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Connecticut SIM: Payment model work group meeting #2 reference materials

Reference materials
June 3, 2013

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Strategic payment model decisions

Provider landscape context

Detail on current Connecticut and national innovation efforts

We aligned on a set of key questions that will be answered in the work group's final recommendation (1 of 2)

Today's topics of discussion

Strategic design considerations

Illustrative examples of options

1 Metrics

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ What will be the scope of accountability for cost and quality? ▪ What are the sources of value we hope to promote with the payment model? | <ul style="list-style-type: none"> ▪ Population health, episodes of care, discrete encounters ▪ Effective diagnosis and treatment, selection of provider and care setting, chronic disease management |
| <ul style="list-style-type: none"> ▪ What metrics will be used for eligibility for participation and eligibility for payment? | <ul style="list-style-type: none"> ▪ Structure (e.g., EMR adoption), processes (e.g., create a care plan), outcomes (e.g., lower costs, complications) |

2 Payment

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ What is the reward structure? | <ul style="list-style-type: none"> ▪ Global payment, gain/risk sharing, P4P, conditional care coordination fees, conditional FFS enhancements |
| <ul style="list-style-type: none"> ▪ How do we define the level of performance we wish to reward? ▪ How will consumers be incented? | <ul style="list-style-type: none"> ▪ Absolute, relative, improvement |
| <ul style="list-style-type: none"> ▪ What are the targets, pricing, and risk corridors? | <ul style="list-style-type: none"> ▪ Top down (e.g., state programs) or bottoms-up (e.g., at employer level) ▪ Quality targets, care coordination fees and/or bonus payment amount, benchmark trend, minimum savings, risk sharing splits, stop loss, gain sharing limits |

Across each of these design decisions, how important is it for state and commercial payers to be aligned?

We aligned on a set of key questions that will be answered in the work group's final recommendation (2 of 2)

Today's topics of discussion

Strategic design considerations

Illustrative examples of options

3 Attribution

- What will be the rule for attribution?
 - At what level will performance be aggregated for measurement and rewards?
 - What exclusions and adjustments will be applied for fairness and consistency?
- Prospective member selection, plan auto-assignment, retrospective attribution
 - By physician, practice, virtual pod, or ACO/joint venture
 - Risk adjustment and/or exclusions by: beneficiary, clinical, outlier, provider-option, and/or actuarial minimums

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 type for participating providers be phased in?
 - How will payers and providers be enabled to adopt the new payment model?
- Mandatory and universal, staged by geography or other criteria, voluntary
 - Baseline reporting period, transitional payment model (e.g., P4P), direct to end state (e.g., risk sharing)
 - Up-front investment, in-kind support, PMPM fees

Across each of these design decisions, how important is it for state and commercial payers to be aligned?

Reward structure and payment type definitions

Definition

Global payment system

- 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

- 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

- 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

- 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

- 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

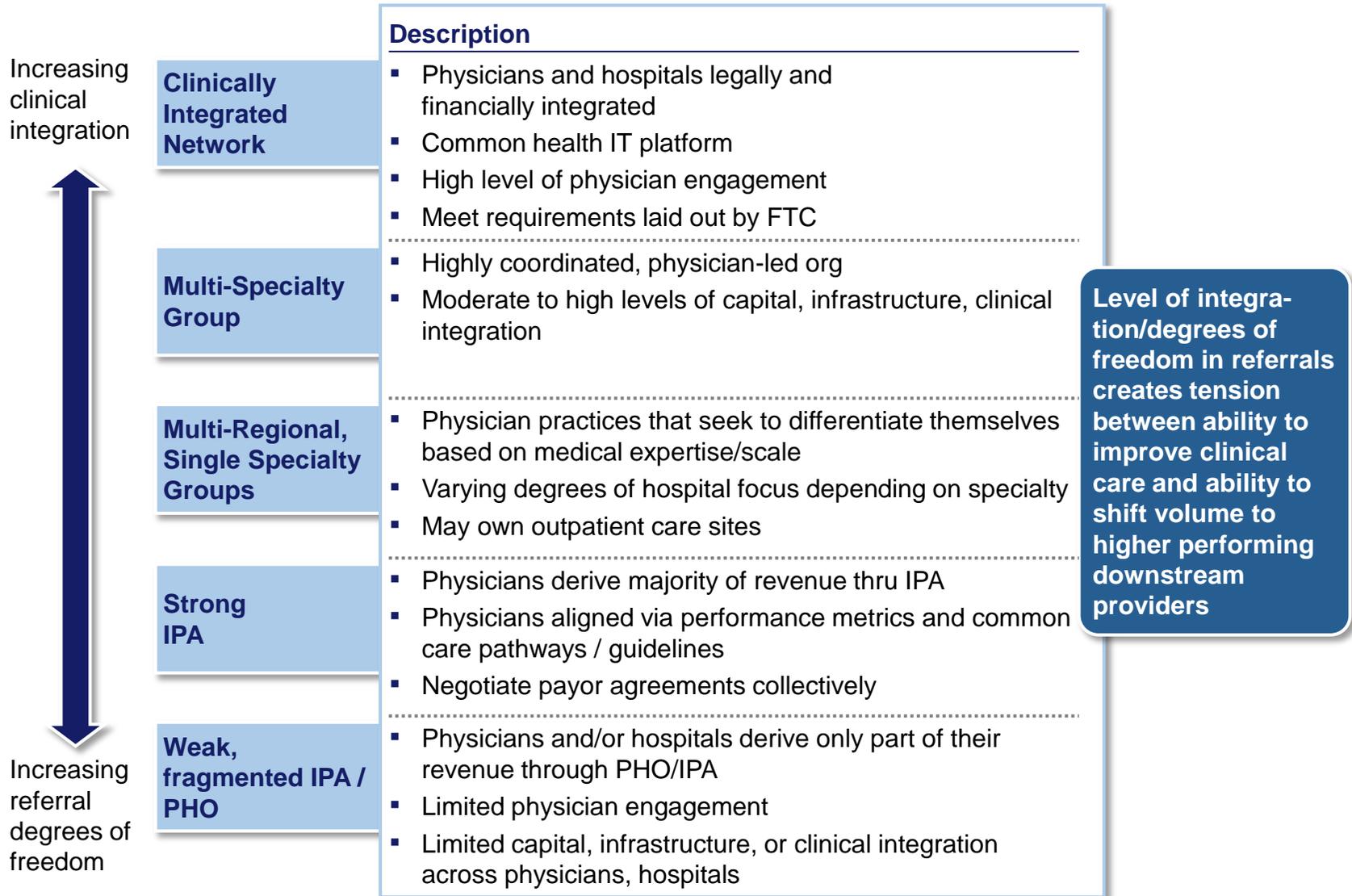
Care management fee

- 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

- 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

Clinical integration (1/2)



Elements of clinical integration

Common patient population

Aligned financial incentives

Common governance

Health information exchange

Shared clinical pathways

Common care coordination

**Levels of integration**

Common legal entity

Joint venture

Co-investment

Employment agreement

Vendor contract

Credentialing/ privileging relationship

Informal relationship

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

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Strategic payment model decisions and definitions

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Detail on current Connecticut and national innovation efforts

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%
Graduate Medical Education (GME)	Percentage of Active Physicians Who Are Age 60 or Older, 2010	27.3%	13	25.2%
	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%
Retention	Percent of Medical School Matriculants from In-State, AY 2010-2011	32.9%	42	67.1%
	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
Physician Supply	Percent Change in Residents and Fellows in ACGME-Accredited Programs, 2000-2010	21.1%	20	18.6%
	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.

Health systems overview

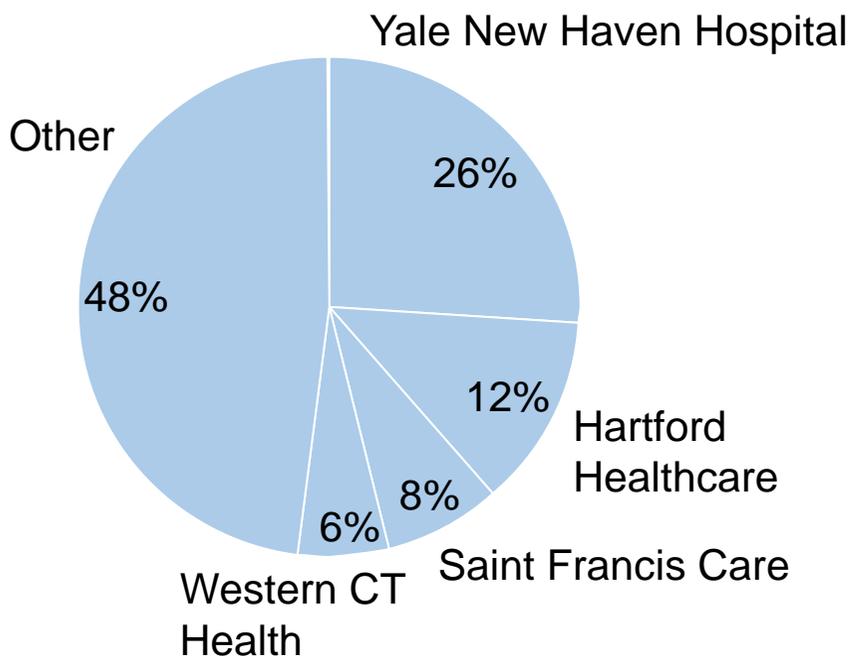
	State presence	Details and recent news
Yale New Haven Health System	<ul style="list-style-type: none"> ▪ Market share: 26% of 2011 total discharges ▪ Hospitals: 4 hospitals: Greenwich Hospital, Bridgeport Hospital, Yale-New Haven Hospital Saint Raphael Campus, Yale-New Haven Hospital ▪ Physician groups: 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 account 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

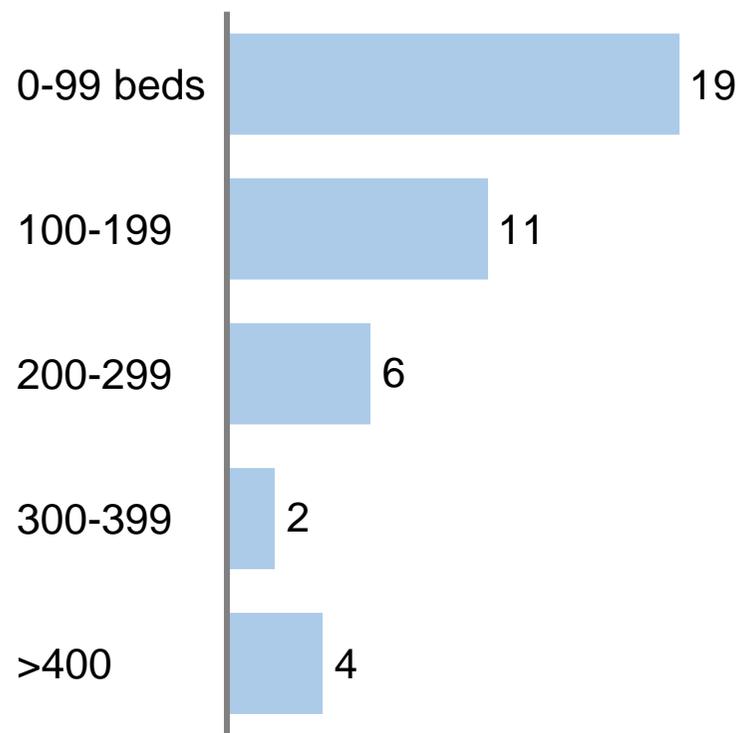


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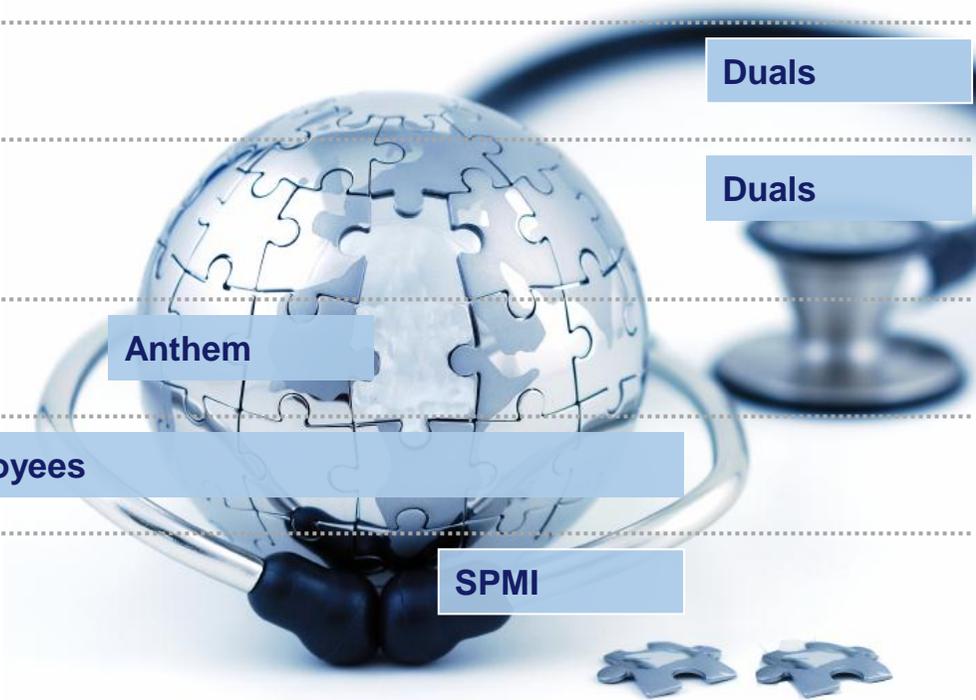
Strategic payment model decisions and definitions

Provider landscape context

Detail on current Connecticut and national innovation efforts

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

CMMI has developed several population-based payment and delivery models

Comprehensive Primary Care Initiative (CPCI)

- Multi-payer patient centered medical home model
- Includes care coordination PMPM payments, shared savings, transformation support
- Pilot launched in fall of 2012 in 7 markets, covering ~500 primary care practices

Medicare Shared Savings Program (MSSP)

- Permanent program for Medicare, created as part of the Affordable Care Act
- Shared savings opportunity for ACOs (1 or 2-sided risk options for first 2 years)
- 220 ACOs signed up from April 2012 to Jan 2013

Pioneer ACO

- CMMI demonstration project for Medicare, for organizations with previous experience with ACO-like models
- Higher level of risk/gain sharing than in MSSP, with transition from FFS to partial population-based payments in 3rd year
- 32 organizations participating in 3-5 year program

Advance Payments ACO

- CMMI program for smaller / rural ACOs with less access to capital who are participating in MSSP
- Provides upfront and monthly payments to fund costs of forming an ACO, to be later re-couped from savings
- 35 ACOs signed up from April 2012 to Jan 2013

FQHC Advanced Primary Practice Demonstration

- CMS demonstration project for FQHCs to become PCMHs (level 3 NCQA)
- Provides monthly care management fee
- 492 FQHCs participating in 3 yr program, launched Nov 2011

Population health model program details: payment (1/2)

	Comprehensive Primary Care Initiative (CPCI)	Medicare Shared Savings Program (MSSP)
Care coordination fees	<ul style="list-style-type: none"> Risk-adjusted prospective PMPM 	<ul style="list-style-type: none"> None
Timing of transition	<ul style="list-style-type: none"> After year 2 have option to participate in shared savings of total Medicare savings in market 	<ul style="list-style-type: none"> Yr1: Pay for reporting, Yr2-3: Pay for performance; Yr 1 -2 upside only, Yr3 upside + downside
% gain sharing	<ul style="list-style-type: none"> TBD; expected to be similar to MSSP for Medicare 	<ul style="list-style-type: none"> Varies depends on ACO patient population + quality metrics. Must achieve MSR.
Benchmark for shared savings	<ul style="list-style-type: none"> TBD; expected to be similar to MSSP for Medicare 	<ul style="list-style-type: none"> National, risk-adjusted benchmark of per capita Part A and B expenditures of 3 prior years
Unit for shared savings	<ul style="list-style-type: none"> Market level 	<ul style="list-style-type: none"> Practice level
Risk adjustment	<ul style="list-style-type: none"> Medicare: FFS – HCC methodology Medicaid/commercial define own 	<ul style="list-style-type: none"> Benchmark is determined on comparable population
Stop loss	<ul style="list-style-type: none"> Upside only 	<ul style="list-style-type: none"> 5-10% phased in over 3 years

Population health model program details: payment (2/2)

	Pioneer ACO	Advance Payments ACO	FQHC Advanced Primary Practice Demonstration
Care coordination fees	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Upfront fixed payment Upfront variable payment Ongoing PMPM fee 	<ul style="list-style-type: none"> Ongoing PMPM fee
Timing of transition	<ul style="list-style-type: none"> 1st 2 years have varying levels of shared-savings. Year 3 move to population-based prospective PMPM that replaces FFS 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> None
% gain sharing	<ul style="list-style-type: none"> 60% Yr1, 70% Yr2, 50% Yr3 but population-based 	<ul style="list-style-type: none"> Participate in MSSP for shared savings 	<ul style="list-style-type: none"> None
Benchmark for shared savings	<ul style="list-style-type: none"> 3 year national expenditure for comparable Medicare beneficiaries adjusted for ACO's eligibility, age and sex. Updated annually 		<ul style="list-style-type: none"> None
Unit for shared savings	<ul style="list-style-type: none"> Practice level 		<ul style="list-style-type: none"> None
Risk adjustment	<ul style="list-style-type: none"> Benchmark is determined on comparable population 		<ul style="list-style-type: none"> None
Stop loss	<ul style="list-style-type: none"> 10%-15% depending on year 		<ul style="list-style-type: none"> None

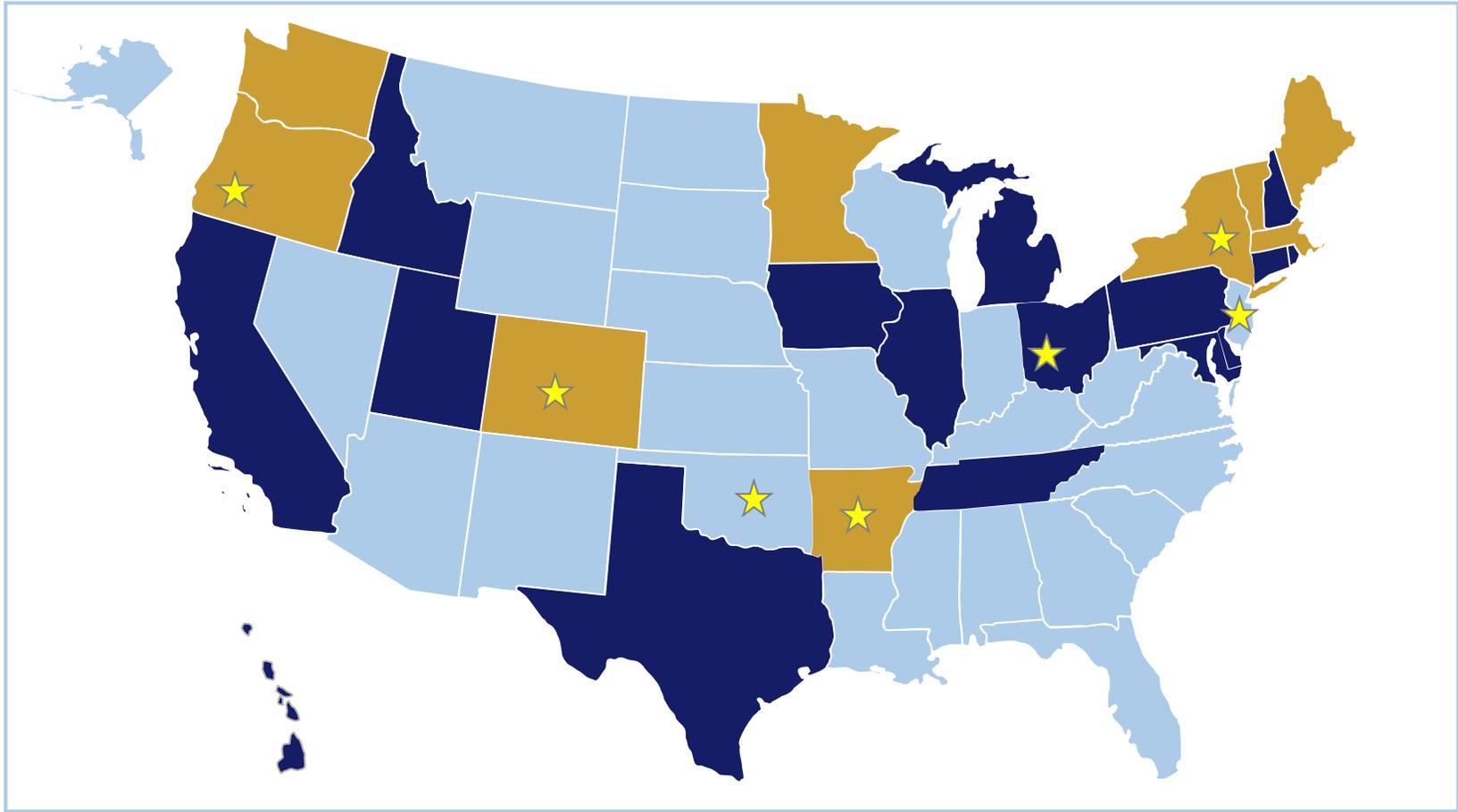
Population health model program details: design (1/2)

	CPCI	Medicare Shared Savings Program (MSSP)
Practice pre-requisites	<ul style="list-style-type: none"> Use of health information technology Ability to demonstrate recognition of advanced primary care delivery by accreditation bodies Service to patients covered by participating payers Participation in practice transformation and improvement activities 60% of revenue tied to participating payers Minimum of 200 non-institutionalized Medicare beneficiaries eligible for Part A and enrolled in Part B Use EHR 	<ul style="list-style-type: none"> 5,000 Medicare FFS beneficiaries 50% of PCPs must be meaningful users of EMR
Metrics to continue participation	<ul style="list-style-type: none"> Meeting set of specified milestones to build capacity and infrastructure Access not being compromised 	<ul style="list-style-type: none"> Must meet quality performance standards Must not cherry-pick healthy individuals
Quality metrics	<ul style="list-style-type: none"> Patient experience Care coordination Preventative Health At-risk population mgmt 	<ul style="list-style-type: none"> Patient/Care Giver experience Care coordination Patient safety Preventative health At-risk populations
Transparency	<ul style="list-style-type: none"> Practices provide with own cost, quality and utilization data + community level utilization and cost data 	<ul style="list-style-type: none"> Practices get de-identified data that is used to determine benchmarks Practices gets aggregated performance reports quarterly
Attribution model	<ul style="list-style-type: none"> CMS lookback model (18 months, based on claims and most use) Private payers can choose own methodology 	<ul style="list-style-type: none"> ACO that has highest amount of allowed charges for patient's primary care services

Population health model program details: design (2/2)

	ACO – Pioneer Model	FQHC Advanced Primary Practice Demonstration	ACO – Advance Payments
Practice pre-requisites	<ul style="list-style-type: none"> ACO or FQHC 50% of providers meet meaningful use of EMRs 15,000 aligned beneficiaries (5,000 if in rural area) per ACO Enter into contracts with other payers so that 50% of revenue comes from such arrangements 	<ul style="list-style-type: none"> 200 Medicare FFS beneficiaries in 12 month look back period (including duals) Accept Joint Principles or PCHM 	<ul style="list-style-type: none"> Must be accepted into shared savings program Either have no inpatient facilities + <\$50M in total annual revenue Or inpatient facilities are critical access hospitals/low-volume rural hospitals + <\$80M in total annual revenue
Metrics to continue participation	<ul style="list-style-type: none"> Utilization not being compromised 	<ul style="list-style-type: none"> Readiness evaluation every 6 months (compared to practice’s baseline readiness evaluation) 	<ul style="list-style-type: none"> Unspecified - likely same as Medicare shared savings
Quality metrics	<ul style="list-style-type: none"> Patient experience Care coordination Preventative Health At-risk population mgmt (Same as MSSP) 	<ul style="list-style-type: none"> NCHQ Survey Tool to assess practice readiness (goal for each practice is to reach Level 3 recognition by year 3) 	<ul style="list-style-type: none"> Unspecified - likely same as Medicare shared savings
Transparency	<ul style="list-style-type: none"> ACO performance against quality metrics publicly stated on website 	<ul style="list-style-type: none"> Practice specific claims-based cost + utilization reports that show progress + how practice compares to other participating practices 	<ul style="list-style-type: none"> Unspecified - likely same as Medicare shared savings
Attribution model	<ul style="list-style-type: none"> ACO sends list of providers to CMS and CMS attributes beneficiaries. ACO tells provider prospectively list of beneficiaries 	<ul style="list-style-type: none"> Based on Medicare claims data in last 12 months 	<ul style="list-style-type: none"> Unspecified - likely same as Medicare shared savings

16 states were awarded Model Design grants and 6 received testing grants (3 pre-testing)



1 Comprehensive Primary Care Initiative

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