HIP: Payment work group – session 2

Discussion document

January 28, 2016

January 28th Agenda: Payment model

Work group 2

Time	Session description	Session type
9:00-9:30	Introduction, reminder of priorities, recap from last meeting, and themes across work groups	Presentation
9:30-10:30	Presentation from Center for Value-Based Insurance Design	Presentation
10:30-10:40	Break	
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Goal of work group session 2 is to test the preliminary strategy

Purpose/principles

- Gather input from multiple 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 are happening 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	Chair: Secretary Murphy

Problem statement:

- 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:

- 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:

- 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:

- Join 3, 2-3hr work group meetings between now and HIP Plan submission (May, 2016)
  - Webinar (Nov 5th, 2015)
  - Kickoff (Nov 9th, 2015)
  - Review / input on draft model design options (Jan 25th, 2016)
  - Review / input on full draft of HIP Plan (Mar 28th, 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

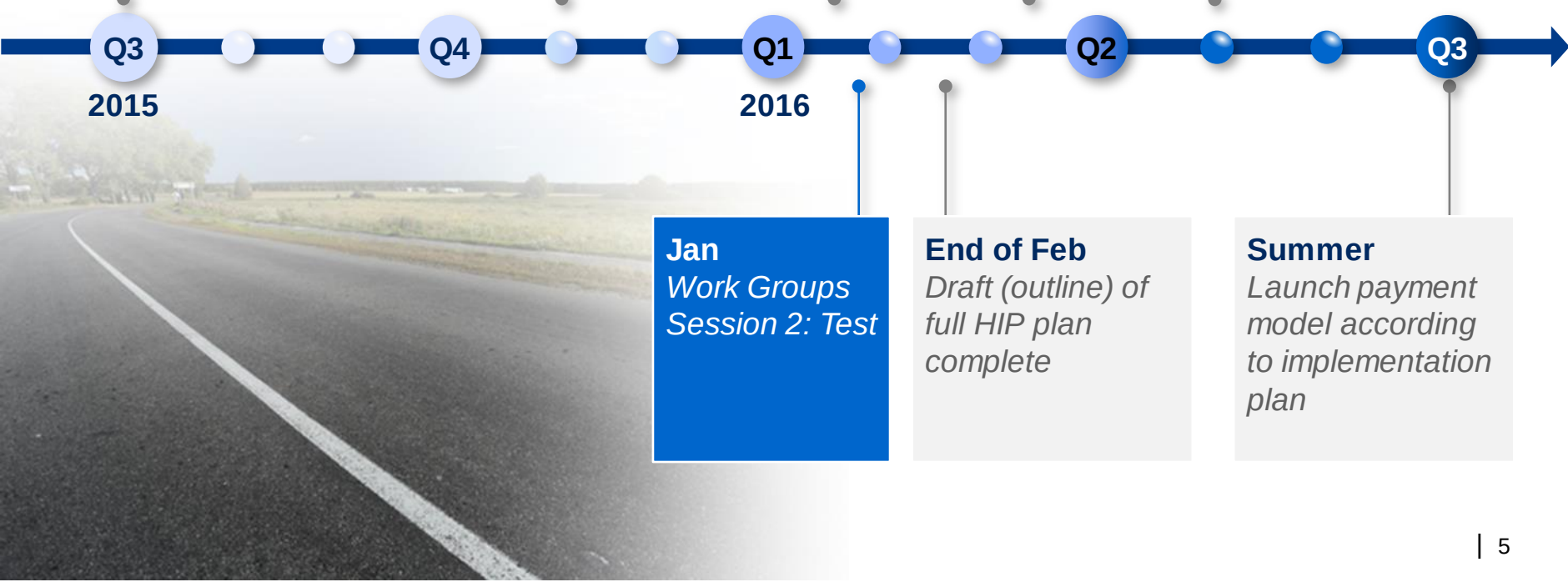
July
Stakeholder engagement kickoff at NGA

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

Jan through Dec
Catalyst payer survey

March
Work Groups Session 3: Refine

May
Submit HIP plan to CMMI



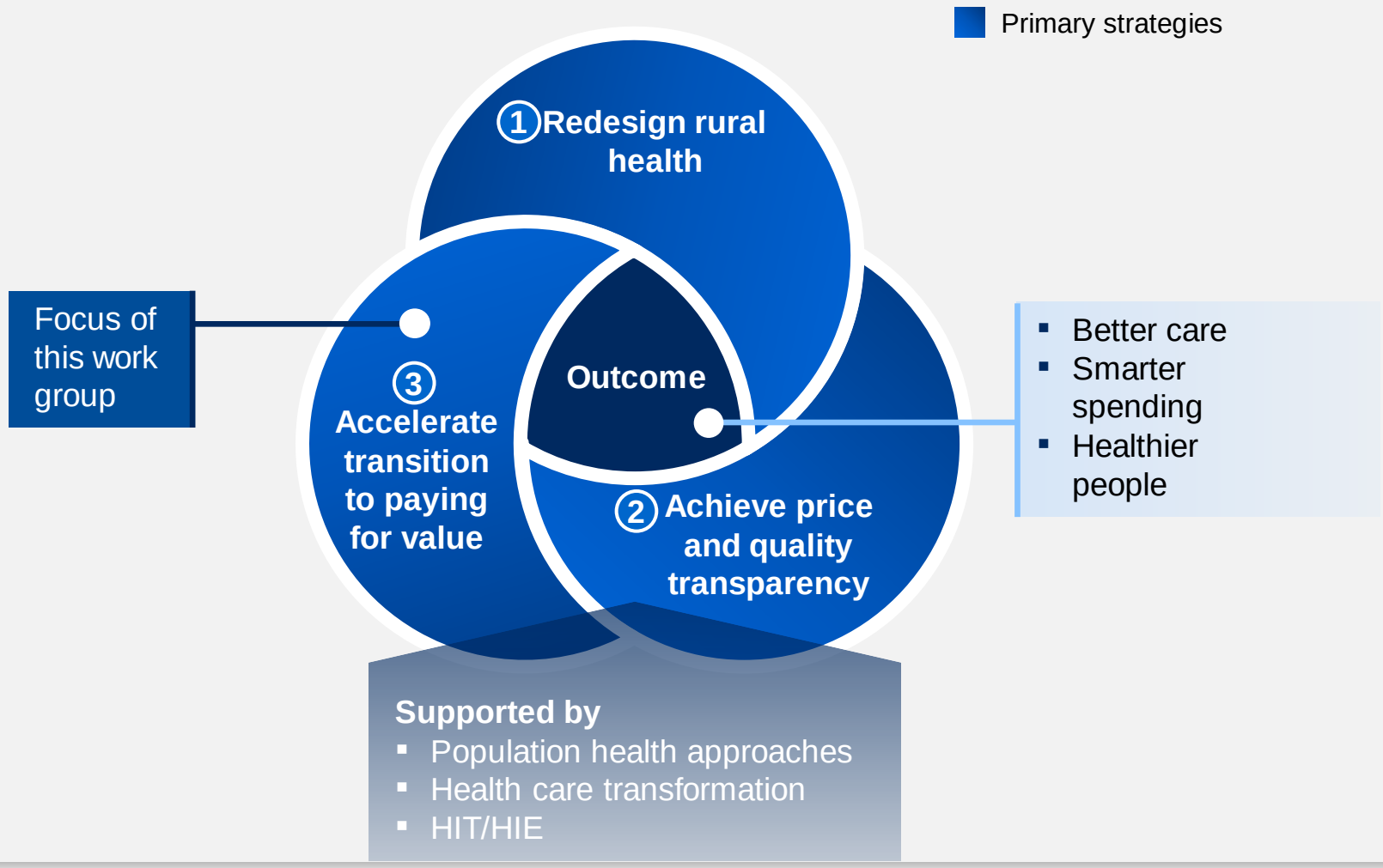
Jan
Work Groups Session 2: Test

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

Summer
Launch payment model according to implementation plan

Reminder: Objectives for Health Innovation in Pennsylvania (HIP)

In-going approach to accelerate innovation in PA



2 Price and quality transparency end state vision and objectives

Performance transparency

- Patients, providers, employers, and other stakeholders have clear understanding of cost and quality performance

"Shoppable" care transparency

- Patients are empowered, enabled, and incented to make value-conscious decisions around their care choices

Rewarding value

- Level of transparency enables the implementation of innovative payment models to reward providers for delivering patient outcomes and cost-effectiveness

Consumer behavior change

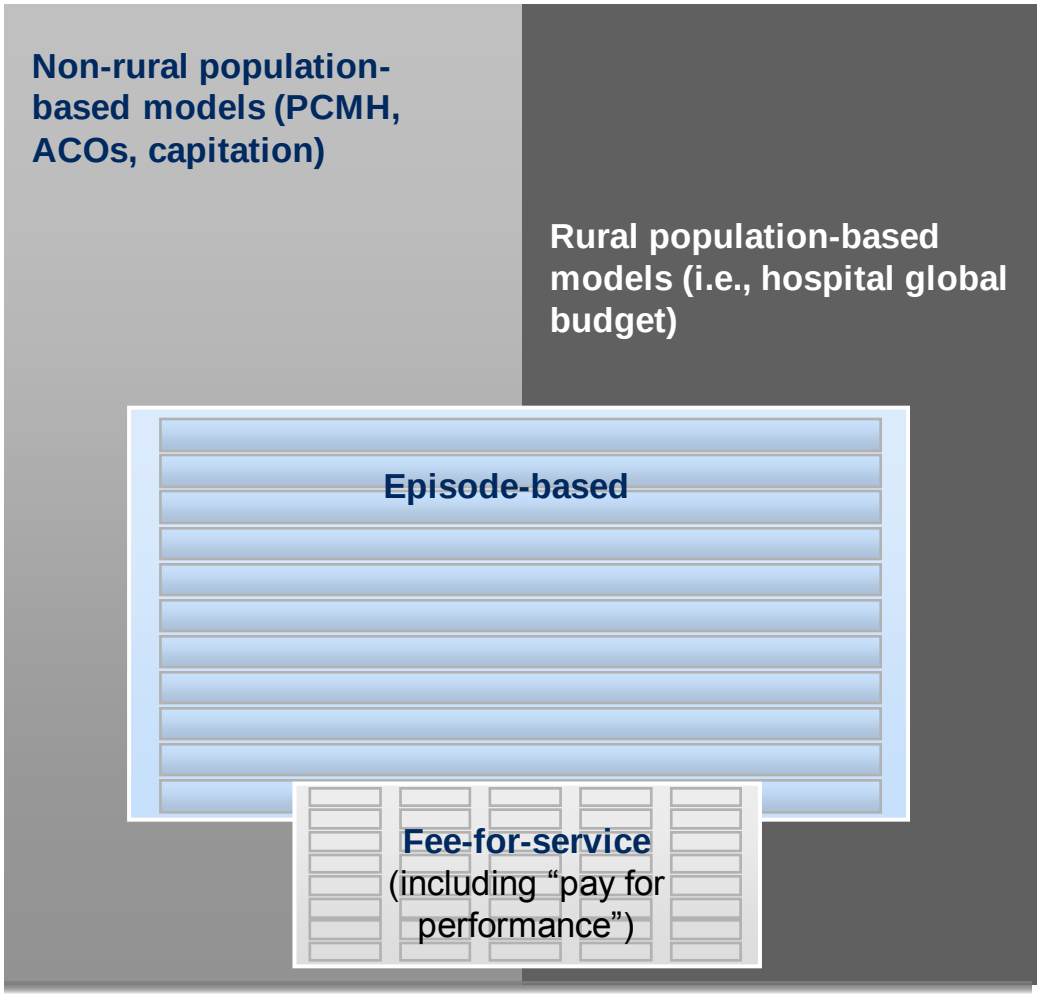
- Consumers are able to understand the impact of their behaviors on their own personal health

Commonwealth plays different roles to achieve objectives:

- **Catalyzer** of health care change for all
- **Actor,** via actions that improve state run programs

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

Payment approach



Most applicable — Detail to follow

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

- Health care access for rural population
- Payment model tailored to unique needs of rural health / hospitals

- 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

3 What we heard from payment work group session 1: guiding principles for payment innovation

Guiding principles for payment innovation:

- The work group should build on existing payment innovation in PA
- New payment models should incorporate a ramp-up time period to allow providers time to prepare
- Payment model innovation needs to be sustainable so that providers (and payers) invest in developing the necessary capabilities to be successful, but also flexible enough so that it can adapt and improve over time
- Different types of providers (e.g., geography, size) may require different payment models

3 What we heard from payment work group session 1: input on payment model approach

Advanced Primary Care	▪ Advanced primary care efforts, led by stakeholders throughout the Commonwealth, are currently in development or underway across Pennsylvania ▪ Standardizing measures and definitions across payers may offer the greatest opportunity for impact and will be addressed through a combination of the transparency and payment work groups
Episode-based payments	▪ Input from stakeholders suggests that there is an opportunity for episode-based payments as a feasible and attractive model ▪ The payment work group will focus on developing a plan to explore episode-based payment specific to the needs of the Commonwealth

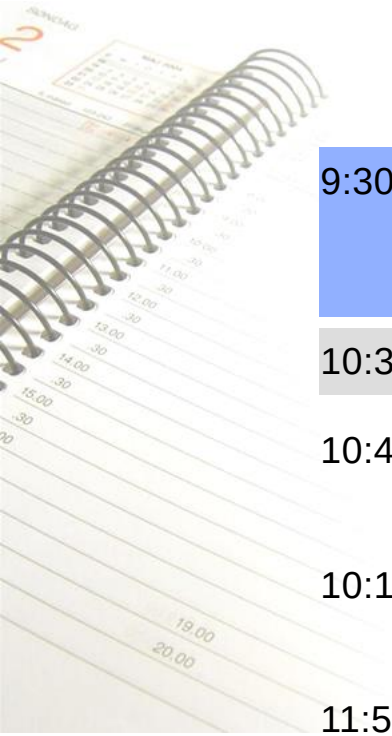
3 Approach for advanced primary care innovation in PA based on what we have heard and our analyses

- Throughout 2016, payers will continue with **existing / planned advanced** primary care innovation initiatives
- In mid-2016, the Commonwealth will convene payers to define a **common vision / definition** for advanced primary care and begin to identify potential areas for multi-payer alignment to support provider adoption of advanced primary care at scale:
  - Where payers would like to standardize approach or align in principle to support scaling and provider adoption (e.g., align on a common set of quality measures across plans)
  - What enablers are necessary (e.g., price and cost transparency)
- In 2017, payers will align on all advanced primary care **design elements and prepare strategy to roll-out model to scale**
- Beyond 2018, payers will roll-out advanced primary care model statewide

- **Any thoughts or input on this approach?**
- **We will look for time in March to discuss in detail what areas may be helpful in the next 3-12 months to align on**

January 25th Agenda: Payment model

Work group 2



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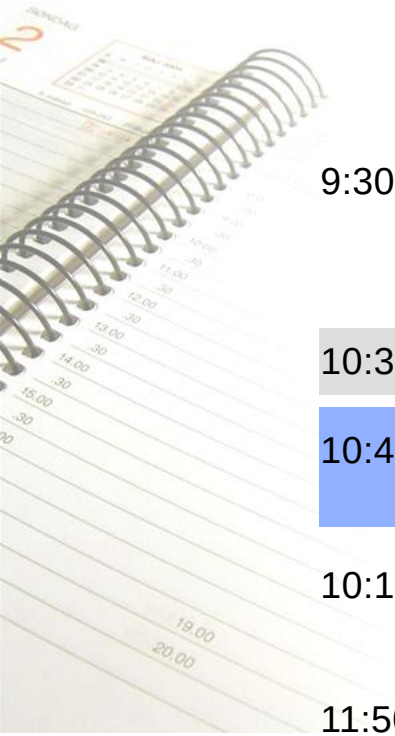

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Episode-based payment models are designed to reward coordinated, team-based, high-quality care for specific conditions or procedures

The goal	**Coordinated, team-based care** for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)
Accountability	A provider 'quarterback', or **Principal Accountable Provider** (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)
Incentives	**High-quality, cost-efficient care** is rewarded beyond current reimbursement, based on the PAP's average cost and total quality of care across each episode

~50 – 70% of costs may be addressable through episodes vs. population based models

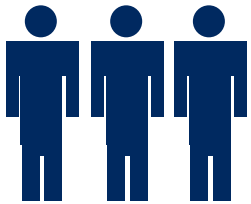
NATIONAL DATA

	Examples	Percent of total spend			
		Commercial	Medicaid	Medicare	
Prevention	Routine health screenings	~5	~5	~3-5	Addressed through population-based model (e.g., advanced primary care)
Chronic care (medical)	Diabetes, chronic CHF, CAD	~15-25	~10-15	~20-30	
Acute outpatient medical	Ambulatory URI, sprained ankle	~5-10	~5-10	~5-10	Potentially addressable through episodes
Acute inpatient medical	CHF, pneumonia, AMI, stroke	~20-25	~5-15	~20-30	
Acute procedural	Hip/knee, CABG PCI, pregnancy	~25-35	~15-25	~20-25	
Cancer	Breast cancer	~10	<5	~10	
Behavioral health	ADHD, depression	~5	~15-20	~5	
Supportive care	Develop. disability, long-term care	N/A	~20-30	N/A	

Retrospective episode model is an example episode-based payment archetype

Patients and providers continue to deliver care as they do today

1



Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

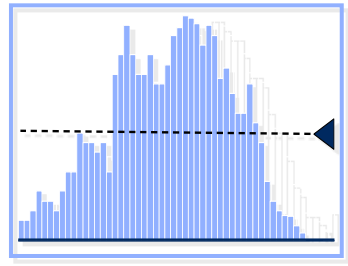
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a **'Principal Accountable Provider'** (PAP) for each episode

5



Payers calculate **average cost per episode** for each PAP

Compare average costs to predetermined 'commendable' and 'acceptable' levels

6

Based on results, providers will:

- **Share savings**: if average costs are below commendable levels quality and standards are met
- **Pay part of excess cost:** if average costs are above acceptable levels
- **See no change in reimbursement**: if average costs are between commendable and acceptable levels

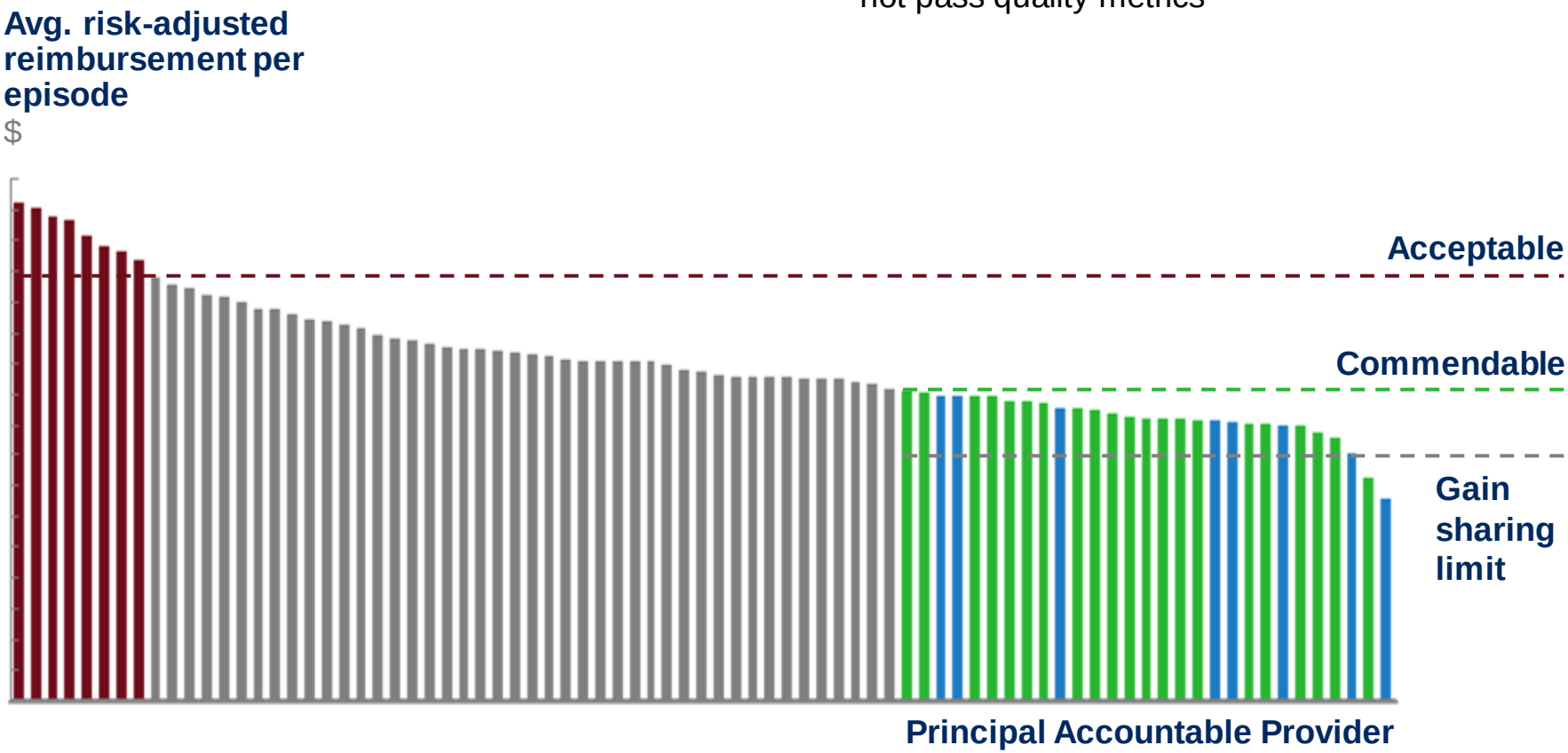
SOURCE: State example

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

ILLUSTRATIVE

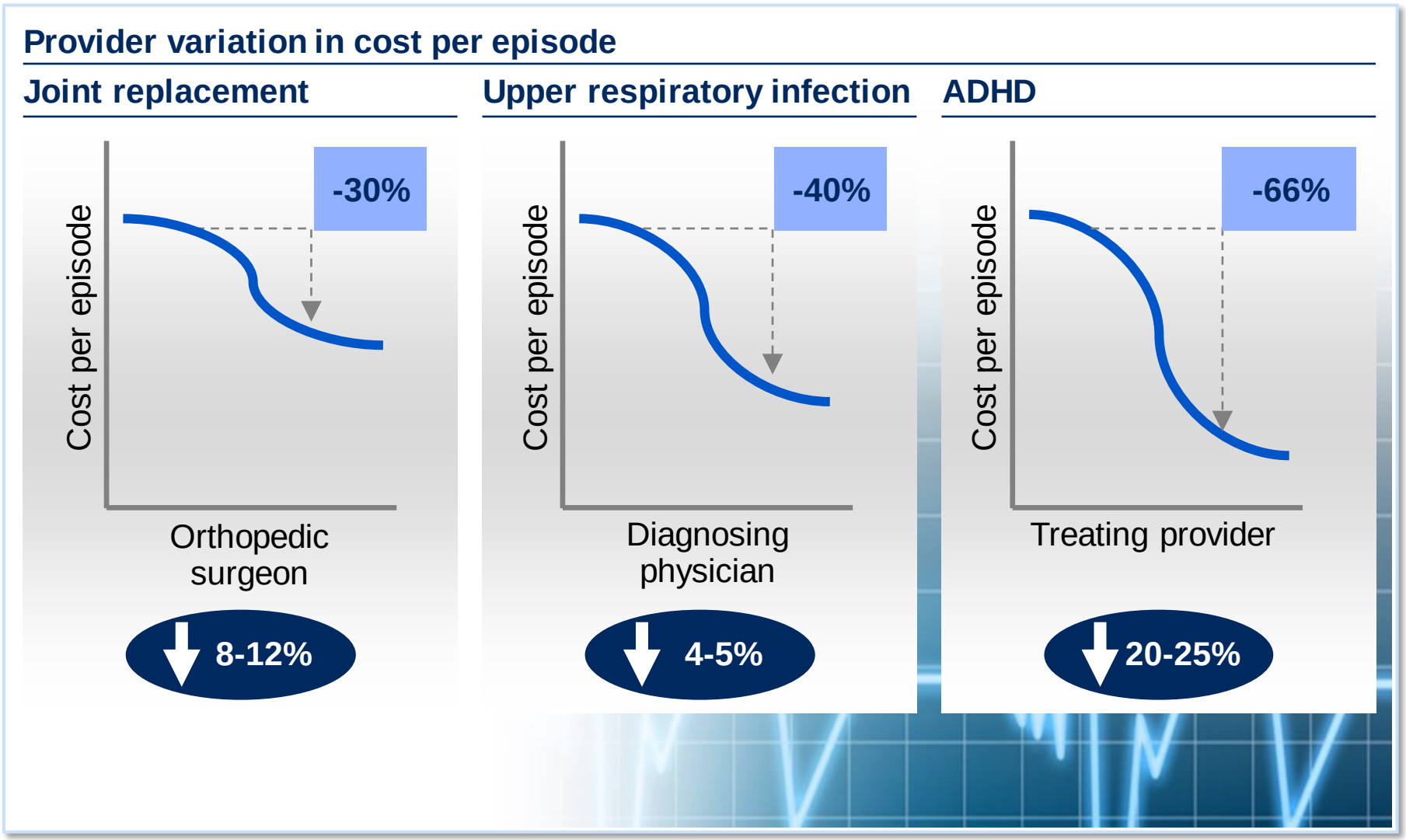
- ***Risk sharing*** Negative incentive payment
- ***No change*** No incentive payment
- ***No Change*** Eligible for incentive payment based on cost, but did not pass quality metrics
- ***Gain sharing*** Eligible for incentive payment



NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

SOURCE: State example

Episode-based payment model can have significant year 1 impact on costs (state example)



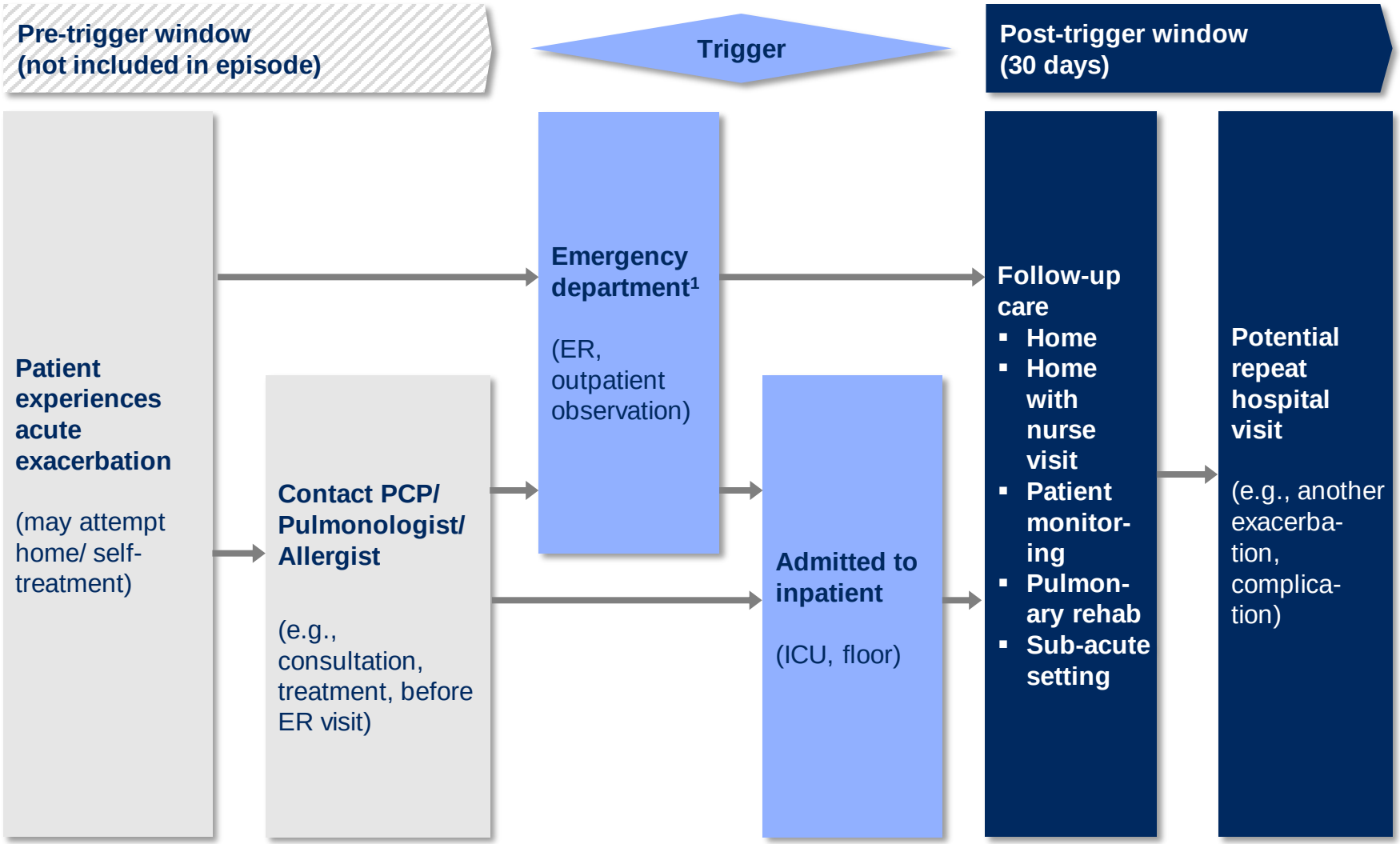
SOURCE: State example

Asthma acute exacerbation example: overview

Category	Episode definition
1 Episode trigger	▪ Asthma specific diagnosis on an ED, observation or IP facility claim ▪ Contingent code with confirming diagnosis
2 Episode window	▪ *Trigger:* Starts on day of admission and ends on day of discharge ▪ *Post-trigger:* Begins day after discharge and ends 30 days later
3 Claims included	▪ *Trigger window:* All ▪ *Post-trigger window:* – Relevant care and complications including diagnoses, procedures, labs, DME and pharmacy – Readmissions (except those not relevant to episode)
4 Principal account-able provider	▪ Facility where the trigger event occurs ▪ In case of transfer, PAP is first facility
5 Quality metrics	*Linked to gain sharing:* ▪ Follow-up visit within 30 days ▪ Filled prescription for controller medications (based on HEDIS list) ▪ *For reporting only:* ▪ Repeat exacerbation within 30 days ▪ IP vs. ED/Obs treatment setting ▪ Smoking cessation counseling ▪ X-ray utilization rate ▪ Follow-up visit within 7 days
6 Potential risk factors	▪ Comorbidities (e.g., pneumonia, obesity); age
7 Exclusions	▪ Clinical (e.g., cystic fibrosis, end stage renal disease, intubation, MS, oxygen during post-trigger window) ▪ Business (e.g., dual coverage, inconsistent eligibility) ▪ Patients < 2 years old and > 64 years old ▪ Death in hospital, left AMA

SOURCE: Public state example

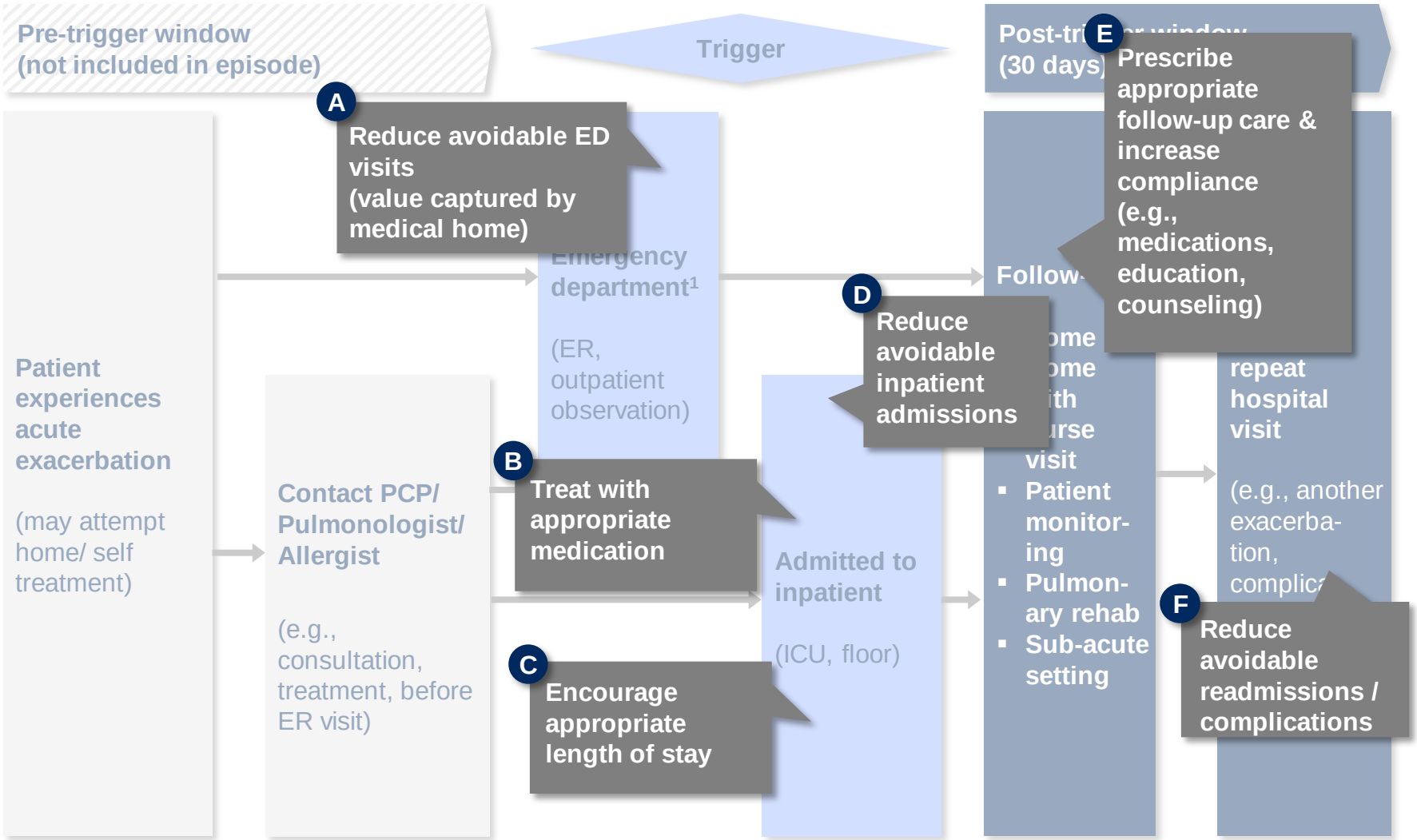
Asthma acute exacerbation example: patient journey



1 May include urgent care facility

Source: AR clinical workgroups

Asthma acute exacerbation example: potential sources of value

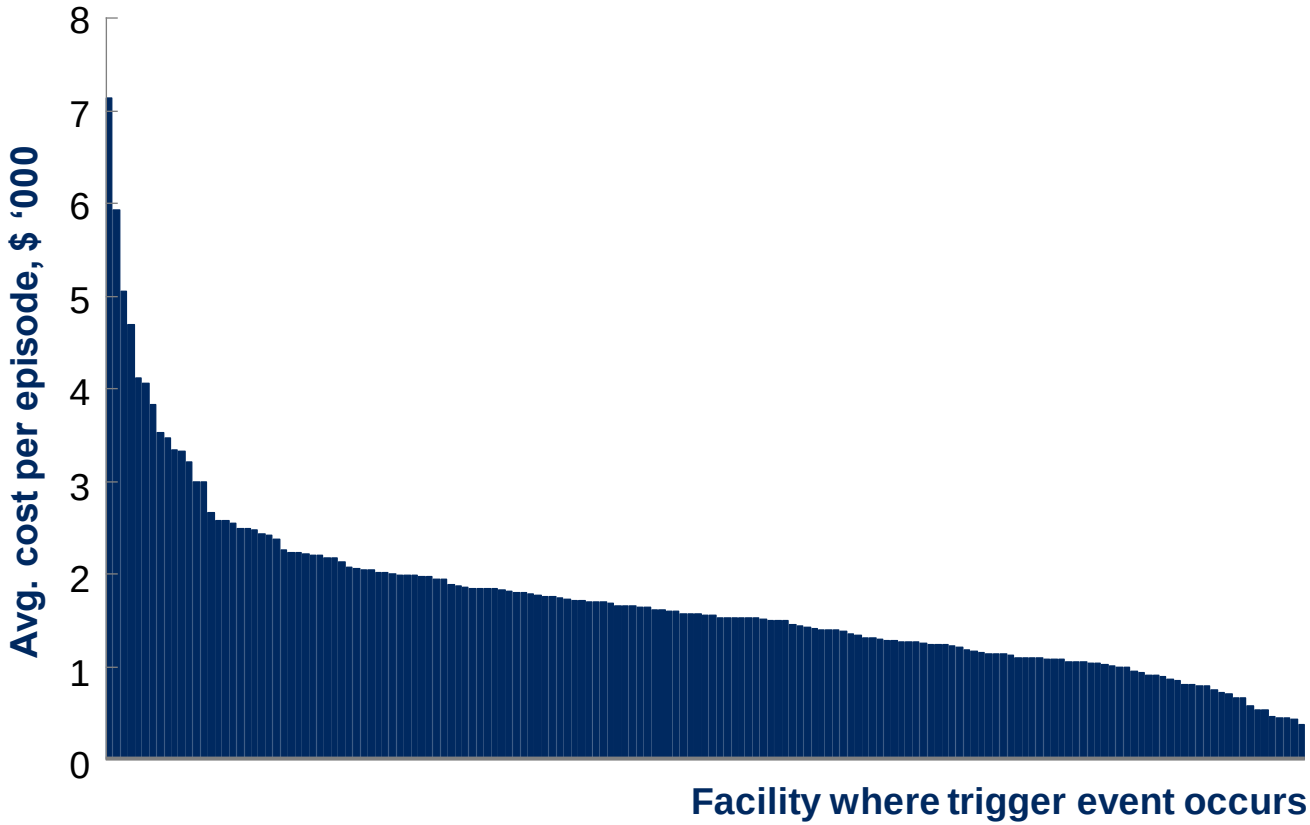


1 May include urgent care facility

Source: AR clinical workgroups

Asthma acute exacerbation example: Provider Performance

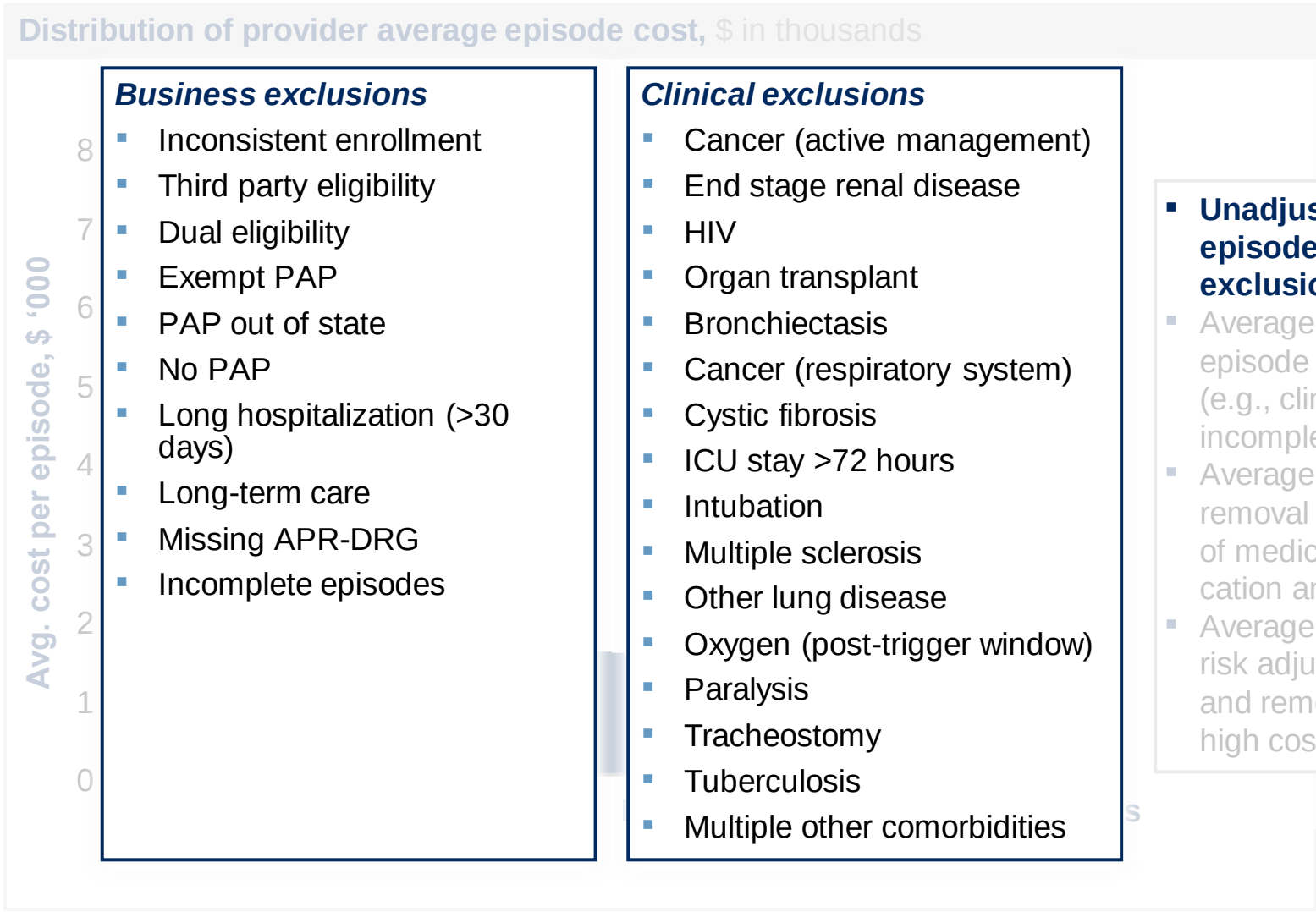
Distribution of provider average episode cost, $ in thousands



- **Unadjusted episode cost, no exclusions**
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Public state example

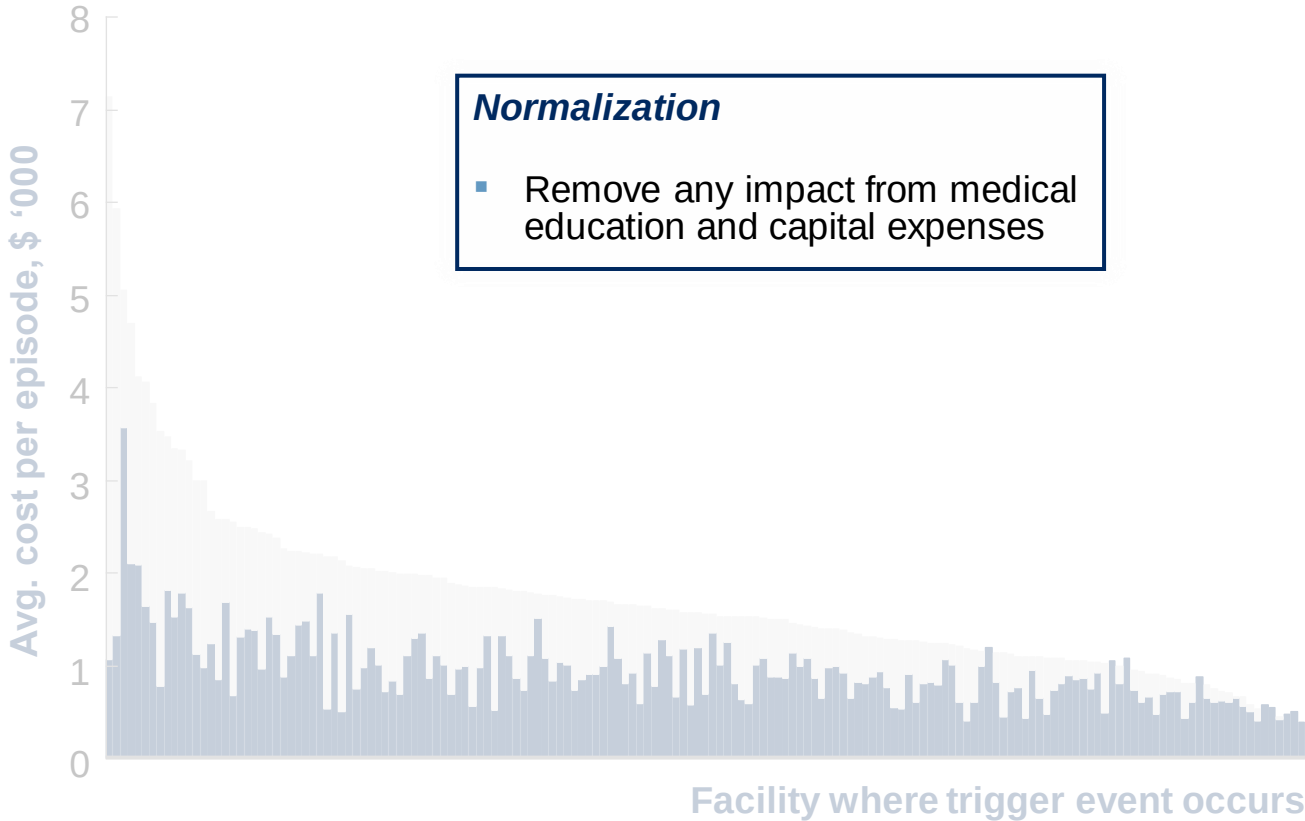
Asthma acute exacerbation example: Provider Performance



SOURCE: Public state example

Asthma acute exacerbation example: Provider Performance

Distribution of provider average episode cost, $ in thousands



Normalization

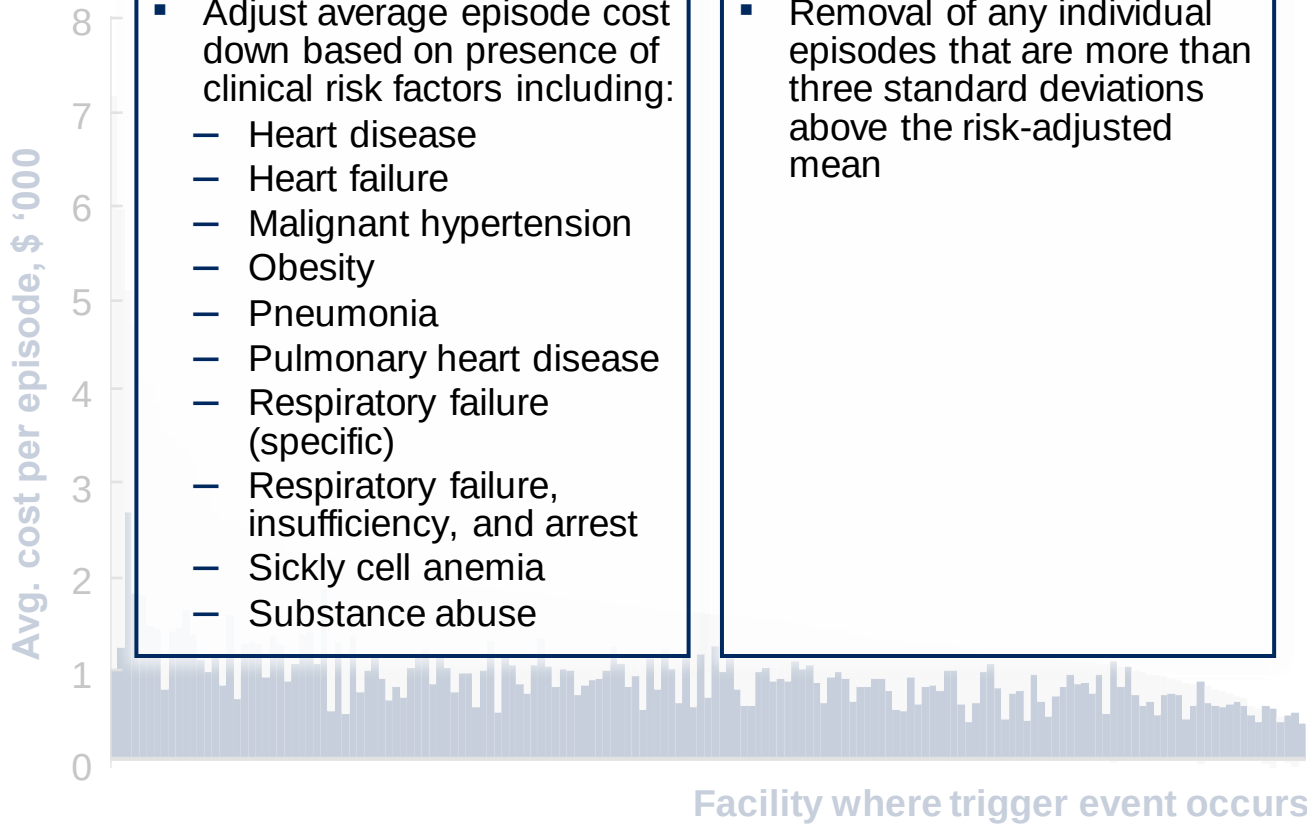
- Remove any impact from medical education and capital expenses

- Unadjusted episode cost – no exclusions
- **Average cost after episode exclusions (e.g., clinical, in-complete data)**
- Average cost after removal of impact of medical education and capital
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Public state example

Asthma acute exacerbation example: Provider Performance

Distribution of provider average episode cost, $ in thousands



Risk adjustment

- Adjust average episode cost down based on presence of clinical risk factors including:
  - Heart disease
  - Heart failure
  - Malignant hypertension
  - Obesity
  - Pneumonia
  - Pulmonary heart disease
  - Respiratory failure (specific)
  - Respiratory failure, insufficiency, and arrest
  - Sickly cell anemia
  - Substance abuse

High cost outliers

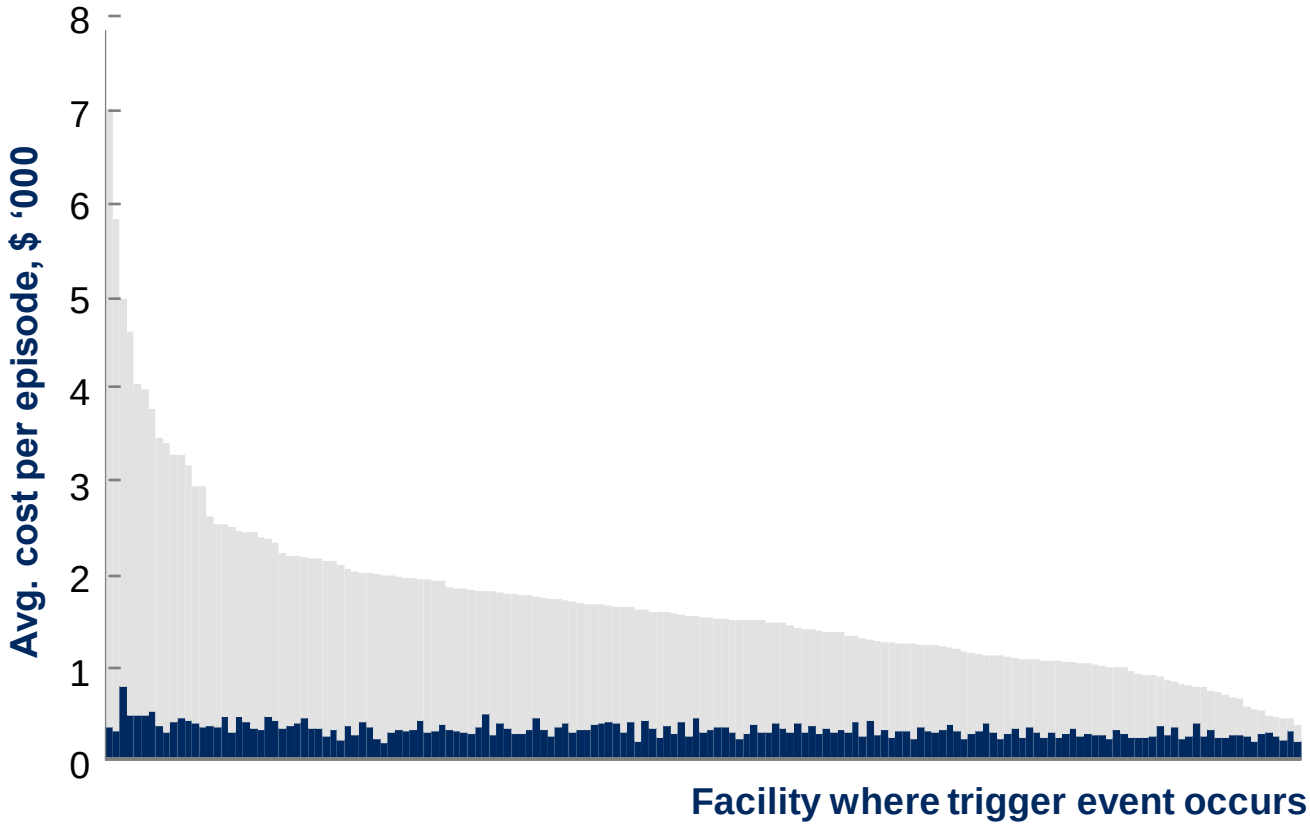
- Removal of any individual episodes that are more than three standard deviations above the risk-adjusted mean

- Unadjusted episode cost – no exclusions
- Average cost after episode exclusions (e.g., clinical, in-complete data)
- **Average cost after removal of impact of medical educa-tion and capital**
- Average cost after risk adjustment and removal of high cost outliers

SOURCE: Public state example

Asthma acute exacerbation example: Provider Performance

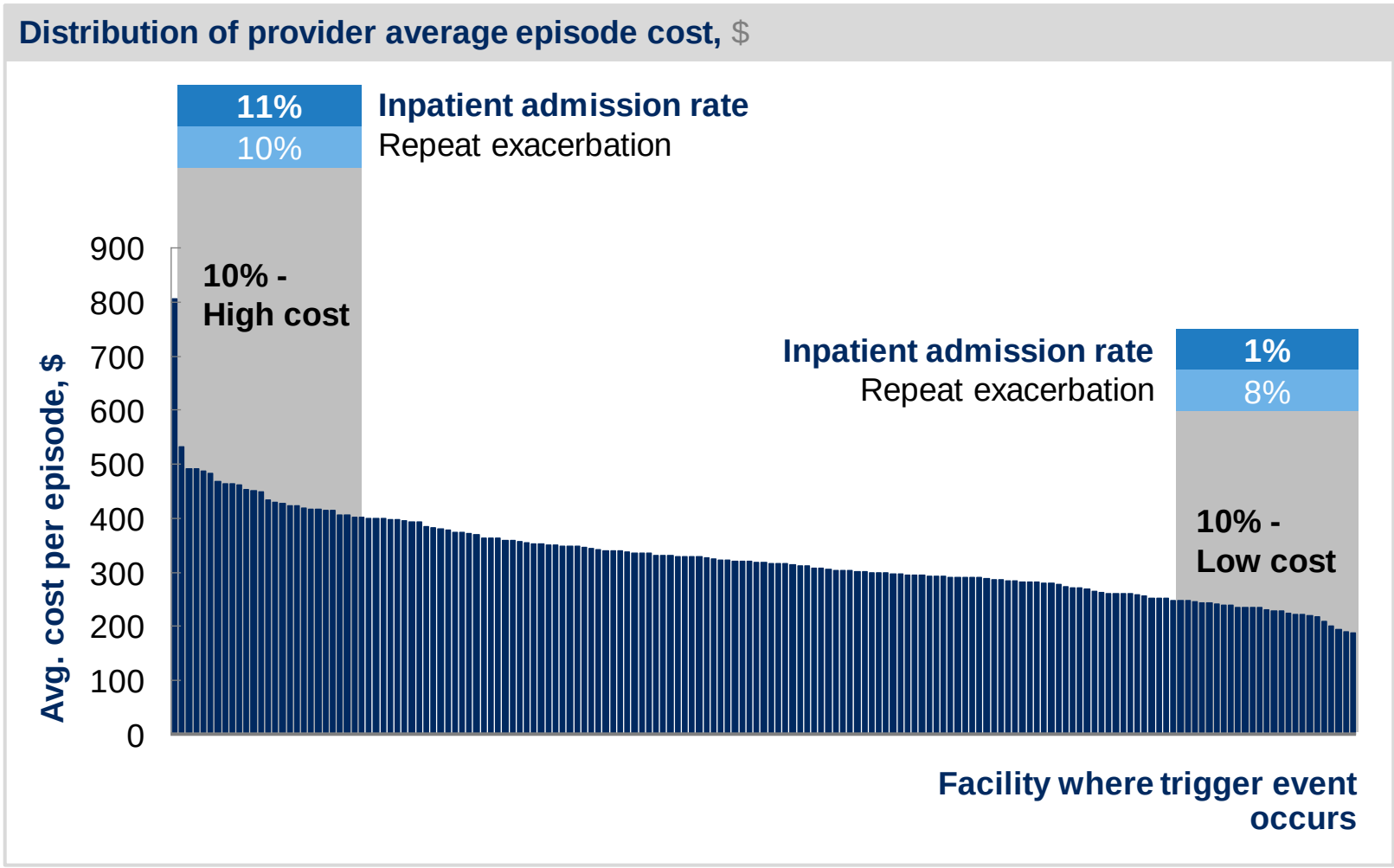
Distribution of provider average episode cost, $ in thousands



- Unadjusted episode cost, no exclusions
- Average cost after episode exclusions (e.g., clinical, incomplete data)
- Average cost after removal of impact of medical education and capital
- **Average cost after risk adjustment and removal of high cost outliers**

SOURCE: Public state example

Asthma acute exacerbation example: variation across providers



NOTES: Average episode spend distribution for PAPs with five or more episodes; each vertical bar represents the average spend for one PAP.

SOURCE: Public state example

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There are three archetypes to the approach to payment model innovation

"Standardize approach"	"Align in principle"	"Differ by design"
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)	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, adm. systems)	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: Quality Measures	**Example: Gain Sharing**	**Example: Amount of Gain Sharing**

State example: Multi-payer episode approach

	"Standardize approach"	"Align in principle"	"Differ by design"
Accountability	▪ Single accountable provider will be identified for majority of episodes ▪ Type of provider may vary, but payers align on accountable providers for each episode	▪ Common vision to not categorically exclude unique providers	▪ Adjustments to episode cost (e.g., cost normalization) may vary by payer
Payment model mechanics	▪ Model follows a retrospective approach; episode costs are calculated at the end of a fixed period of time ▪ Payers adopt common set of quality metrics for each episode	▪ Model includes both upside and downside risk sharing ▪ Aligned principle of linking quality metrics to incentives ▪ Agree to evaluate providers against absolute performance thresholds	▪ Payers may choose to have min number of episodes for provider participation ▪ Type and degree of stop loss may vary
Performance management	▪ Commitment to launch reporting period prior to tying payment to performance	▪ Aligned approach to have episode-specific risk adjustment model ▪ Aligned approach to exclude episodes with factors not addressable through risk adjustment	▪ Payers independently determine method and level for gain sharing ▪ Risk adjustment methodologies may vary across payers
Payment model timing and thresholds		▪ Performance period length for each episode and launch timings aligned where possible	▪ Start / end dates for each episode may vary ▪ Payers each determine approach to thresholding (incl. level of gain/risk sharing) ▪ Outlier determinations will be at discretion of each payer

Breakout exercise for episode-based payments

Directions:

- Join your group's poster and take some post-its
- 20 mins: Each group will address one section of the charter. With your group, think through:
  - What has been omitted that should be included?
  - What changes do you suggest (e.g., an element should be in the "standardize approach" category instead of the "align in principle" category?
  - What questions does this raise?

  Note: please write your thoughts on post-it notes and stick them on the poster
- 20 mins: At the end of the exercise, one member from each group will present their group's findings to the rest of the workgroup

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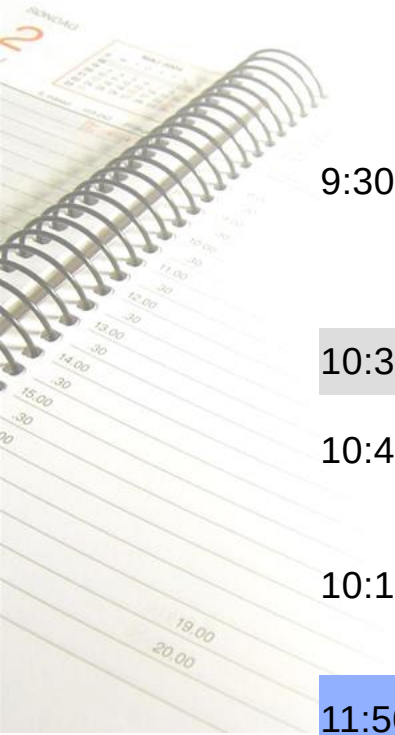

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What we heard from other work groups

Work group	What we heard
Price & quality transparency	▪ Price and quality transparency is critical for enabling any type of payment model innovation ▪ Standardizing and agreeing-on a set of metrics helps enable transparency initiatives, which are then focused on single set of metrics increasing the ease of implementation
Population health	▪ Payment innovation will help lead to improved population health by incentivizing actions that improve quality and outcomes, rather than paying for volume
Health care transformation	▪ Payment innovation should help enable care delivery transformation, including the integration of behavioral health and primary care and investment in telehealth models
HIT	▪ HIT strategies should build off current capabilities to enable new payment strategies

Commonwealth should act as a leader and convener by guiding the vision for payment innovation, and bringing stakeholders together

Next steps

- Identify additional topics, themes, and examples from other states that should be discussed in future payment work group sessions
- Test level of readiness in episode-based payment models in your organization and episodes to prioritize
- Participate in follow-up ad-hoc meetings on metrics standardization
- Meet in March for work group session 3 to refine strategy and identify interdependencies across broader plan
- Continue to provide input on payment model strategic plan

Questions