



State Innovation Model: Payment model work group kickoff reference materials

STATE OF CONNECTICUT

Reference materials
May 20, 2013

Table of contents

Strategic payment model decisions and definitions

Connecticut and SIM design context

Payment model work group charter

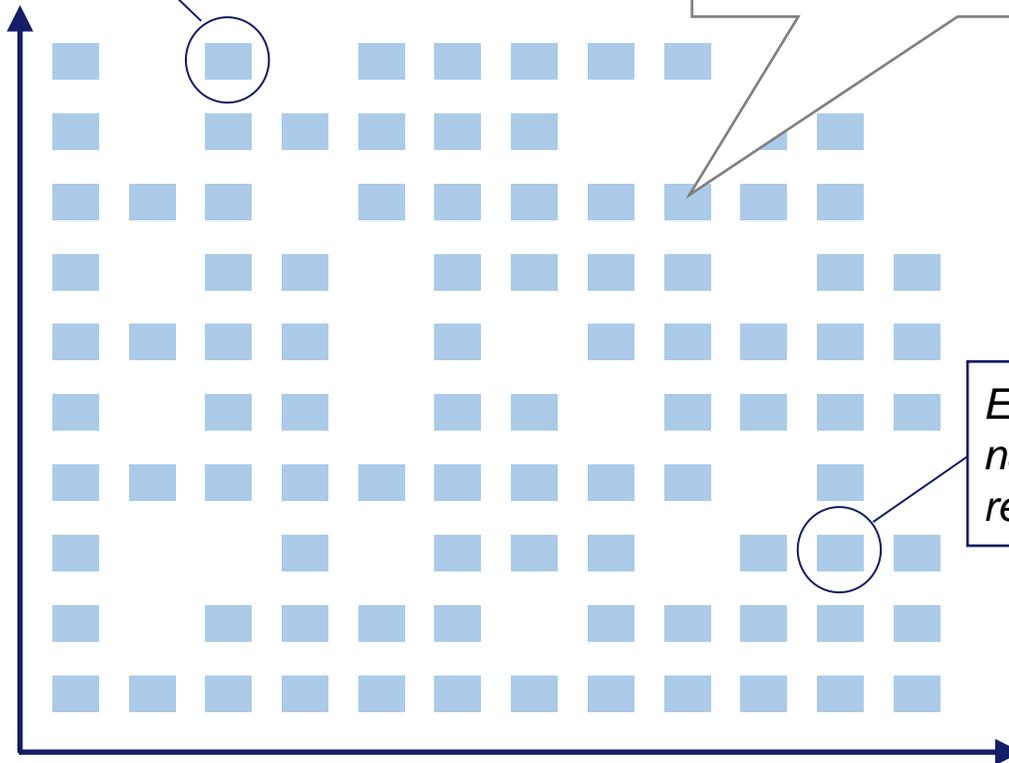
1 The payment work group design decisions will depend on care delivery work group's selection of a care delivery model

	Description	Examples
<p>Population health</p>	<p>Provider(s) responsible for the overall health of a population of patients over a set period of time and often targets highest cost group of patients with high touch care management</p>	<div data-bbox="1022 305 1159 445">  </div> <p>Relationships with CT physician groups to support practice of evidence-based medicine and coordinated care, particularly for patients with chronic conditions</p> <div data-bbox="1013 533 1178 568">  </div> <p>Patient centered primary care program which supports access to primary care and enhances care coordination</p> <div data-bbox="1037 631 1149 739">  </div> <p>Connecticut state PCMH pilot for self-funded employees and Medicaid enrollees that seeks to enhance the quality and capacity of primary care practices for state employees and youth</p>
<p>Episodes of care</p>	<p>Provider(s) with direct or indirect control over majority of care delivery for a defined acute procedure or condition are responsible for all care associated with the procedure or condition (e.g., CABG)</p>	<div data-bbox="990 844 1196 879">  </div> <div data-bbox="999 925 1178 988">  </div> <p>Best practices created for discrete episodes based on national or local guidelines and enforced standard clinical protocols</p>
<p>Discrete encounters</p>	<p>Specialty or service specific providers with direct control over discrete components of care delivery</p>	<div data-bbox="1009 1100 1178 1222">  </div> <p>Dedicated specialty hospital treats discrete eye procedures at lower costs and higher quality than in US</p>

1 The Fee-For-Service system largely bounds accountability at a discrete encounter

Type of provider or discrete service

- PCP
- Specialist
- Hospital
- Pharmacy
- Home health
- Etc.



Example: Retail clinic visit for sore throat

“Encounter-based”

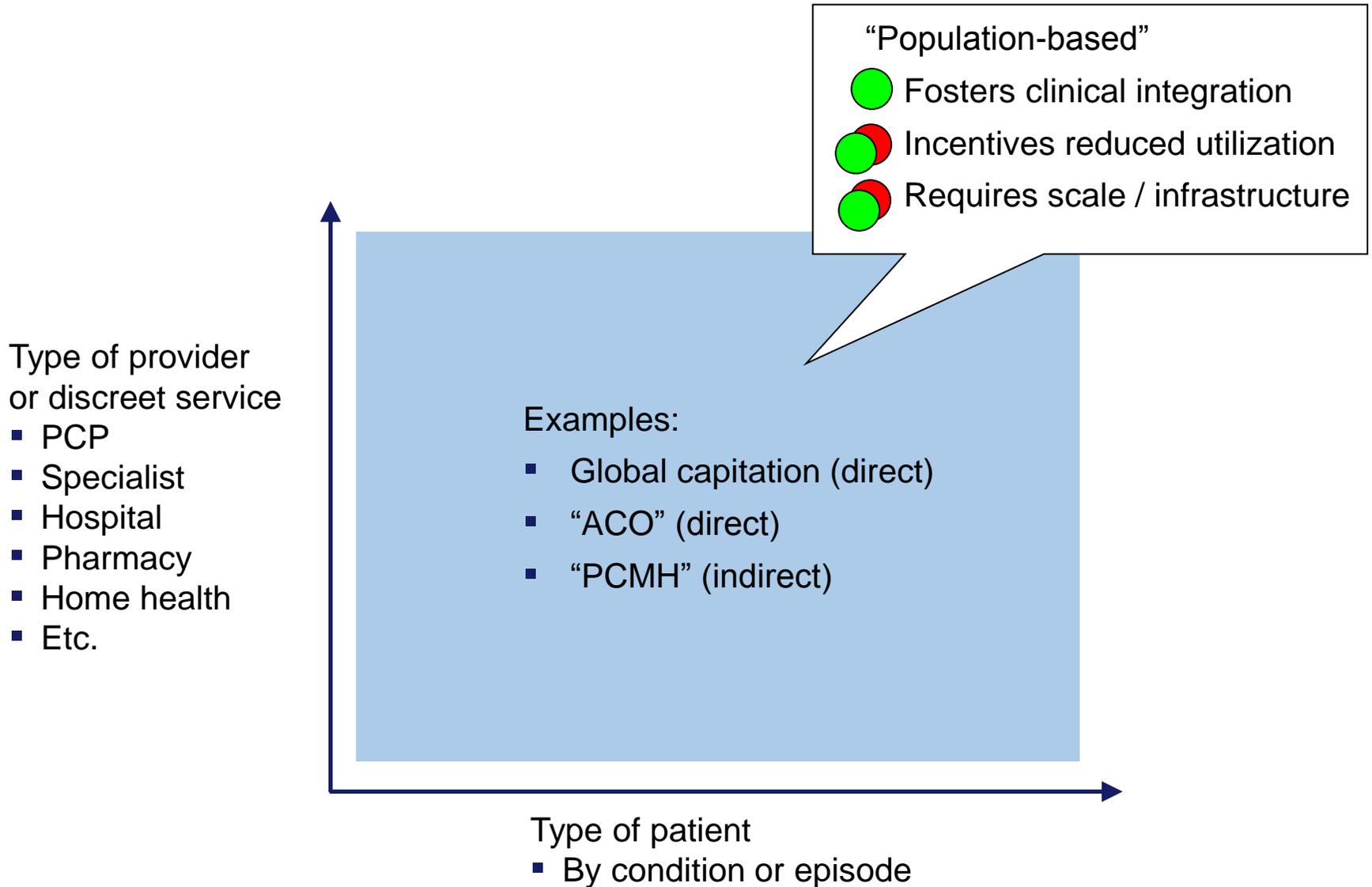
- Fosters specialization
- Contributes to gaps in care
- Incentivizes increased utilization

Example: national reference lab test

Type of patient

- By condition or episode

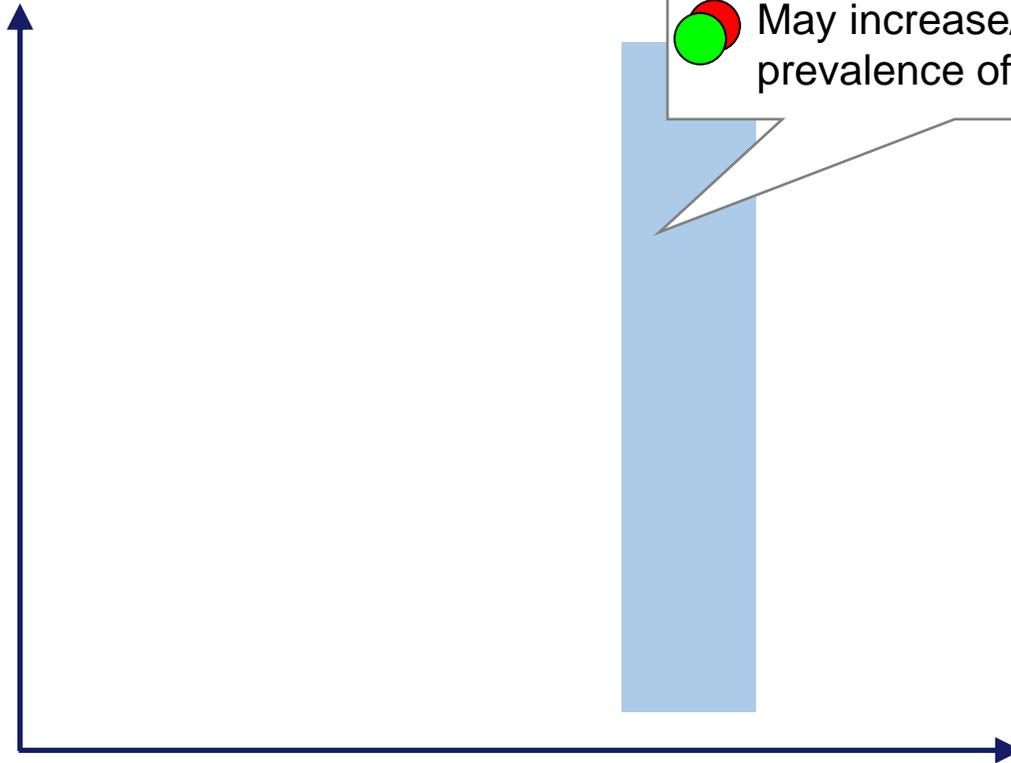
1 ACO and PCMH models commonly create accountability for total cost of care for population



1 Episode-based payment creates accountability for all the products and services tied to a procedure or chronic condition

Type of provider or discreet service

- PCP
- Specialist
- Hospital
- Pharmacy
- Home health
- Etc.



“Episode-based”

- Fosters clinical integration
- Incentivizes lower cost per episode
- May increase/decrease treated prevalence of condition

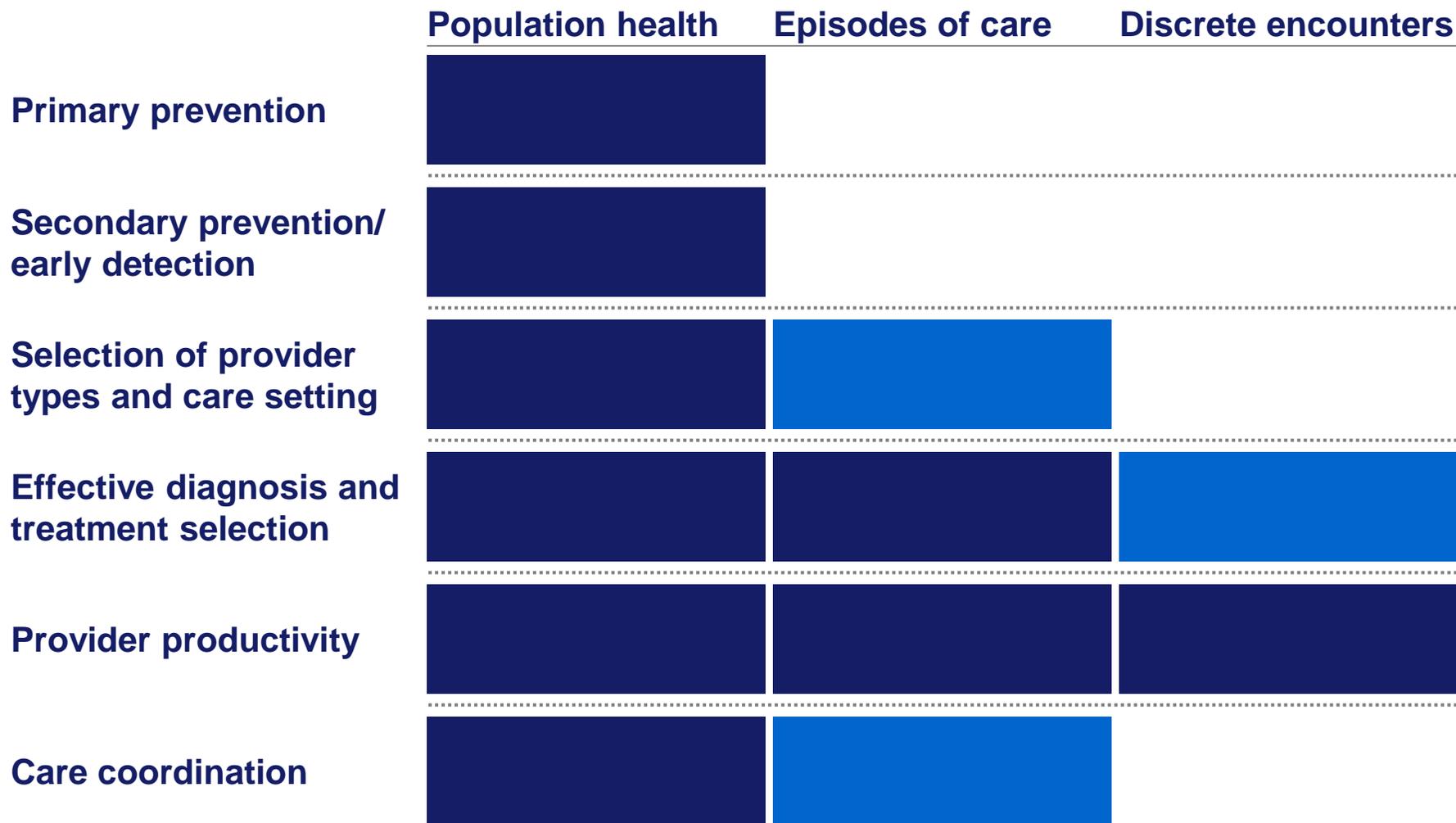
Type of patient

- By condition or episode

1 Models target different sources of value—that is, drivers of health, quality, cost, and experience

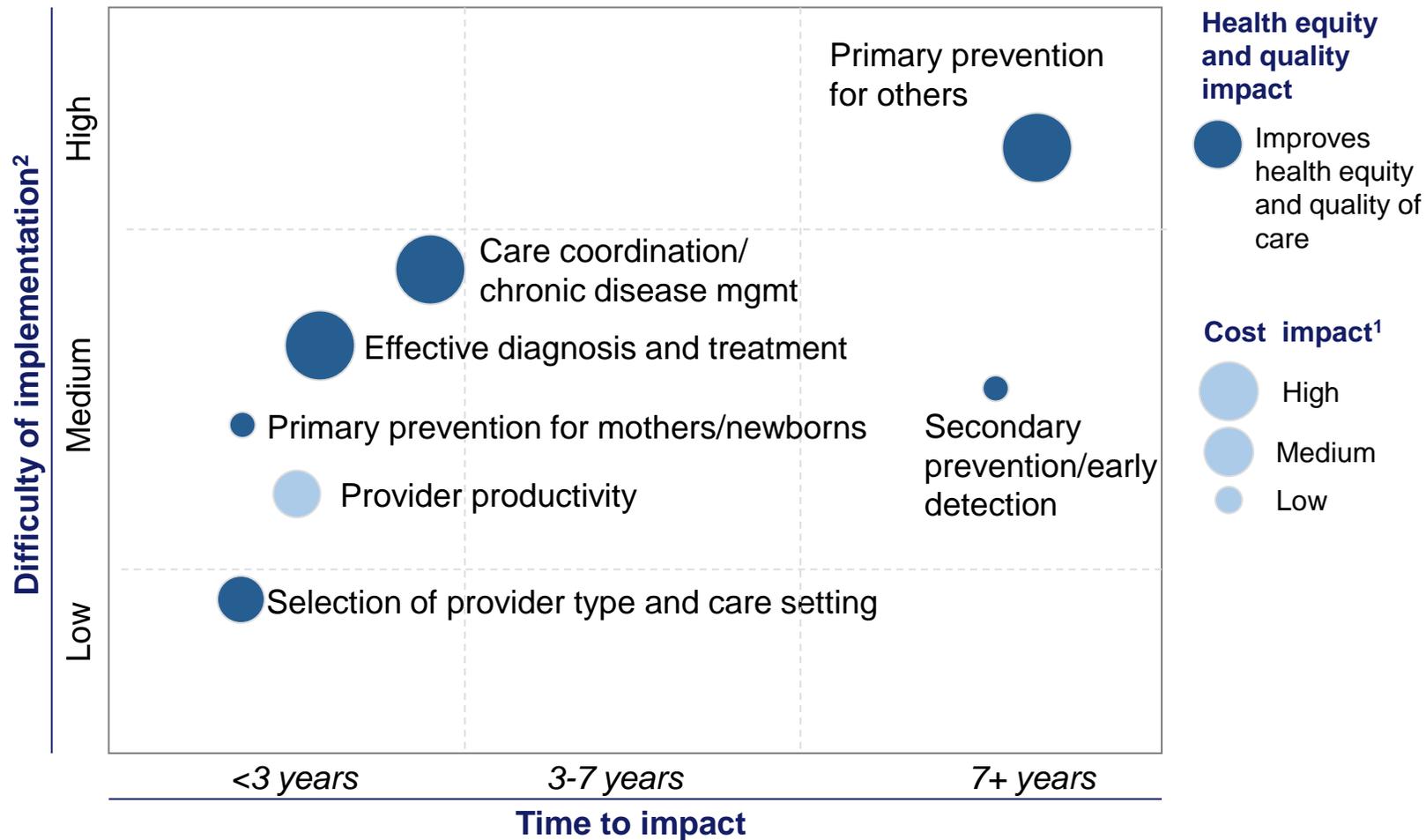
Level of Influence¹

■ Direct ■ Sometimes



¹ Influence will vary by type of organization involved (e.g. integrated delivery system vs. Independent Practice Association)

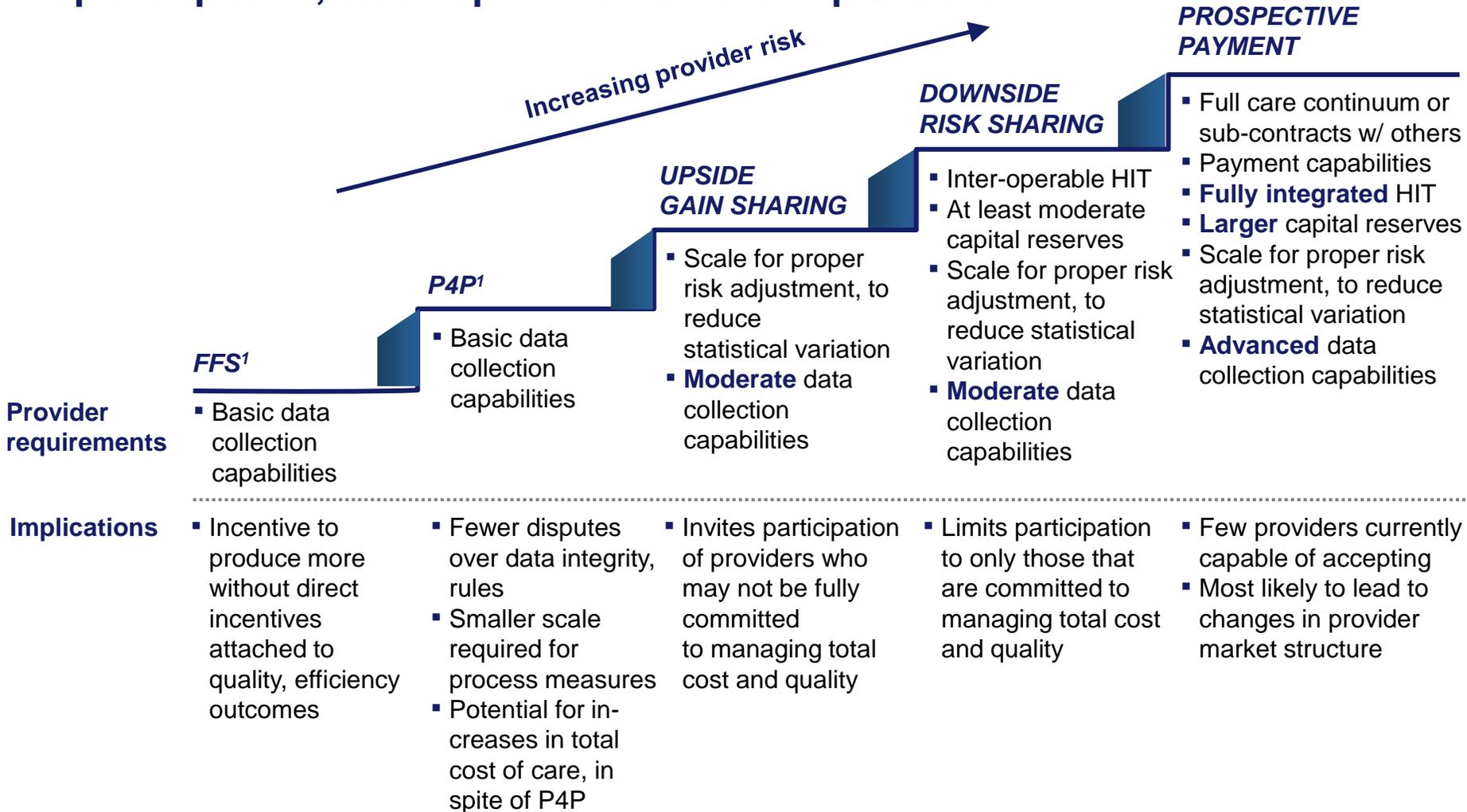
1 The care delivery model work group is considering sources of value to focus on within the design of the care delivery model



1 Estimate of total cost of care savings based on literature reviews, case examples, and CT and national statistics

2 Includes assessment of historical success rates and execution risk

2 The structure of risk/rewards has several implications for provider participation, and required scale and capabilities



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

Definitions for payment model reform (1/2)

	CDC Definition	FHEA Definition
Primary prevention	<ul style="list-style-type: none"> Interventions applied to an individual before the individual acquires a disease Aims to prevent disease occurrence 	<ul style="list-style-type: none"> Measures provided to individuals to prevent the onset of a targeted condition
Secondary prevention	<ul style="list-style-type: none"> Interventions after a disease has occurred but before the patient has noticed any symptoms Aims to identify and treat disease early 	<ul style="list-style-type: none"> Measures that identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease but in whom a condition is not clinically apparent
Tertiary prevention	<ul style="list-style-type: none"> Interventions when a patient has symptoms of disease Aims to prevent damage from disease, slow progression, prevent complications, and heal the patient 	<ul style="list-style-type: none"> Measures activities involving the care of established disease, with attempts made to restore to highest function, minimize the negative effects of disease, and prevent disease related complications

SOURCE: Centers for Disease Control and Prevention; Fitzgerald Health Education Associates

Definitions for payment model reform (2/2)

	<u>Definition</u>
Global payment system	<ul style="list-style-type: none"> ▪ A group of services that is aggregated or bundled together as a means to determine payments (typically prospective) for all of the care rendered to a particular patient or population over a given time period
Risk sharing	<ul style="list-style-type: none"> ▪ The process of sharing responsibility for (or taking accountability for) the value of patient care by agreeing to tie a portion of payment to achievement of quality and cost targets
Shared savings or gain sharing	<ul style="list-style-type: none"> ▪ The difference between the actual costs incurred and the established budget for a population attributed to a risk-bearing entity. Typically, if the actual costs are less than the established budget, some portion of the difference (or “savings”) is distributed among the physicians and other providers and the remainder is retained by the payer. In the event actual costs exceed the budget, there is no distribution
Episode based bundling	<ul style="list-style-type: none"> ▪ A group of services that is aggregated together as a means to determine payment (typically prospective) for a finite episode of care, which usually is often focused around a procedure
Pay for performance	<ul style="list-style-type: none"> ▪ A health insurer or other payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician’s fee-for-service compensation
Care management fee	<ul style="list-style-type: none"> ▪ Typically a Per Member Per Month (PMPM), often associated with the Patient-Centered Medical Home (PCMH), which is designed to recognize specific care processes for patients with chronic diseases.
Fee for service	<ul style="list-style-type: none"> ▪ The most common payment model used by most public and private payers that assigns a discrete fee (usually based on the relative value units) for a specified service defined by each CPT or HCPCS code

FTC guidelines for ACO innovation

CMS may approve ACOs that meet the following criteria

- 1 A formal legal structure that allows the ACO to receive and distribute payments for shared savings
- 2 A leadership and management structure that includes clinical and administrative processes
- 3 Processes to promote evidence-based medicine and patient engagement
- 4 Reporting on quality and cost measures
- 5 Coordinated care for beneficiaries

Table of contents

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Connecticut and SIM design context

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Connecticut's public health profile ranks above national average on almost all indicators, often ranking in the top 5 states

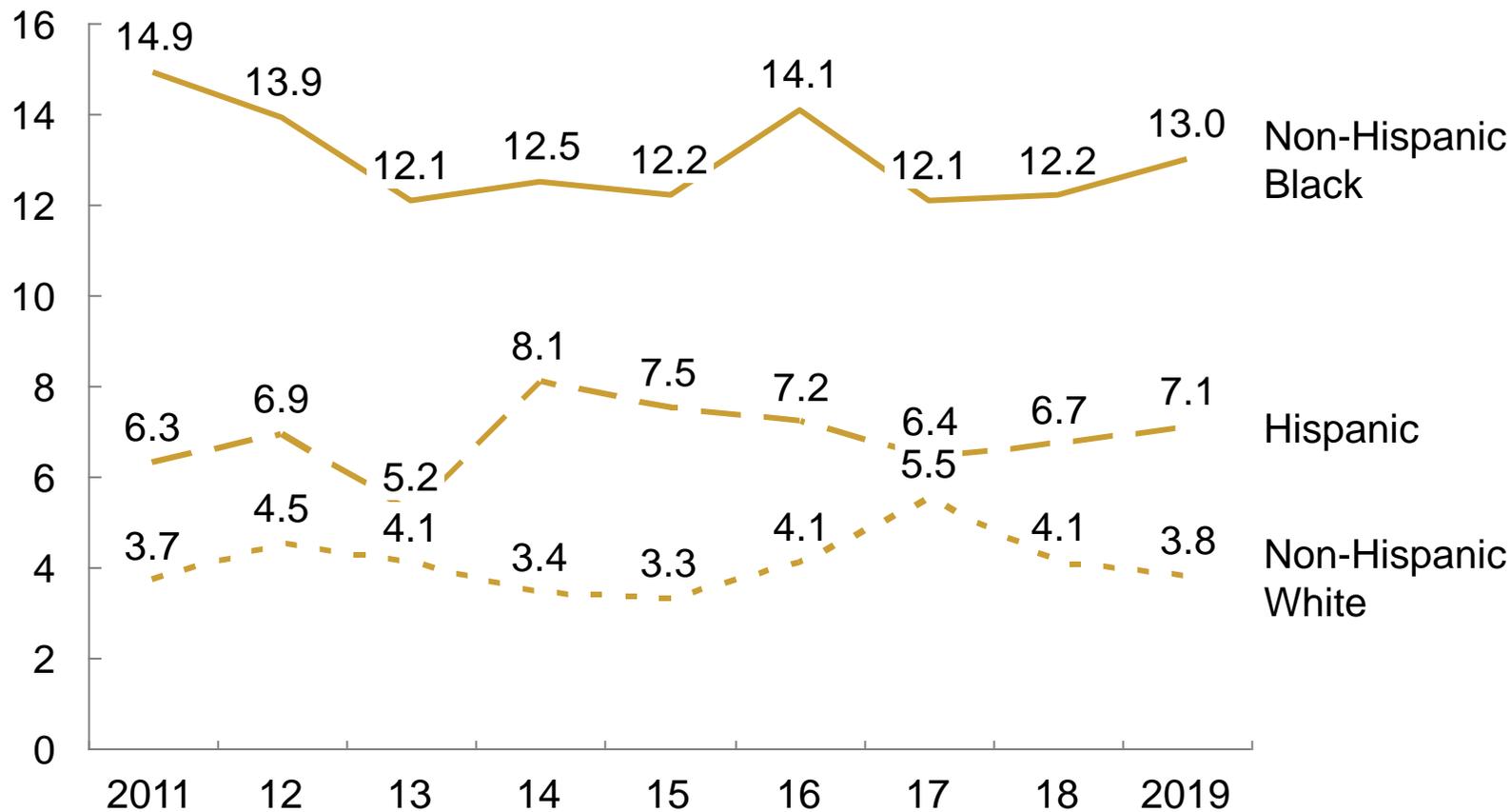
- Top 10%
- Top 25%
- Top 50%

Measure	2012 value	State rank
<i>Determinants</i>		
Smoking (Percent of adult population)	17.1%	5
Obesity (Percent of adult population)	24.5%	7
Immunization coverage (Per of children 19-35)	157.9	2
Preventable Hospitalizations (Per 1,000 Medicare enrollees)	60.4	23
<i>Health outcomes</i>		
Diabetes (Percent of adult population)	9.3%	19
Infant Mortality (Deaths per 1,000 live births)	5.8%	17
Cardiovascular Deaths (Deaths per 100,000 population)	239.2	17
Cancer Deaths (Deaths per 100,000 population)	176.4	15
Premature Death (Years lost per 100,000 population)	5943	5
Poor Mental Health Days (Number of days in last 30 days person indicates their activities are limited due to mental health difficulties)	3.6	5

Health inequities, however, persist as illustrated in the difference in infant mortality rates across ethnicities

Infant mortality rate Connecticut, 2001-2009

Death per 1,000 live births



Note: Infant mortality defined as death within 1 year of birth

SOURCE: Connecticut Department of Public Health, Vital Statistics (Registration Reports), 2001-2009, Table 12

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

In addition, patient experience in CT hospitals reaches national averages but timeliness of treatment falls significantly behind

■ Average
■ Below average

	Connecticut average	National average
Patients who reported they would recommend the hospital	71%	70%
Patients who reported that their pain was “Always” well controlled	69%	70%
Patients who gave their hospital a rating of 9 or 10 out of 10	67%	69%
Patients assessed and given influenza vaccination	82%	86%
Pneumonia patients given the most appropriate initial antibiotics	96%	95%
Outpatients having surgery who got the right kind of antibiotic	95%	97%
Avg time before patients w chest pain/possible HF got an ECG	9 minutes	7 minutes
Time patients with broken bones had to wait before pain med	61 minutes	62 minutes
Time patients spent in ED before admission as inpatient	341 minutes	274 minutes

Quality varies across regions



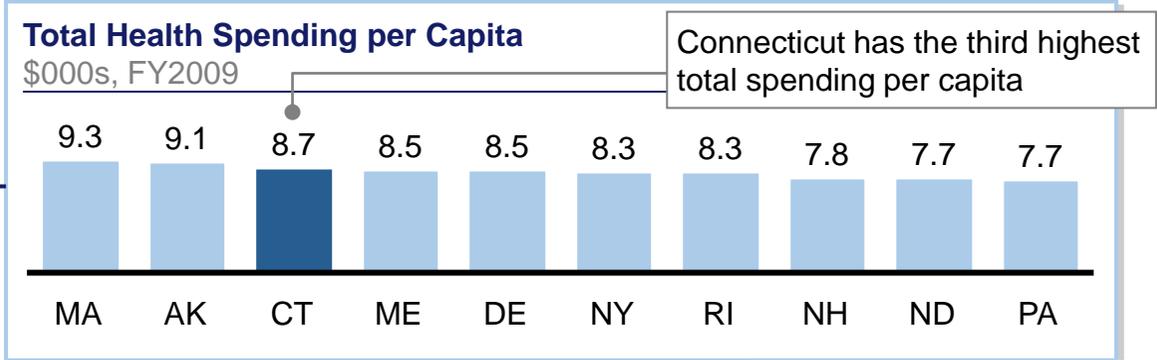
	Yale New Haven ¹	Hartford	Saint Francis	Western CT	CT Avg	National average
Patients who reported they would recommend the hospital	80%	76%	76%	79%	71%	70%
Patients who gave their hospital a rating of 9 or 10	74%	66%	69%	72%	67%	69%
Patients assessed and given influenza vaccination	71%	79%	81%	96%	82%	86%
Pneumonia patients given the most appropriate initial antibiotics	93%	79%	99%	98%	96%	95%
Outpatients having surgery who got the right kind of antibiotic at the right time	92%	93%	95%	99%	95%	97%
Time patients spent in ED before admission as an inpatient	297	488	488	260	341	274 minutes

¹ System-level performance figures were calculated as averages of figures reported from hospitals within the health system

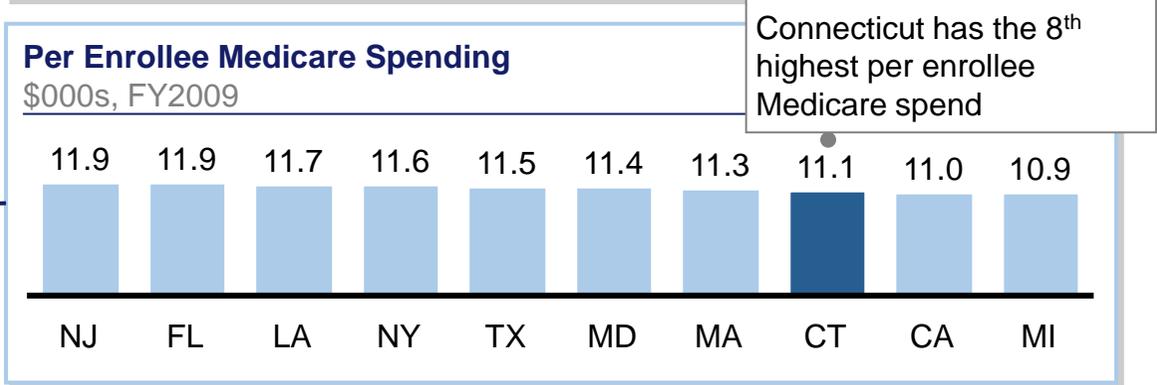
At the same time, there is opportunity to decrease the level of healthcare spending in Connecticut...

Per capita cost of care

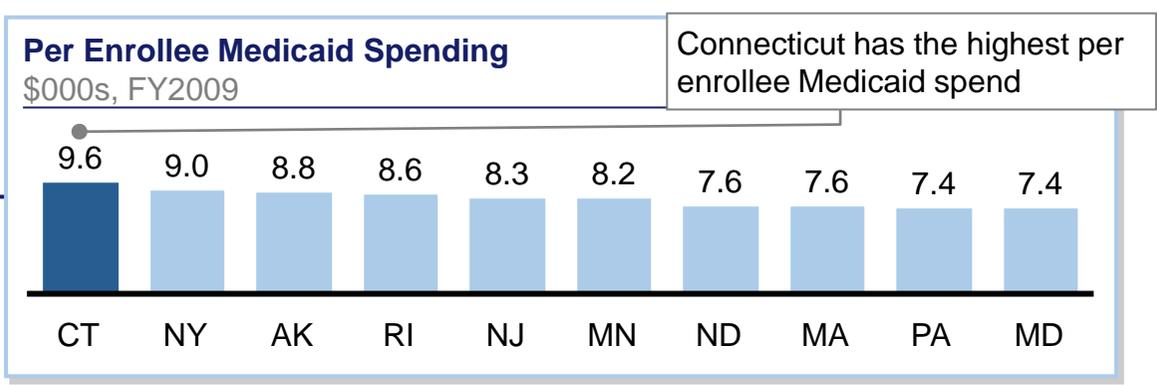
Overall
\$ per person



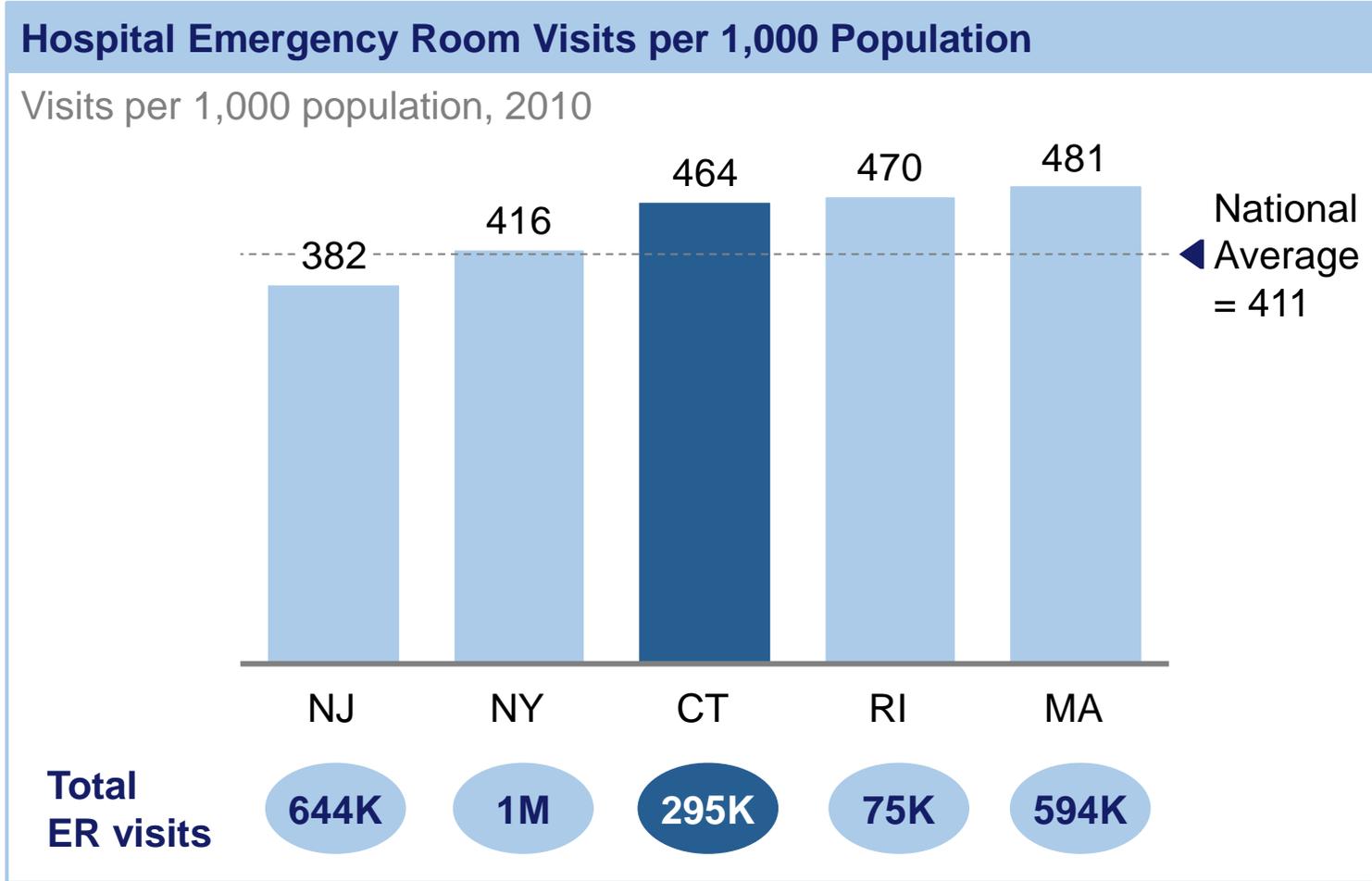
Medicare
\$ per person



Medicaid
\$ per person



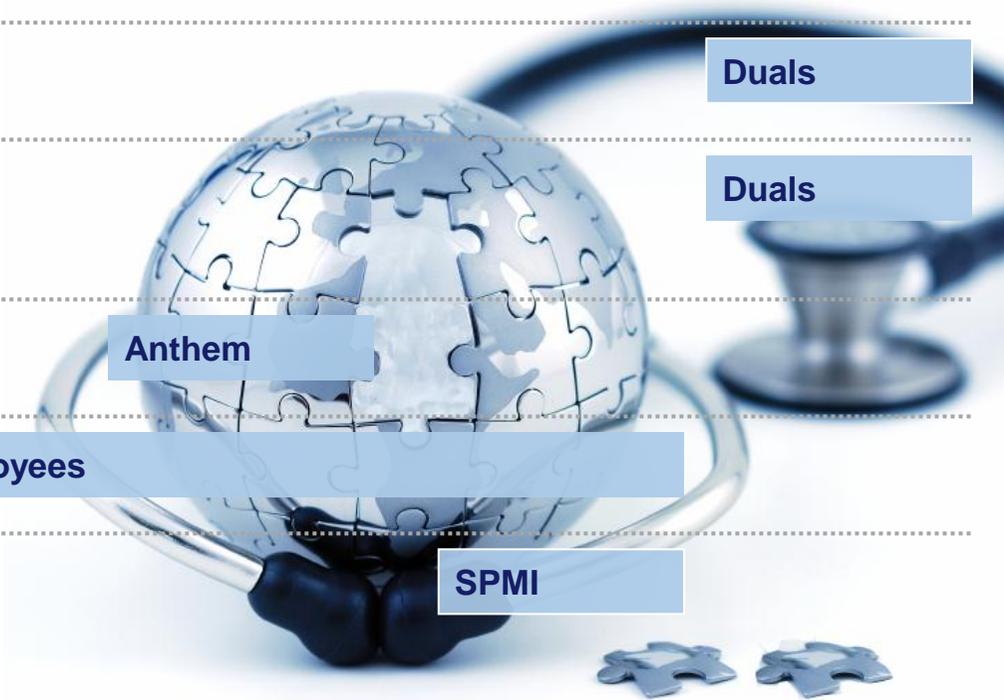
...through efforts that increase the value of care delivery, such as decreasing inefficient utilization of emergency departments



SOURCE: Kaiser State Health Facts, Health Indicators Warehouse, National Center for Health Statistics, CDC.

CT has many payment and care delivery innovations, but no model shared across Medicaid, Medicare, and Commercial insured populations

	Children	Adult	Special needs ¹	Duals, elderly
Patient-centered medical home <i>Enhanced FFS performance payment, TCOC accountability (Anthem)</i>	Medicaid			
	Anthem			
ACO <i>ProHealth, Hartford Healthcare, St. Francis, Primed, Collaborative ACO</i>	Cigna			Medicare
Integrated Care Initiative – ASO <i>SSP with state</i>				Duals
Integrated Care Initiative – Health Neighborhood <i>TCOC SSP with providers</i>				Duals
Episode-based payment <i>Joint replacement pilot</i>		Anthem		
Health enhancement program <i>Consumer based incentives</i>	State employees			
SPMI health homes <i>Care coordination capitation</i>			SPMI	



¹ Includes LTSS, SPMI, and DD patients

The 6 testing states are using SIM to drive innovation at scale (1 of 2)

Brief description of approach

Arkansas

- **Population-health model:** PCMH for majority of Arkansans by 2016
- **Episodes:** episodes designed for all acute and complex chronic conditions (50-70% of spend) over 3-5 years

Maine

- **Population health model:** Formation of multi-payer Accountable Care Organizations (ACOs)
- Alignment of benefits from MaineCare (the state's Medicaid program) with benefits from Medicare and commercial payers to achieve and sustain lower costs for the Medicaid, Medicare and CHIP populations

Massachusetts

- **Population health model:** Support for primary care practices to transform into PCMHs
- **Discrete encounters:** Shared savings / shared risk payments for primary care with quality incentives based on a statewide set of quality metrics

Minnesota

- **Population health model:** ACOs with expanded scope of care to include long-term social services and behavioral health services
 - Created linkages between the ACOs and Medicare, Medicaid, and commercial insurers to align payments to provide better care coordination
 - Established “Accountable Communities for Health” to integrate care with behavioral health, public health, social services, etc., and to share accountability

The 6 testing states are using SIM to drive innovation at scale (2 of 2)

Brief description of approach

Oregon

- **Population health model:** System of Coordinated Care Organizations (CCOs), which are risk-bearing, community-based entities governed by a partnership among providers, the community, and entities taking financial risk for the cost of health care
- CCO model will begin with Medicaid and be spread to additional populations and payers, including Medicare and state employee plans

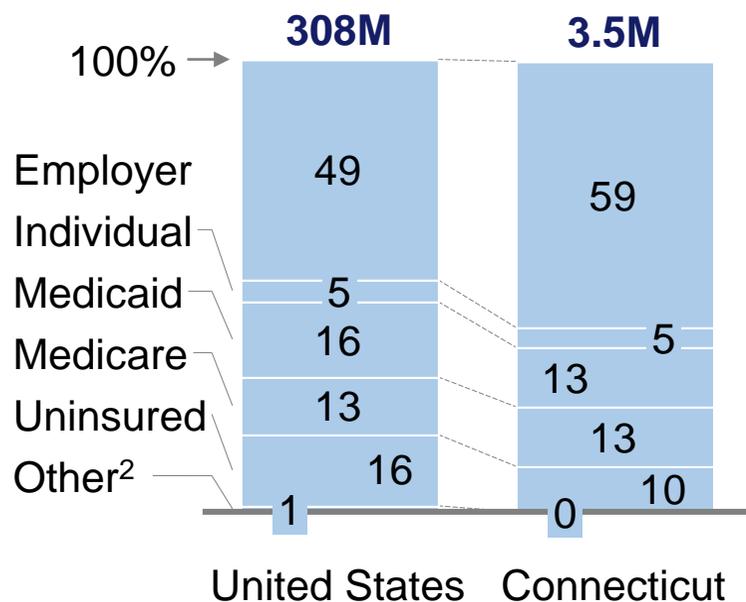
Vermont

- **Population health:** Shared-savings ACO model that involves integration of payment and services across an entire delivery system
- **Episodes:** Bundled payment model that involve integration of payment and services across multiple independent providers
- **Discrete encounters:** pay-for-performance model aimed at improving the quality, performance, and efficiency of individual providers Formation of multi-payer ACOs

Connecticut residents get 64% coverage through commercial market, with 13% coverage from each of Medicare and Medicaid

Population breakdown by insurance status¹

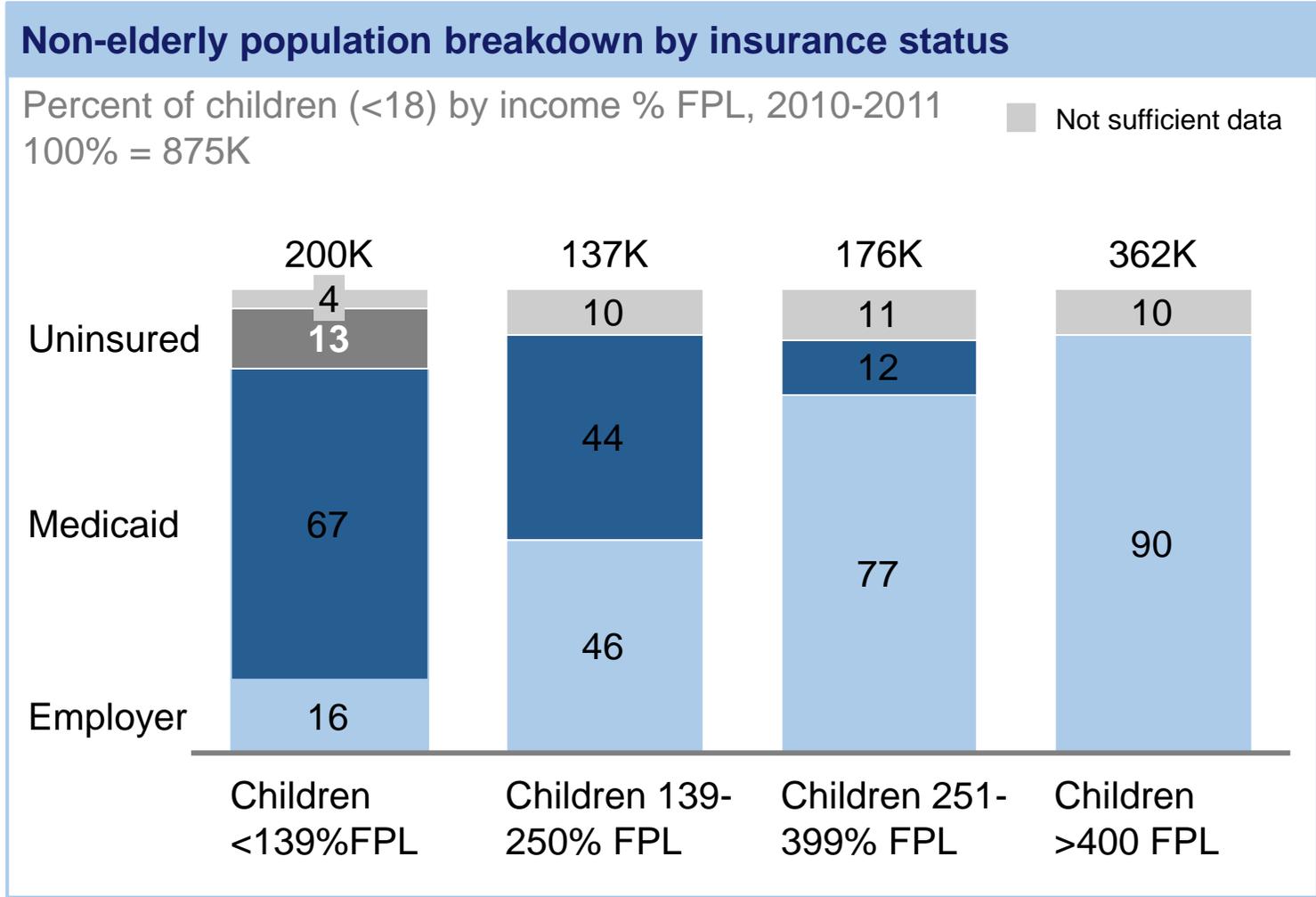
Number of covered lives, percent of total, 2010-2011



¹ All two-year health coverage estimates were produced by Kaiser Family Foundation based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS). For current Medicaid and Medicare enrollment figures, please refer to slide 30 in the Medicaid section, which report enrollment data from the Centers for Medicare and Medicaid Services (CMS).

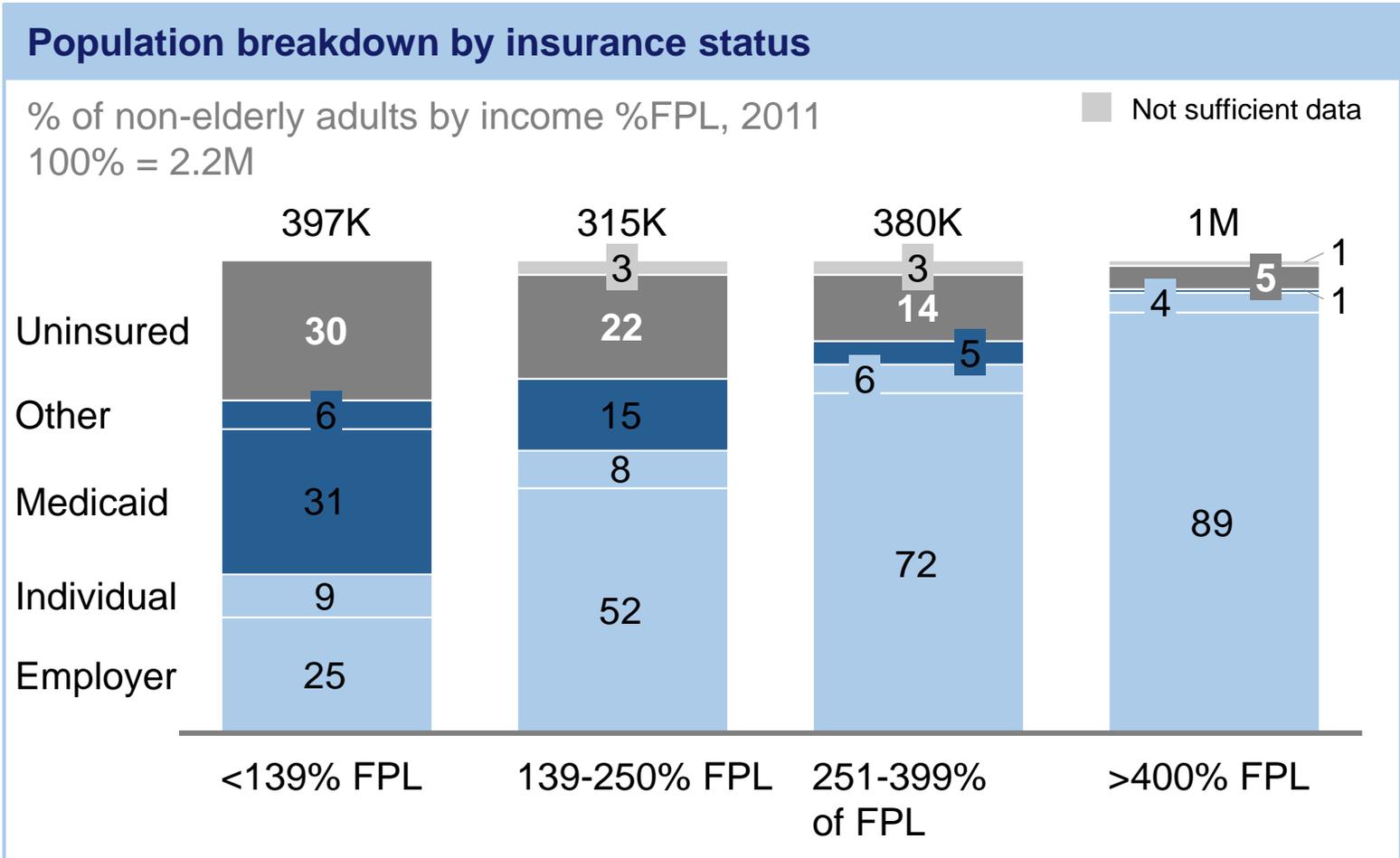
² "Other" Public includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees.

Nearly 70% of children in households with incomes up to 139% of FPL are covered by Medicaid



Note: No data was reported on coverage by "Other Public" payor

>90% of non-elderly adults with incomes >400% of FPL are covered by commercial insurance, mostly by employers



Health systems overview

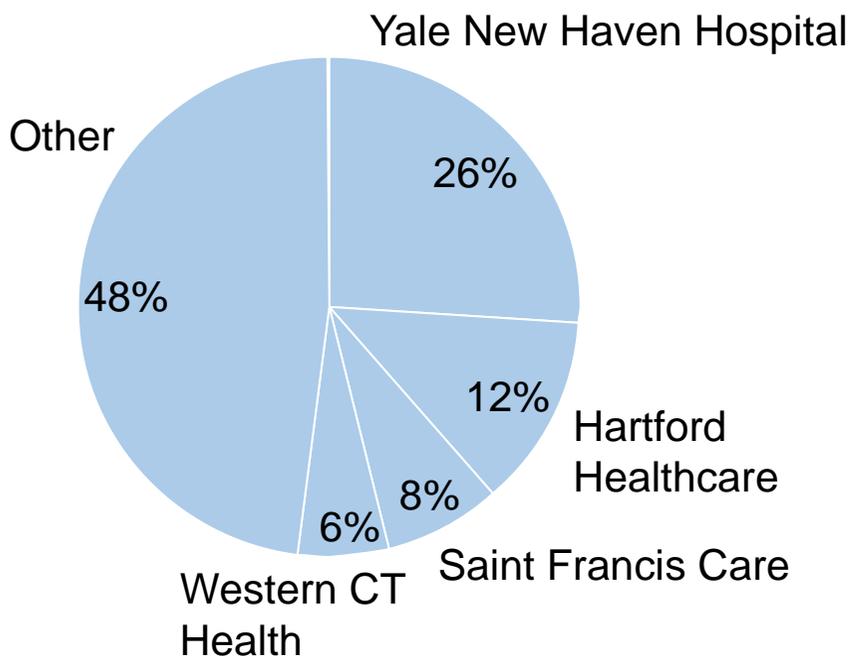
	State presence	Details and recent news
Yale New Haven Health System	<ul style="list-style-type: none"> ▪ Market share: 26% of 2011 total discharges ▪ Hospitals: 4 hospitals: Greenwich Hospital, Bridgeport Hospital, Yale-New Haven Hospital Saint Raphael Campus, Yale-New Haven Hospital ▪ Physician groups: Yale Medical Group (>800 physicians), Yale-New Haven Medical group (>600 physicians), Northeast Medical Group (>350 physicians) 	<ul style="list-style-type: none"> ▪ Facilities: Yale Cancer Center (a comprehensive cancer center designated by the National Cancer Institute), Father Michael J. McGivney Cancer Center, with campuses in New Haven and Hamden, Leona M. and Harry B. Helmsley Ambulatory Medical Center, 7 urgent-care centers in East Haven, Fairfield (2), Monroe, Shelton, Stratford, and Trumbull, 5 radiology centers affiliated with Bridgeport Hospital, Yale New Haven Cancer Network, Yale New Haven Health System Heart Institute ▪ Expansion: Bridgeport Hospital completed a \$1.5M renovation of its burn unit in September 2012 and consolidation of 42 pediatric beds at Bridge Hospital with pediatric services at Yale-New Haven Children's Hospital in February 2012 ▪ Accountable care organization: Yale New Haven Health System created a task force and care management pilot in 2011 to coordinate efforts to assume accountable for the health of individuals
Hartford Healthcare	<ul style="list-style-type: none"> ▪ Market share: 12% of 2011 total discharges ▪ Hospitals: 4 hospitals: Natchaug Hospital, Windham Hospital, MidState Medical Center, Hartford Hospital ▪ Physician groups: Hartford Physicians (>800 members), Hartford Medical Group (>50 physicians) 	<ul style="list-style-type: none"> ▪ Facilities: West Harvard Surgery Center, Lifestar, the state's only air ambulance system, Hartford Hospital Eye Surgery Center ▪ Expansion plans: Hartford Hospital received a \$10M grant from the state to support a 30,000-square-foot expansion of the hospital's Center for Education, Simulation and Innovation in September 2012 ▪ Accountable care organization: Hartford Hospital is a member of the ACO Readiness Collaborative of Premier Healthcare Alliance ▪ Pay for performance: Eastern Rehabilitation Network has attained 100% of the payout in its P4P contract with ConnectiCare for the second year in a row. Incentive payments were worth>\$150K. Performance metrics focus on patient satisfaction, outcomes, and utilization
Saint Francis Care	<ul style="list-style-type: none"> ▪ Market share: 8% of 2011 total discharges ▪ Hospitals: 2 hospitals: Mount Sinai Rehabilitation Hospital, Saint Francis Hospital 	<ul style="list-style-type: none"> ▪ Accountable care organizations: Saint Francis Hospital and Saint Francis HealthCare Partners have been collaborating on the development of an ACO. A Steering Committee and 7 subcommittees have been established. ▪ Medical home: Connecticut Institute for Primary Care Innovation, a partnership between the University of Connecticut and Saint Francis, is aimed at educating medical students on the implementation of PCMHs
Western Connecticut Health Network	<ul style="list-style-type: none"> ▪ Market Share: 6% of 2011 total discharges ▪ Hospitals: 2 hospitals: New Milford Hospital, Danbury Hospital ▪ Physician groups: Western CT Health Network (>100 physicians) 	<ul style="list-style-type: none"> ▪ Facilities: Biomedical Research Institute in Danbury ▪ Expansion plans: Construction continued on a new patient tower, which will include more single-patient rooms, an expanded ER, a neonatal ICU in 2012. The project is expected to be complete in 2014.

SOURCE: Press search, HealthLeaders InterStudy: South Connecticut, Hartford.

The 4 largest health systems accounting for ~50% of hospital discharges

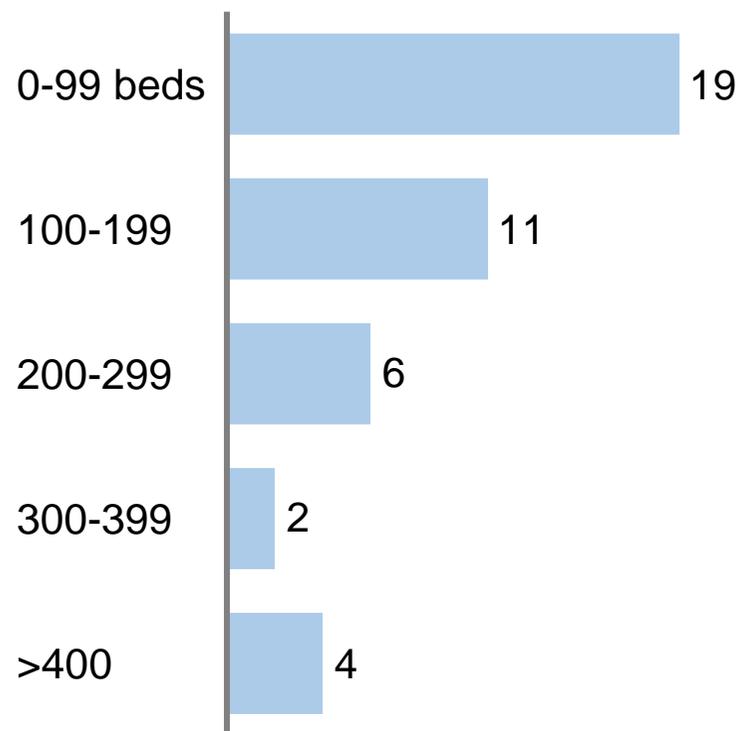
Health system market share

Percent of discharges, 100% = ~395K discharges, 2011



Connecticut hospitals by bed size

Number of hospitals, 2011



Connecticut Physician Workforce Profile

2	State Population:	3,526,937	Total Female Physicians:	3,707
0	Total Active Physicians:	11,678	Total Medical or Osteopathic Students:	882
1	Primary Care Physicians:	3,725	Total Residents:	2,106
0				

For additional data, including maps and tables, please see the AAMC 2011 State Physician Data Book online at <https://www.aamc.org/download/263512/data/statedata2011.pdf>

		CT	CT rank	State median
Undergraduate Medical Education (UME)	Active Physicians per 100,000 Population, 2010	331.1	5	244.2
	Total Active Patient Care Physicians per 100,000 Population, 2010	273.0	4	215.1
	Active Primary Care Physicians per 100,000 Population, 2010	105.6	9	91.0
	Active Patient Care Primary Care Physicians per 100,000 Population, 2010	89.9	12	80.4
	Percent Active Female Physicians, 2010	31.8%	15	29.3%
	Percent of Active Physicians who are International Medical Graduates, 2010	27.5%	8	17.8%
	Percentage of Active Physicians Who Are Age 60 or Older, 2010	27.3%	13	25.2%
Graduate Medical Education (GME)	Students Enrolled in Medical or Osteopathic School per 100,000 Population, AY 2010-2011	25.0	28	27.9
	Students Enrolled in Public Medical or Osteopathic Schools per 100,000 Population, AY 2010-2011	10.8	35	19.7
	Percent Change in Students Enrolled in Medical or Osteopathic Schools (2000-2010)	5.3%	41	15.9%
	Percent of Medical School Matriculants from In-State, AY 2010-2011	32.9%	42	67.1%
Retention	Total Residents/Fellows in ACGME Programs per 100,000 Population as of December 1, 2010	59.7	4	26.2
	Total Residents/Fellows in Primary Care ACGME Programs per 100,000 Population as of Dec. 1, 2010	24.1	4	10.2
	Percentage of International Medical Graduates in ACGME Programs as of December 1, 2010	40.1%	6	23.1%
	Ratio of Residents and Fellows (GME) to Medical and Osteopathic Students (UME), AY 2009-2010	2.3	1	1.1
	Percent Change in Residents and Fellows in ACGME-Accredited Programs, 2000-2010	21.1%	20	18.6%
Physician Supply	Percent of Physicians Retained in State from Undergraduate Medical Education, 2010	18.6%	41	39.2%
	Percent of Physicians Retained in State from Undergraduate Medical Education (Public), 2010	32.0%	37	45.5%
	Percent of Physicians Retained in State from Graduate Medical Education, 2010	35.1%	45	45.7%
	Percent of Physicians Retained in State from UME and GME Combined, 2010	50.6%	42	67.4%

State Rank: How a particular state ranks compared to the other 49. Rank of 1 goes to the state with the highest value for the particular category.

State Median: The value directly in the middle of the 50 states, so 25 are above the median and 25 are below and excludes the District of Columbia.

Connecticut's commercial population is concentrated and mostly covered by WellPoint, Aetna, UnitedHealth, and Cigna

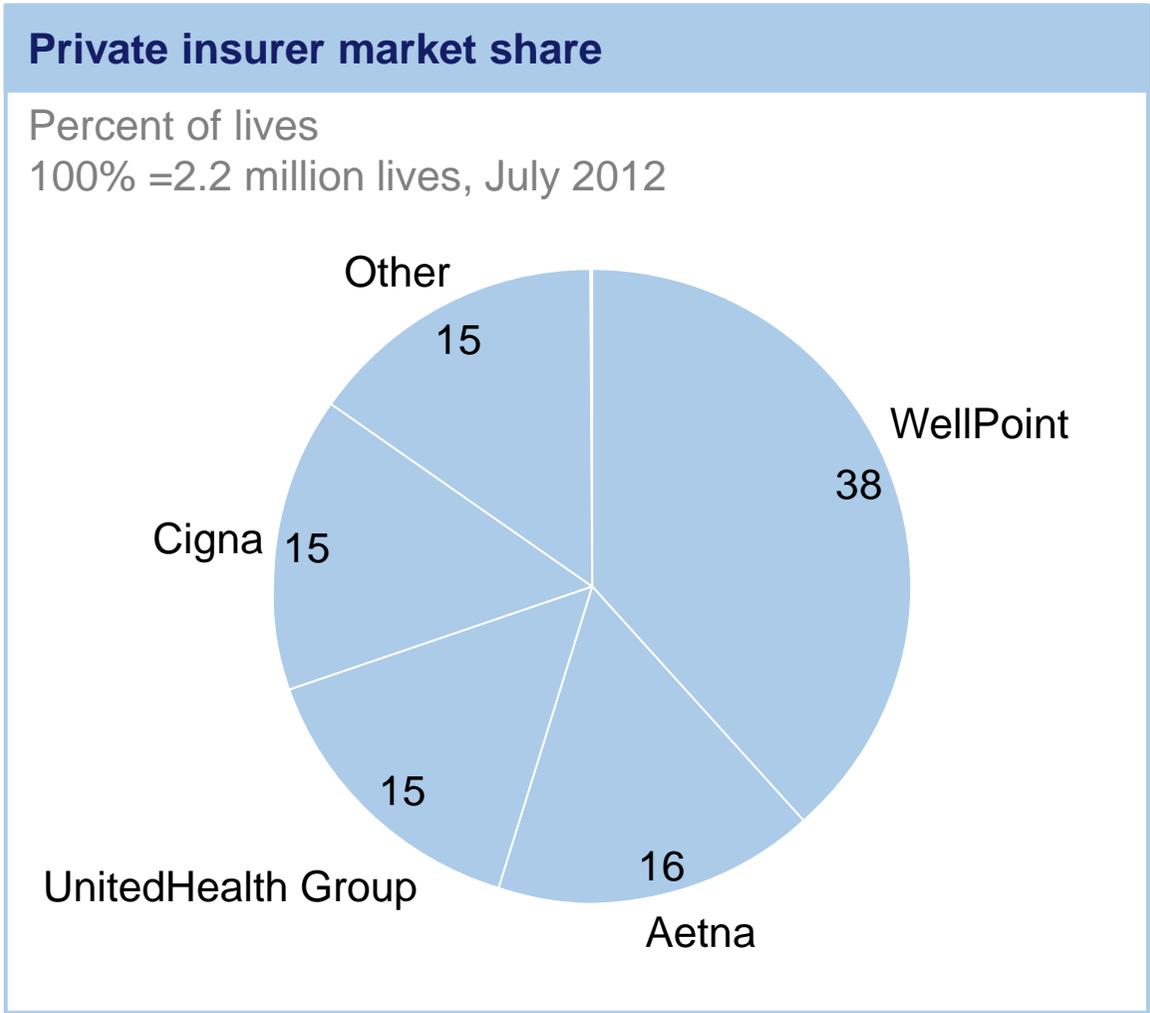


Table of contents

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Payment model work group charter

Payment work group charter

Mandate

The payment work group will develop for recommendation to the State Health Care Innovation Plan steering committee a proposal on the design and plan for implementing a payment model that promotes value (i.e., the improvement of leading health indicators and delivery of quality outcomes and services relative to total cost); supports a person-centered care delivery model that integrates primary care, preventive care, specialty care, public health, and behavior health; enables the capture of prioritized sources of value within the target population; and ultimately holds providers accountable for total cost of care. This work group will assess key options for design of the payment model and propose to the SHIP

Key questions for work group recommendation

- 1 What is the scope of accountability around on payment to be based?
- 2 What are the target sources of value to promote under the new care delivery and payment models within the target populations?
- 3 Which individuals will be held accountable, and what is the scope of their accountability?
- 4 What metrics will be used for eligibility for participation, eligibility for payment, and level of payment?
- 5 What is the reward structure?
- 6 At what level will performance be aggregated for rewards?
- 7 How do we define the level of performance we wish to reward?
- 8 What will be the member attribution methodology?
- 9 What exclusions and adjustments will be applied for fairness and consistency?
- 10 What will be the pace of roll-out of the new payment model throughout the state?
- 11 At what pace should participating providers progress to end-state payment model
- 12 What are the targets, pricing, risk corridors?

Key milestones

Date (week of)	Milestone
June 3	<ul style="list-style-type: none"> ▪ Alignment on hypothesis leading payment model option
July 1	<ul style="list-style-type: none"> ▪ Agreement on design parameters of leading option, metrics to measure performance and reimburse providers under new care delivery and payment model
July 15	<ul style="list-style-type: none"> ▪ Proposal on plan for implementing leading option; method to track key quality metrics

Interdependencies

- Care delivery work group: Types of providers to include in new payment model, target behaviors of providers and consumers to enable under new payment model, metrics required to measure desired behaviors
- Health Information Technology work group: Key metrics that will be tracked under the new payment model, types of data and information required to support the new payment model, types of linkages across data required to support the new payment model, method to track key metrics