

Framework for Transforming the Health Care Payment System in Colorado

Center for Improving Value in Health Care

July 21, 2011



CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Higher Quality. Lower Cost.
A Healthier Colorado.

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Executive Summary

The cost of health care is rising so quickly that some economists predict it will overwhelm federal and state budgets within 10 to 15 years.¹ The upward trajectory of Colorado's health care costs has profound implications for the state's economy, the ability to attract and retain jobs, and the quality of life in Colorado. Our resources are finite. As more and more of our economy's resources go to pay for health care, funding is siphoned from other critical areas, such as education, infrastructure and our wonderful parks.

There is widespread agreement that one of the major underlying causes of the unyielding rise in health care costs is the way health care is currently paid for. Providers are financially rewarded for the volume of care provided over value. Over the years, many efforts have been made to change how care is paid for, and these have resulted in varying degrees of success. There are also many organizations in health care that understand this issue and are doing outstanding work to help solve it. However, it is not an issue that can be addressed without an aggressive, collaborative and coordinated statewide strategy to accelerate this transformation and to help curb soaring health care costs. The Center for Improving Value in Health Care (CIVHC) is uniquely positioned to lead those efforts.

The foundation of CIVHC's work is the Institute for Healthcare Improvement's Triple Aim model which was created to a) improve population health; b) improve the patients' experience of care; and c) bend the per capita cost curve. It is essential to address these three aims simultaneously because, "[w]ithout balanced attention to these three overarching aims, health care organizations may increase quality at the expense of cost, or vice versa. Alternatively, they may decrease cost while creating a dissatisfying experience for patients."²

CIVHC's primary role in achieving the Triple Aim is to help communities and stakeholders:

- Envision a roadmap and build consensus on an action plan to achieve the Triple Aim for Coloradans.
- Develop tools to assess the current status of our health and payment systems.
- Support efforts to move toward fully integrated health care delivery systems, global payments, health care and public health system integration.
- Engage patients as partners in improving and maintaining their health.
- Support pilot programs that are consistent with the roadmap presented here.

Of particular importance is examining ways to improve how health care is paid for. The current fee-for-service payment mechanism, which represents the vast majority of health care reimbursement in Colorado, is based on quantity of care without rewarding quality of care. Individual satisfaction, shared decision-making, use of evidence-based practices,

¹ New America Foundation and University of Denver's Center for Colorado's Economic Future (2009). *The Future of Colorado's Health Care: An Economic Analysis of Health Care Reform and the Impact on Colorado's Economy* [pdf document - preview report]. Retrieved from: http://www.coloradotrust.org/attachments/0000/9690/EconomicForecastHealthCareColorado2009_final.pdf

² Douglas McCarthy and Sarah Klein, Issues Research, Inc. (2010). *The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs* [pdf document]. Retrieved from: http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2010/Jul/Triple%20Aim%20v2/1421_McCarthy_triple_aim_overview_v2.pdf

prevention efforts, appropriate utilization of services, administrative simplification, and care coordination are all important factors to improving the health of Coloradans, but none are currently incentivized through the fee-for-service payment system.

Over the past year, CIVHC has worked extensively with members of its Payment Reform, Delivery System Redesign, and Consumer Engagement Advisory Groups, along with other interested stakeholders, to lay out a framework for moving the payment system toward outcome-based reimbursements for care in Colorado. As part of this process, a statewide strategy session was held in January in which broad consensus emerged on the need to move toward payment and delivery reform. Over the course of the spring, significant work was done by the Delivery, Payment and Consumer Engagement groups to vet the various initiatives, and to provide input about how to make these efforts more effective. In particular, significant input from CIVHC's Consumer Engagement Advisory Group raised awareness of the need to have consumers at the center of the discussion and an equal participant in both the rewards and risks associated with new models of payment.

In late spring, the leadership of the various advisory groups of CIVHC reviewed the work to date. While it was clearly acknowledged that multiple promising efforts have already been initiated in Colorado, there was an apparent need for a catalytic and coordinated approach to statewide payment efforts that would accelerate the necessary changes to quickly move Colorado towards Triple Aim objectives. Please see the acknowledgements in Appendix D for a comprehensive list of individuals who contributed to the development of this framework.

The approach to transforming payment in Colorado focuses on initiatives and actions that will catapult Colorado to the forefront. CIVHC is boldly pushing for transformative changes in relatively short timeframes that would change payment for a majority of Coloradans by 2018 with a midway point in 2015.

The advisory leadership recognized that there are organizations and providers who are already taking steps to advance their organizations and practices. In assessing how best to move Colorado forward to achieve the Triple Aim, two themes emerged:

1. There is broad consensus that the vast majority of Coloradans must be cared for in a system in which reimbursements fall under a global payment made to highly integrated systems. CIVHC wants to support all caregivers and patients to receive care in these types of systems by 2018. In such systems, there would be very little fee-for-service.
2. CIVHC also recognizes that most providers and systems are in a fee-for-service mode and believes that setting a midway goal of moving a large number of patients into a system of bundled payments, where possible, and promoting care management, medical home methodologies would move Colorado toward its Triple Aim goals of better care coordination and lower cost.

Transformation at the midway point would mean that in addition to the estimated 20% of Coloradans already in some type of global payment, over 50% of Coloradans would be covered by outcome-based payment methodologies by the end of 2015. These payment methodologies are believed to support a movement towards achieving Triple Aim objectives and to lead to further integration of care systems as more providers are required to come together to share in payments and participate in improvement initiatives that these payment mechanisms require to be successful. This plan would be designed to bring in not only the commercial market but also the public payers.

While CIVHC will continue to find ways to move towards the fuller global payment model and integrated care systems, the following action plan focuses on achieving the midway goal of 2015. It describes the efforts of three teams who over the course of the summer and early fall will be asked to develop three major components that are aimed at achieving the 2015 goals:

1. Operations team: Develop the actual payment mechanism (coordinate with CIVHC's data group which will develop metrics and measures to demonstrate the impact of bringing large numbers of Coloradans into the midway payment mechanism) and ultimately develop the plan's description and supporting documentation as to why and how this system would benefit Coloradans if implemented by 2015.
2. Strategy and Implementation Team: CIVHC would use the broad representation of its Executive Committee to develop plans and implementation strategies that would include achieving buy-in and collaboration from key stakeholders including consumers, businesses, providers, payers and public entities. The team would also identify the barriers, supports and initiatives that would help pave the way for a quick migration to this midway payment mechanism.
3. Marketing and Communication Team: This team would develop the descriptions, stories and strategies to gain understanding, buy-in and eventually roll-out of the payment mechanisms described in this document.

Nearly everyone engaged in health reform and committed to achieving Triple Aim objectives recognizes that achieving these aims requires bold, innovative and relentless effort. This framework is designed to push the conversation and actions such that Colorado will emerge as a centerpiece for creative leadership and achieving Triple Aim objectives of better health, better care and lower costs that will continue to ensure that Colorado remains one of the best places to live and work in the United States.

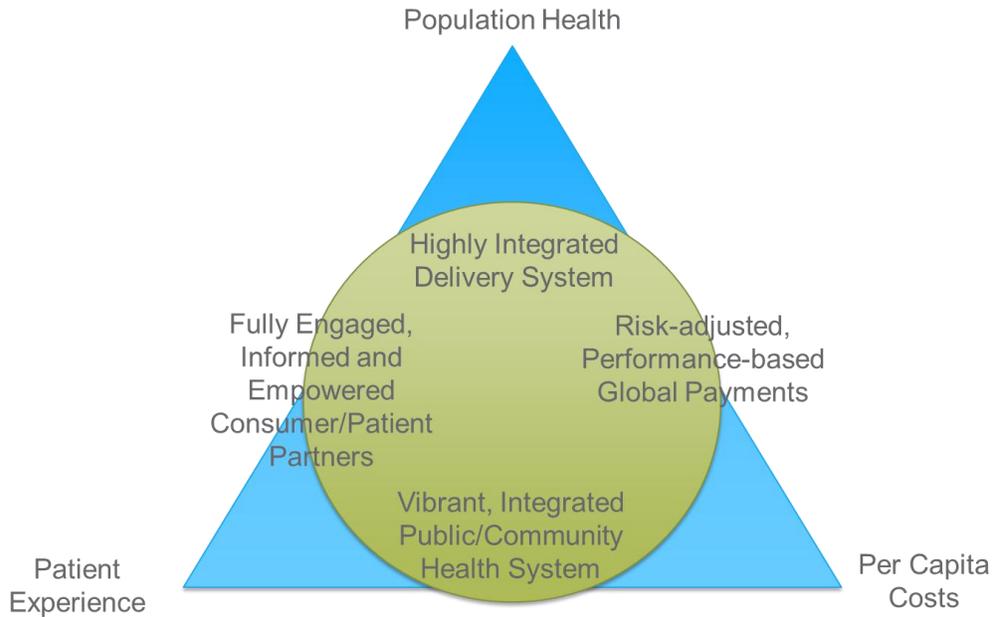
Developing a Framework for Transforming Colorado's Payment System

The Importance of Addressing Payment to Impact the System

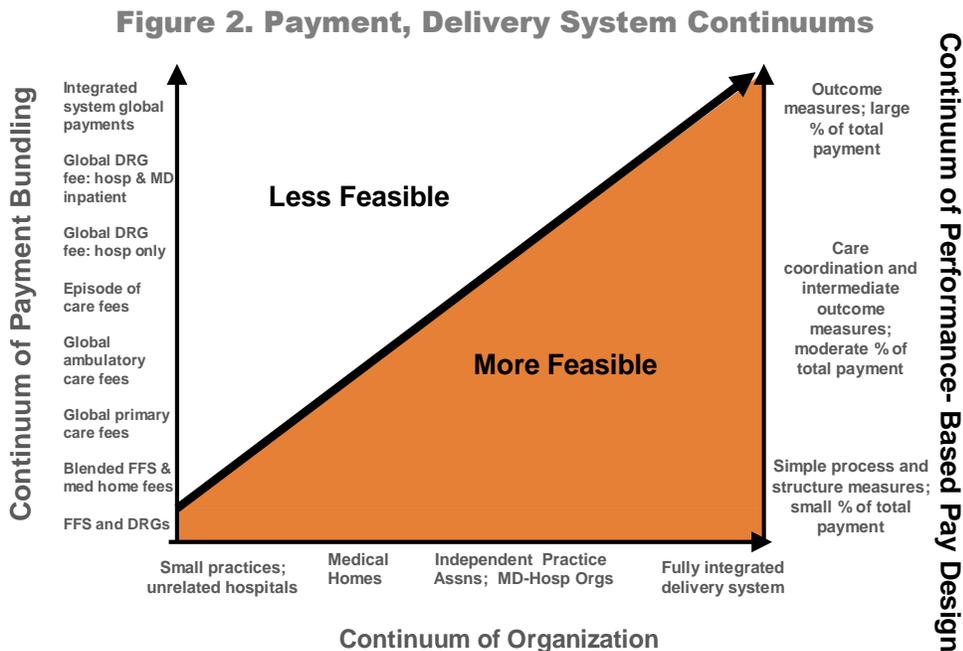
The Institute for Healthcare Improvement Triple Aim initiative was created to improve population health as well as patients' experience of care while simultaneously bending the per capita cost curve. Figure I depicts the characteristics of a high performing health care system.

We believe that, by improving the way we pay for health care and transforming the current fee-for-service payment mechanism to one that rewards quality of care, we can impact individual satisfaction, shared decision-making, use of evidence-based practices, prevention efforts, appropriate utilization of services, administrative simplification, and care coordination. All of these are important factors to improving the health of Coloradans, but none are currently incentivized through the fee-for-service payment system.

FIGURE 1. MODEL TO ACHIEVE TRIPLE AIM



CIVHC realizes it may not be possible for every community to have highly integrated systems that can accept risk-adjusted, performance-based payments for the care of a population. Therefore, our goal is for communities, providers and payers to move as far along the payment and delivery system organization continuums, shown in Figure 2, as they can.



Source: Modified version of slide from Shih et al, The Commonwealth Fund, August 2008.

CIVHC's primary role in achieving the Triple Aim is to help communities and stakeholders by doing the following:

- Envision a roadmap and build consensus for an action plan that achieves the Triple Aim for Coloradans.
- Develop tools to assess the current status of their health and payment systems.
- Support their efforts to move toward fully integrated health care delivery systems, global payments, health care and public health system integration.
- Engage patients as partners in improving and maintaining their health.
- Support pilot programs that are consistent with the roadmap presented here.

The Process to Address the Health Care Payment System

CIVHC's Process and Charge for the Advisory Groups

Over the past year, CIVHC's Delivery System Redesign and Payment Reform Advisory Groups, with significant feedback from the Consumer Engagement Advisory Group, have taken initial steps to help CIVHC frame a plan for transforming the health care system statewide. This includes establishing principles for improving the health care delivery and payment systems, and conducting a series of informational interviews among health care leaders and stakeholders across the state.

In January of 2011, CIVHC conducted a joint strategy session of these two advisory groups, and also invited CIVHC's Board of Directors and other stakeholders throughout the state who were not already represented among these groups. CIVHC invited Harold Miller to facilitate the session. Miller, President and CEO of the Network for Regional Healthcare Improvement and the Executive Director of the Center for Healthcare Quality and Payment Reform, is a nationally recognized expert in health care payment reform. The purpose of the session was to develop recommendations on accelerating payment reform over the next few years, and to obtain consensus on these recommendations among the participating stakeholders.

The participants were divided into three working groups to develop recommendations within the following categories: improving outcomes and reducing costs for patients with chronic disease; improving outcomes and reducing costs for patients with major acute conditions; and improving patient health and use of preventive services. Each group was given a list of issues prepared by Miller for which they were required to develop recommendations through consensus.

After the three groups reached consensus on recommendations for each of the questions posed, they were reconvened into the larger group to discuss conclusions. Upon each group's report, the larger group voted electronically on whether they agreed with the recommendations presented. Many participants were surprised to find a significant level of support for each working group's recommendations. The following captures areas of consensus as well as areas requiring future reconciliation.

Areas of consensus:

- Primary care providers should move away from fee-for-service and be paid larger care management fees to support high quality, cost-effective and coordinated care.
- There should be movement towards bundled payments and episodes of care to help align with the Triple Aim objectives and create more integrated care delivery systems.

- Payment methods should support collaboration and reduce fragmentation.
- Payment methods should be chosen primarily upon their efficacy to reward value rather than volume.
- Cost and utilization data among providers needs to be fully transparent.
- Shared decision-making among patients and their providers is critical to improving the quality and value of care delivered.
- No additional payments should be made to providers for preventable adverse events.

Areas requiring further reconciliation:

- Additional study required to determine how new payment models would be relevant and applicable to rural communities and small provider practices.
- Specific details necessary to determine how specialists are paid within bundled payments.
- More information needed on role of public health in disease prevention and wellness interventions within communities and how those services can be integrated into payment structures.
- More discussion required on how behavioral health, pharmacy, durable medical equipment, home health, long-term care, and hospice care are included in bundled payment models.

(Note: A draft report of the initial recommendations can be found here:

http://civhc.datausa.com/civhc/media/Main/PDFs/Delivery_Redesign/Draft-Recommendations---January-6-2011.pdf.)

After the January session, the Payment Reform and Delivery System Redesign groups reconvened in March and April to review the initial recommendations for evidence base, impact of recommendations for various stakeholders, discrepancies among the various recommendations, and needs for further clarification. Meanwhile, the Consumer Engagement Advisory Group also provided feedback regarding the extent to which the initial recommendations supported patient-centered care and shared decision-making. CIVHC's staff compiled all the information gathered from the three advisory groups and then worked with the Advisory Leadership Committee to evaluate responses and plan for next steps.

The Framework for Transforming the Health Care Payment System in Colorado

The Mileposts

The Advisory Leadership laid out a six milepost framework that offers a path for communities to evolve to the destination of highly integrated systems of health and health care delivery. The destination includes community and public health as full partners, with providers paid risk-adjusted, performance-based global payments and patients fully informed, engaged and empowered.

After further reflection the Advisory Leadership concluded that, among the mileposts, CIVHC's best strategy for accelerating the changes required is to focus on a midway point and a final destination. The advisory leadership recognized that there are organizations and providers who are already taking steps to advance their organizations and practices. In assessing how best to move Colorado forward to achieve the Triple Aim, two themes emerged:

- I. There was broad consensus among the advisory leadership that, based on the current understandings and the literature, Triple Aim can only be achieved if the vast majority of Coloradans are cared for in a system in which reimbursements fall under global payments made to highly integrated systems. CIVHC wants to support all

caregivers and patients to receive care in these types of systems by 2018. In such systems, there would be very little fee-for-service. This 2018 goal is described as the Destination.

2. CIVHC also recognizes that most providers and systems are currently in a fee-for-service mode and believes that the solution involves setting a midway goal by 2015 of moving a large number of patients into a system of bundled payments, where possible, and promoting care management/medical home methodologies. In reaching this 2015 goal, called the Midway Point Payment Model, Colorado moves toward Triple Aim goals of better care coordination and lower cost.

(Note: For more information on evidence related to advanced payment models and other reforms, please see Appendix B.)

With systems like Kaiser Permanente and Denver Health and independent physician associations such as Physician Health Partners and NewWest leading the way and already operating beyond the midway point, CIVHC is focusing its attention on moving a high percentage of patients and providers past the midway point threshold by 2015 to achieve Triple Aim objectives.

The mileposts serve as a tool by which communities can determine where they currently reside on the payment reform path and what steps can be taken to transition to payment models that encourage higher quality and care integration. In the following summary of stages, (Figure 4 on the following page) communities, third party payers, providers, and patients will be starting at different mileposts. In some cases a milepost may be skipped. CIVHC believes this will achieve the Triple Aim of improving the health of Coloradans, enhancing the patient experience of care (including quality, access and reliability) and reducing, or at least controlling, the per capita cost of care. In each of the mileposts, we highlighted the payment mechanisms as well as the expected state of the delivery system and the roles of patient engagement, as well as community and public health.

FIGURE 4

Summary of Stages in the CIVHC Framework for Transforming the Health Care Payment System in Colorado

	Milepost 1 <i>Enhanced Fee-for-Service with Minimal System Integration</i>	Milepost 2 <i>Enhanced Fee-for-Service with Small Care Management Payments and Some Medical Homes</i>	Midway Point 2015 <i>Some Bundled Payments; Some Components of System are Integrated</i>	Milepost 4 <i>Large Care and Care Management Payments with Greater System Integration (Medical Homes and IPAs)</i>	Milepost 5 <i>Comprehensive Care and Care Management Payments & Global Inpatient Facility-based Fees with Integrated Ambulatory Care Systems and PHOs</i>	Destination 2018 <i>Global Payments and Highly Integrated Health Systems</i>	
Payment Mechanism							
Primary care	Mainly FFS; some enhanced FFS for primary care evaluation & management	Mostly FFS and small care mgmt. payment for medical homes	Small care mgmt. payment for medical homes	Some bundled payments for all costs associated with defined episodes of care.	Reduced FFS; large care mgmt. payment for medical homes	Monthly risk-adjusted, capitated global fees for all primary, specialist and non-hospital care.	Global payments to highly integrated systems; no FFS payments
Chronic care	FFS	Additional small care mgmt. payment for patients with chronic conditions	Additional small care mgmt. pmt. for patients with chronic conditions		Reduced FFS; large care mgmt. pmt. for medical homes		
Specialist care	FFS	FFS; periodic care management payment for preventive svcs (if serving as primary care provider).	FFS; periodic care mgmt. payment for preventive svcs (if serving as primary care		Paid out of large care mgmt. payment to primary care provider		

			provider).				
	Milepost 1	Milepost 2		Midway Point 2015	Milepost 4	Milepost 5	Destination 2018
Inpatient care	Mainly DRGs and FFS for doctors	Mainly DRGs and FFS for doctors	Some bundled payments for facilities taking the lead in managing care. Include inpatient warranty.*	Mainly DRGs and FFS for doctors; Would include inpatient warranty.*	Mainly DRGs and FFS for doctors; Would include inpatient warranty.*	Bundled payment for all inpatient care, including physician services, eligible for quality-of-care performance payments. Include inpatient warranty. Inpatient providers would be grouped into cost/quality tiers.*	
Delivery System							
	A variety of small, medium & large single & multi-specialty practices; some hospital systems	Small, medium and large single and multispecialty practices and independent hospital systems. A few more partially or fully integrated delivery systems and more medical homes than under Milepost 1.	Medical homes in most of CO. In urban areas, partially integrated delivery systems. More fully integrated delivery systems in place than today.	A majority of the system would consist of large multispecialty groups and integrated delivery systems; all primary care would be provided through medical homes.	Larger multispecialty groups and greater consolidation/mergers among physician groups.	Providers would operate within highly integrated systems in which patients' care is coordinated and case managed and where health related information is shared among providers.	

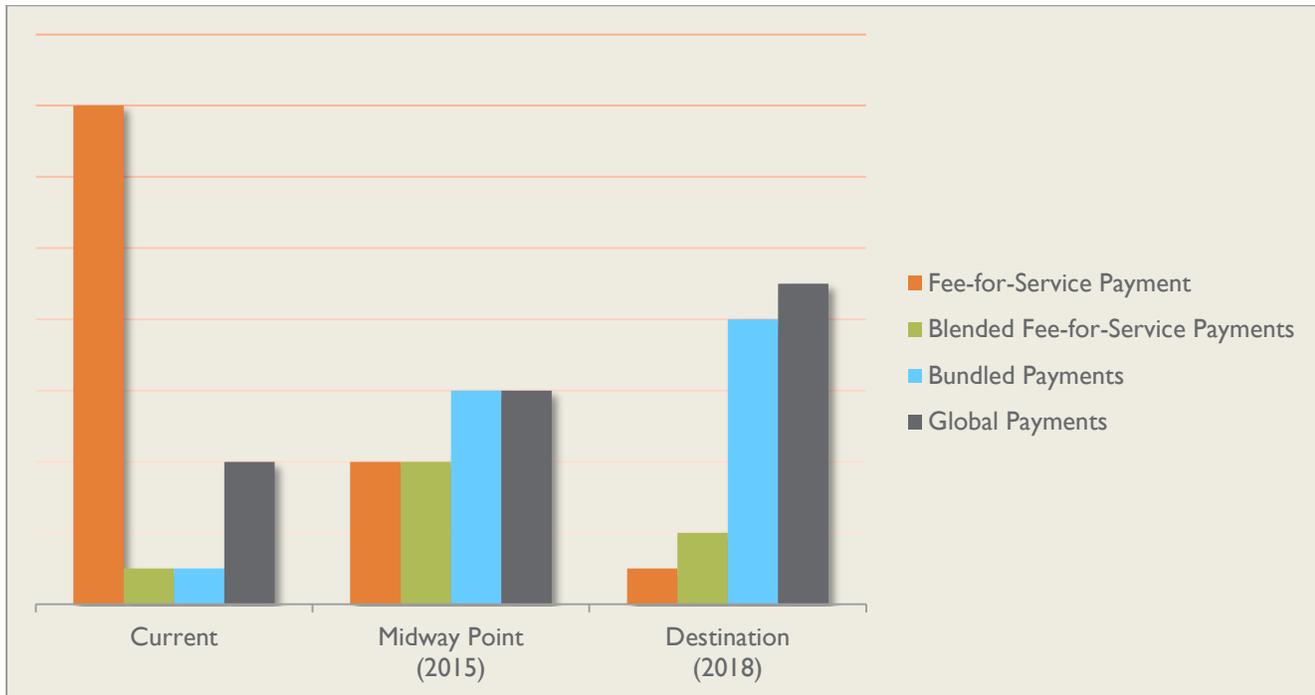
*No payments will be made for preventable adverse events.

	Milepost 1	Milepost 2	<u>Midway Point</u> 2015	Milepost 4	Milepost 5	<u>Destination</u> 2018
Patient Engagement						
	Patient premiums and cost-sharing would be reduced for preventive care received from a high-quality, reasonably-priced, convenient provider and for active, continuing participation in health promotion activities.	Incentives for engaging in healthy habits, having a medical home. Have tool available to fully participate in decisions about their care.	Encouraged to select a medical home, if one is available; have financial and non-financial incentives to fully participate in care decisions; providers discuss preventive care and health improvement activities and educate patients about the value of having a medical home; evidence-based shared decision making on acute procedures.		Same as MP 3/4. Data available to patients, with differing health literacy levels factored in. PCP's and specialists grouped into tiers based on quality, cost and patient experience measures. Patients would be informed about the tiers in which providers and practices are ranked.	Full, equal partners; have financial and non-monetary incentives, information, assistance, tools to participate in decisions about their care; would receive care, and health improvement and maintenance supports; make informed choices about their care and healthy choices.
Community and Public Health						
			Annual third-party payer assessment support community pool for primary, community-based prevention.			Community and public health are full partners in the health system, providing services best delivered on a population-wide basis in community settings.

How CIVHC Measures Success in 2015 and 2018

As stated above, CIVHC’s intent is to decrease the use of fee-for-service payment methods in favor of more outcomes-based payment methods that incentivize higher quality, more integrated care. The graph below serves as an illustration of how CIVHC would measure progress toward achievement of this payment reform effort over the next seven years. These metrics and tracking mechanisms will be developed by the Data and Transparency Advisory Group as part of the overall implementation effort.

FIGURE 3



Please note that actual percentages for these categories have not yet been determined and are only represented here to illustrate the anticipated shift in payment methods.

- **Fee-for-Service Payments** – The predominant payment mechanism today. Small practices and unaffiliated hospitals will likely receive mainly fee-for-service payments by the midway point.
- **Blended Fee-for-Service Payments** – Models of payments that combine fee-for-service with some level of enhanced payment to support care coordination, pay for performance incentives, or medical home.
- **Bundled Payments** – This includes acute and chronic partial bundles and comprehensive bundles as described in the midway point below.
- **Global Payments** – Defined by a single payment for all care while receiving care within a fully-integrated delivery system.

The Destination

It was agreed by CIVHC’s Advisory Leadership Committee that by achieving the Destination by 2018, our efforts would lead the developments already occurring in the marketplace and would achieve our charge of bending the cost curve to

control, or even reduce, per capita health expenditures. The following outlines the key characteristics of the Destination.

DESTINATION
PAYMENT MECHANISM
With only few exceptions, there would be no fee-for-service payments. Integrated care systems would be organized to receive severity and risk-adjusted, performance-based global payments to care for a population. Care would be coordinated among the patient’s providers and a mechanism for shared savings would be included.
DELIVERY MECHANISM
Providers would operate within highly integrated systems in which patients’ care is coordinated and where health related information is shared among providers.
CONSUMER/PATIENT ENGAGEMENT
Patients would be full, equal partners and would have the financial and non-monetary incentives, information, assistance and tools (e.g., decision aids) to fully participate in decisions about their care. Patients would receive the care, health improvement and maintenance supports to be as healthy as they can be and would be empowered to make informed choices about their care and healthy choices.
PUBLIC HEALTH
Public health would be a full partner in the delivery system, delivering services most cost-effectively administered in community settings (e.g., school-based health centers).

The Midway Point

Although multiple organizations are currently in the process of moving toward global payment in Colorado, it is recognized that a vast majority of individuals receive care in highly fragmented health care systems. In addition to a destination, CIVHC and its stakeholders determined that it was important to develop a clear midway point in which a variety of payment bundling mechanisms are introduced.

Bundled payment for care encourages providers and other stakeholders to work together on innovative strategies that reduce system inefficiencies, improve the quality of care, share savings, and initiate steps toward full system integration and global payments. The midway point described below will be the primary focus of CIVHC’s work over the next three years.

THE MIDWAY POINT

PAYMENT MECHANISM

By 2015, the amount of fee-for service payments would be decreased by a specific percentage (TBD). Payments for almost all care would be bundled among facilities and providers in one of the three following categories:

Comprehensive Bundles – (e.g. maternity care) x% of payments for all care (inpatient and outpatient) for a specified population will be severity and risk-adjusted, and bundled into a single payment to be shared among all providers and facilities participating in that patient’s care. *Please see Figure 5 below for example.*

Partial Bundles: Outpatient/Chronic – (e.g. diabetes, COPD, CHF) x% of payments for all outpatient care for a specified population (that is not already being paid through global bundles) would be severity and risk-adjusted, and bundled into a single payment to be shared among all providers and facilities providing outpatient care for that patient. *Please see Figure 5 below for example.*

Partial Bundles: Inpatient/Acute – (e.g. knee replacement) x% of payments for all inpatient care for a specified population (that is not already being paid through global bundles) will be severity and risk-adjusted, and bundled into a single payment to be shared among providers and the facilities, including post-acute care. A warranty for treatment for any related complications or readmissions that occur within 90 days of the procedure would also be included in the bundle. *Please see Figure 5 below for example.*

Primary Care - Care Management Payment (CMP): x% of primary care providers would be paid a monthly care management payment per-patient in addition to current fee levels for all care they provide (that is not already covered under a bundled payment). The care management payment would pay for services such as patient education and self-management support delivered by a nurse practitioner, care coordination, or access to physicians by telephone. This method would also apply to a specialist who serves as the primary care provider. The following factors would be included in establishing payments:

- Primary care practices meet medical home accreditation standards.
- Pay-for-performance bonuses would be paid based on the practice’s performance on measures of the quality of care provided to patients with chronic disease.
- In addition to pay-for-performance bonuses based on the practice’s performance on measures of the quality of care for patients with chronic disease, the practice would be required to reduce the rate of non-urgent ER visits, ambulatory care sensitive hospitalizations, and/or high-tech diagnostic imaging below specified target levels for its chronic disease patients.
- CMP’s would be increased if utilization is below target levels and reduced if exceeded.

- CMP would be severity-adjusted.

DELIVERY MECHANISM

A significant portion of the system would have partially integrated delivery systems. There would also be more fully integrated delivery systems in place than currently exist today.

CONSUMER/PATIENT ENGAGEMENT

- Patients would be encouraged to select a medical home if one is available.
- Patients would be financially and non-financially incentivized to fully participate in decisions regarding their care.
- Providers would discuss the importance of preventive care and health improvement activities with their patients. They would educate patients about the value of having a medical home.
- If medical research evidence indicates a major acute care intervention (e.g., surgery) may not be appropriate in certain cases, this information would be provided to the provider and to the patient. It would be conveyed in such a way that the patient understands and has an opportunity to ask questions about the evidence and how it applies to his/her condition. A decision about whether or not to get care that evidence indicates may not be appropriate would be the result of shared decision-making, input and support from a health care team, involvement of the family, availability of costs and quality information at the time of service, the specific facts of a patient's situation, information about alternative treatments or tests, as well as the evidence.
- Although the Consumer Engagement Advisory Group does not recommend a sanctioned approach, if sanctions are to be applied and if patients would pay all or a portion of the difference in cost between major acute care and alternative treatments/services when the need for major acute care is uncertain or not recommended, then sanctions would ALSO be applied to the suppliers of such care.

PUBLIC HEALTH

Third-party payers would pay an annual community health assessment into a community pool for primary, community-based prevention. The assessment would be based on their portion of covered lives in the community.

Illustrating How Payments are Dispersed in the Midway Point Payment Model

The following table is an example how the payment mechanism might operate for different clinical conditions across providers.

FIGURE 5

	PRIMARY CARE FEE-FOR-SERVICE WITH CARE MANAGEMENT PAYMENT	PARTIAL BUNDLE: ACUTE <i>e.g. Hip Replacement</i>	PARTIAL BUNDLE: CHRONIC <i>e.g. COPD Care</i>	COMPREHENSIVE BUNDLE <i>e.g. Maternity Care</i>
Primary Care Provider	Fee-for-Service and Care Management Payment	Fee-for-Service - <i>No change</i>	Bundled Payment - <i>Primary care provider</i> - <i>Pulmonologist</i> - <i>Cardiologist</i>	Bundled Payment - <i>OB/Gyn</i> - <i>Anesthesiologist</i> - <i>Well baby, through x weeks</i>
Specialist	Fee-for-Service - <i>No change</i>	Bundled Payment - <i>Orthopedist</i> - <i>Anesthesiologist</i> - <i>Physical Therapist</i> - <i>Rehabilitation Facility</i>		
Care Facility	Fee-for-Service - <i>No change</i>		Fee-for-Service - <i>No change</i>	
Post-Care Facility	Fee-for-Service - <i>No change</i>		Fee-for-Service - <i>No change</i>	

Next Step: Develop an Action Plan to Achieving Midway Point Payment Model

Overview of the Action Plan

As this framework has taken shape in consultation with the leaders of the advisory groups, it is necessary to now focus efforts on moving from a general framework for payment reform to developing a very specific and detailed action plan to achieving it. This plan will set specific milestones, timelines and engagement strategies that will achieve our Triple Aim objectives and allow Colorado to thrive as a great place to live and work.

CIVHC has begun the initial process of pulling together three teams to develop an Action Plan from July 11 to October 13, 2011. Each team will focus on one of the following three components:

- Operations for payment and delivery system reform in Colorado
- Communications and outreach
- Implementation and launch.

Overall outcomes would develop a compelling case statement for Colorado moving to the midway point. It would include:

- Payment methodology
- Impact analysis and case statement for reaching the midway point by 2015
 - Potential impact on Colorado’s health system
 - How the model could impact costs and premiums
 - Strategic impact on achieving triple aim objectives
 - Metrics to measure the number and impact of Coloradans receiving care under outcome based payment systems (see Figure 3)
- How would you implement it:
 - Marketing and communications
 - Community assessment tools
 - Build consensus among key stakeholders
 - Spread the methodology to both commercial markets but also public payers
 - Specific role of CIVHC in working with each of the stakeholders to achieve the goals.

This has been further developed as a charge to the teams and a list of desired outcomes, which can be found in Appendix C.

Bundled Payments to Deliver Health Care without Costing Coloradans More

In our efforts to make the case statement, our charge to the operations group will not only be to develop a dashboard and metrics to demonstrate achievement of the payment goals (Figure 3), but also to develop an illustration much like the following example to show how moving towards a system with severity and risk-adjusted, single bundled payments of care can create increased value.

Current (approximation)

FIGURE 6

<u>Bundle</u>	<u>Volume (all payers)</u>	<u>Average Cost per Case</u>	<u>Approximate Cost per Year</u>
Partial Bundles: Acute <i>Examples: hip replacement without complication</i>	4,000	\$75,000	\$300,000,000
Partial Bundles: Chronic <i>Examples: COPD with minor complications</i>	5,000	\$15,000	\$75,000,000
Comprehensive Bundle <i>Example: full-term birth without complication</i>	65,000	\$5,000	\$325,000,000

Midway Point Savings (approximation)

FIGURE 7

<u>Bundle</u>	<u>Target Percentage Covered by Bundle</u>	<u>Savings Percentage In Bundle Payment</u>	<u>Approximate Savings per Year</u>
Partial Bundles: Acute <i>Examples: hip replacement without complication</i>	30%	5%	\$4,500,000
Partial Bundles: Chronic <i>Examples: COPD with minor complications</i>	30%	5%	\$1,125,000
Comprehensive Bundle <i>Example: full-term birth without complication</i>	30%	5%	\$4,875,000

Conclusions

Colorado is already recognized nationally for its many innovative health reform initiatives, and in particular for its collaborative and pragmatic approaches to achieve important goals. However, without coalescing the overall efforts into some very focused initiatives over the coming years, it is unlikely that Colorado will ultimately achieve its Triple Aim objectives.

Utilizing the midway point initiative as a catalyst for change provides an opportunity for Colorado to enhance health care experiences, contain costs and improve the health of Coloradans over the coming few years. These efforts should help maintain Colorado's position as one of the best places to live and work in the United States.

Appendices

Framework for Transforming the Health Care Payment System in Colorado



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Appendix A: Mileposts to Achieving Triple Aim

This section describes suggested mileposts along the path to full implementation of the Model to Achieve the Triple Aim in as many regions of Colorado as possible. This is not a strict stepwise progression. Communities, third party payers, providers and patients will be starting at different mileposts. In some cases a milepost may be skipped altogether. The purpose of the mileposts presented here is to offer one way for communities to evolve to the Midway Point and beyond to a destination of highly integrated systems of health and health care delivery that include community and public health as full partners, with providers paid risk-adjusted, performance-based global payments and with patients fully informed, engaged and empowered. CIVHC believes this will achieve the Triple Aim of improving the health of Coloradans, enhancing the patient experience of care (including quality, access, and reliability) and reducing, or at least controlling, the per capita cost of care.

Descriptions of what each milepost looks like are based on input from participants at a day-long strategy session for stakeholders held on January 6, 2011. More than 60 individuals attended the meeting. Meeting participants were divided into three break-out groups that developed recommendations for their vision of how acute care, chronic care and preventive/primary care services should be delivered and paid for by 2015. CIVHC's Payment Reform, Delivery System Redesign, and Consumer Engagement Advisory Groups reviewed the break-out groups' recommendations, considered the evidence of what works, and worked to resolve any discrepancies among the recommendations. The result is the suggested mileposts along the path to the destination milepost, which are presented below.

Note: In Mileposts 1, 2, 4, and 5, a placeholder has been provided for public health. Further feedback is needed from public health experts in Colorado to determine their role at each stage of this process.

MILEPOST 1: Enhanced Fee-for-Service with Minimal System Integration
PAYMENT MECHANISM
PRIMARY CARE: Primary care practices would be paid fee-for-service AND Evaluation and Management (E&M) fee levels would be increased and new service fees codes added to: 1) enable primary care physicians to spend more time counseling patients; 2) compensate for time spent on patient phone calls, coordinating with specialists, etc.; and 3) pay for non-physicians for patient education and self-management support. Primary care practices would be eligible for pay-for-performance bonuses.
CHRONIC CARE: Paid for Fee-for-Service.
SPECIALITY CARE: Paid for Fee-for-Service.
INPATIENT CARE: Paid for same as currently.
DELIVERY MECHANISM
The delivery system would consist of a variety of small, medium and large single and multispecialty practices and independent hospital systems that would have contracts in place, when necessary, to obtain care not provided directly

by them. There would be a limited number of partially or fully integrated delivery systems.

CONSUMER /PATIENT ENGAGEMENT

Patient premiums and cost-sharing would be reduced for preventive care received from a high-quality, reasonably-priced, convenient provider (e.g., urgent care providers, pharmacies, etc.) and for active, continuing participation in health promotion activities.

PUBLIC HEALTH

MILEPOST 2: Enhanced Fee-for-Service with Small Care Management Payments and Some Medical Homes

PAYMENT MECHANISM

PRIMARY CARE: Primary care practices would be paid fee-for-service AND medical homes would receive small care management payments (to coordinate and manage patient care.) Fees would depend, in part, on the degree to which there is demonstrated care coordination, patient satisfaction levels (e.g., with their care, cultural competency, respect shown to them, accessibility of services, etc.) and genuine patient involvement in decisions about their care.

CHRONIC CARE: In addition to the primary care payments just described, for each patient with a chronic condition, primary care practices would be paid a Small Monthly Care Management Payment (SM-CMP) to provide flexible funds to enable the physician to spend more time with patients.

SPECIALITY CARE: Specialists would be paid fee-for-service for most services AND would receive a periodic care management payment for preventive services if they took partial or full responsibility for the frequency or cost of care.

INPATIENT CARE: Paid for same as currently AND facilities taking the lead in managing care would receive a fixed severity adjusted bundled payment to cover the costs of certain procedures and diagnoses in three broad categories: acute episodes (e.g. knee surgery), chronic conditions (e.g. diabetes), and delimited conditions that have both outpatient and inpatient components (e.g. pregnancy). Payments for preventable adverse events would be prohibited.

DELIVERY MECHANISM

The delivery system would still consist mainly of small, medium and large single and multispecialty practices and independent hospital systems. There would be a few more partially or fully integrated delivery systems and more medical homes than under Milepost 1.

CONSUMER/PATIENT ENGAGEMENT

- Patient premiums and cost-sharing would be reduced for preventive care received from a high-quality, reasonably-priced, convenient provider (e.g., urgent care providers, pharmacies, etc.) and for active, continuing participation in health promotion activities. Providers would discuss with their patients who have chronic conditions and make information available to them about the importance of preventive care self-care management and health improvement activities.
- Patients would be encouraged to select a health care home, if one is available. Within a health care home:
 - Services provided through a health care home would have low/no cost sharing.
 - Patients would have low or zero co-payments for medications and other treatments (e.g., cardiac rehabilitation) that are part of a jointly designed and agreed-to treatment/management plan between patient and doctor.
 - Patients would be offered financial and/or non-monetary incentive to improve their health and adhere to treatment plans developed jointly with their health care home team.
 - Providers would encourage patients, and materials and educational programs would be developed to inform patients about the importance of having and making consistent use of a health care home, including appropriate use of ERs.
 - Patients with a health care home would have barrier-free access to alternatives to the emergency room for non-emergency care.
 - A patient's health care home would immediately be informed when a patient receives emergency room care which could have been provided elsewhere or avoided with adequate health care home care management/access and patient education.
- Patients would be encouraged to, and have financial and non-monetary incentives and the information, assistance and tools (e.g., decision aids), to fully participate in decisions about their care.

PUBLIC HEALTH

THE MIDWAY POINT: Some Bundled Payments; Some Components of System are Integrated

PAYMENT MECHANISM

PRIMARY CARE: The provider taking the lead in managing care would receive a fixed severity adjusted bundled payment to cover the costs of certain procedures and diagnoses in three broad categories: acute episodes (e.g. knee surgery), chronic conditions (e.g. diabetes), and delimited conditions that have both outpatient and inpatient components (e.g. pregnancy). Primary care practices would also receive a small monthly care management payment for care coordination.

CHRONIC CARE: For chronic care services that are not part of a bundled payment, primary care practices would receive a small monthly care management payment.

SPECIALITY CARE: For specialty care services that are not part of a bundled payment, specialists would receive fee-for-service payments.

INPATIENT CARE: For inpatient care that is not part of a bundled payment, risk-adjusted diagnosis-based payments would be made that would include both facility-based and physician care. Payments for preventable adverse events would be eliminated. For all other services, facilities would continue to be paid for same as they are currently.

DELIVERY MECHANISM

There would be medical homes in most of the state. A significant portion of the system, at least in urban areas, would have partially integrated delivery systems. There would be a few more fully integrated delivery systems in place than today. The balance of the system would be characterized by traditional free standing hospitals, physician practices and clinics.

CONSUMER/PATIENT ENGAGEMENT

- Patients would be encouraged to select a medical home, if one is available.
- Patients would be encouraged to and have financial and non-financial incentives to fully participate in decisions regarding their care.
- Providers would discuss the importance of preventive care and health improvement activities with their patients. They would educate patients about the value of having a medical home.
- If medical research evidence indicates a major acute care intervention (e.g., surgery) may not be appropriate in certain cases, this information would be provided to the provider and to the patient, conveyed in a way that the patient understands and has an opportunity to ask questions about the evidence and how it applies to his/her condition. A decision about whether or not to get care that evidence indicates may not be appropriate would be the result of shared decision-making, input and support from a health care team, involvement of the family, availability of costs and quality information at the time of service, the specific facts of a patient's situation, information about alternative treatments or tests, as well as the evidence.
- Although the Consumer Engagement Advisory Group does not recommend a sanctions approach, if sanctions are to be applied and if patients would pay all or a portion of the difference in cost between major acute care and alternative treatments/services when the need for major acute care is uncertain or not recommended, then sanctions would ALSO be applied to the suppliers of such care.

PUBLIC HEALTH

Third-party payers would pay an annual community health assessment into a community pool for primary, community-based prevention. The assessment would be based on their portion of covered lives in the community.

MILEPOST 4: Large Care and Care Management Payments with Greater System Integration (Medical Homes and IPAs)

<p>PAYMENT MECHANISM</p>
<p>PRIMARY CARE: Fee-for-Service fees paid for individual services would be reduced. Primary care practices would receive a Large Care and Care Management Payment (LM-CMP) for each patient that elects them as their health care home. This payment would be risk-adjusted. This payment would cover all non-facility-based care.</p>
<p>CHRONIC CARE: For patients with chronic conditions, the LM-CMP would take into account the additional expenses of caring for patients with chronic conditions (e.g., patient education, management, evaluation, etc.) and would include the cost of all required specialty care. Primary care practices would be required to meet Level 3 medical home accreditation standards to receive the LM-CMP and would be eligible for pay-for-performance bonuses based on quality of care given to patients with chronic diseases. In addition, practices would be required to reduce the rate of non-urgent ER visits, ambulatory sensitive hospitalizations, and/or high-tech diagnostic imaging below specified target levels for its chronic disease patients or its LM-CMP would be reduced. If it exceeded target levels, it would receive an increase in the LM-CMP for chronic care patients.</p>
<p>SPECIALITY CARE: Specialist care would be paid as part of the LM-CMP AND for all other services would be paid Fee-for-Service.</p>
<p>INPATIENT CARE: Paid for same as under Milepost 3 AND payments for preventable adverse events would be prohibited.</p>
<p>DELIVERY MECHANISM</p>
<p>A majority of the system would consist of large multispecialty groups and integrated delivery systems; all primary care would be provided through medical homes.</p>
<p>CONSUMER/PATIENT ENGAGEMENT</p>
<ul style="list-style-type: none"> • Patient engagement would have the same features as described in Milepost 4. • Although the Consumer Engagement Advisory Group does not recommend a sanctions approach, if sanctions are to be applied and patients are penalized for switching health care homes or consistently seeking care outside the health care home, providers should be fined if: <ul style="list-style-type: none"> ○ Their patients switch to another provider because the provider/practice did not provide true 24/7 access, ○ Did a poor job of addressing the patients' concerns or limitations, recommended care that was not evidence-based, and/or ○ Failed to provide primary care that could have avoided an ER visit, etc. • Insurers should be penalized if: <ul style="list-style-type: none"> ○ They charge a patient more for inappropriate utilization but don't provide patients with the tools and information to determine what exactly is inappropriate utilization for the problem for which they are seeking care.

PUBLIC HEALTH

MILEPOST 5: Comprehensive Care and Care Management Payments & Global Inpatient Facility-based Fees with Integrated Ambulatory Care Systems and PHOs

PAYMENT MECHANISM

PRIMARY CARE: Fee-for-Service fees paid for individual services would be eliminated. Primary care practices would receive a Comprehensive Care and Care Management Payment (C-CMP) for each patient to cover the costs of all outpatient services, including those delivered by other outpatient providers. The payment would be risk-adjusted. The C-CMP would also be based on certain quality of care factors (e.g., meeting quality indicators, reducing unnecessary testing, etc.).

CHRONIC CARE: For patients with chronic conditions, would take into account the additional expenses of caring for patients with chronic conditions (e.g., patient education, management and evaluation).

SPECIALITY CARE: Specialist care would be paid as part of C-CMP.

INPATIENT CARE: Facilities would get a single, prospectively determined, diagnosis-related payment for all inpatient care, including physician services, and would be eligible for quality-of-care performance payments. They would receive no payment for preventable adverse events. Inpatient care providers would be grouped into cost/quality tiers.

DELIVERY MECHANISM

There would be larger multispecialty groups and greater consolidation/mergers among physician groups.

CONSUMER/PATIENT ENGAGEMENT

- Patient engagement would have the same features as described in Milepost 4.
- Patients requiring inpatient care, their providers and third party payers would receive information on facilities' relative value (quality and cost) for all care associated with an inpatient admission. Information that would be available in sufficient time and in a format to allow for informed decision-making.
- Transparent, easily accessible, understandable data would be available to patients. Differing health literacy levels would be factored in. Since primary care practices and specialists would be grouped into tiers based on quality, cost and patient experience measures, that information and assistance in interpreting the information would be available to assist patients and their providers to make informed choices about where to get care. Patients would be informed about the tiers in which providers and practices are ranked.
- Although the Consumer Engagement Advisory Group does not recommend a sanctions approach, if sanctions are to be applied then patients who use, and any provider who refers them to, a higher cost/lower quality-tiered facility would be responsible for a portion of the difference in cost for using that facility.

PUBLIC HEALTH

DESTINATION MILEPOST : Global Payments and Highly Integrated Health Systems

PAYMENT MECHANISM

PRIMARY CARE: There would be no Fee-for-Service payments. Integrated care systems would be organized to receive risk-adjusted, performance-based global payments to care for a population. Care would be coordinated through the patient’s primary care medical home. The practice would be responsible for attending to all aspects of the patient’s care.

CHRONIC CARE: There would be no case rate payments based on DRGs. Integrated care systems would be organized to receive risk-adjusted, performance-based global payments to care for a population. Care would be coordinated through the patient’s primary care medical home. The practice would be responsible for attending to all aspects of the patient’s care.

SPECIALITY CARE: There would be no Fee-for-Service payments. Integrated care systems would be organized to receive risk-adjusted, performance-based global payments to care for a population. Care would be coordinated through the patient’s primary care medical home. The practice would be responsible for attending to all aspects of the patient’s care.

INPATIENT CARE: There would be no Fee-for-Service payments. Integrated care systems would be organized to receive risk-adjusted, performance-based global payments to care for a population. Care would be coordinated through the patient’s primary care medical home. The practice would be responsible for attending to all aspects of the patient’s care.

DELIVERY MECHANISM

Providers would operate within highly integrated systems in which patients’ care is coordinated and case managed and where health related information is shared among providers.

CONSUMER/PATIENT ENGAGEMENT

Patients would be full, equal partners and would have the financial and non-monetary incentives, information, assistance and tools (e.g., decision aids) to fully participate in decisions about their care. Patients would receive the care and health improvement and maintenance supports to be as healthy as they can be and make informed choices about their care and healthy choices.

PUBLIC HEALTH

Public health would be a full partner in the delivery system, delivering those services most cost-effectively delivered on a population health based in community settings (e.g., school-based health centers).

Appendix B: Evidence Supporting the Framework

- Note that the limited evidence that exists indicated that, for some conditions, **episode-of care payments** can improve efficiency and generate cost savings.
- Research indicates **global payments** can result in lower costs without affecting quality or access.³ Existing evidence comes from experience with traditional capitation, which is a form of global payment.
- Little research exists on the effect of **performance-based pay** on health care costs. What evidence exists has produced mixed results.⁴ There is evidence of improved quality care. Combining pay-for-performance with other strategies, such as global payments and care coordination programs, may result in cost containment that could be achieved by using just pay-for-performance.
- Evidence indicates non-payment for **preventable adverse events** saves costs.⁵
- **Medical/health care homes:** Some studies show significant medical home savings; others have found minimal or no overall savings but report other benefits (e.g., improved care quality, reduced medical errors, higher patient satisfaction, enhanced health care access and fewer health disparities).⁶ Most studies that support medical homes' potential to reduce overall spending have not assessed a complete version of the approach. Instead, they have looked at selected components, such as ensuring all patients have a primary care doctor or establishing care coordination programs for patients with diabetes or heart disease.
- **Wellness promotion:** Studies of worksite wellness programs demonstrate that well-designed programs can reduce employer and employee health expenditures on absenteeism, at least for large employers.⁷
- **Patient education:** Evidence base from 14 systematic reviews of health literacy programs: utilization and cost – some positive effects; health knowledge – improved; patients' experience – improvements in satisfaction and self-efficacy; health status – unknown. Evidence base from 49 systematic reviews of patient self-care: utilization and cost – some positive short-term effects health knowledge – improved; patients' experience – positive short-term effects; health status – limited short-term effects.⁸
- **Shared decision-making:** Evidence base from 17 systematic reviews: utilization and cost – mainly positive effects; health knowledge – improved; patients' experience – improved; health status – no effect.⁹

³ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2010). *Global Payments to Health Providers* [pdf document]. Retrieved from: http://www.ncsl.org/portals/1/documents/health/GLOBAL_PAYMENTS-2010.pdf

⁴ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2011). *Health Care Provider Patient Safety* [pdf document]. Retrieved from: <http://www.ncsl.org/portals/1/documents/health/PATIENTSAFETY-2011.pdf>

⁵ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2010). *Global Payments to Health Providers* [pdf document]. Retrieved from: http://www.ncsl.org/portals/1/documents/health/GLOBAL_PAYMENTS-2010.pdf

⁶ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2010). *Medical Homes* [pdf document]. Retrieved from: <http://www.ncsl.org/portals/1/documents/health/MedicalHomes-2010.pdf>

⁷ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2010). *Employer-Sponsored Health Promotion Programs* [pdf document]. Retrieved from: <http://www.ncsl.org/portals/1/documents/health/WorksiteWellness-2010.pdf>

⁸ Somekh, D. (2005). *Patient empowerment, the key to quality improvement* [PowerPoint document]. Retrieved from: http://www.esqh.net/www/about/presentations/files/folder_1207649000/Athens_December_2005.ppt

⁹ IBID.

- Evidence is mixed but indicates that, properly structured, state **all-payer rate setting** can slow price increases but not necessarily curb overall cost growth. Uniform pricing strategies that allow providers to set all-payer rates (same actual payment rate for all payers) are too new to assess their effect on costs.¹⁰ This requires standard and commonly accepted tiers that the entire provider community subscribes to. This requires standard quality protocols which don't currently exist across all settings and types of services.

¹⁰ National Conference of State Legislatures, Health Cost Containment and Efficiency Series (2010). *Equalizing Health Provider Rates: All-Payer Rate Setting* [pdf document]. Retrieved from: http://www.ncsl.org/portals/1/documents/health/ALL_PAYER_RATES-2010.pdf

Appendix C: Charge to the Action Plan Teams and Desired Outcomes

Operations Team

The charge of the Operations team is to identify the specific steps that need to be taken by CIVHC to significantly advance specific payment methodologies throughout Colorado that encourage more integrated, high-quality, efficient care.

The Operations team will deliver a midway payment model. This model will include:

- A fleshed out midway point payment model that includes further descriptions of key components such as “bundled payments.”
- Baseline info related to current payment system and methodology to assess the impact of choosing various “bundles” to achieve midway point goals (utilizing Data Group and/or CHI).
- Methodology for choosing which bundles would achieve goals.
- The general case for the overall strategy. This would include information on some of the key potential strategies (e.g., knee surgery or diabetes management bundled payment) and their potential, in order to convince stakeholders to get on board.
- A suggested outline of CIVHC’s role in getting to the midway point to be referred to the implementation team.
- Possible barriers, stakeholder concerns (and any suggestions) to be referred to the implementation and communications teams.

Activities include:

- Clearly set forth components of the payment reform midway point (e.g., episode of care payments, primary care payments, global payments, etc.) and work with the Data and Transparency Advisory Group (Data Group) to put some numbers on midway point goal (e.g., x% of Coloradans are getting care via bundled payments, or x% of total care payments are being made via bundled or payments, etc.)
- Identify some bundled payments for services/conditions that show promise (actual evidence, modeling results, etc.). Discuss criteria for targeting certain services/conditions and how, if bundled, they would achieve the midway point targets noted above. Have Data Group crunch projections on possible savings for some examples for commercial, Medicaid and Medicare populations.
- Identify barriers to successfully reaching midway point that must be addressed.
- Note some of the benefit design questions/issues that may need to be addressed to support payment reform.
- Note delivery system models that need to be in place to deal with payment reforms.
- Identify a few current, illustrative initiatives in Colorado (e.g., Prometheus project, patient-centered medical homes, etc.) and how they may intersect and complement the midway point goals.
- Make suggestions for CIVHC’s specific role. Possible roles: track metrics on progress towards midway point; provide/fund technical assistance; identify grant opportunities to help payers and providers move to midway point; work with business community to push this model; educate different stakeholder groups in the community on the importance of this model; stay up-to-date and disseminate information on evidence base for different new payment models related to bundled payments for conditions, services, populations.

Communications and Outreach Team

The charge of the Communications team is to identify effective strategies and tactics to engage the individuals, business leaders, providers, carriers and policy makers who CIVHC will need to work with to improve the health care payment and delivery systems in their communities.

This team will deliver an integrated and strategic communications plan. The plan will include:

- Messaging and terminology standards.
- A situation analysis of the communications landscape.
- An audience analysis including current thinking and where we hope to migrate that thinking to through our outreach.
- The barriers and benefits of the operations plan to our audiences.
- A map of other activities that will complement, distract or run tangentially to our efforts.
- Communications objectives, strategies, tactics and metrics.

Activities include:

- Understanding the current level of awareness, education and activation for each of our key audiences.
- Discovering the best way to engage each of our key audiences.
- Providing a reason why people/communities should care about CIVHC and payment reform.
- Crafting a clear benefit statement for payment reform (relatable to each audience).
- Exploring the tools and resources we will need to reach and educate our audiences.
- Packaging the operations plan.

Implementation and Launch Team

The charge of the Implementation team is to ensure that there is strong alignment with CIVHC's strategic objectives in the development of the Action Plan.

The Implementation team will deliver a pathway to launch the action plan. Specifically, it will include:

- A plan to gain commitment from key stakeholders to implement payment model that will achieve 2015 midway point milestones defined by Operations team.
- A plan for spread of payment model's integration into CIVHC's broader strategic initiatives for community engagement and participation in broad Triple Aim initiatives (Race to Health model).
- Strategies for handling key public policy issues and/or legislative requirements associated with implementing the payment model by defined deadlines.
- Recommendations to leverage our action plan for payment model implementation with other key initiatives, both locally in Colorado and nationally. This includes, but is not limited to, benefit design, insurance exchange and adoption of payment model by public payers.

Activities include:

- Developing a plan for building support and removing barriers with key stakeholders to achieve midway point and destination of the payment model.
- Ensuring that the Action Plan clarifies the specific role of CIVHC and how we engage other stakeholders and organizations.
- Identifying key policy and potential legislative issues associated with the Action Plan.
- Serve as sounding board and reactor to work of two other teams.

Appendix D: Payment Reform Strategy Session Participants

Name	Title	Organization	Category
<i>Note: Participants in Italics registered, but did not attend the session</i>			
Arja Adair	President/CEO	Colorado Foundation for Medical Care	Research/Data
Chris Adams	Executive Director	Engaged Public	Independent Consultant
Phyllis Albritton	Executive Director	CORHIO	HIE/HIT
Polly Anderson	Policy Director	Colorado Community Health Network	Provider
Lalit Bajaj	Physician	The Children's Hospital	Provider
<i>Crystal Berumen</i>	Director of Clinical Improvement and Patient Safety	Colorado Hospital Association	Provider
Vinita Biddle	Benefits Strategist	Dept of Personnel & Administration	Government
Mike Bloom	President/CEO	North Colorado Health Alliance	Provider
Michael Boyson	Director of Health Center Operations	Colorado Community Health Network	Provider
Jay Brooke	Executive Director	High Plains Community Health Center	Provider
Tom Dameron	President	CIGNA	Insurer
George DelGrosso	Executive Director	Colorado Behavioral Healthcare Council	Provider
Erin Denholm	CEO	Centura Health at Home	Provider
Jo Donlin	Director of External Affairs	Division of Insurance	Government
Amy Downs	Director for Policy and Research	Colorado Health Institute	Research/Data
Kelly Dunkin	VP Philanthropy	The Colorado Health Foundation	Funder
Cari Fouts	Director of Communication & Development	Colorado Rural Health Center	Provider
Karen Frederick-Gallegos	Director of Quality Initiatives	Colorado Medical Society	Provider
<i>Alfred Gilchrist</i>	Executive Director	Colorado Medical Society	Provider
Thomas Gottlieb	President	Denver Oncology Consortium	Provider
<i>Natalie Gregory</i>	Medical Home Initiative Program Manager	CDPHE	Government
Gretchen Hammer	Executive Director	Colorado Coalition for Medically Underserved	Consumer
Maureen Hanrahan	Consultant	CIVHC	Independent Consultant
Marjie Harbrecht	Executive Director	HealthTeamWorks	Research/Data
Marian Heesaker	Nurse/Director of Health Initiatives	Director of Health Initiatives	Provider
Debby Henkens	Business Development Manager	QSE Technologies	Tech
Aubrey Hill	Health Systems Analyst	Colorado Coalition for Medically Underserved	Consumer
Mike Huotari	VP Legal and Government Affairs	Rocky Mountain Health Plans	Insurer
Jessie Israel	Director of Regulatory Policy	Colorado Hospital Association	Provider
Debra Judy	Policy Director	Colorado Consumer Health Initiative	Consumer
David Kaye	Coordinator/Volunteer	St. Anthony's Central	

Name	Title	Organization	Category
John Kefalas	Representative	State Legislature	Legislator
Barbara Ladon	COO	ArpeggioHealth	Independent Consultant
<i>Mark Levine</i>	Chief Medical Officer	Ctrs for Medicare & Medicaid Svcs, Region VIII	Government
Lorez Meinhold	Director of Health Reform Implementation & Senior Health Policy Analyst	Colorado Governor Bill Ritter Jr.	Government
Paul Melinkovich	Director of Community Health	Denver Health	Provider
Donna Marshall	Executive Director	Colorado Business Group on Health	Business
Tom Nash	VP of Financial Policy	Colorado Hospital Association	Provider
Lynn Parry	Co-Chair, Society Physicians Congress for HC Reform	Colorado Medical Society	Provider
Laurel Petralia	Program Officer	The Colorado Trust	Funder
Annette Quintana	Chief Executive Officer	Istonish	Business
Sue Radcliff	Public		Public/Consumer
Marc Reece	Associate Director	Colorado Association of Health Plans	Insurer
Jordan Reigel	VP Network Management, CO, MT, NM & WY	UnitedHealthcare	Insurer
Jody Reuler	Executive Director	Rocky Mountain Health Care Coalition	Business
<i>Jay Ringhofer</i>	Senior Vice President	Lockton	Business
Sara Russell Rodriguez	Director, Chronic Disease Prevention Branch	CDPHE	Public Health
Barbara Ryan	Executive Director	Mental Health Center for Boulder County	Provider
Jean Scholz	Executive Director	Colorado Center for Nursing Excellence	Provider
Chet Seward	Senior Director, Division of Health Care Policy	Colorado Medical Society	Provider
Kelly Shanahan-Marshall	IBD Pilot Project Director	Engaged Public	Independent Consultant
Kelly Stahlman	Project Manager	CO Alliance for Health & Independence	Consumer
Allison Summerton	Research Analyst	Colorado Health Institute	Research/Data
Dick Thompson	Executive Director	Quality Health Network	HIE/HIT
Billy Wynne	Senior VP & Principal	Health Policy Source	Independent Consultant
Barbara Yondorf	Consultant	Rose Community Foundation	Consumer
Jed Ziegenhagen	Rates Manager	Health Care Policy & Financing	Government
Karen Zink	Owner/Women's Health Nurse Practitioner	Southwest Women's Health Associates	Provider