

HIP: Payment work group – session 1

Discussion document

November 9, 2015

November 9th Agenda: Payment model

Work group 1



Time	Session description	Session type
1:00-1:30	Introduction and goals; payment model vision and principles	Presentation
1:30-2:00	Gallery walk part 1: current state of PA payment	Gallery walk and breakout discussion
2:00-2:10	Break	
2:10-2:40	Gallery walk part 2: VBP innovation across states	Gallery walk and breakout discussion
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Goal of work group session 1 is to provide input and align on principles



Purpose/principles

- Gather input from multi-stakeholders with the objective of building a plan with the highest likelihood of success
- Collaborate with stakeholders across the State to align around a set of guiding principles
- Share informed view of what initiatives (led by stakeholders or the Commonwealth) are happening in PA and across the country

Session 1

Provide input and align on principles

Session 2

Test preliminary strategy

Session 3

Refine strategy and identify interdependencies across broader plan

Work group charter: Payment

Work group title: Payment	Convener: Secretary Murphy
Problem statement: <ul style="list-style-type: none">▪ Current fee-for-service system is unsustainable, with health care costs taking an increasing share of state budgets, employer costs, and consumer pocket books▪ States are leading efforts to move public and private payers to value-based payment – PA will join federal efforts in establishing a four-year goal to move from volume to value▪ Set of multi-payer new models will be needed to drive quality and cost improvements, across types of care (i.e., episodic, advanced primary care / chronic) and care settings (in particular, recognizing unique needs of rural hospitals)	
Mandate for this group: <ul style="list-style-type: none">▪ Explore opportunities to implement a material number of multi-payer bundled payments at-scale (30-50+) for high-cost procedures▪ Develop recommendations to accelerate moving to advanced primary care models▪ Develop methodology for multi-payer global budgets for rural hospitals	Types of decisions to provide input on for HIP Plan: <ul style="list-style-type: none">▪ Payment models to prioritize▪ Types of episodes to prioritize▪ Target areas for advanced primary care acceleration▪ High-level payment model methodology▪ Principles for payment models incentives (i.e., upside / upside-downside), role of quality metrics▪ Areas for multi-payer standardize approach, general alignment, differ by design▪ General pace of scale-up and rollout▪ Identify opportunities for shared infrastructure (if any)
Participation expectations: <ul style="list-style-type: none">▪ Join 3, 2-3hr work group meetings between now and HIP Plan submission (May 2016)<ul style="list-style-type: none">– Webinar (Nov 5th, 2015)– Kickoff (Nov 9th, 2015)– Review / input on draft model design options (Jan 2016)– Review / input on full draft of HIP Plan (Mar 2016)▪ Potential ad hoc additional meetings▪ Communicate updates from work group within your organization & collect feedback to share back with the work group	

Milestones for HIP

July
Stakeholder engagement kickoff at NGA

- Nov**
- *Webinar briefing for work group members*
 - *Work Groups Session 1: Input*

Jan
Catalyst for Payment Reform payer survey

March
Work Groups Session 3: Refine

May
Submit HIP plan to CMMI

Q3

2015

Q4

Q1

2016

Q2

Q3

Dec / early Jan
Work Groups Session 2: Test

End of Jan / Feb
Draft (outline) of full HIP plan complete

Summer
Launch payment model according to implementation plan

Requirements for payment to drive cost-reducing innovations



re-Set expectations and align payment

Create clear roles for different types of providers; pay through a mix of enhanced fee-for-service, episode-based, and population-based payments



Significant

Maximize the proportion of provider revenue and earnings that are subject to outcomes-based payment



at Scale

Ensure that a critical mass of providers transition to outcomes-based reimbursement



Stable

Clarify long-term vision and make a long-term commitment to providers



Striving but practical

Design the new approach so that it is effective in current regulatory, legal, and industry structures



Sustainable

Ensure that providers that adapt thrive financially



Supportive

Champion innovation with information, insights, and infrastructure



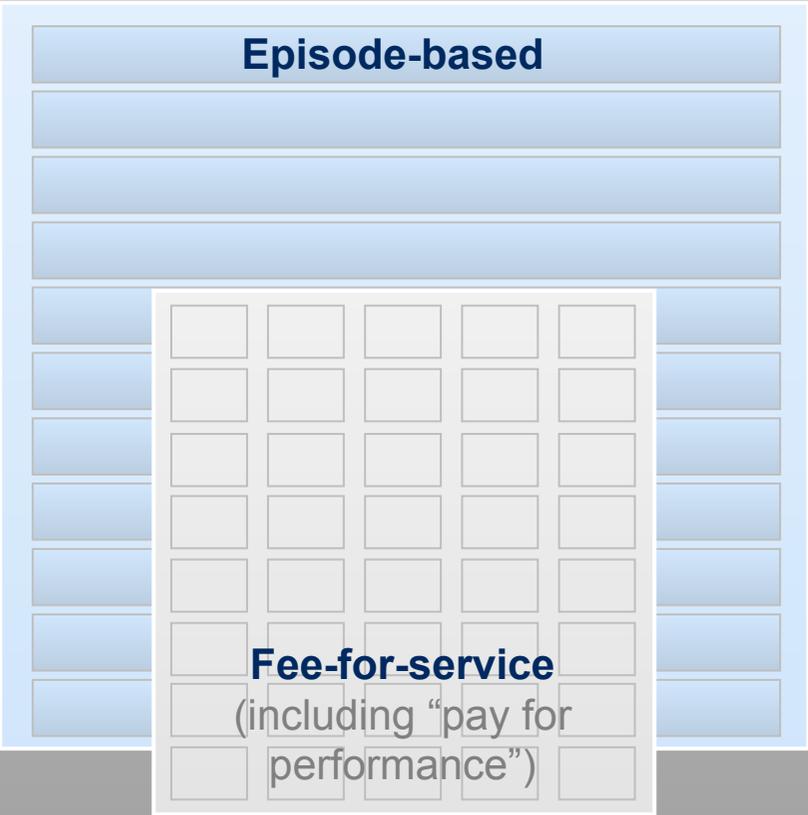
Sync with consumers

Align payment with benefits, network design, and consumer engagement

The end state for value-based payment is the nesting of three models for performance measurement and rewards

Payment approach

Population-based (PCMH, ACOs, capitation)



Most applicable

- Primary prevention for healthy
- Care for chronically ill (e.g., managing obesity, CHF)

-
- Acute procedures (e.g., CABG, hips, stent)
 - Most inpatient stays including post-acute care, readmissions
 - Acute outpatient care (e.g., broken arm, URI)

Discrete services correlated with favorable outcomes or lower cost

Why population-based models and episodes?

Pop. models provide the foundation for total cost/quality accountability

- **Population-based** accountability transcends delivery system
- **Large long-term impact:** prevention and chronic disease management
- Requires providers to fully **transform business model** away from FFS
- Requires significant provider **capabilities and commitment**

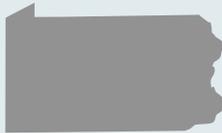
Episodes “nested” within total cost of care for more specific accountability

- **Patient-centered** design around the “patient journey” thru delivery system
- **Faster to impact:** clear and specific opportunities for improvement
- **Stages business model transition** away from FFS for specialists/hospitals
- **Faster to scale**, independent of market structure or capabilities

Fit with other models

Both models being implemented agnostic of provider structure, including as “carve out” or “carve in” for ACO or capitation

A multi-stakeholder, statewide approach provides the scale needed for meaningful payment and delivery transformation...

	What does scale mean?	Why is it important?
Provider 	<ul style="list-style-type: none">▪ Meaningful portion of revenue tied to value for <i>individual</i> providers (e.g., hospitals, specialists)	<ul style="list-style-type: none">▪ Supports shifts in individual provider practice patterns▪ Drives improvements in operational efficiency
Regional 	<ul style="list-style-type: none">▪ Substantial portion of providers within a major <i>market</i> participate in new payment and delivery model	<ul style="list-style-type: none">▪ Drives infrastructure development▪ Supports holistic collaboration▪ Practice patterns are rooted in medical community culture▪ Delivers pressure from bottom-up on regulatory environment
State 	<ul style="list-style-type: none">▪ Multiple markets within the state are transitioning to new value-based payment and delivery models	<ul style="list-style-type: none">▪ Supports major payers in state (including Medicare / Medicaid) to develop ability to support model at scale▪ Influences state medical school curriculums and related workforce initiatives

...but also requires three archetypes to the design

“Standardize approach”

Standardize approach (i.e., identical design) only when:

- Alignment is critical to provider success or significantly eases implementation for providers (e.g., lower administrative burden)
- Meaningful economies of scale exist
- Standardization does not diminish potential sources of competitive advantage among payers
- It is lawful to do so
- In best interest of patients (i.e., clear evidence base)

**Example:
Quality Measures**

“Align in principle”

Align in principle but allow for payer innovation consistent with those principles when:

- There are benefits for the integrity of the program for payers to align
- It benefits providers to understand where payers are moving in same direction
- Differences have modest impact on provider from an administrative standpoint
- Differences are necessary to account for legitimate differences among payers (e.g., varied customers, admin. systems)

**Example:
Gain Sharing**

“Differ by design”

Differ by design when:

- Required by laws or regulations
- An area of the model is substantially tied to competitive advantage
- There exists meaningful opportunity for innovation or experimentation

**Example:
Amount of Gain Sharing**

Collaboration will be required to scale these initiatives and overcome common challenges

Engaging providers in change

Most providers are willing to change, however, there is not a consistent set of glide paths for them to adapt

Ensuring sufficient scale

In isolation, most private payers do not have critical scale in all regions to introduce change

Common set of challenges to implementing payment reform at scale

Changing patient behaviors

Inconsistency in plan designs, programs and patient education makes it difficult for changes to stick

Developing infrastructure

Expensive for single entity to develop the required infrastructure (e.g., information exchange, provider portals)

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Advanced primary care discussion questions

- Are you currently implementing advanced primary care pilots?
- How are the models discussed here similar or different to your advanced primary care pilots and the pilots you have observed?
- What are your biggest priorities for advanced primary care? (e.g., targeting patient populations, including certain providers, targeting specific sources of value or spend, etc.)
- What capabilities are needed to support advanced primary care?
- What themes have you observed through our discussions on advanced primary care?

Episode discussion questions

- Are you currently working on any episode-based initiatives?
- How are the models discussed here similar or different to those you are working on or have observed?
- What are your biggest priorities for episode-based payments? (e.g., including certain providers, targeting sources of value or spend, etc.)
- What capabilities are needed to support episode-based payments?
- What themes have you observed through our discussions on episode-based payments?

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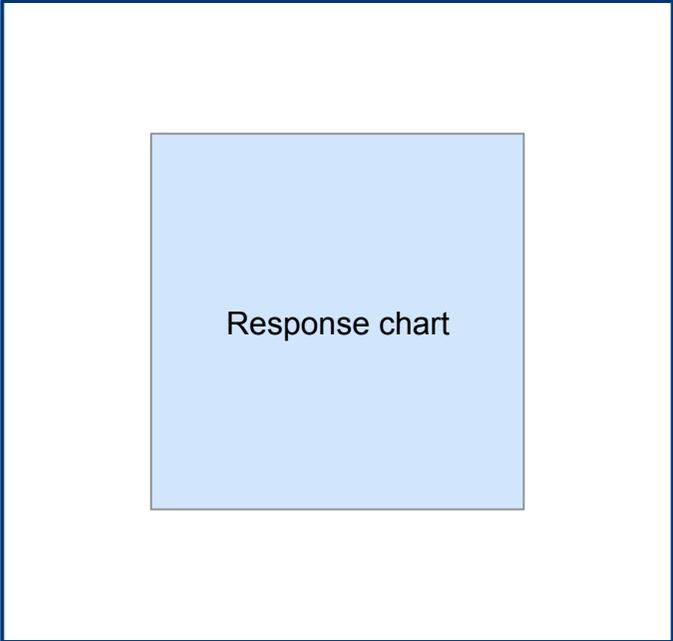


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Advanced primary care payment model: Question 1

What are the 3 most significant barriers to building advanced primary care payment models at scale in PA?

- A. Lack of provider integration
- B. Shared accountability between payers and providers
- C. Standardization across providers (e.g., patient needs)
- D. Provider support to improve performance
- E. Ensuring high quality care
- F. Reflecting true performance/minimizing statistical variability
- G. Payer admin capabilities & need for non-clinical data
- H. Ensuring stakeholders achieve return on investment
- I. Aligning patient incentives
- J. Other (please discuss with broader group)

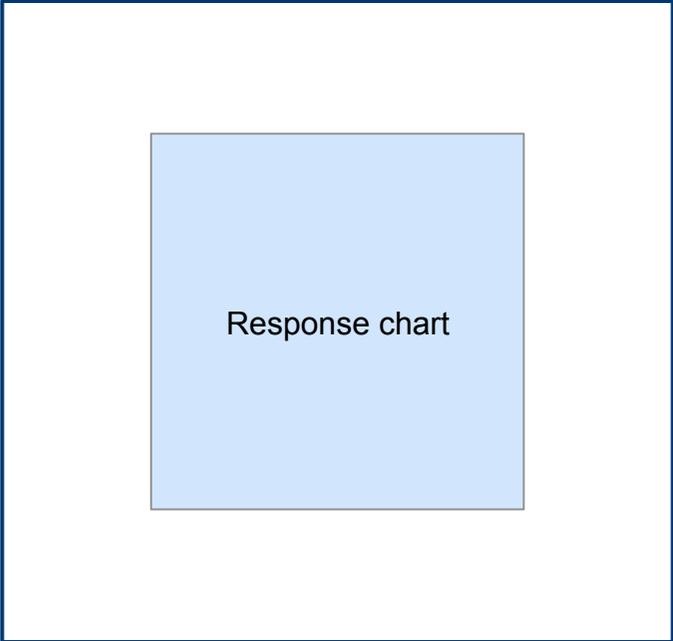


Response chart

Advanced primary care payment model: Question 2

Which 3 barriers can state leadership help overcome to build advanced primary care payment models at scale in PA?

- A. Lack of provider integration
- B. Shared accountability between payers and providers
- C. Standardization across providers (e.g., patient needs)
- D. Provider support to improve performance
- E. Ensuring high quality care
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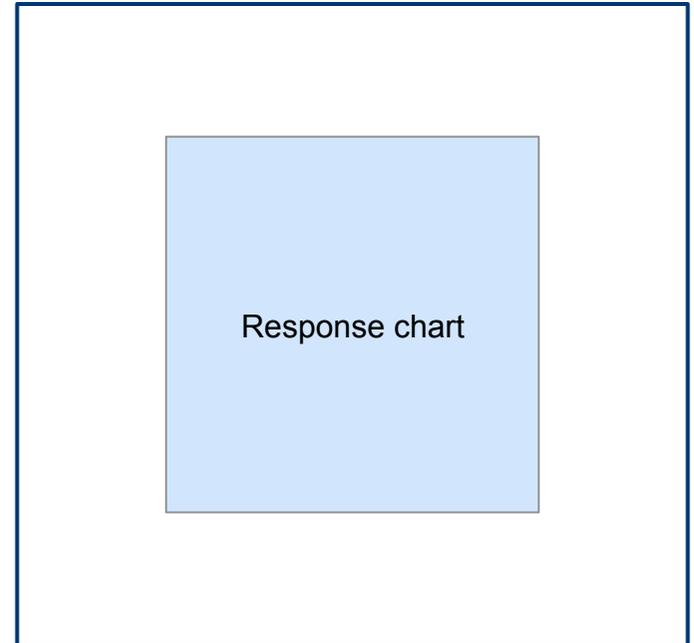


Response chart

Episode payment model: Question 1

What are the 3 most significant barriers to building episode payment models at scale in PA?

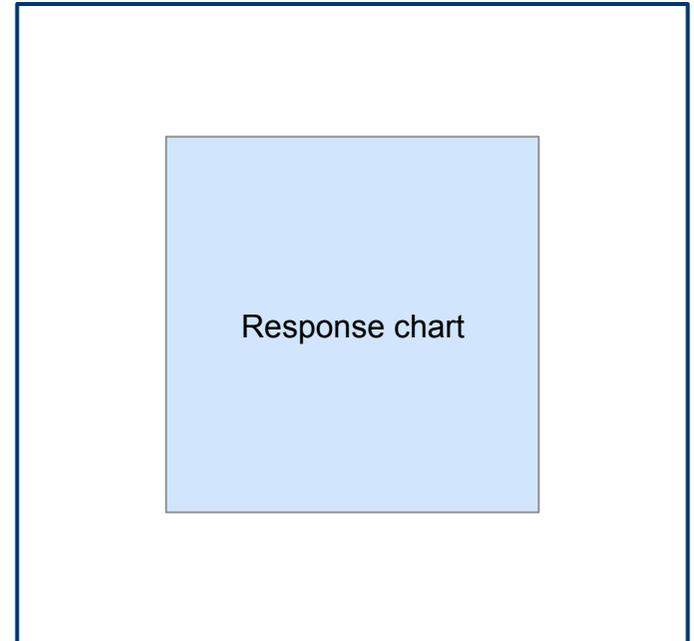
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Episode payment model: Question 2

Which 3 barriers can state leadership help overcome to build episode payment models at scale in PA?

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Overall payment model discussion questions

- What are the biggest opportunities for advanced primary care and episode-based payments?
- What can we leverage from the payment models we have discussed to ensure that the work group and PA SIM are able to fulfill its broad mandate for payment innovation?
- Which design decisions and capabilities should there be a “standardized approach,” “alignment in principle,” or “differ by design”?

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Next steps

- Participate in follow-up webinars / calls
- Meet in January for work group session 2 to test preliminary strategic plan
- Continue to provide input on payment model strategic plan; preliminary draft to be shared prior to work group session 2

Questions

