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# Connecticut SIM: Payment model discussion document

Work group #6  
July 29, 2013

# Agenda

Consider approach and level of standardization required on consumer attribution *30 min*

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Review our recommendations on payment model design *75 min*

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Discuss process for ongoing refinement and broader syndication *15 min*

## Guiding principles for selecting consumer attribution methodology

### Guiding principles

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- 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?

## 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) – if no historical claims data exists, alternative rationales (e.g., provider quality) can be used

#### 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 in Connecticut

**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

## How standardized do we want attribution methodologies to be across participating payers?

- 1 One common methodology shared across all payers
- 2 Payers aligned on general principles (e.g., retrospective vs. prospective, member selection vs. attribution, provider type eligible for attribution) but not on technical details
- 3 Payers apply unique methodologies
- 4 Another option

# We have developed a set of recommendations centered around the key design questions on which we aligned during our first meeting

Categories	Original questions	Recommendations
<b>1 Payment</b>	<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>How will consumers be incented?</li> <li>What are the targets, pricing, and risk corridors?</li> </ul>	<ul style="list-style-type: none"> <li>Recommend an end state goal of a total cost of care payment model that covers 80% of the population by year 5 of testing – this will include a transitional P4P model (see below)</li> <li>Providers should be rewarded for both performance improvement and absolute performance</li> <li>Payers will be encouraged to provide incentives to consumers</li> </ul>
<b>2 Metrics</b>	<ul style="list-style-type: none"> <li>What will be the scope of account-ability for cost and quality? (<i>care delivery</i>)</li> <li>What are the sources of value we hope to promote with the payment model? (<i>care delivery</i>)</li> <li>What metrics will be used for eligibility for participation and eligibility for payment?</li> </ul>	<ul style="list-style-type: none"> <li>Both the total cost of care and pay for performance will be tied to a common scorecard for The Triple Aim; we will define v1.0 of that scorecard, to be refined following application submission</li> <li>In year 1 of the pay for performance track, providers should be eligible for rewards for quality alone, in subsequent years, rewards should be contingent on both quality and cost savings</li> <li>The metrics scorecard will outline which metrics will be used as practice standards and determinants of payment, acknowledging that some metrics will require a reporting period</li> </ul>
<b>3 Attribution</b>	<ul style="list-style-type: none"> <li>What will be the rule for attribution?</li> <li>At what level will performance be aggregated for measurement and rewards?</li> <li>What exclusions and adjustments will be applied for fairness and consistency?</li> </ul>	<ul style="list-style-type: none"> <li><i>[Placeholder for today's discussion on attribution]</i></li> <li>For the purposes of robust measurement, performance should be aggregated across payers, as very few providers will have sufficient patient panel sizes without some level of purchaser aggregation</li> <li>Performance will be aggregated across providers predominantly through corporate entities and/or formal legal/financial frameworks of integration; for providers who prefer less formal solutions, the creation of a geo-centric public utility will be considered</li> <li>The model will include risk adjustment and exclusions to ensure consumer access and protect providers from high-cost events</li> </ul>
<b>4 Rollout</b>	<ul style="list-style-type: none"> <li>What will be the pace of roll-out of the new payment model throughout the state?</li> <li>At what pace should accountability and payment type for participating providers be phased in?</li> <li>How will payers and providers be enabled to adopt the new payment model?</li> </ul>	<ul style="list-style-type: none"> <li>Connecticut will establish a two-track approach to reward providers for effective management of a population of patients; Track 1 will offer pay-for-performance payments to support providers currently unable to manage a panel of patients to do so by year 5; Track 2 will be a total cost of care model for providers able to manage the health and overall costs of a panel of patients in year 1</li> </ul>

# We will continue to address strategic design considerations until testing grant submission

Detail on following page

## Relevant design considerations

## Proposed meeting timeline

### Payment work group

- Incorporation of feedback from broader stakeholder community

- Work session for a detailed read through of payment section for SHIP submission during October

### Metrics task force to deepen metrics scorecard

- What will be measured as part of v1.0 scorecard?
  - Development of v1.0 of scorecard
  - Determination on how metrics will be used as practice standards, eligibility for payment, or level of payment

- Four meetings through August/September
- Ongoing basis subsequently

### Payer-specific considerations (may continue into testing phase)

- What are the targets, pricing, and risk corridors?
- How will consumers be incented?

- Ongoing basis

# “Version 0.1” scorecard for population health management

## Illustrative measures

### Quality

#### *Whole-person-centered care and population-health management*

- Completion of whole-person-centered assessment
- Development of whole-person-centered treatment plan
- Demonstrated use of risk stratification

#### *Enhanced access to care*

- 24/7 availability of a live voice
- Availability of non-visit based options (e.g., ability to perform e-consults)
- Practice adherence to NCLAS standards

#### *Team-based coordinated care*

- Track, follow-up on, and coordinate tests, referrals, and care at other facilities
- Demonstrated infrastructure to coordinate with community resources, including behavioral health practitioners and community-based sites of care
- Post-discharge planning

#### *Consumer engagement*

- Availability of shared decision making tools

#### *Evidence-informed clinical decision-making*

- HIT adoption
- Maintenance of disease registry
- Adult weight screening and follow-up
- Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention

#### *Performance management*

- Demonstrated completion of regular performance reviews
- Provider performance along quality index covering clinical process and outcomes measures (e.g., immunizations, preventive screening, optimal chronic disease management)

#### *Consumer experience*

- CAHPS and other consumer experience surveys

### Costs

- Potentially avoidable complications
- Hospitalization rate
- Emergency room utilization
- Generic prescribing rate

- Total cost of care per capita
- Trend in cost of care
- Use of high- vs. low-cost providers
- Use of high- vs. low-cost site of care

# The roadmap for the program will be refined by the SHIP, core team and work group co-chairs

▼ Evaluation phase start  
 ▼ Formal reviews by governing body

	2014	2015	2016	2017	2018	2019
<b>Targets</b> (cost impact, enrollment, impact on quality/patient experience, health inequalities)		30% consumers treated by accredited medical homes	50% consumers treated by accredited medical homes		80% consumers treated by accredited medical homes	
	Quality and patient experience targeted (structure & process)	Additional assessment of programmatic success against efficiency and outcomes based targets				
	Patient experience survey selected	Patient experience survey launched				
<b>Accountability</b> (metrics, practice standards)	Practice/ standards committee established	Continuous measurement and quality improvement				
	Full end-state metrics/ standards finalized					
<b>HIT</b>	Analytics engines (standardized across payers) set up to monitor provider performance	Providers educated on care management tools and have access to qualified vendor marketplace			HITE-CT established	
	Patient and provider portal established					
<b>Workforce development</b>	To be determined by UCHC workforce task force					
<b>Transformation support</b>	Regional provider collaboratives and transformation support launched			State wide provider collaboratives and support publishing of best practices achieved		
	Community-based support services defined	Community-based support services developed	Community-based support services launched and continuously improved			
	Regulatory/policy changes implemented	Ongoing policy review and improvement				

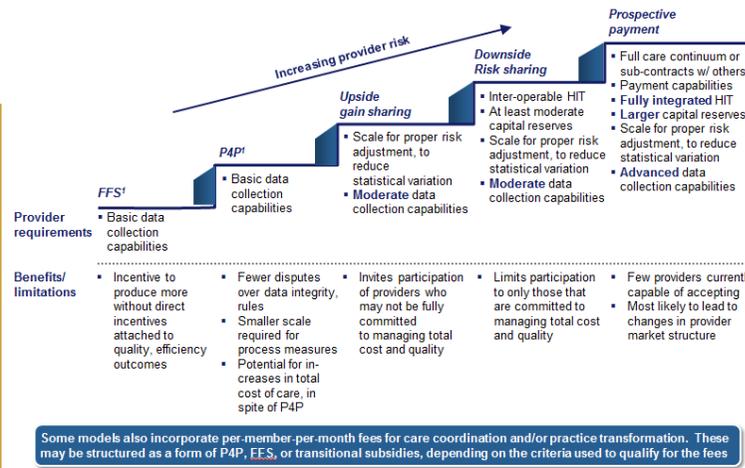
# APPENDIX

# 1 Reward structure recommendation

- The reward structure will reward providers for managing the health quality and costs for a panel of patients
  - Key aim of reward structure is total cost of care accountability; providers will determine on a payer-by-payer basis whether they will accept upside gain-sharing, downside risk-sharing, or capitation payments
  - A transitional pay-for-performance model will be put in place in Year 1 to help enable smaller providers to ultimately manage total cost of care
- In both models, providers will be rewarded for both absolute performance and performance improvement

REWARD STRUCTURE

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



REWARD STRUCTURE

We will hold providers accountable for both absolute performance and performance improvement

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

## 2 Metrics recommendation

- In year 1 of the pay for performance track, providers should be eligible for rewards for quality alone; in subsequent years, rewards should be contingent on both quality and cost savings
- Both the total cost of care and pay for performance tracks will be tied to a common scorecard for the Triple Aim
  - This scorecard will be accompanied by a set of practice standards that are required for initial and ongoing participation in the care delivery and payment models, with a low barrier to initial entry
  - It will also differentiate whether metrics will be used to determine eligibility of payment and level of payment in Year 1. Metrics that are selected but cannot, for various reasons, be used to hold providers accountable in Year 1 will be reporting only for that year
  - We will define a Version 1.0 of that scorecard through the metrics taskforce, to be refined following submission of the grant application

METRICS

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"> <li>Health risk factors (e.g. obesity)</li> <li>Prevalence of illness and injury</li> </ul>	<ul style="list-style-type: none"> <li>All payers should adopt common measures for The Triple Aim</li> <li>Metrics should be based on nationally recognized measure sets, to the extent possible</li> <li>Performance should be tracked and reported to all providers independent of payment model</li> </ul>
Health care	<ul style="list-style-type: none"> <li>Consumer experience (e.g., engagement, satisfaction)</li> <li>Quality of care                             <ul style="list-style-type: none"> <li>Structure</li> <li>Process</li> <li>Outcomes</li> <li>Care coordination</li> </ul> </li> </ul>	
Costs	<ul style="list-style-type: none"> <li>Total cost of care</li> <li>Resource utilization, e.g.,                             <ul style="list-style-type: none"> <li>Hospital days per 1,000</li> <li>Emergency room visits per 1,000</li> <li>Generic prescribing rates</li> </ul> </li> </ul>	

METRICS

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

Illustrative CMMI core measures	Work group additions
<ul style="list-style-type: none"> <li>Follow-up hospitalization after mental illness</li> <li>Tobacco use assessment and tobacco cessation intervention</li> <li>CAHPS surveys</li> </ul>	<ul style="list-style-type: none"> <li>Completion of wellness assessments and treatment plans</li> <li>Primary care quality measures, incl. quality indices</li> </ul>

Our "Version 0.1" medical home scorecard to be refined in coming weeks

Population health aspect	Measure title	Population health aspect	Measure title
Whole-person-centered care and population health mgmt.	<ul style="list-style-type: none"> <li>Assessment completion rates<sup>1</sup></li> <li>Risk-stratification of consumer panel conducted</li> <li>Whole-person-centered treatment plan</li> </ul>	Team-based, coordinated, care (cont.)	<ul style="list-style-type: none"> <li>3-item care transition measure</li> <li>Demonstrated use of intensive case mgmt. tools</li> <li>Assessment of consumer progress towards treatment and follow-up when necessary</li> </ul>
Enhanced access to care (structural and cultural)	<ul style="list-style-type: none"> <li>Access to care outside normal business hours</li> <li>E-consult capability</li> <li>Transition services</li> <li>Convenient availability including same day access</li> <li>Availability of non-visit based options (e.g. telehealth through telephone, email, text, video)</li> </ul>	Consumer engagement	<ul style="list-style-type: none"> <li>Patient portal</li> <li>Demonstrated use of "Choosing Wisely" campaign to raise awareness at the point of care</li> <li>Provision of quality/cost information at point of care</li> <li>Periodic review to ensure self-management care plan takes into account targeted considerations</li> </ul>
Team-based, coordinated, comprehensive care	<ul style="list-style-type: none"> <li>Care planning infrastructure</li> <li>Follow-up after hospitalization for mental illness</li> <li>Medication reconciliation</li> <li>Demonstrated infrastructure to coordinate with community resources, including behavioral health practitioners and community-based sites of care</li> <li>Adoption of medication prescribing</li> <li>Post-discharge continuing care plan created</li> <li>Post-discharge continuing care plan transferred to next level of care provider upon discharge</li> <li>Care transition record transmitted to Health Care professionals</li> <li>Transition record with specified elements received by discharged by patients</li> </ul>	Evidence informed clinical decision making	<ul style="list-style-type: none"> <li>Quality index<sup>2</sup></li> <li>Adoption of HIT infrastructure</li> <li>Ability for providers with HIT to receive lab data</li> <li>Maintenance of disease registry</li> <li>Ensure use of actionable data (e.g. disease registry)</li> <li>Evidence-based standardized care pathway</li> <li>Bi-directional provider information sharing (e.g. HIE)</li> <li>Demonstrated implementation and periodic review of evidence-based guidelines</li> </ul>
Enhanced access to care (structural and cultural)		Performance management	<ul style="list-style-type: none"> <li>Total medical cost per member</li> <li>Utilization index<sup>3</sup></li> <li>Participation in learning collaborative</li> <li>CAHPS and other patient surveys collected</li> <li>Completion of performance review based on practice data to improve whole center/ness</li> </ul>

1 Based on claims data 2 Either based on clinical data that is already being measured, but is not reported today or a one-time measurement  
 3 Clinical data that is not being measured today 4 Completion of whole person assessments that consider consumer/affirmity, risk, and behavioral health factors and able to self-manage care 5 Detail on subsequent pages; utilization index for reporting purposes only  
 Note: Italicized measures indicate CT specific additions (both by the payment work group and to meet specific care delivery work group intervention)

### 3 Attribution recommendation

- *[Placeholder for today's discussion on consumer attribution strategies]*
- For robust performance measurement, aggregation will be recommended across purchasers at a minimum
  - This recommendation will allow for nearly all providers in Connecticut to participate in the P4P model
- Additional aggregation will be required for smaller providers to participate in the total cost of care model
  - Providers will be encouraged to aggregate through joining (or forming) corporate entities or other formal legally and financially integrated structures or to participate in a form of geo-centric aggregation, with resources and support provided by a public utility

CONSUMER ATTRIBUTION

Minimum scale is required for meaningful quality measurements

Triple Aim goals	Types of metrics	Minimum patient population <sup>1</sup>	
Health	▪ Health risk factors (e.g. obesity)	▪ Moderate (100-1,000)	
	▪ Prevalence of illness and injury		
Health care	▪ Patient satisfaction	▪ Low to moderate (<1,000)	
	▪ Quality of care		
	— Structure		— Low (<100)
	— Process		— Moderate (100-1,000)
Costs	— Outcomes	— High (5,000+)	
	▪ Total cost of care	▪ High (5,000+)	
	▪ Resource utilization, e.g.,		
	— Hospital days per 1,000		— Moderate (100-1,000)
— Emergency room visits per 1,000	— Moderate (100-1,000)		
	— Generic prescribing rates	— 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

<sup>1</sup> Rule of thumb, to be validated for each metric based on relevant population

PERFORMANCE AGGREGATION

Potential models for aggregating provider performance

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

**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

## 4 Rollout recommendation

- Establish a two-track approach to reward providers for effective management of a population of patients
  - Track 1 will offer pay-for-performance payments to support providers currently unable to manage a panel of patients to do so by year 5
  - Track 2 will be a total cost of care model for providers able to manage the health and overall costs of a panel of patients in year 1
- Roll-out is staged with the goal that 80% of all consumers in Connecticut will be accounted for in a total cost of care accountability model by year five of testing the model

### ROLLOUT

We aligned on a two-track approach to enable providers to adopt innovative reforms ILLUSTRATIVE

