



Delaware Center for
Health Innovation

Outcomes-based payment for population health management

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Introduction

PURPOSE OF THIS PAPER

Since July 2014, the Delaware Center for Health Innovation (DCHI) has been convening stakeholders to establish goals for primary care transformation as a key element of Delaware's Health Innovation Plan, contributing to our broader aspirations for improved health, health care quality and experience, and affordability for all Delawareans. While our early work has focused on primary care, in the future we hope to build on this foundation with improved behavioral health and specialty care, as well as better integration among primary care, behavioral health, and specialty care.

Last spring (May 2015), we published our perspective on primary care practice transformation, followed by perspectives recently introduced on care coordination, the integration of behavioral health with primary care, and a proposed governance model by which Healthy Neighborhoods may organize to integrate public health, health care delivery, and community-based efforts to improve population health.

In the following consensus paper, we further elaborate our perspective on outcomes-based payment for primary care providers or for larger systems or networks assuming accountability for the health and health care of a population. Our perspectives are organized in three parts: (1) a vision for outcomes-based payment for population health management; (2) principles for payment model design and implementation; and (3) strategies to promote availability and adoption of outcomes-based payment models in accordance with these principles.

DELAWARE HEALTH INNOVATION PLAN

Delaware aspires to be a national leader on each dimension of the Triple Aim: better health, improved health care quality and patient experience, and lower growth in per capita health care costs.

In 2013, the Delaware Health Care Commission convened stakeholders across the state – including consumers, providers, payers, community organizations, academic institutions, and state agencies – to work together to build a strategy to achieve these goals. That work culminated in Delaware's State Health Care Innovation Plan followed by the award of a four-year, \$35 million State Innovation Model Testing Grant from the Center for Medicare and Medicaid Innovation to support the implementation of the plan. Combined with additional investments by purchasers, payers, and providers of care in Delaware, grant funds are intended to support changes in health care delivery to create more than \$1 billion in value through 2020. DCHI was established in the summer of 2014 to work with the Health Care Commission and Delaware Health Information Network (DHIN) to guide the implementation of the strategy as described in the Innovation Plan as a partnership between the public and private sectors.

OUTCOMES-BASED PAYMENT AS ONE OF THREE FORMS OF SUPPORT

Leaders in Delaware's provider community agree that better integrating and coordinating care for high-risk populations will require meaningful changes in operational processes and development of new capabilities among primary care providers. Over the past several months, DCHI has contemplated three forms of support for primary care providers, including independent providers and those working as part of a larger group, system or network. We provide working definitions below, as context for our recommendations in the pages that follow.

- **Practice transformation support** describes transitional financial support and/or technical assistance to help providers adopt changes in clinical and operational processes. While the transformation of primary care practices to population-based models of care delivery may be a journey of continuous improvement, we refer here to finite support over one or two years.
- **Care coordination funding** would help providers coordinate care between patients' office visits or other encounters with the health care system. Advances could include improved communication and coordination between patients and their providers, or among otherwise unconnected providers. Care coordination may be funded through fee-for-service payments tied to care coordination, fixed payments paid per member per month, or another method.
- **Outcomes-based payments** may be paid to providers for quality, experience, and efficiency. The Delaware Health Innovation Plan reflects stakeholder consensus that payers should offer primary care providers (or their affiliated groups or systems) two types of outcomes-based payment models: Total Cost of Care (TCC) models that pay providers for controlling growth in the per capita total cost of care including primary care, medical care, behavioral health care, and pharmacy; as well as Pay-for-Value (P4V) models that pay providers for efficiency based on one or more measures of utilization as a proxy for total cost of care. Stakeholders recommended that under either model, providers should achieve standards for quality and patient experience to receive payments tied to the efficiencies achieved.

Vision for outcomes-based payment

In contrast to fee-for-service payment, outcomes-based payment rewards providers for improved health, quality of care, consumer experience, and/or efficiency. DCHI's goal is that, by the year 2020, all Delawareans will have a primary care provider, with more than 95% of healthcare spending falling within an outcomes-based payment model.

CORE BELIEFS

Our vision and strategy for outcomes-based payment is grounded in several core beliefs as outlined following.

- 1. Our vision is that primary care serve as a platform for clinical integration as well as empowerment of consumers to participate in management of their own care.** Less than 10 percent of health care spending is expended on primary care (in some populations as little as 5 percent). However, primary care providers have the potential to influence the great majority of care—either directly through diagnosis and treatment, or indirectly through referrals to other providers. Primary care therefore provides a strong foundation for engaging consumers in defining their own goals for their health and health care, and accessing care accordingly. Primary care providers may also facilitate the integration of care delivered by other providers in the system, including specialists, hospitals, and other parts of the care delivery system. Our strategy toward outcomes-based payment therefore focuses initially on primary care providers (or networks of providers that include primary care providers), organizing around the needs of consumers.
- 2. Providers may adopt varied structures to achieve the scale and capabilities necessary to integrate care.** Delaware's delivery system includes independent primary care providers (PCPs), large medical group practices or independent practice associations (IPAs), as well as PCPs who are financially and/or operationally integrated with health systems. Our experience and research bears out evidence of effective care delivery under all of these structures, and so our vision for outcomes-based payment does not prescribe a single structure but rather is meant to support better outcomes agnostic of provider structure. That said, we do believe there may be benefits from scale in organizing to manage care for a population. Primary care providers may find it helpful to either fully integrate or establish formal collaborations with other providers in order to achieve the scale sufficient to share administrative or clinical processes including, as an example, capacity to coordinate care for high-risk patients in between office visits. Given the concentration of health care spending in hospital care, and the resources and management capacity of our health systems, we believe our health systems may make an important contribution to the shift to outcomes-based payment including the adoption of risk for total cost of care as well as investments in capabilities to manage population health.

- 3. All payers should participate in the transition to outcomes-based payment, if we are going to realize meaningful transformation as a system.** Providers will struggle to finance and operationalize new capabilities and processes if they are applicable to only a small fraction of the patients they care for. Financially, it may be impractical to realize a meaningful return on investment if rewards are restricted to only a fraction of patients. Clinically and operationally, it may be impractical to differentiate between patients based on payer. For these reasons, we believe that the transition to outcomes-based payment is one we must undertake on a multi-payer basis. By coordinating efforts across payers, providers can implement new processes that extend to all of their patients, reducing the complexity that may arise with multiple competing business rules, and improving the return on investments in new capabilities.
- 4. Rather than a “one size fits all” approach to payment, we should encourage multiple “on-ramps” to outcomes-based payment, suitable to providers who differ in scale, capabilities, and capacity to shoulder financial risk.** We believe that all providers should be working toward the same goals for better health and better care at a lower cost (The Triple Aim). However, we recognize that providers are starting from different points with respect to scale, capabilities, and financial resources. In recent months, a significant proportion of PCPs in Delaware have organized into accountable care organizations (ACOs) or Clinically Integrated Networks (CINs) in order to achieve the scale necessary to share administrative and clinical capabilities as well as to pool performance for participation in total cost of care risk sharing under the Medicare Shared Savings Program (MSSP). However, at least as many PCPs continue to operate independently, and lack the scale or experience necessary to move directly into TCC models. We therefore maintain our view that payers should offer multiple options to providers for outcomes-based payment. Over time, we hope for the substantial majority of primary care providers to participate in TCC models as they gain the capabilities necessary to do so and as other providers in our delivery system likewise build the capabilities to effectively integrate with primary care.
- 5. Model design and implementation should support improvements in provider satisfaction.** Improvements in care delivery will not come easy, and will require significant investments as well as expenditure of effort by providers to achieve our goals for improved health and health care at a lower cost. However, we cannot be successful if new payment models are designed or implemented in a manner that erodes provider satisfaction. To the contrary, we need to ensure that providers who are committed to our shared goals are supported in making the transition, both financially and operationally. We should also strive to be parsimonious with new administrative processes incumbent to new payment models.
- 6. Our expectations for multi-payer alignment should strike a balance between the benefits of standardization with the practical challenges that our payers face in operationalizing solutions across multiple states.** Greater standardization across payers in the detailed business rules of outcomes-based payment would reduce

complexity and administrative burden for providers in Delaware. However, we recognize that all of Delaware’s payers (CMS for Medicare, our Medicaid Managed Care Organizations, and our Commercial insurers) are simultaneously working to standardize and simplify their own programs across national or multi-state footprints. We will strive to identify opportunities to standardize across payers (e.g., quality measure definitions) where doing so poses meaningful opportunities to reduce administrative burden to providers or promote a more consistent and high-quality experience for Delawareans. However, we also wish to afford reasonable flexibility for payers to retain differences in detailed business rules where standardization on solutions unique to Delaware would introduce extraordinary costs that would then be passed on to consumers and other health care purchasers in our community. As we gain experience with outcomes-based payment, we will continue to re-evaluate opportunities for greater standardization and simplification.

Principles for model design and implementation

We recognize that the way in which payers and providers implement outcomes-based payment may vary based on differences in provider scale and structure, and in patient needs. However, we also believe there is a benefit to defining a common framework. Following from the core beliefs previously outlined, we have defined twelve (12) principles for payment model design and implementation that we hope will be widely embraced by payers and providers across Medicare, Medicaid, and Commercially insured populations. These principles reflect the consensus of the DCHI Board based on our collective experience with outcomes-based payment, discussions with stakeholders participating on DCHI committees, input from other local stakeholders and interviews with experts with experience drawn from outside of Delaware.

- 1. Payers should offer primary care providers the opportunity to participate in either Total Cost of Care models or Pay-for-Value models.** Total Cost of Care (TCC) models should reward providers for controlling growth in the per capita total cost of care including primary care, medical care, behavioral health care, and/or pharmacy costs which also achieving goals for quality of care. Prospective payment or capitation is just one example of a TCC model; other alternatives include gain sharing or risk sharing based on comparison of total fee-for-service payments to a benchmark or target for total cost of care. Providers who may not be ready to shoulder risk for total cost of care should be afforded an alternative P4V model that provides bonuses based on quality and efficiency measures, e.g. frequency of readmissions and emergency department visits.
- 2. Payers should define provider eligibility for outcomes-based payment based on criteria that are objective and openly communicated.** We recognize that some parameters for outcomes-based payment models (in particular, TCC risk sharing arrangements) may be terms of negotiation between payers and providers and

therefore may remain proprietary and confidential. However, we also believe that we can only achieve our goals for system transformation if opportunities for transition to outcomes-based payment are widely accessible to providers based on objective eligibility criteria and openly communicated pathways for adoption. Payment models that are available on an exclusive basis, or that require one-off contracting decisions based on subjective criteria have commonly experienced slow uptake by providers. By defining objective criteria for provider eligibility for outcomes-based payment models (e.g., minimum panel size, minimum quality thresholds, achievement of certain practice transformation milestones), we can set clear expectations for providers for hurdles they must clear which may stimulate practice transformation as well as organization of providers into IPAs, ACOs, or CINs as needed to achieve the scale and capabilities necessary to succeed under outcomes-based payment models. By communicating eligibility criteria and performance requirements openly, payers afford DCHI and other interested stakeholders an opportunity to support provider outreach and enrollment in these models.

- 3. Patient attribution to providers should be based on transparent methodologies, with prospective notification to patients and providers, and processes for systematic adjustments over time.** Outcomes-based payment models will depend on the assignment or attribution of patients to a provider (or provider organization) for purposes of performance measurement. The Medicare Shared Savings Program which has recently gained broad adoption in Delaware relies on a retrospective method of attributing patients based on the PCP who delivered the greatest proportion of primary care during the performance period. This approach—for better and for worse—allows for changes in the attributed patient panel based on patterns of utilization during the performance period. Conversely, Medicaid Managed Care Organizations have typically tied outcomes-based payment models to the same prospective selection (or assignment) of a PCP that underpins the Medicaid program more broadly. Under either approach, providers require accurate and timely information regarding the list of patients attributed to their panel, so that providers can organize outreach and care coordination efforts around that panel. Payers should also make the detailed rules for patient attribution transparent to providers (as well as consumers, if requested); payers using retrospective attribution methods should be prepared to provide information, if necessary, to support attribution if it appears to conflict with provider or consumer experience. Payers are encouraged to adopt continuous improvement processes that improve the effectiveness of patient attribution while also improving access to care and consumer engagement, for example: (a) providing periodic notification of PCP attribution to both providers and consumers; (b) surfacing instances where members are not accessing care from their previously attributed PCP; (c) diagnosing barriers to access, whether patient specific or systematic for a given PCP; and (d) re-assigning patients to other PCPs based on either observed patterns of utilization and/or requests from patients or providers, subject to reasonable review to minimize the potential for selection bias in panels.

- 4. Payers may adopt minimum panel sizes and/or minimum savings rates (or similar) to mitigate the effect of random chance on outcomes-based payments.** Quality and cost outcomes may be influenced by a combination of patient characteristics and provider practice patterns. Notwithstanding the use of risk adjustment and clinical exclusions, there may remain differences in patient mix that can be exacerbated by small panel sizes. At small panel sizes, random chance may also impact performance independent of patient mix—for example, the potential for an unusual concentration (or paucity) of serious acute events falling within a given performance period, by virtue of statistical variation within small numbers. For these reasons, payers may establish minimum panel sizes as a criteria for participation in outcomes-based payment models; and/or minimum “denominators” for specific quality measures incorporated into those payment models. Payers may also establish a minimum threshold for the level of savings (or risk) that must be met before triggering gain sharing (or risk sharing), to reduce the potential for payouts that may be simply due to random chance. The Medicare Shared Savings Program uses a minimum panel size of 5,000 beneficiaries, and a minimum savings rate of 2 percent of total cost of care; providers are eligible to share in total estimated gains/losses as long as they exceed 2 percent of total cost of care. Some Commercial and Medicaid payers may adopt lower minimum panel sizes for TCC models but with higher minimum savings rates or with stipulations that providers share only in gains/losses incremental to the established minimum savings rate. As a general rule, quality and utilization measures may be less impacted by random chance that are measures of total cost of care; for this reason, some P4V models may impose lower requirements for minimum panel size than TCC models.
- 5. Outcomes-based payment should support formal affiliations of providers as necessary to achieve the scale and capabilities necessary to effectively support clinical integration and population health management.** Small providers may not individually have sufficient patient volume (with any one payer) necessary to qualify for participation in outcomes-based payment models. Some payers outside of Delaware have facilitated virtual pooling by such providers, wherein payers pool performance across providers without any formal affiliation agreement among those providers. While such arrangements may hasten adoption of outcomes-based payment, they may represent only superficial relationships among providers without any shared governance or common processes. In contrast with these virtual pooling arrangements, DCHI encourages that providers should instead establish more formal affiliations, including that of an IPA, ACO, CIN, or similar structure, which may provide the legal and financial framework for building the capabilities necessary to support clinical integration and population health management. Recognizing that independent physicians may need assistance to aggregate formally, DCHI will consider possible solutions to facilitate aggregation (e.g., legal support and technical assistance) for small practices to support their ability to enter into TCC models.

- 6. Outcomes measurement should be based on a balanced scorecard for quality of care and efficiency.** While some pay-for-value models may tie rewards exclusively to quality, such models rarely provide sufficient financial incentive to truly transform care and may not contribute meaningfully toward our goals for affordability. We are also interested to ensure that new payment models do not reward efficiency without some reasonable safeguard for access and quality of care. We therefore recommend that both TCC and P4V models should include requirements for both quality of care and efficiency, whether the latter is based on total cost of care or measures of resource utilization. Quality and efficiency measures may be reflective of both care delivered directly by primary care providers, as well as the total cost and/or quality of care affecting that provider's panel of patients as they engage with the broader health care system. Over time, we encourage that models should incorporate measures of consumer experience, as well, although we acknowledge that instruments for measuring consumer experience outside of the hospital are still nascent in their development.
- 7. Measures should be based on the DCHI Common Scorecard to create consistent incentives across a patient panel while minimizing complexity and administrative burden for providers.** DCHI has collaborated with payers, providers and other stakeholders across the state to develop the Common Scorecard to align stakeholders on a set of common metrics. Version 2.0 of the Scorecard, scheduled to be introduced statewide in the spring of 2016, is comprised of 26 quality and efficiency metrics that address chronic disease management, preventive services, acute care, utilization, and cost. Payers and providers may base outcomes-based rewards on a subset of these measures that are most relevant to the patient population covered by that contract. However, we recommend that outcomes-based contracts between PCPs (or systems) and private payers (whether Commercial, Medicaid, or Medicare Advantage) should be wholly or largely (at least 75%) based on measures derived from the Common Scorecard. [Note: Currently, the Medicare Shared Savings Program requires electronic submission of clinical data for measures that fall outside of the DCHI Common Scorecard. These measures have not been included in v2.0 of the DCHI Common Scorecard for private payers in order to minimize the administrative burden to providers in adopting outcomes-based payment for Commercial and Medicaid populations. However, as capabilities for electronic capture of clinical data become more widespread, the DCHI Common Scorecard will evolve to incorporate more of these measures, potentially allowing for further alignment of quality measures with Medicare].
- 8. Total cost of care should incorporate reasonable exclusions and adjustment for differences in patient risk.** Measurement of total cost of care should incorporate reasonable exclusions of certain patient populations, either based on clinical criteria and/or cost outlier thresholds, both to minimize the potential for the extraordinary needs of a single patient to unduly impact the provider's total cost of care performance, and to eliminate any disadvantage to providers whose patient panel has

a disproportionate share of patients with extraordinary needs. For similar reasons, risk adjustment should be applied to comparisons of a provider's total cost of care to targets or benchmarks. Prevailing risk adjustment algorithms are based largely on diagnostic criteria captured from claims data. As we increase the consistency of electronic data capture of clinical information throughout the state, we hope that risk adjustment algorithms may, over time, incorporate this information for greater reliability. DCHI also recognizes the potentially significant impact of social determinants of health not only for the prevalence of illness and injury, but also for the effectiveness of our health care system in engaging consumers in their own care. Accordingly, we are interested to explore how socio-economic factors may be incorporated into risk adjustment models used for outcomes-based payment and for risk stratification of consumers for outreach and engagement.

- 9. Payers and providers should incorporate both prospective and retrospective approaches toward tying rewards to estimated savings.** Outcomes-based payment models commonly use one of two competing methodologies for estimating savings as a basis for payment: (a) performance against a prospectively established target; or (b) performance against a regional or national benchmark, measured retrospectively for the same period during which the participating provider's performance is measured. Both methods have their merits and their respective challenges. Prospectively established targets create a clear and transparent standard against which providers will be evaluated; however, they fail to anticipate or account for exogenous factors that may affect a provider's performance (e.g. pandemic flu, introduction of new medical technology, or unanticipated changes in fee schedules to other providers). Conversely, benchmark trends measured retrospectively account for some (if not all) of these exogenous factors but may create an impression among providers that they are "working against a moving target" or one that is subject to "black box calculations"; many may also question the comparability of an external benchmark. DCHI is not prepared to prescribe a single method. Rather, we recommend that outcomes-based payment models that are based on one of these methods should make full use of the alternate method for informational purposes: (a) where rewards are based on performance against a prospectively established target, payers and providers should reach agreement in advance on the types of exogenous factors that may be reviewed for possible retroactive adjustments; (b) where payment models are based on retrospective benchmarks, providers should nonetheless be given a "good faith" projection prospectively, perhaps based on historical trend information, so that they have a point of reference against which to evaluate costs as they accumulate over the performance period.
- 10. Payers and providers should be free to independently negotiate pricing and risk corridors.** There are multiple options for the percent of total savings or losses that could accrue to the provider. Shared savings could be "upside only" or both "upside and downside" with two-way risk. DCHI recommends that the percent of shared savings be left to individual payer-provider negotiations, recognizing that upside only

models with less risk on the providers generally translate to 30% - 50% of savings, while the greater level of shared savings from participation in a two-way risk payment model reflects the greater risk assumed by providers in that approach (e.g., 85% of savings that are achieved, as well as 85% of cost increases against the benchmark). Notwithstanding the benefits of standardization, we recognize that some parameters of provider risk sharing arrangements may be terms of negotiation between payers and providers that may be tailored based on those parties' respective tolerance for risk and forecasts for pace of value capture over time.

- 11. Providers accepting financial risk for a population should have access to claims data as necessary to effectively manage that risk.** If a provider is going to manage risk for a population, they should access to the same claims information that is commonly used by payers to identify opportunities for improvement. This includes claims information for care delivered not only by the risk-bearing provider but also by other providers caring for the same population; risk-bearing providers may therefore not have line of sight to that cost or utilization information unless claims data are provided by payers. This data may be shared directly between the payer and the risk-bearing provider. Alternatively, we may work to establish an All-Payer Claims Database that would warehouse this data on behalf of all payers and providers in the community, allowing for risk-bearing providers to access this information more efficiently than if each risk-sharing relationship required configuration of claims data and data transfer in an ad hoc manner.
- 12. Independent physicians without the capability to analyze claims data should be provided actionable insights into opportunities for improvement.** Independent physicians may not have the capabilities or financial resources to independently analyze claims data in order to extract insights regarding opportunities for improvement. Such analytic capabilities may be provided by payers as a value-added service to providers participating in outcomes-based payment. To the extent that payers share claims data with an All-Payer Claims Database, population health management analytic capabilities could be offered by payers, by ACOs, or other third-parties on a payer-agnostic basis, so that physicians may receive performance insights in a structure and format that is consistent across their entire patient panel.

Strategies to promote adoption

In collaboration with the Delaware Health Care Commission and the Delaware Health Information Network, DCHI will employ several initiatives to ensure the availability and adoption of outcomes-based programs consistent with our vision and recommended principles for model design and implementation. These include the following:

1. Meeting with payers, health systems, ACOs, and CINs as well as with major professional associations, to share our vision and proposed design principles
2. Increasing payer participation in the DCHI Board and supporting committees
3. Raising awareness of purchasers and consumers regarding the importance of outcomes-based payment, and increase transparency into adoption and performance
4. Working with the State to align state regulations and purchasing of health care with our beliefs and principles, including Medicaid, State Employees Health Plan, as well as requirements for Qualified Health Plans
5. Educating practicing physicians regarding outcomes-based payment as an alternative to other approaches to cost control; contributing to aligned communications strategies and materials for rollout of primary care practice transformation support
6. Encouraging providers to proactively initiate conversations with payers to move towards outcomes-based payment
7. Evaluating new payment models as they are introduced, to consider whether they confirm with the design and implementation principles outlined here
8. Creating transparency around the availability and adoption of new payment models through the overall DCHI program dashboard