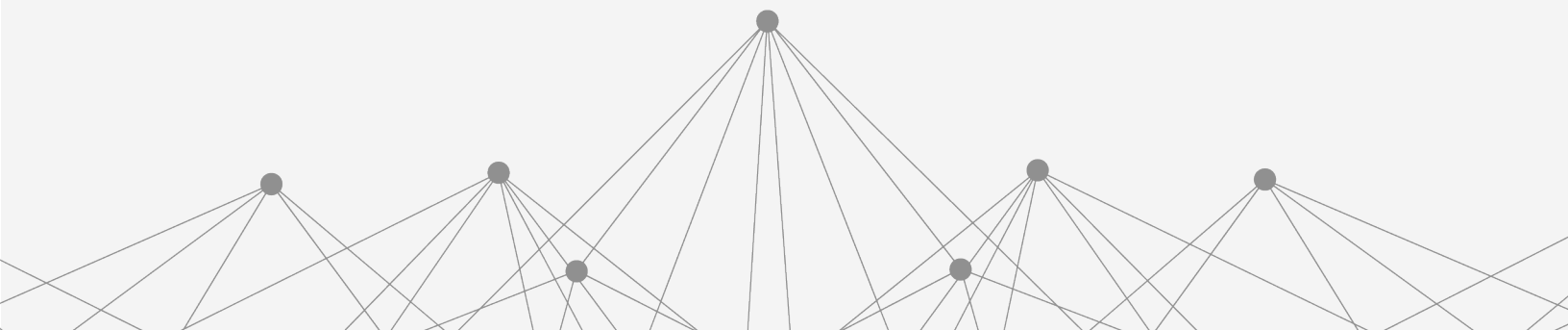
Delaware Center for Health Innovation

payment model monitoring

Charter

OCTOBER 2014



1. SCOPE

1.1 Purpose

To enable care coordination and cost-effective diagnosis and treatment, our goal is for most care in the state to transition to outcomes-based payments. The models will incentivize both quality and management of total medical expenditures over the next five years. Delaware's plan is for all payers to introduce at least one Pay for Value (P4V) program that incorporates reimbursement tied to quality and utilization management for a panel of patients, and one Total Cost of Care (TCC) program with shared savings linked to quality and total cost management for a panel of patients, for eligible PCPs beginning in July 2015. The approach will build from the different models in the system today and support the broader delivery system transformation underway (e.g., population health improvements, behavioral health access and integration). Core technical details will continue to be defined between payers and providers (e.g., shared savings level, minimum panel size), however all payers will support the following common principles to simplify participation for providers:

- **Attribution of all Delawareans to primary care physicians** (pediatrics, family medicine, general internal medicine) or advanced practice nurses working under Delaware's Collaborative Agreement requirement.
- **Flexibility to include independent primary care providers**, as well as those employed by or affiliated with a health system.
- **At least one P4V and one TCC model available from each payer,** with at least one model that has some form of funding for care coordination, whether in the form of per member per month fees or payments for non-visit based care management.
- **Payment tied to common scorecard** for all models, with a minimum percentage linked to common measures and the rest linked to performance on payer-specific measures.
- **Commitment by all payers working in partnership with providers to achieve 80%** of payments in these models within five years.

The goal of the Payments Model Monitoring Committee ("PMMC" or "Payments Committee") is to ensure successful availability and adoption of value-based payment across the state.

1.2 Core areas of focus

There are three core responsibilities for the PMMC:

- **Identifying and designing common elements of value-based payment models.** In addition, the Committee will monitor the effectiveness of these elements and make adjustments as necessary. The Committee will actively seek resolution when parties are not operating consistently with the design principles.
- **Creating awareness and understanding of new payment models.** The Committee will develop communication materials and timelines to engage practices, health systems, and provider organizations.
- **Monitoring availability and enrollment in new payment models.** The Committee will work with commercial and state payers to ensure Delaware meets its targets for value-based model penetration (as individual payers and providers negotiate agreements).

1.3 Interdependencies

The Payment Model Monitoring Committee's work is highly dependent on the overall strategy and approach that will be developed by the other Committees of the Delaware Center for Health Innovation. While the PMMC will ensure payment models tie to the common provider scorecard, the Clinical Committee will assume responsibility for designing the scorecard itself, and the Technical Advisory Group will manage data collection and help ensure data integrity. The PMMC will also coordinate with the Clinical Committee as they design and provide resources across the provider community (e.g., information on enrollment, care coordination, practice transformation support).

The Committee's work will be highly interdependent with ongoing value-based programs from each commercial and state payer. There will also be a need to align with self-insured employer accounts.

2. COMPOSITION

2.1 Expertise / experience required for Committee members

The Payment Model Monitoring Committee requires a diverse set of expertise and experience. The Committee should consider a balance of individuals with the following backgrounds:

- Individuals from public and private payers with expertise in payment model design and implementation, including provider contracting
- Individuals from providers, both private practice and larger health systems
- Employers
- Individuals with knowledge of insurance regulation

2.2 Expectations for Committee members

Expectations for Payment Model Monitoring Committee membership are as follows:

- Meetings will typically be held monthly
- Committee members are expected to serve for a term of one year
- Because continuity and engagement are important, members are expected to attend at least 75% of all meetings either in person or by phone
- Members should not send delegates in their place
- Committee membership is likely to include some additional time commitment outside of scheduled meetings

3. DELIVERABLES

3.1 High-level milestones by year

Milestone[1]	Timing
Provider education and awareness campaign launched	Q1 2015 (with annual re-fresh and re-launch)
New Medicaid MCO contracts begin	Q1 2015
Provider enrollment begins	Q2 2015 (with annual enrollment cycles going forward)
Common scorecard implementation (shadow reports for first practices that enroll)	Q2 2015
Practice transformation begins	Q3 2015
Provider baseline reporting launched	Q3 2015
Performance period and care coordination fees begin for providers enrolled in 2015	Q1 2016
Plan Year 2016 QHPs begin providing coverage with requirement for payer participation in new payment models	Q1 2016
First quarterly performance reports released	Q2 2016
Next wave practices begin practice transformation and start receiving baseline performance reports	Q3 annually from 2016
QHP requirements for Plan Year 2018 reviewed	Q3 2016
New state employee TPA contracts begin	Q3 2017

[1] From Delaware's CMMI SIM Model Testing Grant Application; will be updated in conjunction with HCC based on CMMI's review of the Operational Plan

4. METRICS

4.1 Accountability targets

Metric[2]	Description	Frequency	Target
New models offered	Payers offering at least one P4V and one TCC model		100% by Q1 2016
Utilization of new models	Fraction of payments made through a value-based model		80% of payments within 5 years
Provider enrollment	Fraction of DE primary care providers enrolled in new payment models		60% by 2016, 80% by 2017, 90% by 2018

[2] From Delaware's CMMI SIM Model Testing Grant Application

APPENDIX

Committee Members: October 2014-June 2015

	Name	Organization
1	Tom Brown (Co-Chair)	Nanticoke Health Services; Nanticoke Physician Network
2	Paul Kaplan (Co-Chair)	Highmark
3	Greg Bahtiarian	Mid-Atlantic Family Practice
4	Tom Corrigan	Christiana Care Health System
5	RJ Franzoi	Aetna
6	Steve Groff	Delaware Division of Medicaid and Medical Assistance
7	Rebecca Jaffe	Rebecca Jaffe and Associates
8	Darrin Johnson	UnitedHealthcare Community Plan of Delaware
9	Brenda Lakeman	Delaware Office of Management and Budget
10	Mike Martinell	WL Gore
11	Rich Pierznik	Highmark
12	Alex Sydnor	Beebe Medical Center
13	Michael Tretina	Bayhealth Medical Center