input

- 1 Total Cost of Care Model should largely be restricted to **corporate entities** that are fully integrated legally and financially
- 2 We should promote the formation of **ACOs and other formal joint ventures** as a framework for co-investment in clinical integration
- 3 Payers should support **virtual panels** as a low-overhead alternative to ACOs or other formal joint ventures
- 4 Payers should establish **geographic risk pools** for providers that are too small to achieve minimum scale requirements
- 5 *[Another Option]*

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Guiding principles for selecting consumer attribution methodology

Guiding principles

- 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 guiding principles 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)	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Optimally positioned to support consumers on women's health related issues
Other physicians (e.g., geriatrics, endocrinologist, cardiologist, psychiatrist)	<ul style="list-style-type: none"> ▪ Have deep insight into needs of patient sub-populations with specific set of comorbidities/ existing conditions
Nurse practitioners, APRNs, PAs	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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?

Existing attribution strategies

Payers

Consumer attribution model

Medicaid

- Practice assignment determined based on current attribution status:
 - **Unassigned members:** members without ingoing assignment are attributed using plurality logic based on provider who has billed the most codes from January 2012 to most current quarter
 - **Self-selection process:** members can contact CHNCT to select their PCP. The plurality logic applies if consumer then sees another PCP with a different tax ID number or group Medicaid ID (reviewed quarterly)
 - **Previously attributed members:** members remain with current PCP unless they have seen multiple PCPs, in which case the plurality logic applies

Medicare

- **MSSP:** Beneficiary assignment is determined retrospectively at the end of the year for each benchmark and performance year based on plurality of primary care visits to participating ACOs
- **CPCI:** program encourages prospective attribution, but allows payers to submit their own attribution strategies as part of application
- **Pioneer ACO:** may use prospective or retrospective attribution (prospective using three years prior claims, or retrospective using claims from performance period and potentially from prior periods)

Anthem

- Decision-tree framework: if a member identifies a provider, this provider is selected for them. If no provider is selected, a member is attributed based on the provider with whom they have highest E&M visits (assuming claims history). If claims history is not available, member may be unassigned.

Cigna

- Consumers are aligned to a PCP (i.e., family practice, internal medicine, geriatric medicine, pediatrics, adolescent medicine) based on their claims. If consumers are not aligned to a PCP, they can be attributed to an NP, PA, or OB/GYN

Aetna

- Corresponds to Medicare Shared Savings Program
- Guiding principles include prioritizing simplicity and market consistency as criteria for attribution model selection

Next steps

- Sub-group to convene to suggest refinements to metrics scorecard and to recommend Year 1 approach

- Core team to synthesize working hypotheses for our next meeting

- Participants to consider implementation timeline in advance of our meeting on July 29

