



Connecticut SIM: Payment model reference materials

Updated for workgroup #3
June 17, 2013

Agenda

Review of progress to date

Breakout materials

Background: Reward structure

Background: Quality measurement

Welcome to the third SIM design payment model work group

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VISION

The SHIP has outlined a vision for care delivery and payment innovation in Connecticut

Establish a whole-person-centered health care system that promotes value over volume, eliminates health inequities for all of Connecticut, and improves affordability

- Understanding and consideration of the needs of a whole-person that impact health
- Integration of primary care, behavioral health, population health, consumer engagement, oral health, and community support
- Shared accountability for total cost that controls the cost of health care and ensures quality health care
- Increased access to the right care in the right setting at the right time
- Migration to workforce and HIT capabilities that promote workforce efficacy and support the goals of the new care delivery and payment models
- Supported by Medicaid, Medicare, and private health plans alike

CARE DELIVERY

At its last meeting, the care delivery work group defined a set of interventions mapped to the six components of a population health model

	Description
1 Whole-person-centered care and population health mgmt	<ul style="list-style-type: none"> Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health Assess and document consumer risk factors to stratify consumer population and identify high-risk consumers for early interventions
2 Enhanced access to care (structural and cultural)	<ul style="list-style-type: none"> Provide consumers access to culturally and linguistically appropriate routine/urgent care and clinical and mental health advice during and after office hours Provide care to consumers that is accessible in-person or remotely (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services) Improve financially accessibility of care (e.g., minimal co-pays)¹
3 Team-based, coordinated, comprehensive care	<ul style="list-style-type: none"> Leverage multi-disciplinary teams and enhanced data sharing to improve care planning, diagnosis, treatment, and consumer coaching Ensure consumer adherence to care plan and successful care transitions across care settings and care disciplines (e.g., medical, social, behavioral)
4 Consumer engagement ²	<ul style="list-style-type: none"> Appropriately educate and encourage consumers to engage in healthy behaviors and reduce risky behaviors Encourage consumers to partner with the provider to follow-through on care plans, and administer self-care as needed
5 Evidence-informed clinical decision making	<ul style="list-style-type: none"> Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness
6 Performance management	<ul style="list-style-type: none"> Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care Use performance and consumer experience data to identify opportunities to improve and compare performance with other providers

POSTER

BREAKOUT GROUP: Whole person centered care and population health management – interventions

1
Whole-person-centered care and population health management

- Understand the **whole-person context**, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer's health
- Assess and document consumer risk factors to identify **high risk consumers**

Behaviors/processes

- The practice identifies consumers with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
- The practice identifies vulnerable consumer populations
- The practice assesses and documents consumer risk factors
- The practice assesses consumer/family self-management abilities
- The practice assesses and provides or arranges for mental health/substance abuse treatment
- The practice gives referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups
- The practice uses strategies to address stresses that arise in the workplace, home, school etc.

Structures

- The practice has the capability to collect demographic and clinical data for population management

SOURCE: AAHC, ACA, CT Public Health Committee, Joint Commission, NCQA, URAC

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Detailed Care Delivery work group materials are posted on the CT SIM website:
<http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2742&q=334902>

1 Specific interventions to improve financially accessibility will be determined on a payer by payer basis

2 Specific consumer-incentives will be a payer-specific decision to be defined by each participating payer for their population

SOURCE: AAHC, NCQA, Joint Commission, URAC, Agency for Healthcare Research and Quality, Arkansas design grant, team analysis

At its last meeting, the HIT work group discussed how to prioritize HIT capabilities that would enable a population health model

Need to focus on 'must-have' HIT capabilities

Care delivery and payment group inputs will drive prioritization

Leveraging existing assets is particularly relevant for CT

CT HIT design while pragmatic should still seek to be distinctive

Takeaways

- The needs of a population health model continue to evolve and no two implementations are identical
- Resource and time constraints demand a **pragmatic** approach to HIT design that incorporates foundational elements while retaining the **flexibility** to serve stakeholders at different points on the technology adoption curve
- The care delivery work group is highlighting **interventions** that will enable a **whole-person** centered population health model in Connecticut
- The payment work group is prescribing quality measurements (**metrics**) that will be used to hold providers **accountable** in such a care delivery model
- Connecticut has already initiated HIT efforts to better facilitate the exchange of claims and clinical data (**APCD** and **HITE-CT**)
- **DMHAS** is already managing a system of care for behavioral health populations that includes some advanced HIT infrastructure components
- There are aspects of HIT infrastructure design where CT could seek to be **distinctive**
 - Make consumer engagement a foundational element of HIT design
 - Pursue early and effective integration of claims and clinical data
 - In defining the role the state could play in capability building, the current as well as future needs of stakeholders should be considered

We discussed during the last meeting a set of principles that will guide our payment design decisions...

Guiding principles for payment reform

- Variation in payment model should be based on the needs of the whole-person, and not the needs of the health system
- Payment model should complement and enable the care delivery model
- Providers should be rewarded for effective behaviors (quality and cost)
- If successful, providers will be held accountable for elements within the scope of provider control
- Payment model must be financially sustainable
- Payment model should help improve – not detract from – consumer access and health equity
- The payment model should leverage and be complementary to ongoing initiatives in Connecticut
- Payment model should be aligned across payers

...and 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?

...and 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

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ 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? | <ul style="list-style-type: none"> ▪ 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

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ 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? | <ul style="list-style-type: none"> ▪ 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?

NEXT STEPS

We have revised our targets for our remaining two meetings to address the remaining strategic design considerations

MODIFIED TO REFLECT JUNE 3 WORK GROUP DISCUSSION

Workshop title	Description
May 20: Overview and guiding principles	<ul style="list-style-type: none">▪ Review vision for care delivery and payment innovation▪ Align on guiding principles for payment innovation▪ Understand scope of payment model options and design parameters▪ Discuss strategic payment model design considerations
June 3: Strategic payment model design decisions	<ul style="list-style-type: none">▪ Review synthesis of strategic payment model design decisions▪ Discuss data around industry/ provider landscape (e.g., fragmentation)
June 17: Reward structure and metrics	<ul style="list-style-type: none">▪ Align on aspirational reward structure and timeframe for provider transition▪ Discuss how providers will be supported to participate in care delivery and payment model▪ Discuss structures, processes, outcomes, care experience and/or cost/resource use metrics to measure under new payment model (e.g., metrics)▪ Align on metrics and plan for staging accountability for metrics
July 1: Approach to member attribution and risk management	<ul style="list-style-type: none">▪ Discuss changes/ adjustments required to balance metrics across domain types▪ Discuss member attribution and implications on patient panel sizes▪ Understand rationale for using different tools to mitigate volatility (MSRs, virtual pooling, accruals, joint venture, etc.)
July 15: Operationalizing the payment model	<ul style="list-style-type: none">▪ Align on payment implementation plan with phasing, including plan to support provider transition▪ Develop communication plan vis-à-vis providers

Agenda

Review of progress to date

Breakout materials

Background: Reward structure

Background: Quality measurement

BREAKOUT GROUP 1: Consider metrics to promote interventions to improve whole-person-centered care and population health management

ILLUSTRATIVE

<p>1 Whole-person-centered care and population health management</p>	<ul style="list-style-type: none"> Understand the whole-person context, i.e. the full set of medical, social, behavioral, cultural, and socioeconomic factors that contribute to a consumer’s health Assess and document consumer risk factors to identify high risk consumers
<p>Interventions identified by care delivery work group</p> <ul style="list-style-type: none"> Identify consumers with high-risk or complex care needs Identify consumers with conditions related to health behaviors, mental health or substance abuse problems Identify socially vulnerable consumer populations (e.g., childhood exposure to trauma)¹ Assess and document consumer risk factors and health literacy levels¹ Assess consumer/family self-management abilities¹ Assess oral health needs 	<p>CMMI core measures and additional metrics</p> <p>Structure</p> <p>Process</p> <ul style="list-style-type: none"> Screening for clinical depression Follow-up hospitalization after mental illness Initiation and engagement of alcohol and other drug dependence treatment Tobacco use assessment and tobacco cessation intervention <p>Outcome</p> <ul style="list-style-type: none"> CARE Tool CARE-F and CARE-C assessment tools for nursing facilities, day rehabilitation programs, and other ambulatory settings in the community <p>Care experience</p> <ul style="list-style-type: none"> CAHPS surveys <p>Cost/ resource use</p>

¹ Can be outsourced but needs to be performed at point of care

BREAKOUT GROUP 2: Consider metrics to track interventions to enhance access to care (structural and cultural)

ILLUSTRATIVE

2 Enhanced access to care (structural and cultural)

- Provide consumers access to culturally and linguistically appropriate routine/ urgent care and clinical and mental health advice during and after office hours
- Care should be accessible in-person or remotely (e.g. clinic visits, telephonic follow-up, video-conferencing, email, website, community/ home-based services)

Interventions identified by care delivery work group

- Provide access to culturally (e.g., bilingual clinicians), socially (e.g., in neighborhoods where patients have personal connections) and linguistically appropriate care near consumer populations (e.g., geographic proximity)
- Offer extended hours access to routine and urgent care and clinical advice (e.g., evenings and weekends)
- Communicate with consumers across multiple modes (e.g., email, text, to ensure all have access to information)
- Enhance access to specialty care via non-visit-based access to specialist services (e.g., e-consult)
- Ensure human contact throughout the care journey (e.g., someone at office answers phone, knows patient)
- Provide information on where consumers should go for different care needs and on which physician offices are open at different times

CMMI core measures and additional metrics

- Structure**
- Process**
- Proportion of Days covered: 5 rates by therapeutic category
 - Well-child visits in first 15 months of life
 - Well-child visits in the 3rd, 4th, 5th, and 6th years of life
- Outcome**
- Care experience**
- Cost/ resource use**
- Hospital ED visit rate that did not result in hospital admission, by condition

BREAKOUT GROUP 3: Consider metrics to track interventions to improve team-based, coordinated, comprehensive care

ILLUSTRATIVE

3 Team-based, coordinated, comprehensive care

- Leverage multi-disciplinary teams and enhanced data sharing to improve care planning, diagnosis, treatment, and consumer coaching
- Ensure consumer adherence to care plan and successful care transitions across care settings and care disciplines (e.g., medical, social, behavioral)

Interventions identified by care delivery work group

- Provide team-based care from trained staff
- Embed care coordinator in practice
- Closely integrate behavioral and primary care with “warm hand offs” between behavioral and primary care practitioners (on-site if possible)
- Coordinate care including preventive, oral, behavioral, and complementary providers and services
- Emphasize pre-visit planning, assess consumer progress toward treatment goals, and address consumer barriers
- Use intensive case management across time and care settings
- Track, follow-up on and coordinate tests, referrals and care at other facilities (e.g., support hospital discharge planning)¹
- Reconcile consumer medications at visits and post-hospitalization
- Ensure consumer compliance with medications
- Deliver care at sites of intervention conducive to consumers’ environment (e.g., community centers) to be most effective
- Leverage peer support for consumers with chronic conditions or behavioral health issues
- Engage/coordinate with nonmedical services (e.g., housing), domestic violence resources) and other support groups as appropriate (collaboratives where available)

CMMI core measures and additional metrics

- Structure**
- Ability for providers with HIT to receive laboratory data electronically
- Process**
- Post-discharge continuing care plan created
 - Post-discharge continuing plan transmitted to next level of care provider upon discharge
 - Follow-up after hospitalization for mental illness
 - 3–item care transition measure
 - Care transition record transmitted to health care professional
 - Transition record with specified elements received by discharged patients
 - Medication reconciliation
- Outcome**
- CARE Tool
 - Care-F and CARE-C Tools
- Care experience**
- Cost/ resource use**

¹ Ensure provider accountable for this

BREAKOUT GROUP 1: Consider metrics to track interventions to improve consumer engagement

ILLUSTRATIVE

4 Consumer engagement

- Appropriately educate and encourage consumers to engage in healthy behaviors and reduce risky behaviors
- Encourage consumers to partner with the provider to follow-through on care plans, and administer self-care as needed

Interventions identified by care delivery work group

- Work with and support consumers/families in developing a self-care plan and provide tools and resources, including community resources
- Counsel consumers on healthy behaviors (e.g., exercise, nutrition), targeting windows of change
- Institute shared decision-making with consumers
- Communicate at literacy level appropriate for consumers
- Advise consumers with chronic health conditions on methods to monitor and manage their own conditions
- Ensure consumers/caregivers are educated and actively engaged in their rights, roles and responsibilities
- Establish mechanism to engage consumers/care givers and potentially partner with community groups
- Provide consumers immediate, electronic access to their health care information
- Provide consumers transparent cost and quality data
- Host community group sessions (e.g., by disease type)

CMMI core measures and additional metrics

Structure

Process

- Transition record with specified elements received by discharged patients

Outcome

- CARE-F and CARE-C Tool

Care experience

- CAHPS survey
- Family evaluation of hospice

Cost/ resource use

BREAKOUT GROUP 2: Consider metrics to track interventions to encourage evidence-informed clinical decision making

ILLUSTRATIVE

5 Evidence-informed clinical decision making

- Make decisions on clinical care that reflect an in-depth, up-to-date understanding of evidenced-based care reflecting clinical outcomes and cost-effectiveness

Listed by accreditation or legislative bodies

- Adhere to professionally accepted standards of practice, manufacturer’s recommendations, and state and federal guidelines
- Use e-prescribing to ensure medication orders are clear and accurate
- Demonstrate utilization of PCORI (Patient-Centered Outcomes Research Institute) data
- Use patient risk stratifiers to enable targeted effort based on evidence
- Leverage ADT (Admission, Discharge & Transfer) to optimize patient care workflow
- Update discharge medication lists and reconcile
- Use multi-layer, diverse team to enable data synthesis and reconciliation
- Use electronic medical record (EMR) which collects actionable data
- Maintain disease registry

CMMI core measures and additional metrics

Structure

- Adoption of medication e-prescribing
- Adoption of HIT
- Ability for providers with HIT to receive laboratory data electronically

Process

- Preventive process measures (e.g., adult weight screening, childhood immunization status)
- Clinical care measures (e.g., chronic disease testing and care, mental health)
- Medication reconciliation

Outcome

- Mortality, morbidity, functional health status change and patient safety outcomes metrics

Care experience

Cost/ resource use

- Admission statistics by chronic condition (e.g., COPD)

BREAKOUT GROUP 3: Consider metrics to track interventions to improve performance management

ILLUSTRATIVE

6 Performance management

- Collect, integrate, and disseminate data for care management and performance reporting on cost and quality effectiveness of care
- Use performance and consumer experience data to identify opportunities to improve and compare performance with other providers

Listed by accreditation or legislative bodies

- Adhere to professionally accepted standards of practice, manufacturer’s recommendations, and state and federal guidelines
- Use e-prescribing to ensure medication orders are clear and accurate
- Demonstrate utilization of PCORI (Patient-Centered Outcomes Research Institute) data
- Use patient risk stratifiers to enable targeted effort based on evidence
- Leverage ADT (Admission, Discharge & Transfer) to optimize patient care workflow
- Update discharge medication lists and reconcile
- Use multi-layer, diverse team to enable data synthesis and reconciliation
- Use electronic medical record (EMR) which collects actionable data
- Maintain disease registry

CMMI core measures and additional metrics

- Structure**
- Adoption of medication e-prescribing
 - Adoption of HIT
 - Ability for providers with HIT to receive laboratory data electronically
- Process**
- Outcome**
- Care experience**
- CAHPS surveys
 - Family evaluation of hospice
- Cost/ resource use**
- Admissions by chronic condition (e.g., COPD, CHF)
 - ED visit rate that did not result in hospital admission, by condition
 - Total Medicare Part A and B cost calculation recommendations
 - Medicare spending per beneficiary, risk-adjusted and price standardized

1 Requires ability for provider to dispute outcomes

Agenda

Review of progress to date

Breakout materials

Background: Reward structure

Background: Quality measurement

Two high level questions will determine our decision on which reward structure to select

What is our aspirational reward structure?

▪ **Options**

- Prospective payment
- Risk sharing (upside and downside)
- Gain sharing (upside only)
- Pay for performance
- Some combination of the above
- ... any others?

How will providers be set-up for success in the aspirational reward structure?

▪ **Support may be needed for:**

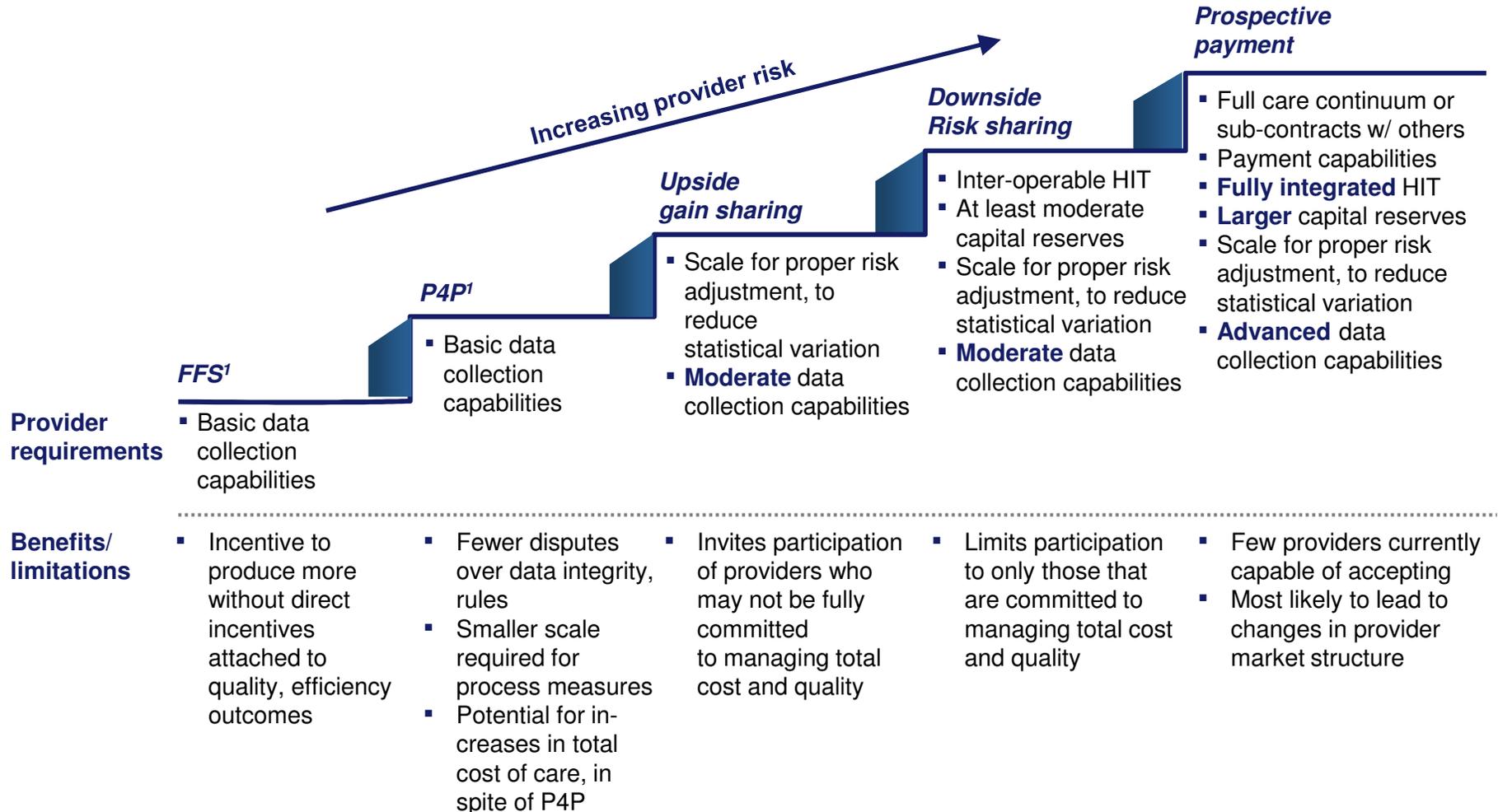
- Clinical integration
- Financial integration
- Financial capabilities
- HIT capabilities
- Care coordination
- ...any others?

▪ **Illustrative types of financial support**

- Upfront investment
- In-kind support
- PMPM fees
- FFS enhancements
- ... any others?

REWARD STRUCTURE

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



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

...and a set of guiding principles can inform our working hypothesis on the reward structure

ILLUSTRATIVE

Key considerations for choosing reward structure

Considerations for our reward structure aspiration

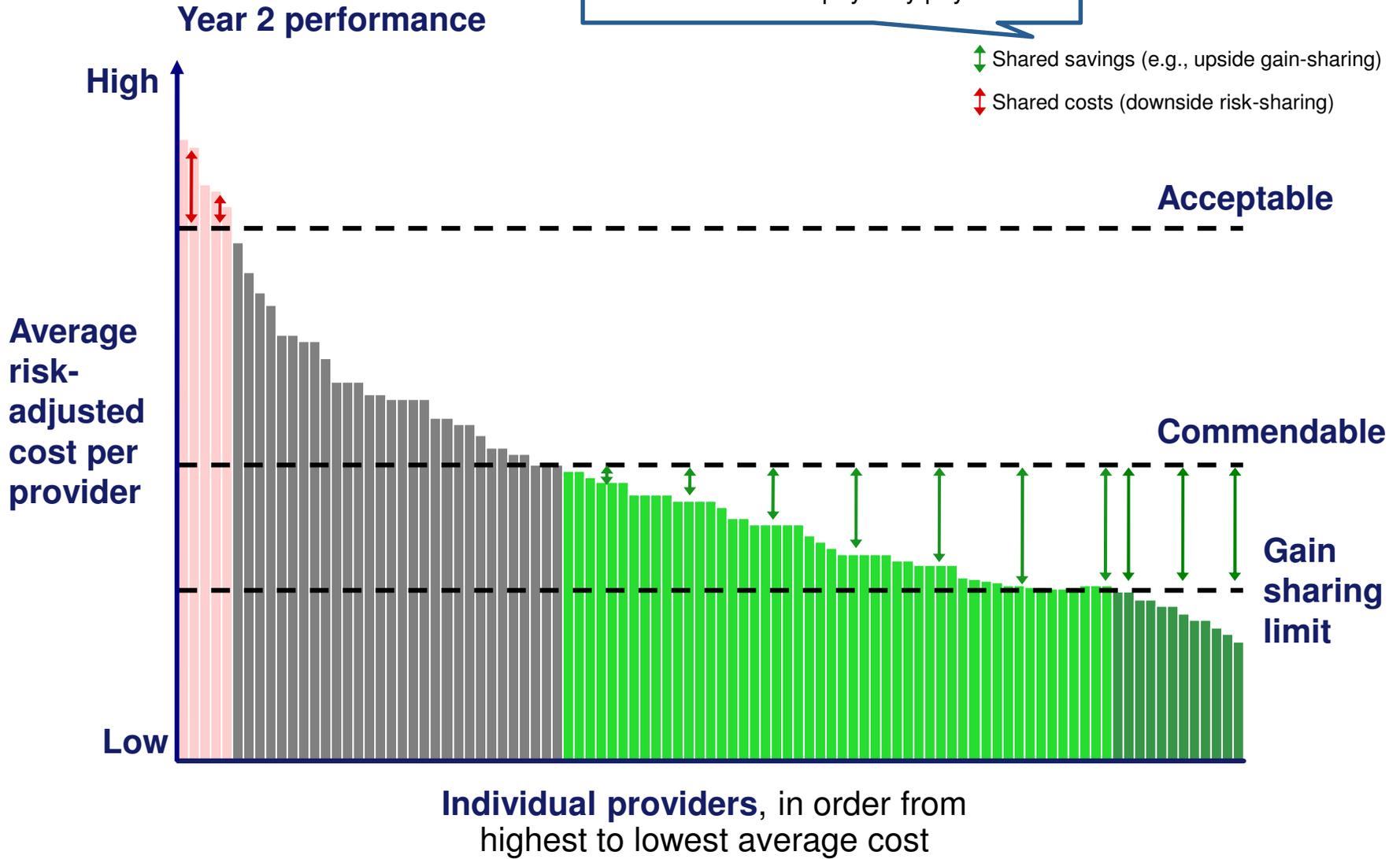
- Will the reward structure drive a set of changes in behaviors that address the needs of the whole-person and improve health outcomes?
- Is the reward structure sufficiently material to motivate changes in behavior?
- How receptive are stakeholders to the reward structure (e.g., are stakeholders open to accepting downside risk)?

Considerations for enabling the reward structure

- How feasible is the reward structure (e.g., are panels at sufficient scale to mitigate volatility, can providers sustain financial risk)?
- Does necessary infrastructure exist for the reward structure (e.g., technological capabilities, data collection)?
- How quickly can the reward structure be rolled-out to meet sufficient scale for impact?
- How capable are stakeholders of managing total cost of care accountability, and how might that affect the ramp-up to end-state payment model (e.g., P4P evolving into upside gain sharing by year 3)
- How important is payer alignment on the reward structure to ultimate reward structure design?

A demonstration of risk sharing (both upside and downside)

Providers shared in costs or savings with payers at a percentage (e.g., 50/50) that is determined on a payer by payer basis



What are the types of provider support required to transition to the aspirational reward structure?

What types of support are required?

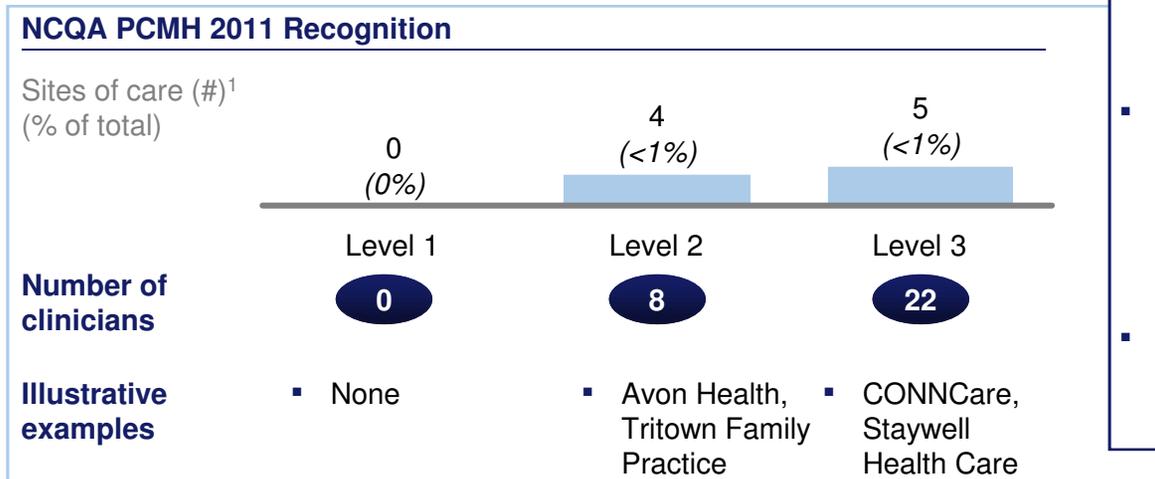
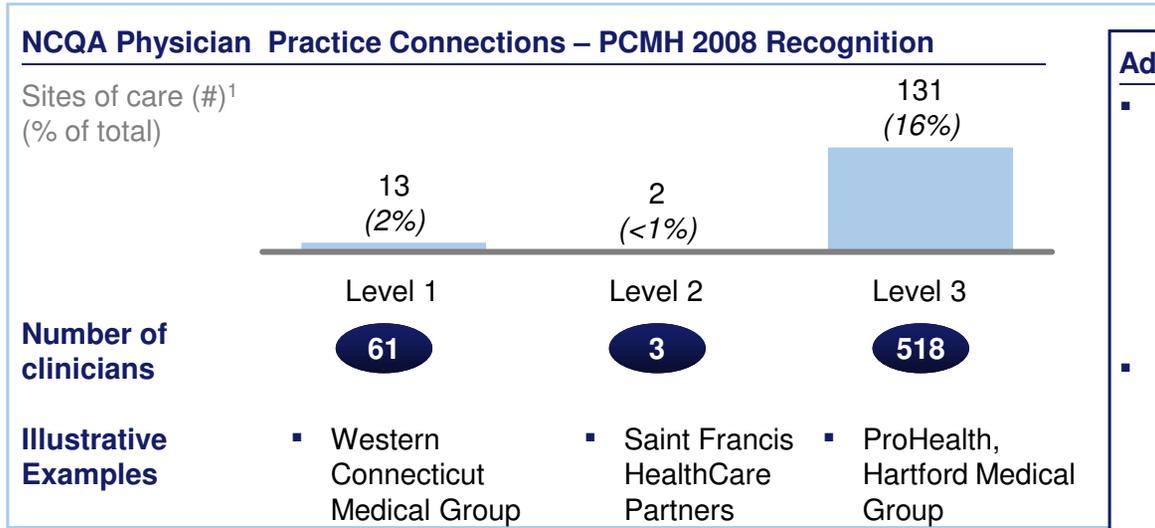
- What is the level of **clinical integration** that providers will require to coordinate care effectively?
- What is the level of **financial integration** providers will require to create pools of patients that are statistically significant?
- What **data, analytical capabilities, and reports** will providers require to succeed within the new model?
- What other **HIT** capabilities will providers require to be set-up for success in the reward structure?
- What **care coordination** supports will providers require to coordinate care effectively?

Options for financial support

- Practice transformation payments (e.g., PMPM for initial years, lump sum grants)
- Care coordination payments (e.g., PMPM)
- In-kind support (e.g., care coordination support/tools)
- FFS enhancements (e.g., additional billing codes for phone consultations, telemedicine)

Some providers are already participating in population-health based payment innovations

NON-EXHAUSTIVE



Additional capabilities

- **CMS** has recognized several ACOs in Connecticut under Medicare Shared Savings (e.g., Hartford HealthCare, ProHealth Physicians, Saint Francis HealthCare Partners, Primed LLC) and its Advanced Payment ACO program (e.g., MPS ACO Physicians, Primed LLC)
- **Commercial payers** are also participating in innovation: Anthem (e.g., episodes pilot, PCMH pilot), CIGNA (e.g., accountable care initiatives with Day Kimball, New Haven Community Group, ProHealth), and Aetna (e.g., coordinated care collaboration with ProHealth)
- The **State of Connecticut** has also launched a number of innovative initiatives including the State employee/Medicaid PCMH pilot, the ICI Duals initiative, HEP, and SPMI health homes
- Roughly 40% of Connecticut physicians have transitioned to **electronic medical records**

1 ~800 sites of care in Connecticut that have at least one PCP

Note: NCQA PPC-PCMH 2008 standards revised in PCMH2011 standards. New applications will be subjected to PCMH2011 standards

SOURCE: NCQA, 2012 Health Leaders InterStudy Report, CMS, SK&A data (methodology: information collected from medical trade associations, phone books, medical school alumni directories, and are phone verified twice a year. Estimated to cover 98.5% of all US physicians)

Agenda

Review of progress to date

Breakout materials

Background: Reward structure

Background: Quality measurement

Next week, we will consider the range of approaches that can be used to hold providers accountable...

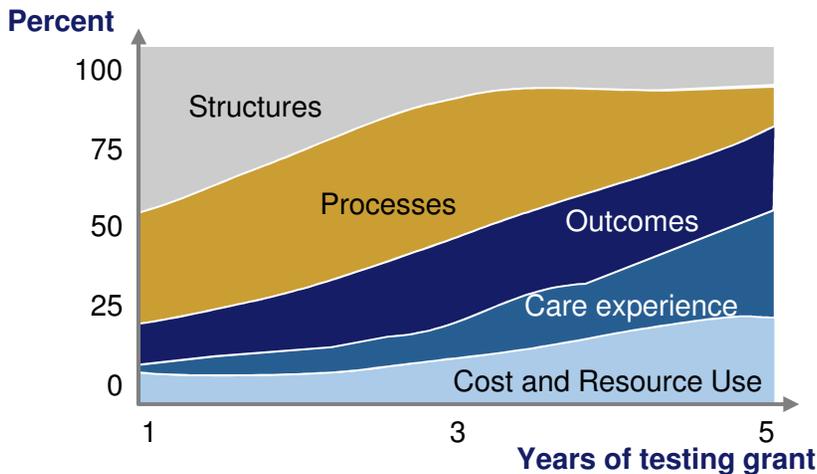
ILLUSTRATIVE

Approaches	Description	Illustrative examples
Reporting	<ul style="list-style-type: none"> ▪ Capturing and reporting of metrics to patients, other providers, and/or to the broader community 	<ul style="list-style-type: none"> ▪ Provider report cards
Condition for participation	<ul style="list-style-type: none"> ▪ Limitation of provider participation in care delivery and payment models to the adoption of or adherence to specific structures, processes, outcomes, care experience and/or cost and resource use metrics 	<ul style="list-style-type: none"> ▪ EMRs that meet meaningful use as a pre-requisite to participate in payment model ▪ Participation in coordinated care team
Contingency for reward	<ul style="list-style-type: none"> ▪ Specifies an outcome or action that is required to receive a specific reimbursement (e.g., a PMPM, fee for service enhancements, P4P bonus) 	<ul style="list-style-type: none"> ▪ Quality baseline to participate in gain-sharing
Consideration when setting reward level	<ul style="list-style-type: none"> ▪ Determines the size of reimbursement (e.g., percent of shared savings, level of PMPM, size of P4P bonus) 	<ul style="list-style-type: none"> ▪ PMPM based on risk-adjusted characteristics of patient panel ▪ P4P bonus pegged to scale of quality or efficiency metrics

...as well as the implied balance of metrics across domain types over time

ILLUSTRATIVE

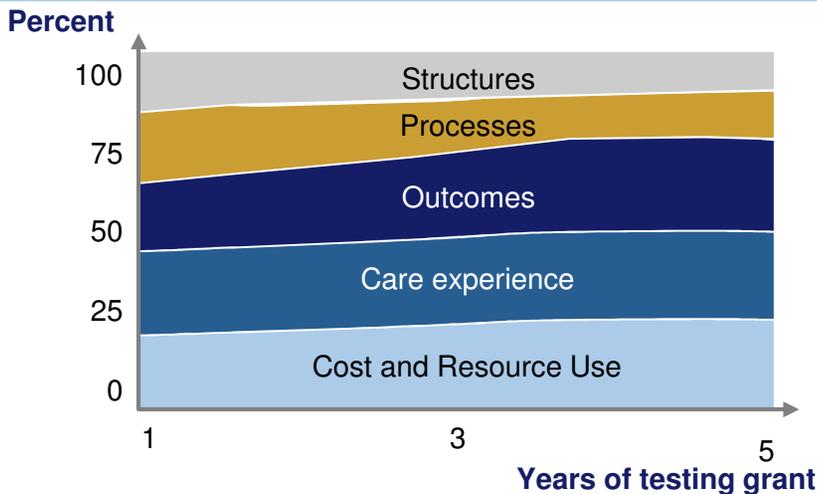
Illustrative option: Potential phasing of payments tied to metrics domains



Potential rationale

- Invest in **structures** in early years to support and encourage providers in their transition to managing total cost of care
- Consistently invest in **processes** to manage adoption of new care delivery model
- Ultimately focus predominantly on **outcomes, care experience, and cost/resource use** – weighted heavily towards later years to allow providers time to adopt to new care delivery and payment models

Illustrative option: Potential phasing of payments tied to metrics domains



Potential rationale

- Consistently invest in **structures** to provide level of ongoing support to providers adopting innovative reforms (e.g., care coordination teams)
- Consistently invest in **processes** to create clear associations between desired behaviors and rewards
- Predominantly hold providers accountable for **outcomes, care experience, and cost/resource use** (with risk adjustment) to place focus on outcomes-oriented whole person centered care

METRICS

Summary of metrics currently tracked nationally and in Connecticut

NON-EXHAUSTIVE

Domain	HEDIS/CAHPS ¹	Medicare ACO ²	Medicaid	Cons. Report Card ⁴	Day Kimball
Structure	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> % of PCPs who qualify for an EHR program incentive payment 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> Percentage of PCP, specialists who are board certified 	<ul style="list-style-type: none"> Referral tracking E-prescribe in use CCHIT technology in use
Process	<ul style="list-style-type: none"> Preventive screenings (e.g., lead, breast cancer) Comprehensive diabetes care 	<ul style="list-style-type: none"> Screening for clinical depression Controlling high blood pressure 	<ul style="list-style-type: none"> Well-child visits Diabetics with LCL-C screenings Child dental visits 	<ul style="list-style-type: none"> Child immunizations Prenatal care in the first trimester Access to care 	<ul style="list-style-type: none"> Childhood and adolescent well-visits Managing chronic illnesses
Outcome	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> Controlling high blood pressure (e.g., HTN patients with BP < 140/90) 	<ul style="list-style-type: none"> Clinical outcomes measures (e.g., HbA1C<7, blood pressure < 140/90)
Care experience	<ul style="list-style-type: none"> Getting needed care; quickly Rating of all health care; personal doctor 	<ul style="list-style-type: none"> How well providers communicate³ Shared decision making³ 	<ul style="list-style-type: none"> Customized version of the PCMH CAHPS tool with supplemental questions 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> Patient satisfaction surveys
Cost and Resource Use	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> Ambulatory sensitive conditions admissions (e.g., COPD, HF) 	<ul style="list-style-type: none"> Child and adult ED utilization rate 	<ul style="list-style-type: none"> Outpatient drug utilization for managed care enrollees 	<ul style="list-style-type: none"> ER visits by chronic conditions (e.g., HTN, COPD, diabetes) Cost measures

1 2012 HEDIS measures reported 2 Medicare Shared Savings ACO 3 CAPHS measures 4 2012 Consumer Report Card

Note: Different programs may use metrics from same source; metrics may apply to one or more domain; measures may fall under multiple domains or be cross-cutting

Core set of measures to be addressed through CMMI sponsored innovations (1/3)

Domain	Measures
Structure	<ul style="list-style-type: none"> ▪ Adoption of Medication e-prescribing ▪ Adoption of Health Information Technology ▪ Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/ Certified EHR System as Discrete Searchable Data
Process	<hr/> <ul style="list-style-type: none"> ▪ Childhood Immunization Status ▪ Influenza Vaccination ▪ Pneumonia Vaccination Status for Older adults ▪ Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention ▪ Colorectal Cancer Screening ▪ Well-Child Visits in the First 15 Months of Life ▪ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ▪ Body Mass Index (BMI) 2 through 18 Years of Age ▪ Adult Weight Screening and Follow-Up ▪ Proportion of Days Covered: 5 Rates by Therapeutic Category ▪ Eye Exam ▪ Foot Exam ▪ Urine Protein Screening ▪ ACE Inhibitor or ARB Therapy—Diabetes and/or LVSD ▪ Oral Antiplatelet Therapy Prescribed for Patients with CAD ▪ Beta-Blocker Therapy—Prior MI or LVEF<40% ▪ Lipid Control ▪ Beta-blocker Therapy for Left Ventricular Systolic Dysfunction ▪ Use of Aspirin or Another Antithrombotic

Note: Intended to be aligned with conceptually, and operationally when possible. Measures on this list include, but are not limited to, measures gathered by the Measure Application partnership, PCMH collaborative, NCQA, CMS quality reporting programs, and AHRQ standards. A majority of these measures have been endorsed by the NQF. Measures may fall under multiple domains and can be cross cutting

Source: CMMI

METRICS

Core set of measures to be addressed through CMMI sponsored innovations (2/3)

Domain

Measures

Process (cont.)

- Complete Lipid Profile and LDL Control <100
- Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
- Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- Primary PCI Received within 90 Minutes of Hospital Arrival
- Median Time to Transfer to Another Facility for Acute Coronary Intervention
- COPD: Bronchodilator Therapy
- Asthma: Asthma Assessment
- Asthma: Pharmacologic Therapy
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Surgery Patients Who Received Appropriate VTE Prophylaxis Within 24 Hours Pre/post-surgery
- Screening for Clinical Depression
- Post-Discharge Continuing Care Plan Created
- Post-Discharge Continuing Plan Transmitted to Next Level of Care Provider Upon Discharge
- Follow-Up After Hospitalization for Mental Illness
- Frequency of Ongoing Prenatal Care
- 3-Item Care Transition Measure
- Care Transition Record Transmitted to Health Care Professional
- Transition Record with Specified Elements Received by Discharged Patients
- Medication Reconciliation

Outcome

- 30-Day Mortality Rate, Risk Adjusted
- Optimal Diabetes Care
- HTN: Controlling High Blood Pressure

Note: Intended to be aligned with conceptually, and operationally when possible. Measures on this list include, but are not limited to, measures gathered by the Measure Application partnership, PCMH collaborative, NCQA, CMS quality reporting programs, and AHRQ standards. A majority of these measures have been endorsed by the NQF. Measures may fall under multiple domains and can be cross cutting

Source: CMMI

METRICS

Core set of measures to be addressed through CMMI sponsored innovations (3/3)

Domain	Measures
Outcome (cont.)	<ul style="list-style-type: none"> ▪ Elective Delivery Prior to 39 Completed Weeks Gestation ▪ Cesarean Rate for Low-Risk First Birth Women ▪ Healthy Term Newborn ▪ Continuity Assessment Record and Evaluation Tool (CARE Tool) ▪ CARE-F and CARE-C Assessment Tools for Nursing Facilities, Day Rehabilitation Programs, and Other ambulatory Settings in the Community ▪ Activity Measure for Post Acute Care (AM-PAC)-CMS DOTPA Short Form Public Domain Version ▪ Surgical Site Infection ▪ Patient Safety for Selected Indicators
Care experience	<ul style="list-style-type: none"> ▪ CAHPS® surveys ▪ Family Evaluation of Hospice ▪ Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment
Cost and resource use	<ul style="list-style-type: none"> ▪ Total Medicare Part A and B Cost Calculation Recommendations (allowed amounts) ▪ Medicare Spending Per Beneficiary, Risk-adjusted and Price Standardized ▪ Hospital All-Cause Unplanned Readmissions, Risk Adjusted ▪ Diabetes Long-term Complications ▪ Chronic Obstructive Pulmonary Disease ▪ Congestive Heart Failure Admission Rate ▪ Bacterial Pneumonia ▪ Adult Asthma ▪ Urinary Tract Infection Admission Rate ▪ Hospital ED Visit Rate that did not Result in Hospital Admission, by Condition

Note: Intended to be aligned with conceptually, and operationally when possible. Measures on this list include, but are not limited to, measures gathered by the Measure Application partnership, PCMH collaborative, NCQA, CMS quality reporting programs, and AHRQ standards. A majority of these measures have been endorsed by the NQF. Measures may fall under multiple domains and can be cross cutting

Source: CMMI

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

HEDIS/CAHPS measures (1/3)

Domain

Measures

Process

- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Childhood Immunization Status (CIS)
- Immunization for Adolescents (IMA)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Lead Screening in Children (LSC)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Appropriate Testing for Children With Pharyngitis (CWP)
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Use of Appropriate Medications for People With Asthma (ASM)
- Medication Management for People With Asthma (MMA)
- Cholesterol Management for Patients With Cardiovascular Conditions (CMC)
- Controlling High Blood Pressure (CBP)
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
- Comprehensive Diabetes Care (CDC)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Use of Imaging Studies for Low Back Pain (LBP)
- Antidepressant Medication Management (AMM)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: 2012 HEDIS measures reported

HEDIS/CAHPS measures (2/3)

Domain

Measures

**Process
(cont.)**

- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Medical Assistance With Smoking and Tobacco Use Cessation (MSC)
- Comprehensive Diabetes Care (CDC)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)
- Prenatal and Postpartum Care (PPC)
- Call Answer Timeliness (CAT)
- Call Abandonment (CAB)
- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)

**Care
experience**

-
- Getting Needed Care (Always + Usually)
 - Getting Care Quickly (Always + Usually)
 - How Well Doctors Communicate (Always + Usually)
 - Customer Service (Always + Usually)
 - Shared Decision Making (Definitely Yes)
 - Rating of All Health Care (9+10)
 - Rating of Personal Doctor (9+10)
 - Rating of Specialist Seen Most Often (9+10)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: 2012 HEDIS measures reported

HEDIS/CAHPS measures (3/3)

Domain

Measures

Care experience (cont.)

- Rating of Health Plan (9+10)
- Access to Specialized Services (Always + Usually)
- Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)
- Family-Centered Care: Coordination of Care (Yes)
- Family-Centered Care: Getting Needed Information (Always + Usually)
- Access to Prescription Medicines (Always + Usually)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: 2012 HEDIS measures reported

CMS Shared Savings ACO metrics (1/2)

Domain

Measures

Structure

- Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment

Process

-
- Medication Reconciliation
 - Falls: Screening for Future Fall Risk
 - Influenza Immunization
 - Pneumococcal Vaccination for Patients 65 Years and Older
 - Body Mass Index (BMI) Screening and Follow-Up
 - Tobacco Use: Screening and Cessation Intervention
 - Screening for Clinical Depression and Follow-Up Plan
 - Colorectal Cancer Screening
 - Breast Cancer Screening
 - Screening for High Blood Pressure and Follow-Up Documented
 - Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (8 percent)
 - Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein Control
 - Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control
 - Diabetes Composite (All or Nothing Scoring): Tobacco Non-Use
 - Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
 - Diabetes Mellitus: Hemoglobin A1c Poor Control
 - Hypertension (HTN): Controlling High Blood Pressure

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: Quality Performance Standards, CMS

CMS Shared Savings ACO metrics (2/2)

Domain	Measures
Process (cont.)	<ul style="list-style-type: none"> ▪ Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (100 mg/dL) ▪ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic ▪ Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) ▪ Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Lipid Control ▪ Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF 40%)
Care experience	<ul style="list-style-type: none"> ▪ CAHPS: Getting Timely Care, Appointments, and Information ▪ CAHPS: How Well Your Providers Communicate ▪ CAHPS: Patients' Rating of Provider ▪ CAHPS: Access to Specialists ▪ CAHPS: Health Promotion and Education ▪ CAHPS: Shared Decision Making ▪ CAHPS: Health Status/Functional Status
Cost and resource use	<ul style="list-style-type: none"> ▪ Risk Standardized All Condition Readmission ▪ Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (ACO version 1.0) ▪ Ambulatory Sensitive Conditions Admissions: Heart Failure (HF) (ACO version 1.0)

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: Quality Performance Standards, CMS

2012 Connecticut Consumer Report Card

Domain	Measures
Structure	<ul style="list-style-type: none"> ▪ Percentage of Primary Care Physicians Who Are Board Certified ▪ Percentage of Physician Specialists Who Are Board Certified
Process	<ul style="list-style-type: none"> ▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Colorectal Cancer Screening ▪ Childhood Immunizations ▪ Prenatal Care in the First Trimester ▪ Postpartum Care Following Delivery ▪ Adult Access to Care ▪ Eye Exams for People with Diabetes ▪ Beta Blocker Treatments after a Heart Attack ▪ Childhood Immunizations ▪ Prenatal Care in the First Trimester ▪ Postpartum Care Following Delivery ▪ Adult Access to Care ▪ Eye Exams for People with Diabetes ▪ Beta Blocker Treatments after a Heart Attack
Outcome	<ul style="list-style-type: none"> ▪ Controlling High Blood Pressure ▪ Cholesterol Management for Patients with Cardiovascular Disease
Cost and resource use	<ul style="list-style-type: none"> ▪ Outpatient Drug Utilization for Managed Care Enrollees

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: 2012 Connecticut Consumer Report Card, published by CID. Reports measures tracked for commercial HMO and indemnity plans

Day Kimball quality measures currently being reported (1/3)

Domain	Measures
Structure	System/Structural/Pay for Performance Measures <ul style="list-style-type: none">▪ E-prescribe in use▪ Risk management/workplace safety▪ Participation in National or State Quality Improvement activity▪ Participation in NCQA or Bridges to Excellence▪ Completion of Healthcare Quality Patient Assessment form▪ CCHIT Technology in use▪ Access or Availability of Records▪ Aim OptiNet Tool and precert in use▪ Access and Communication▪ Test /result tracking▪ Care management/continuity of care▪ Referral tracking▪ Performance/goal tracking <hr/>
Process	Asthma <ul style="list-style-type: none">▪ Use of appropriate medication for people with asthma COPD <ul style="list-style-type: none">▪ Managing chronic illness

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: Day Kimball Healthcare

Day Kimball quality measures currently being reported (2/3)

Domain

Measures

**Process
(cont.)**

Diabetes

- A1C
- Foot exam
- Adults with dx of Type I/II DM with 1 eye screening
- PQRS
- Managing chronic illness
- Early Detection of Chronic Illness
- Adults with dx of Type I/II DM with 1 LDL-C screening

HTN

- PQRS
- Managing chronic illness
- Beta Blocker
- Early Detection of Chronic Illness

Hyperlipidemia

- PQRS
- Early Detection of Chronic Illness

Obesity

- Childhood
- Adult
- PQRS
- Early detection of chronic illness

Osteoporosis

- Managing Chronic Illnesses

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: Day Kimball Healthcare

Day Kimball quality measures currently being reported (3/3)

Domain

Measures

**Process
(cont.)**

Preventative/Maintenance

- Well child visit in first 15 month of life
- Well child visits in 3rd, 4th, 5th, and 6th years of life
- Developmental screening, 9, 18 and 30 month well visit
- Preventive Medicine Screening
- Ongoing assessment and evaluation

Behavioral Health

- % of Adults with new psych dx and meds by PCP, with follow-up visit within 30 days

Rheumatoid Arthritis

- Managing chronic illness

Patient Experience/Satisfaction

- Patient Satisfaction Surveys (Childhood through Adult) (vendor: Press Ganey)

Dental Care

- % of members 2-21 with 1 dental visit/yr 2-3, 4-6,7-10, 11-14, 15-18, 19-21

**Cost and
resource use**

-
- ER visits and readmission rate by chronic condition (e.g., asthma, COPD, diabetes, HTN, hyperlipidemia, obesity, osteoporosis, rheumatoid arthritis)
 - Overall ER utilization and readmission rates

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: Day Kimball Healthcare

Medicaid PCMH measures – Year 1 (1/2)

Domain

Measures

Process

- Well-care visits during the measurement period, including six or more well-child visits with a PCP in the first 15 months of life; one or more well-child visits with a PCP in the third, fourth, fifth, and sixth years of life, and one or more adolescent well-care visits with a PCP or an OB/GYN practitioner for children 12 to 21 years old
- Successful connection of children to dental services, including children age 2 to 21 years of age who had at least one dental visit during the measurement period with a separate report for children under age 3
- The delivery of a developmental screening with a formal tool at 9, 18, and 24 month well child visits
- Adults age 18-75 with a diagnosis of Type 1 or Type 2 diabetes who had at least one LDL-C screening during the measurement period
- Adults age 18-75 with a diagnosis of Type 1 or Type 2 diabetes who received at least one eye screening for diabetic retinal disease: either one retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement year or, a negative retinal exam (no evidence of retinopathy) by an eye care professional during the measurement year or in the year prior to the measurement year
- Adults age 18-75 who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement period or who had a diagnosis of ischemic vascular disease (IVD) during the measurement period and the year prior to the measurement period who had an LDL-C test performed during the measurement period
- Adults age 21-75 with inpatient admissions with a claim for post-admission follow-up within seven days of the inpatient discharge
- Members 5-50 years of age during the measurement period who were identified as having persistent asthma and were appropriately prescribed medication for a prescription that was filled during the measurement period
- Adults with initial new psychiatric condition per PCP claim with medication order and evidence of office follow up

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: DSS

Medicaid PCMH measures – Year 1 (2/2)

Domain

Measures

**Care
experience**

- A customized version of the PCMH CAHPS tool with supplemental questions for evaluation of both PCMHs and overall Medicaid provider network
-

**Cost and
resource use**

- ED visits for children 0 to 21 years of age with asthma diagnosis on the ED claim
- Children from birth to 21 years of age who utilized the Emergency Department three or more time in a six month period during the measurement year
- Adults age 21-75 who utilized the Emergency Department three or more times in a six month period during the measurement period

Note: Measures may fall under multiple domains and can be cross-cutting

SOURCE: DSS