MEMO

To: Megan Burns and Margaret Houy, Bailit Health Purchasing

From: Mark Schaefer, Director, Healthcare Innovation

Date: September 28, 2016

Re: Study of Cost Containment Models and Recommendations for Connecticut: Straw Model (7/12/16)

I want to commend Bailit on their straw model proposal, which I think introduces for discussion a range of reform concepts that may support Connecticut's continued efforts to drive improvement in health, healthcare, and cost. I have a number of comments on the report, which I hope can inform the evolving discussion. The comments are limited to those elements of the model related directly to care delivery and payment reform.

APPROACH AND TIMETABLE

One notable aspect of the straw model is the fact that it builds on a foundation of successful reforms that Connecticut has undertaken in the past decade including, in the case of Medicaid, state administered claims payment and an Administrative Services Organization (ASO) infrastructure as well as multi-payer care delivery and payment reforms such as PCMH and ACO models. This approach gives the same organizations that are stepping forward to participate in the Medicaid, Medicare and commercial shared savings programs the opportunity to take on further clinical and community integration capabilities and cost accountability as Consumer Care Organizations (CCOs).

Most of these reforms have been evolutionary rather than revolutionary, which is to say, they have occurred over a period of years through a cycle of design, build, test, and expand. The ASO model used by DSS for Medicaid is an example of this. The original ASO was launched in 2006 and limited to addressing the behavioral health needs of HUSKY children and families. The behavioral health ASO was later expanded to adults, and also replicated in oral health and medical. This process took 6 years. However, it allowed the state to develop the experience to ensure that the benefits would be achieved with each new population and any risks (to consumers and providers) mitigated. This approach also recognized that the success of any model depends on ensuring that sufficient time and effort is put into developing necessary capabilities. This can take years.

Accordingly, with respect to the comments herein and other elements of the proposed reforms, the question is whether and how the changes might be staged over a period of time, allowing each set of changes to be tested and assimilated by the payer, consumer and provider community before undertaking the next phase of change.

SCOPE

I agree with several commenters that the care delivery and payment reform strategy should be one that can be implemented across all payers. This would build on the work of the State Innovation Model (SIM) initiative, which is promoting the alignment of quality and cost accountable contracting with the same entities across the

commercial, Medicaid, and Medicare markets. An example of this work is the Department of Social Services' PCMH+ program, which builds on their successful PCMH program by combining innovative care delivery enhancements (e.g., new care coordination requirements) and the opportunity to share in savings.

Many of the reforms that are needed, such as flexibility in primary care payment to enable a more varied workforce and methods of patient engagement, will serve all populations. It will enable providers to engineer improvements that do not have to be compartmentalized by payer populations. Moreover, some of the improvements in health and behavior that we should be promoting including changes in diet, exercise, and lifestyle are common to every population of Connecticut residents. Medicare participation is critical in light of the volume of health services and expenditures that are committed to serving this population. The participation of commercial payers is also important. The commitment of commercial payers should be solicited in advance through an application process for those elements of the plan that are explicitly multi-payer, similar to what CMMI has done with CPC+.

PAYMENT REFORM

COMPREHENSIVE PRIMARY CARE BUNDLE

The promise of shared savings alone will not be sufficient to enable the widespread adoption of non-reimbursable activities and team-based care models, especially because such activities may reduce practice revenue or increase the cost of doing business without realizing near term savings such as through reduced hospital and ED use. The State should implement primary care payment reforms that will give providers needed flexibility to change the way that they practice in primary care settings with the goal of enabling providers to:

a. diversify the care team to include non-reimbursable functions and team members such as patient navigation and community health workers, and

b. incorporate non-visit based patient engagement techniques such as phone, e-mail, text and electronically facilitated telehealth interactions.

I would recommend that the proposed reforms include a multi-payer *comprehensive primary care bundle* such as CMMI introduced with Comprehensive Primary Care Plus (CPC+). This model retains a fee for service foundation, while supporting the flexible provision of primary care services. This flexibility will better enable providers to accommodate the additional expectations of payers under various shared savings programs as well as the SIM Community and Clinical Integration Program (CCIP) and CMMI Transforming Clinical Practices Initiative (TCPI). This reform would also make it easier for practices to adopt team-based care models to *reduce health equity gaps*, such as the incorporation of community health workers as health coaches—a key element of the CCIP standards. This flexibility may also enhance our efforts to restore the joy of practice, for physicians and for all members of the care team. As part of a staged approach, this type of reform could be introduced as an incremental advance in payment methods, one that would build naturally on the value-based payment models that are being instituted by all of Connecticut's payers and in advance of the Consumer Care Organization (CCO) model that is proposed in the straw model.

HEALTH EQUITY AND SUBSPECIALTY REIMBURSEMENT

Medicaid subspecialty reimbursement may be one of the more significant contributors to income related disparities in access to subspecialty services and chronic illness outcomes. Any payment reform with an eye on the

long view should address this structural inequity by providing a level of reimbursement in Medicaid that is comparable to that provided in Medicare. However, reimbursement parity for subspecialty care must be accompanied by payment reforms that promote economy and efficiency, otherwise, we will see the same pattern of over-use and excessive growth in costs that has been characteristic of Medicare and commercial. This policy could potentially be cost-neutral if limited to providers participating in the proposed CCO population based payment model, assuming agreement can be reached on trend assumptions that would be the basis for shared risk *and* if the reimbursement methods could be aligned with the CMS' Alternative Payment Model (APM) strategy (see more on this below).

POPULATION BASED PAYMENTS WITH DOWNSIDE RISK

I agree with the premise of the straw model, which is that upside only shared savings program models may not provide accountable healthcare organizations with enough of an incentive to improve value and substantially reduce waste. The preponderance of such arrangements may explain in part the mixed results that have been observed to date in the Medicare Shared Savings Program (MSSP) and similar programs. CMS has taken the position that more than nominal downside risk is an essential component of our next generation of payment reforms and the only means to ensure that providers reorganize their businesses around improving quality and reducing waste. They cite behavioral economic theories of loss aversion as the basis for their new payment models, such as the Next Generation ACO Model and CPC+.[1] For example, under CPC+ providers are paid projected savings up front and then potentially recouped if utilization targets are not achieved.

Few if any Connecticut providers have entered into risk arrangements under Medicare or commercial shared savings program contracts, despite the fact that they have the opportunity to do so and that such arrangements are typically accompanied by more attractive gain share arrangements. This may be in part because success under these models requires advanced care delivery and analytic capabilities and such capabilities are still evolving. They are also dependent in part on a statewide strategy for health information exchange that would enable providers to monitor a patient's care (and associated quality and cost performance) wherever that patient goes for care. The absence of the necessary infrastructure to handle risk is one of the reasons provider risk models failed in the 1990s. CCIP and TCPI are among the initiatives intended to help providers develop these capabilities, along with the requirements of PA 16-77 and SIM Health Information Technology (HIT) infrastructure investments, which will support health information exchange and electronic clinical quality measure (eCQM) production. However, these efforts will take time to realize.

Population based payment with downside risk is a necessary element of our change strategy. Moreover, downside risk for total cost of care must be in place in order for us to address the above noted disparity in subspecialty reimbursement. Parity in subspecialty reimbursement can only be achieved if there is a counter-incentive to discourage inappropriate use—specifically, a risk-based market that rewards reductions in waste and encourages the management of total cost of care. As important as this strategy is, I am not recommending it as an immediate course of action. The administration committed to upside-only shared savings program arrangements in PCMH+ for the duration of the SIM test grant in order to better understand and gain experience with total cost of care accountability in a Medicaid context. This commitment should be honored.

Accordingly, I recommend the following developmental course in preparation for a CCO model:

[1] http://jama.jamanetwork.com/article.aspx?articleid=2513625%20

a. focus on assessing and supporting the development of capabilities necessary for providers to succeed in risk-based global budget models;

b. encourage providers to begin assuming risk in Medicare and commercial payment arrangements; and

c. introduce downside risk in Medicaid as a phase of CCO deployment, beginning after the conclusion of the SIM test grant.

Under-service safeguards should be an essential component of the downside risk strategy, building on the work of the Care Management Committee and the SIM Equity and Access Council. In particular, the State should examine whether it is possible to introduce social-demographic risk adjustment to ensure that there are appropriate incentives to serve individuals with the most complex health needs. Finally, the role of the Quality Council's recommended Core Measure Set for value-based payment should also be considered, *especially* as it relates to the development and use of measures of health equity performance.

ALTERNATIVE PAYMENT METHODS

The straw model recommends setting targets for the adoption of APMs. APMs targeted toward episodes (conditions or procedures) could help improve quality, safety and cost of care. However, such APMs do not discourage unnecessary procedures and as such should be implemented alongside or as component of the proposed population based payment model.

My primary concern about episode-based APMs is that they are expensive to design, build and maintain, prohibitively so if one targets a wide range of conditions and procedures. If all of Connecticut's payers pursue episode-based APMs independently, the lack of payer alignment will create an environment within which it may be impossible for providers to succeed. To my knowledge, Medicare is the only payer that is preparing to implement a large number of such APMs across a wide range of subspecialties, and they are doing so on a national scale such that the costs of development may yield a return on investment in time.

In addition, APM targets may not be achievable for Medicaid in some areas. For example, it will be difficult to implement episode-based APMs if one is limited to the current Medicaid subspecialist fee schedule because the total worth of the bundle will be below cost. Coupled with the risk of incurring costs in excess of the bundle, such APMs might be an unpopular proposition—one can lose a little or one can lose a lot, but in either case one loses.

I recommend that the State engage CMS to determine whether and how the reimbursement methods for professional services under the state employee plan and Medicaid could be aligned with those of Medicare. The primary purpose would be to examine how Medicare's episode-based APM reimbursement strategy could be extended to these publicly insured populations, thus capitalizing on CMS' investments and infrastructure for their design and deployment. This approach is not without precedent. It is the sort of alignment that Maryland was able to achieve many years ago across all payers with respect to hospital reimbursement.

This policy would likely have a favorable impact on the state budget for state employee healthcare, assuming that the Medicare fees that are the basis for episode-based APMs replace the higher commercial fees that are in place today. Conversely, there could be an adverse impact on the state budget associated with implementing these models in Medicaid, unless limited to CCO program participants with downside risk. Limiting access to these arrangements to subspecialists that participate in the CCO model would provide considerable incentive to participate in the CCO model and serve Medicaid recipients, in keeping with one of Bailit's original straw model recommendations.

ALIGNING WITH THE QUALITY PAYMENT PROGRAM

Under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), CMS introduced the Quality Payment Program (QPP), which, among other things, will reward providers who participate in Advanced Alternative Payment Methods (AAPM). The definition of an AAPM has not been finalized, but more than likely will include a requirement for more than nominal risk-sharing. The proposed population based payment model may in fact meet that test.

Connecticut providers will be best served if all of the payers that they contract with use payment arrangements that meet the AAPM test, whether Medicaid, Medicare or commercial. Doing so will enable providers to opt out of the Merit-based Incentive Payment System (MIPS) and be a factor in determining whether a provider qualifies for a payment incentive. Specifically, the AAPM payment incentive calculation will consider a provider's AAPM penetration across all patient populations. In other words, commercial and Medicaid AAPMs will factor into provider reimbursement under Medicare.

MEDICARE WAIVER

For maximum impact, several of the above strategies would require the participation of Medicare (e.g., comprehensive primary care bundles) or a full partnership with Medicare (multi-payer APMs). Without Medicare participation, providers will be left to figure out how to engineer care delivery reforms that differ by payer population—an approach that is costly, burdensome, and inefficient. This is the reason that CMMI established multi-payer alignment as a pre-eminent principle in its SIM initiative, as well as select care delivery and payment reforms such as CPC+.

CMS has recently offered to consider customized partnerships with SIM participating states, of the sort that it has undertaken with Maryland around hospital payments and, more recently, global hospital budgets. We have the unique opportunity to use our status as a SIM state, and our reform agenda, to engage Medicare in partnership that could influence the evolution of care delivery and payment reforms in Connecticut for years to come. I recommend that this be part of an explicit multi-payer strategy, as a complement to potential Medicaid 1115 waiver and DSRIP initiatives.

CARE DELIVERY REFORM

The straw model places an appropriate emphasis on provider capabilities that support improvements in coordination of care and methods to address social determinants of health. Bailit should consider whether and how the proposal might incorporate CCIP, which was developed by the SIM Practice Transformation Task Force. The core standards that comprise CCIP focus on individuals with complex health needs, individuals experiencing health equity gaps, and individuals with unmet behavioral health needs. The standards place a special emphasis on social determinant risks and health equity, e.g., by requiring the collection of more comprehensive social and demographic information as part of a whole person assessment, community linkages with community support providers, the integration of community health workers in care teams, and the development of methods for identifying and addressing sub-population specific health equity gaps.

With some exceptions, PCMH+ participating Advanced Networks and FQHCs, are required to participate in CCIP and arguably will be better prepared to take on the additional responsibilities envisioned for CCOs. One might consider establishing the CCIP standards as a foundational expectation for CCOs and examining how the requirements of CCOs can further refine or build upon CCIP foundational capabilities.

COMMUNITY HEALTH IMPROVEMENT

Connecticut SIM has, among its aims, several issues under the broad category of community health improvement that may not be addressed in the proposed straw model. The first is a strategy for primary or secondary prevention, specifically, incentivizing reductions in the incidence and prevalence of acute and chronic conditions. The prevention or elimination of health problems tend not to be rewarded by today's accountable care models, most of which base their cost targets on the clinical risk of the population. Under these models, there is more of a financial opportunity when one has more sick people on one's attributed panel, rather than less. If, in an effort to mitigate this problem, payers introduce disease prevalence measures onto payment scorecards or use an alternative market reference for costs projections, there could be adverse selection—i.e., an incentive to select healthier patients in an effort to improve disease prevalence scores or to reduce costs.

The second issue is the problem of non-attributed populations—individuals who have not seen a primary care provider and instead go without care or seek care from an emergency department in the face of an urgent or emergent problem. Addressing the basic health problems of such individuals such as overweight and hypertension will remain out of reach unless this is called out as a primary aim for which our design must have a proposed solution.

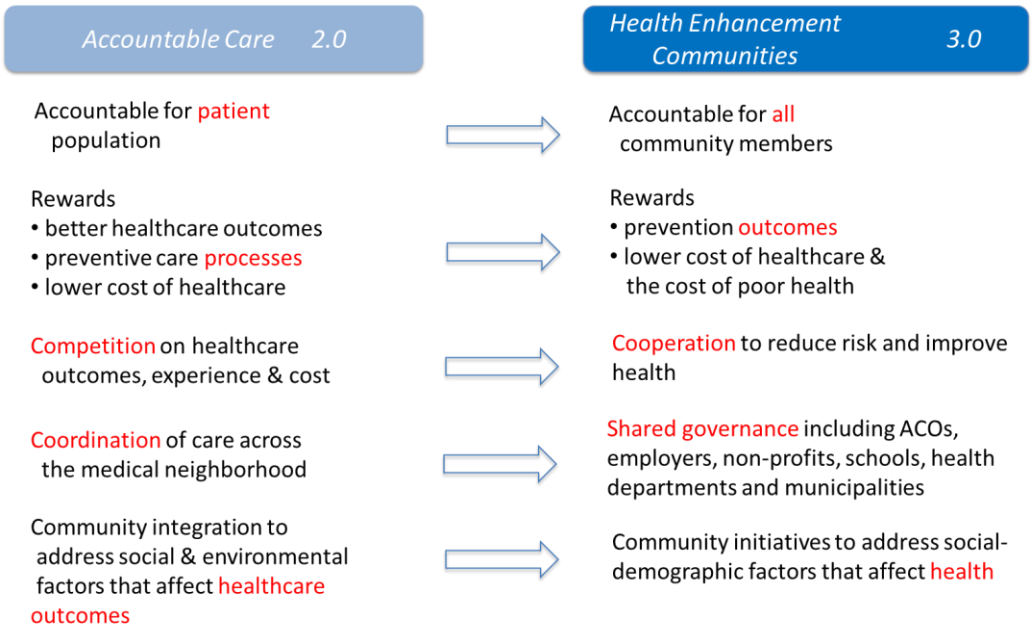
The third issue is the need to incentivize cross-sector collaboration, which might include the introduction of cross-sector rewards for addressing the above issues, especially when the needed solution lies outside of the direct influence or resources of a CCO. Housing code enforcement and food deserts are two examples. There are Connecticut health systems that have demonstrated that they can help drive these solutions, but it is not something that commonly occurs nor is it rewarded by today's healthcare market or emerging payment reforms.

It is these kinds of issues that the Department of Public Health is trying to address through SIM-funded population health planning, conducted in collaboration with the Department of Social Services and the SIM PMO. Given that the target date for implementation of the Health Enhancement Community (HEC) model is the latter part of 2019 or early 2020, it seems reasonable to consider whether and how comprehensive reforms of the sort envisioned with the proposed straw model, and the federal vehicles for those reforms (e.g., 1115, DSRP or Medicare waiver) could enable the achievement of SIM community health improvement objectives. The State had in mind the need for such authorities to support HECs in its SIM test grant application. Federal agreements of this kind may take years to design and implement and they are typically approved for periods of three to five years during which substantial revisions may be difficult to undertake. If the SIM community health improvement strategy is not considered at the outset, it may be five to ten years before we have another opportunity.

Now it may be that the problems for which we are trying to solve can be addressed in the CCO design, such that HECs are unnecessary. Or it may be that HECs become an aligned strategy, one in which the necessary financial means and model can be incorporated into any application for federal authority or participation. In either case, my recommendation is that we adopt as part of our straw model the aims for an HEC solution that have been developed for population health planning under SIM (see figure below). Specific elements that should be considered include:

a. a governance structure that coordinates cross-sector health improvement initiatives and serves as single point of accountability and fiduciary for an HEC,
b. the inclusion of measures of community-wide prevention outcomes on CCO and HEC performance scorecards, and
c. a model for financing a wellness trust or similar vehicle to support community health improvement interventions and to reward cross-sector participants for improving community health.

We would welcome the opportunity to dialogue further about alignment with the HEC concept with our partners at the Department of Public Health and the Department of Social Services.



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