How-To Manual for Redesigning Medicaid Payment Policies:

Lessons from a Local Demonstration Project to Improve the Value of Care for Children with Medically Complex Conditions

Funded by the Robert Wood Johnson Foundation and UPMC *for You*

UPMC Center for High-Value Health Care

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UPMC *for You*

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Table of Contents

Click on a topic to jump to the appropriate page.

Introduction

A key focus of U.S. health care payment reform is to promote greater value by more efficiently addressing consumer needs. This manual is the product of a local payment reform demonstration project to enhance the value of care for one of our nation's most vulnerable populations: children with medically complex conditions. Funded by the Robert Wood Johnson Foundation and UPMC *for You*, the largest Medicaid physical health managed care organization (MCO) in western Pennsylvania, the demonstration project involved multiple stakeholders working in or served by the UPMC integrated delivery and financing system headquartered in Pittsburgh, Pennsylvania. The entire demonstration project was conducted over the three-year period from May 15, 2012 to May 14, 2015. The implementation of the project was conducted between March 2013 and December 2014.

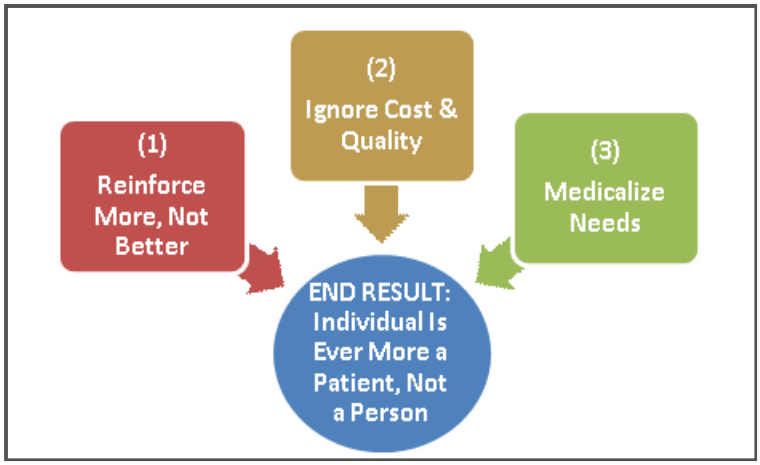
Background and Context

Scientific and medical advances have led to reduced mortality and prolonged survival of children and youth with a variety of complex and continuing special health needs. The federal- and state-funded Medicaid program plays a critical role in providing medical and supportive services to these individuals – many of whom require intensive, ongoing, and costly treatment involving multiple caregivers, complicated medication regimens, technological supports, and other home- and community-based services. UPMC *for You* data illustrate that children and youth with medically complex conditions have significantly higher service utilization and incur greater medical expenses compared to similarly aged subgroups of Medicaid beneficiaries. While some of this service use and spending is expected simply by virtue of associated medical conditions, the way that clinical and nonclinical services are paid for and/or purchased leaves opportunity for improving the care for this population.

According to the Centers for Medicare & Medicaid Services (CMS)[1], recent state-level efforts to improve the value of care for Medicaid beneficiaries have focused on shifting from traditional fee-for-service (FFS) plans to managed care arrangements where states contract with Managed Care Organizations (MCOs) to oversee care for defined patient populations through fixed annual capitation payments. As a result, almost two-thirds of Medicaid beneficiaries in the U.S. are now in some form of managed care. However, most providers continue to be reimbursed through FFS arrangements. Relatively few families of children with special needs are able to get into home and community-based waiver programs. Many families face high out-of-pocket expenses for non-covered items, including nonclinical goods and services needed to maintain and improve the health and well-being of their child.

[1] Centers for Medicare and Medicaid Services website http://cms.hhs.gov/ May 1, 2012.

Figure A: Results of Current FFS Medicaid Payment System



As Figure A illustrates, this payment structure hinders the delivery of high-value care for children and youth with medically complex conditions in several ways. First, FFS reimbursement can reinforce more, not necessarily better, care because payments are made based on the quantity rather than the quality of care provided. Second, those involved in making clinical care decisions have little or no information about how much care actually costs or how it might be improved to better meet the needs of a specific patient population. Third, Medicaid acute care funding for services not on the state fee schedule – as well as some services such as inpatient care, some durable medical equipment, and private duty nursing – is reviewed for medical necessity, which may not always meet individual and family needs. This reality may actually incentivize providers to "medicalize" those acute needs in order for Medicaid to pay for them. The end result is that the individual receiving care becomes ever more a patient and not a person.

Approach and Timeline

Despite ongoing payment reform efforts across the nation, little is known about how to redesign the acute Medicaid payment systems in ways that will better and more efficiently address the needs of medically vulnerable populations. As the Robert Wood Johnson Foundation has noted, promising new payment models exist, but many of these approaches remain unproven and implementation is inherently complicated and risky.

Stakeholders in Allegheny County decided to tackle these challenges through a stepped approach designed to redistribute Medicaid dollars in a way that would improve care quality while maintaining or reducing the total cost of care for a target population of children with medically complex conditions. Together, we developed a value-based payment model with three main components as illustrated in Figure B. The work described in this manual lasted two and a half years, and involved a series of overlapping design and implementation phases from 2012 to 2014 as illustrated in Figure C. Work on evaluation and transitioning our learning from this demonstration to larger scale policy and payment changes is ongoing.

Figure B: Components of a Value-Based Payment Model

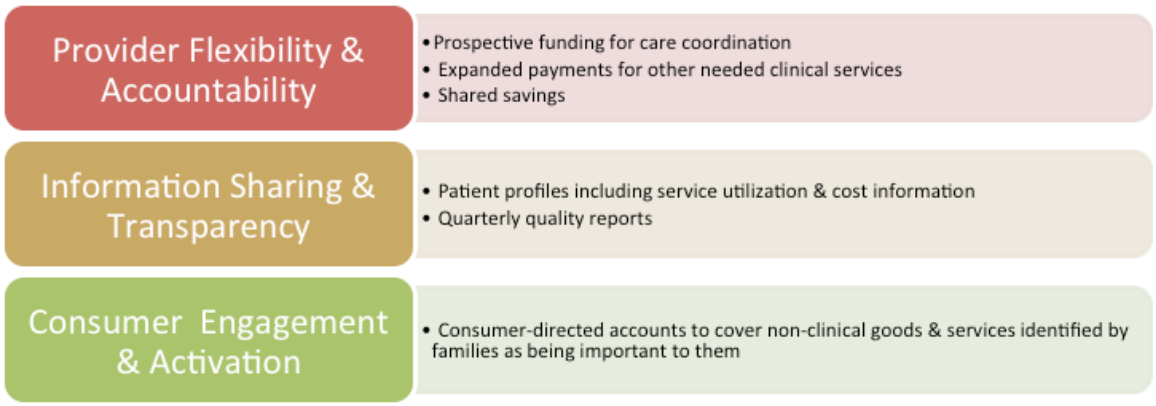
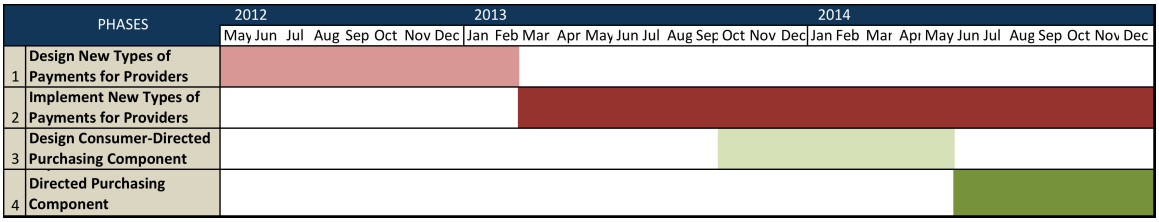


Figure C: Timeline of Payment Reform Planning and Implementation Phases



About This Manual

This how-to manual is intended to serve as a roadmap for other health care providers, payers, and consumers who are searching for replicable strategies, methods, and tools to guide similar and/or related payment reform efforts. The remaining content is divided into six sections:

- **Sections I, II, and III** describe the steps that were taken over the course of this three-year demonstration project organized into three categories as follows:
    - Getting started **(Section I)**;
    - Designing a value-based payment model **(Section II)**;
    - Implementing a value-based payment model **(Section III).**
- **Section IV** provides a summary of lessons learned by phase and overall.
- **Section V** is a toolkit that contains tools, information, and other resources that were either developed or acquired as part of the demonstration project.
- **Section VI** is a glossary that defines commonly used terms.

I. Getting Started

Step 1: Engage Key Stakeholders around a Shared Vision

Payment reform success depends on effectively engaging multiple stakeholders around a shared vision for improvement tackled through changing the way health care services are currently paid for or purchased. The vision must be compelling enough to generate enthusiasm and commitment over time. It should also reflect a common language and a core set of principles that transcend the varying interests and concerns of different stakeholder groups.

Step 1.A: Leverage existing partnerships to identify improvement opportunities through payment reform

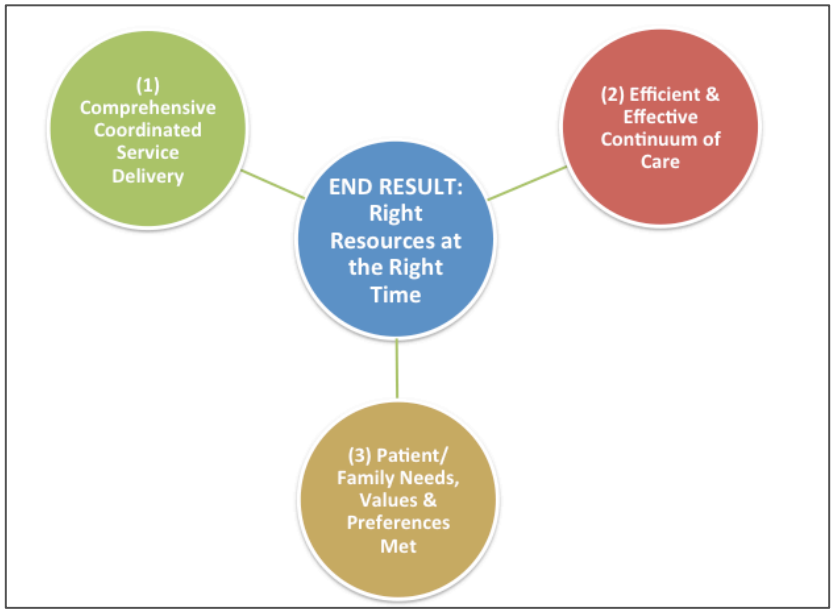
In Pittsburgh and Allegheny County, children under age 21 with medically complex conditions can be enrolled in the region's Medicaid managed care program, of which UPMC *for You* is one of four plan options. Most of these children receive their clinical care through Children's Hospital of Pittsburgh of UPMC (Children's Hospital) and its affiliated network of pediatric providers and specialists. UPMC is a large integrated delivery and financing system that includes UPMC *for You*, the largest Medicaid physical health MCO in western Pennsylvania, and Community Care, the county's sole Medicaid behavioral health MCO. Together, these organizations are responsible for managing the physical and behavioral health needs of children and youth enrolled in Medicaid in our region, including children with medically complex conditions. They share a mutual desire to improve care for this target population. Other community organizations, government agencies, and interested consumers are equally committed to achieving the same goal and were key partners throughout this payment reform demonstration project.

Early in the project, UPMC *for You* brought together representatives of these key stakeholder groups in a kick-off meeting to discuss the challenges faced by providers in managing care for this population, the frustrations of patients and their families in navigating the health care system and accessing needed goods and services, and the high costs associated with the current health care delivery process, as well as opportunities to address these issues through payment reform. Providers and administrators realized that payment changes could reduce suboptimal, inefficient, and often redundant "siloed" care. They were particularly interested in being able to use information currently inaccessible, such as what services other than their own are being provided to their patients and the actual reimbursement rates of their services in order to improve patient care. Consumers realized that self-directed purchasing by patients and families could enhance the quality of care without increasing costs, and payers realized that changes in how services are paid for or purchased could bridge the gap between current service delivery and patient/family needs. All stakeholders recognized the inevitability and desirability of health care payment reform and embraced the opportunity to serve as innovators in this particularly critical area of child and adolescent health care.

Step 1.B: Articulate a compelling vision for value-based payment reform

Once an important opportunity to improve the value of care through payment reform is agreed upon by all parties, a shared vision for transforming service delivery through value-based payment can emerge. In the UPMC *for You* demonstration project, consideration of the problems resulting from the current Medicaid payment structure (Introduction, Figure A) led to the shared vision of payment reform illustrated in Figure I.A.

Figure I.A: Shared Vision for UPMC *for You* Payment Reform



This vision incorporates three main components:

1. Comprehensive, coordinated service delivery.
2. Transparency of cost and quality to achieve an efficient and effective continuum of care.
3. Direction from patients and families to ensure that their needs, values, and preferences are adequately understood and met rather than just medicalized.

The desired end result is that the individual under care receives the right resources at the right time, and that the care is high-value patient- and family-centric care.

Step 1.C: Develop a common language and core set of principles for moving the vision forward

In order to transcend the varying interests and concerns of different stakeholder groups, it is also important to develop a common language and core set of principles that will resonate with all partners and sustain their enthusiasm and commitment over time. This is an ongoing process

as stakeholders from different cultures and with varying backgrounds and experiences learn to work together and trust each other through what is inherently a difficult and long-term process of change. Here are some examples of language and principles that evolved over the course of the UPMC *for You* demonstration project:

- Focus on improving the patient experience of care rather than reducing costs
- Respectfully listen to and consider all key stakeholder perspectives, most importantly those of patients and families
- Accept that desired service delivery improvements will not happen simply because payment systems have changed
- Support providers and patients/families as they adapt to new service delivery approaches
- Be flexible and timely in meeting needs of patients/families and the providers who serve them

Given that payment reform is intended to drive a different kind of service delivery, the language and principles of one need not and should not be antithetical to the language and principles of the other. In fact, over the course of the UPMC *for You* demonstration project, providers became much more eager to embrace the value-based payment model when they recognized its implicit connections with the patient-centered medical home model. As described in Step 10, developing strategies, methods, and tools to leverage these connections was an important and ongoing focus of our work.

Step 2: Build a Collaborative Learning Infrastructure

Payment reform success also requires a collaborative learning infrastructure that supports stakeholder engagement and partnership through all phases of the process. Important issues to consider when building this infrastructure include the optimal timing and process for engaging different stakeholder groups, how to set up an organizational framework for effectively conducting the work, and what other types of activities can help to support and promote collaborative learning.

Step 2.A: Involve all those who provide, pay for, or receive care as appropriate to the phases of the work

Five different types of stakeholder groups have critical roles to play in the payment reform process. These groups and their roles can be summarized as follows:

- **Payers** – Provide financial resources, data, and analytic capabilities required to jump-start and guide the process and have the authority to implement changes to existing Medicaid payment and purchasing systems.
- **Providers** – Have clinical knowledge to identify and implement best care practices in close partnership with patients and families and technical expertise to integrate new staff and payment mechanisms into the existing practice environment.

- **Patients/families/consumers** – Ensure that needs and preferences of patients and their families/caregivers are understood and addressed and are critical partners in implementing service delivery changes.

- **Leaders of community organizations** – Generate ideas and important contacts and mobilize community resources as needed to support payment reform goals.

- **Local/state/national purchasers and policymakers** – Lend a desired level of gravitas to the undertaking by placing the payment reform in the broader context of health care system change and are well-positioned to support model dissemination.

In the UPMC *for You* demonstration project, representatives from each of these groups were involved in various ways. Faced with the initial task of designing and implementing payment changes for providers, much of our early efforts focused on effectively engaging providers and practices in the payment reform process. Once we began designing and implementing purchasing changes for consumers, we stepped up our efforts to more adequately engage patients and families. The participation of consumers was supported through paying for parking and stipends for their time, as well as any other necessary travel expenses. The ongoing engagement of providers and practices was also partially remunerated through modest practice stipends.

Step 2.B: Set up an organizational framework that allows for multiple levels and types of engagement

The UPMC *for You* demonstration project was organized around and conducted through several overlapping structures:

- Advisory board
- Leadership team
- Payment design work group for provider components of model
- Payment design work group for consumer-directed accounts
- Family engagement subgroup
- Outcomes subgroup
- Payment implementation task force
- Support team

Table I.A provides an overview of the infrastructure once it reached a steady state near the end of year one, including the type/size of the groups which were organized, as well as their roles, member information, and meeting frequency.

All local payer stakeholders are identified by their main employment relationship with one of the business units of the UPMC Insurance Services Division (i.e., the UPMC Health Plan, UPMC *for You*, or Community Care). Provider stakeholders are identified through their main employment relationship with either Children's Hospital of Pittsburgh of UPMC, one of its affiliate pediatric provider networks, or the University of Pittsburgh Physicians, a group of primary and specialty providers affiliated with the University of Pittsburgh Schools of the Health Sciences. As explained further in Step 3, four pediatric practices participated in the UPMC *for You* demonstration project—all were related to UPMC. One practice had patients at two sites, so both participated.

The work of the collaboration was organized around an operational plan that specified the tasks to be completed in each phase of the payment reform process by whom and when. A copy of the operational plan template is provided in **Section V, Toolkit I.A, Operational Plan Template**. To maximize opportunities for full stakeholder participation, meetings were conducted both in person and virtually through webinars and teleconferences. Initially, meetings were scheduled via Outlook, but based on feedback from some of the participating physicians. This process was later modified to include a shared meeting calendar with dates for all project-related activities for three to six months out. Between scheduled meetings, much of the ongoing work was coordinated through focused email exchanges and electronic sharing of information. There were also monthly conference calls dedicated to the care coordinators, led by UPMC *for You* project team members.

Table I.A: UPMC *for You* Collaborative Infrastructure for Payment Reform (Grant Co-Directors worked with every group)

Group Type (Size)	Role	*Member Information*		Meeting Frequency
		Title	Organization	
Advisory Board (13 members)	Provided guidance and strategic oversight for the overall payment reform process	President	UPMC *for You*	Three times annually
		Vice President	Children's Hospital of Pittsburgh of UPMC/Children's Community Pediatrics	
		Medical Director & Professor of Pediatrics	Children's Hospital of Pittsburgh of UPMC/University of Pittsburgh	
		Physicians/Psychiatrists (2)	Western Psychiatric Institute and Clinic	
		Executive Director	Parent Education and Advocacy Leadership Center	
		Executive Deputy Director	Allegheny County Department of Human Services	
		Health Policy Director	PA Partnerships for Children	
		Family Advisor	PA Department of Health, Bureau of Family Health	
		Chief Medical Officer	PA Department of Human Services	
		Senior Policy Advisor	Centers for Medicare & Medicaid Services	
		Family/Consumer Representatives (2)		
Leadership Team (13 members)	Managed day-to-day work of conducting the demonstration project and all related activities	Payment Reform Project Director	UPMC Health Plan	Weekly
		Payment Reform Project Director	UPMC *for You* and Children's Hospital of Pittsburgh of UPMC	
		President	UPMC *for You*	

		Director of Clinical Programs	UPMC *for You*	
		Manager, Maternal and Child	UPMC *for You*	
		Manager, Financial Operations	UPMC *for You*	
		Family Engagement Specialist	Children's Hospital of Pittsburgh of UPMC	
		Regional Director	Community Care	
		Project Director	Community Care	
		Project Manager	UPMC Health Plan	
		Grant Administrators (2)	UPMC Health Plan	
Payment Design Work Group for Provider Components of Model (15 members)	Provided ideas and feedback on the provider components of the payment model and linkages to the service delivery system	Payment Reform Project Director	UPMC Health Plan	Bi-weekly, monthly, or bi-monthly as needed
		Payment Reform Project Director	UPMC *for You* and Children's Hospital of Pittsburgh of UPMC	
		Chief Actuary	UPMC	
		Director, Payment Policy	UPMC Health Plan	
		Clinical Pharmacy Specialist	UPMC Health Plan	
		Regional Director	Community Care	
		Medical Director and Professor of Pediatrics	Children's Hospital of Pittsburgh of UPMC/University of Pittsburgh	
		Director	Children's Hospital of Pittsburgh of UPMC	
		Physician	Children's Hospital of Pittsburgh of UPMC	
		Executive Director	Children's Community Pediatrics	
		Administrator	Children's Community Pediatrics	

		Research Faculty	University of Pittsburgh Physicians	
		Fellow/Physician	General Academic Pediatrics	
		Home Visiting Nurse	UPMC Visiting Nurses Association	
Payment Design Work Group for Consumer-Directed Accounts	Designed framework, content, and operational plan for consumer-directed accounts; interfaced with expert consultants as needed	Payment Reform Project Director	UPMC for You and Children's Hospital of Pittsburgh of UPMC	Weekly during design phase
		Director	UPMC	
		Director, Maternal Child Health Program	UPMC *for You*	
		Manager, Clinical Operations	UPMC *for You*	
		Manager, Financial Operations	Children's Hospital of Pittsburgh of UPMC	
		Family Engagement Specialist Care Coordinators	4 Practices	
		Project Manager	UPMC Health Plan	
		Clinical Program Design Manager	UPMC *for You*	
Family Engagement Subgroup (5 members)	Developed strategies for engaging families in the payment reform demonstration project	Family Engagement Specialist	Children's Hospital of Pittsburgh of UPMC	Bi-weekly or monthly as needed
		Regional Director	Community Care	
		Executive Director	Parent Education & Advocacy Leadership Center	
		Family Support Specialist	Allegheny County Department of Human Services	
		Project Manager	UPMC Health Plan	
Outcomes	Developed strategies	Project Director	UPMC *for You* and Children's Hospital of Pittsburgh of UPMC	Bi-weekly or monthly

Subgroup (6 members)	for evaluating the payment reform demonstration project	Manager, Business Analysis	UPMC Health Plan	as needed
		Executive Director	Children's Community Pediatrics	
		Quality Director	Children's Community Pediatrics	
		Fellow/Physician	General Academic Pediatrics	
		Project Manager	UPMC Health Plan	
Payment Implementation Task Force (17 members)	Supported on-the-ground implementation of payment model components and service delivery changes at the practice level	Director, Clinical Operations	Participating Pediatric Group	Monthly
		Director, Clinical Operations	Participating Pediatric Group	
		Controller	Participating Pediatric Group	
		Lead Physicians (4)	Participating Pediatric Group	
		Office Managers (4)	Participating Pediatric Group	
		Care Coordinators (5)	Participating Pediatric Group	
		Health Plan Liaison/Care Manager	UPMC *for You*	
		Project Manager	UPMC Health Plan	
Support Team (4 members)	Provided analytic, technical, and administrative support for all aspects of the payment reform demonstration project	Senior Director, Health Economics	UPMC Insurance Services Division	Ongoing as needed
		Manager, Finance and Analytics	UPMC *for You*	
		Health Plan Liaison/Care Manager	UPMC *for You*	
		Project Manager	UPMC Health Plan	

Step 2.C: Organize other opportunities to support and promote collaborative learning

Outside of the formal work of designing and implementing the payment model, the UPMC *for You* Leadership Team also sought to create additional learning opportunities for all key stakeholders. Over the course of the three-year demonstration project, for example, three learning collaboratives were organized to educate providers and other key stakeholder groups on both payment reform and relevant clinical topics. Table I.B provides the dates and themes for each collaborative.

Other activities for supporting informal networking and innovative thinking among key stakeholder groups included:

- Communal opportunities with UPMC, University of Pittsburgh and community leaders to view TEDMED live streaming in 2013 and 2014.
- A conference call midway through implementation led by UPMC *for You* for participating physicians, care coordinators and administrators about how to read and understand a financial pro forma and how to make that information actionable.
- A mini-learning collaborative webinar, Reviewing Medical Records for Care Improvement Opportunities, in July 2013 (early in implementation) to provide strategies for overcoming electronic health record (EHR) barriers to clinical communication and care coordination, especially between primary care providers and subspecialists.
- An October 2014 lecture by Dr. Heidi Feldman called Redesigning Health Care for Children with Disabilities: Strengthening Inclusion, Contribution, and Health.

Table I.B: Learning Collaborative Dates and Themes

April 2013	February 2014	July 2014
Title: Stakeholder Perspectives on Payment Reform **Format:** Panel discussion **Learning Objectives:** What is the business rationale for pediatric practices to participate in this payment reform demonstration project? What is the Department of Human Services' interest in this effort? How will the lessons learned from this demonstration project inform/guide current and future Medicaid payment policy? What is CMS's interest in this effort? How will the lessons learned from this demonstration project inform/guide current and future payment reform initiatives? What types of barriers do families commonly encounter at the physician/practice level that might be addressed through this payment reform demonstration project? What can providers do to implement payment reform successfully? What is the role of physician leaders/ champions in ensuring payment reform success?	**Title:** Transition to Adult Care: Use of Shared Decision Making as a Key Tool **Format:** Role-play demonstration, discussion **Learning Objectives:** Understand the complexities of transitioning to adulthood for young adults with disabilities Recognize that transition is a process, with transfer of providers as events within this process that should not be the starting or end point. Identify techniques for engaging patients and family members in shared decision making. **Program Description** In this learning collaborative, two role plays of doctor-patient encounters were used to demonstrate issues around transition and how a shared decision making approach can be used to help patients and families achieve a successful transition into adult care. Themes included: barriers to independence for children with disabilities, importance of supporting young adult self-determination, techniques for engaging patients and families, steps involved in the transition process, tools and resources for providers and families, consumer-driven care.	**Title**: Shared Decision Making-Part 2: Considering Health Care Costs **Format:** Case-based workshop discussion **Learning Objectives**: Appreciate the importance for clinicians to develop cost consciousness as a healthcare improvement strategy Integrate knowledge of health care costs into clinical decision making – with and by patients and families. Demonstrate skills consistent with Accreditation Council for Graduate Medical Education (ACGME) core competency #6 "Systems-based practice – actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to use system resources to provide optimal care" **Program Description** The overarching goal of this session was to prepare a group of cost-conscious health care professionals to be champions for promoting and demonstrating high-value care. Clinical cases about seizures and asthma were described as part of an interactive presentation that included a dynamic Excel sheet showing adjustable cost data by line of business. Themes included: cost of medications and utilizations, and care planning opportunities.

Step 3: Identify Target Population and Participating Providers

To identify a target population for payment reform, stakeholders must have access to current data on health care service utilization and cost and the ability to analyze these data for relevant care and spending patterns across different patient groups. Once these patterns are identified, stakeholders can determine which patients and providers to involve, both initially and over the long-term, in any specific payment model.

Step 3.A: Access current data to identify relevant care and spending patterns across different patient groups

To facilitate this process, UPMC Health Plan analysts developed the Population Dynamic Interactive View tool (Population DIVe), a portable, Microsoft Excel tool that lets stakeholders run rapid custom analyses on a defined population (in this case, UPMC for You members younger than 18 years old residing in Allegheny County) around costs and type of services used with embedded geographic tools to locate members by geography as well as by pediatric practice. The tool and users' instructions are provided in **Section V, Toolkit I.B.1 and Toolkit I.B.2.** Table I.C lists the generic data elements that are needed to populate this tool as well as elements specific to the UPMC *for You* demonstration project.

Table I.C: Data Elements to Identify a Target Population for Local Payment Reform

Generic Data Elements	Specific Data Elements for UPMC *for You* Demonstration Project
Age and/or gender	Any individual younger than 21 years old as of June 30, 2012
Insurance product	UPMC *for You* members
Place of residence	Resides in Allegheny County, Pennsylvania
Comprehensive claims data	Medical, pharmacy, and behavioral health claims data
Number of claims years	Two years of claims data with at least three months of claims run-out
Active member months	At least one member month in calendar years 2010 and 2011
Specific conditions of interest	Medically complex conditions, other related chronic conditions
Service utilization by provider	Pediatric/primary care, specialty/ancillary care

Using this tool, stakeholders will be able to:

- Profile conditions, service utilization, and costs for a specified patient population.
- Isolate consistently high spenders within a specified patient population for whom service delivery improvements would be most likely to result in cost savings.

- Calculate the average total cost of care for top spending patients over a designated time period.

- Determine the high-cost conditions affecting this top-spending group, the highest-percentage-cost services utilized by this group, and the highest-cost specialists and ancillary services utilized by this group.

- Identify a subset of primary care providers who serve the top-spending group.

In the UPMC *for You* demonstration project, we used the Population DIVe tool to identify the top 10 percent of spenders (N=1,272) among the UPMC *for You* pediatric population served through Medicaid in calendar years 2010 and 2011, recognizing that this group would present the greatest potential for cost savings. Because high spending did not correlate directly with one or even a small number of complex medical conditions, stakeholders chose to focus the payment reform on improving the way services are delivered for the entire high-cost group, regardless of medical conditions. Specific medical service categories were then examined in terms of their impact on the total cost of care for the high-spending group. Medical services accounting for more than 45 percent of total care costs in 2011 were inpatient medical surgical (14.96%), home and hospice care (14.65%), specialist services (5.92%), injectable drugs (4.88%), and durable medical equipment and medical supplies (4.83%). Since it was unclear to what extent this service mix was unnecessary, duplicative, or wasteful, given the complex medical conditions of the children and youth in this population, stakeholders determined that the best way to improve the value of care for the high-spending group would be to strengthen primary care service delivery in general, rather than target any service category in particular.

Step 3.B: Identify providers/practices and patients to involve in the payment model

The 1,272 children were spread out over dozens of different practices pediatric and specialty practices, making implementation challenging; therefore the Payment Design Work Group decided to reduce the number in the target population strategically in order to work with fewer practices. Given the predominant focus on strengthening primary care, the Population DIVe tool was then used to identify a subset of pediatric providers that serve a significant proportion of the high-spending group. Four of these practices, collectively providing primary care for over 20 percent of the total high-spending group (n=276), were invited to participate in the demonstration project as payment reform champions with the expectation that this model could be expanded to other providers if the payment model demonstrated success in improving the value of care.

In order to ensure that the target population would remain as stable as possible, prior to implementing the provider-focused components of the payment model, we removed 13 of the adolescents who would turn 21 before the end of the full model implementation period (most children become ineligible for Medicaid at age 21). This left us with a total of 263 children and youth (average age in 2012: 8.1 years; 40% female) in the target population who were distributed by practice as follows:

- Practice A-146;
- Practice B-30;
- Practice C-30;
- Practice D-57.

Throughout the demonstration project, we also removed a subset of patients who failed to continuously meet our inclusion criteria either because they were no longer insured through UPMC *for You*, no longer residing in Allegheny County, or no longer receiving their principal care from one of the four participating primary care practices.

II. Designing a Value-Based Payment Model

Step 4: Establish a Financial Accounting Process

Once patients were identified as receiving primary care from of one of the four provider groups, stakeholders worked together to establish an agreed-upon financial accounting process. In cases where providers will assume full financial risk responsibility, the global financial accounting should include adjustments for the risk profile of the patient population. Which services to include under the global financial accounting, pricing/allocation levels for each, and how payments will be made and savings shared are all issues to be considered when deciding on the type of accounting process to use.

Step 4.A: Determine performance targets and shared risk/savings arrangements

In the UPMC *for You* demonstration project, stakeholders agreed that providers and consumers would be supported in enhancing care value through prospective and enhanced FFS payments (see Steps 5 and 8) and consumer-directed purchasing (see Steps 6 and 9) and then share in any net financial gain at the end of the full model implementation period (see Step 11). Actual risk sharing by providers was deferred until sufficient evidence existed that the new payment model would be successful, freeing providers to work on elements of care enhancement without the worry of downside risk. Based on the actual total historic costs of care for the target population in calendar years 2011 ($6.8M) and 2012 ($6.7M) and our previous experience improving care value through the UPMC Patient-Centered Medical Home program, we estimated (conservatively) an ex ante annual savings potential of 4 to 5 percent, or approximately $300,000 per year. The anticipated savings of $300,000 was used as the source of monies to cover the cost of additional services/payments and purchases supported under the model.

Step 4.B: Adopt mutually agreed upon accounting processes

In the UPMC *for You* demonstration project, UPMC *for You* agreed to make payments to providers and families up front as prospective savings alongside traditional FFS billing and reimbursement to account for service costs related to the target population. This process was based on the assumption that the total cost of care for these patients could be reduced through the provision of a potential change in the type and number of services used, including services not currently reimbursed through Medicaid FFS. Participating practices needed additional resources from the beginning of the project and rather than delaying shared savings until after the savings had been accrued, UPMC *for You* provided financial resources from the beginning of the demonstration project. Although payers and providers considered this approach to be the easiest way to incorporate accounting for the new payment model into existing systems, it was not without complications both in terms of provider billing and health plan payments (see Step 8.C).

Step 5: Alter Provider Payments to Support Clinical Best Practices

One of the limitations of traditional FFS payments is their typically inflexible coverage of clinical best practices that may be required to enhance care value for a specified population. Therefore, in designing any new payment model, attention should be paid to inclusion and reimbursement for clinical best practices.

Step 5.A: Work with primary care providers to determine payment changes required to better meet patient needs

For children with medically complex conditions, UPMC *for You* data showed that it is not necessarily a specific medical condition that drives cost of medical care. Following a series of meetings with the Payment Design Work Group, it was hypothesized that some high costs of medical care are related to coordinating that care. It was determined that while some reimbursement for care coordination in primary care practices is presumed to be included in physician office visits (and hence reimbursed by those office visits), the short block of physician time that is currently reimbursable for these services was felt to be insufficient for identifying and addressing the needs of patients with medically complex conditions. Moreover, to enhance care value, other clinical staff that currently cannot bill for time spent coordinating care could be involved and reimbursed for their participation in the care coordination process.

Providers initially identified four types of care coordination activities that are particularly important for better serving children with medically complex conditions:

1. Thorough review of patient medical records;

2. Development of individualized care plans;

3. Consultation with other providers, especially specialists, who care for the same patient; and

4. Care team discussions about care-related goals that may also include the patient and/or caregiver.

In order to ensure that these activities are carried out as efficiently and effectively as possible, the Payment Design Work Group recommended three new types of provider payments be incorporated into the value-based payment model:

1. Upfront payments to support salary and benefits of practice-based care coordinators.

2. New reimbursements to support non face-to-face care coordination services undertaken by primary care billing providers (i.e., physicians).

3. New reimbursements to support care coordination activities undertaken by non-billing providers (i.e., other non-physician staff such as nurses, dieticians, etc.). These payments were not available to the care coordinators who were already being financially supported by the project (see #1).

Through discussions with other key stakeholders on the Advisory Board, members of the Leadership Team were connected with CHANGE, a Children's Hospital of Pittsburgh of UPMC advisory group of youth with a wide range of chronic medical and/or behavioral health conditions and their families. Based on input from this group, long-term planning related to the

transition from pediatric to adult primary care was identified as another important component of comprehensive care coordination for children with medically complex conditions and included as part of the roles and responsibilities of the practice-based care coordinators. See also Steps 6.A and 10.B.

Step 5.B: Consider additional payment changes for other providers engaged in care for target population

Historic care and spending patterns can also help to inform decisions about what other provider payment changes may be required in order to enhance the value of care for a specific target population.

In the UPMC *for You* demonstration project, for example, payments for pediatric subspecialist services were among the five categories of spending that account for more than 40 percent of the total cost of care for the target population. These data suggested that payment changes targeting pediatric subspecialists might be another way to improve quality while reducing costs. Using the Population DIVe tool, we identified the types and numbers of subspecialists involved in the care of patients assigned to each of the participating practices. (Table II.A) Given the wide range and large numbers of subspecialists involved, and the fact that each specialist practice cared for a very small number of these patients, we decided that the most feasible way to ensure effective and efficient specialty service delivery for the target population would be through enhanced care coordination by pediatricians to actively coordinate services involving subspecialists. The Payment Implementation Task Force also worked to enhance communication between pediatricians and subspecialists as part of the overall delivery system changes this project entailed. See Step 10.

Table II.A: Types/Numbers of Subspecialists per Participating Practice

Specialty Type	Practice A	Practice B	Practice C	Practice D	Total
Allergy and Immunology	1	1	1	0	3
Anesthesiology	13	1	2	2	18
Neurological Surgery	1	0	1	1	3
Ophthalmology	2	0	1	1	4
Optometry	1	0	1	1	3
Orthopedic Surgery	3	0	0	0	3
Otolaryngology	3	0	2	1	6
Pediatric Allergy and Immunology	1	1	0	1	3
Pediatric Cardiology	2	0	0	0	2
Pediatric Critical Care Medicine	2	0	0	0	2
Pediatric Dermatology	1	1	1	2	5
Pediatric Endocrinology	5	2	5	4	16
Pediatric Gastroenterology	5	1	1	0	7
Pediatric Hematology/Oncology	1	3	0	1	5
Pediatric Nephrology	0	0	0	1	1
Pediatric Neurology	3	0	0	4	7
Pediatric Ophthalmology	0	1	0	1	2
Pediatric Otolaryngology	3	0	0	3	6
Pediatric Pulmonology	3	0	1	0	4
Pediatric Surgery	3	0	0	0	3
Pediatric Urology	0	0	0	1	1
Physical Medicine and Rehabilitation	1	0	0	1	2
Plastic Surgery	0	2	0	0	2
Podiatry	0	0	0	1	1
Radiology	3	0	0	0	3
Rheumatology	1	0	0	0	1
Total	**58**	**13**	**16**	**26**	**113**

Stakeholders in the UPMC *for You* demonstration project also recognized that identifying and addressing behavioral health needs of children, youth, and families dealing with complex medical conditions can be another important component of improving the value of care for this population. An analysis of Community Care's behavioral health service utilization data showed that approximately 35 percent (n=90) of the target population (n=263) received at least one behavioral health service through Community Care. The annual behavioral health services cost per member who used behavioral health service was $3,173 and accounted for 11 percent of the total annual cost per member for these patients ($29,170). Because this level of service use and cost was actually lower than anticipated, we decided to focus on behavioral health screening, referral, and engagement in treatment as part of the practice-based care coordination activities. Also, see Step 10.

Step 6: Incorporate Consumer Direction in Purchasing

The care of children and youth with complex medical conditions, as well as other medically-vulnerable populations, is a complicated undertaking that involves multiple caregivers, including parents and other family members. However, patients and those closest to them are often not included in decisions about the best ways to support this process outside of the clinical care system. The Self-Determination Initiative of the Robert Wood Johnson Foundation has demonstrated that engaging patients and families in self-directing the purchase of certain nonclinical goods and services can help to address consumers' unmet needs and improve care satisfaction and quality of life without increasing the overall level of health care spending. A unique premise of the UPMC *for You* payment reform demonstration project was that consumer self-direction in purchasing may also hold promise for improving health care value by strengthening consumers' relationships with care coordinators and helping them become more informed purchasers of nonclinical goods and services.

Step 6.A: Solicit input from patients and families to guide the design of consumer-directed accounts

In the UPMC *for You* demonstration project, the family engagement specialist organized a series of focus groups and interviews to gather initial input from patients and families that could be used to inform the design of the consumer-directed components of a value-based payment model. Focus groups and small group interviews, involving a total of 17 participants, were held during the summer of 2013.

Two parent focus groups involved seven mothers of children and adolescents ages three to 21 years with complex medical conditions, including rapid-onset obesity with hypothalamic dysfunction, hypoventilation and autonomic dysregulation, CHARGE syndrome, VACTERL syndrome, seizure disorder, cerebral palsy, autism, hearing loss, leukodystrophy, and polymyositis, among others. All children received in-home nursing care and required the consistent presence of an adult. All used supportive technology such as feeding tubes, ventilators, wheelchairs and communication devices. Five of the seven children had siblings; two of the seven were living in single-parent homes. All of the mothers were Medicaid recipients residing in Allegheny County.

Focus group participants were nominated through a variety of sources, including care coordinators and pediatricians serving the target population; parent advisory groups; and the Parent Education and Advocacy Leadership Center. The focus groups were held at a location

that was easily accessible and familiar to all families. Parking and dinner were provided. Each participant received a $50 gift card in recognition of their contribution and to offset any expenses associated with their participation.

The family engagement specialist conducted the parent focus groups using the discussion guide provided in **Section V, Toolkit II.A.1**. During the discussions, participants identified a range of strategies to reduce current or future costs through the use of alternatives to traditional goods, services, and supports, placing substantial emphasis on the need for long-term planning and prevention of condition-related complications and decline. They also offered numerous suggestions for how Medicaid dollars could be used differently to provide greater value for them, for example, by covering the costs of occasional extra nursing/respite care, variable seating/mobility options, and a range of low-cost but high-use items, among many others. Finally, they noted a number of features that would be most desirable to them in any consumer-directed approach to purchasing, including partnership, fairness, transparency, and easy access.

The family engagement specialist also held two small group interviews with transition-age adolescents and their parents (see also Step 5.A). One group had three parents whose children were approaching the age of transition to adult care and self-determination, and the other had seven adolescents with medically complex conditions who were anticipating or had completed the transition to adult health care. Participants in the latter group consented to have the meeting audio-recorded for later transcription (de-identified). The family engagement specialist conducted these discussions using the guide provided in **Section V, Toolkit II.A.2.**

The family engagement specialist used the focus group transcriptions to create a summary and detailed report on patient/family recommendations related to consumer-directed accounts; the summary is provided in **Section V, Toolkit II.A.3.**

Step 6.B: Receive technical assistance from expert consultants

The UPMC *for You* Leadership Team also received technical assistance from expert consultants at the Boston College National Resource Center for Participant Directed Services on key issues related to setting up consumer-directed accounts. Over a series of meetings and sharing of written resources, these consultants provided useful tips on a range of topics and feedback on our project, including how to determine:

- Which services should be self-directed and the extent of self-directed flexibility.
- The level of financial resources to be available per participant and in total.
- The level of support to be provided when and by whom.
- The level of patient/family and care coordinator training needed.
- Appropriate monitoring and evaluation strategies.

Related tools and resources are available through the National Resource Center at http://www.bc.edu/content/bc/schools/gssw/nrcpds/tools.html.

Step 6.C: Establish parameters for implementing consumer-directed accounts

The estimated five percent savings threshold set to cover all additional payments to providers and consumer purchases under the new payment model (Step 4.A) came to $300,000, of which $250,000 was allocated to cover payments to practices for care coordination and $50,000 was the maximum amount to be allocated for the consumer-directed purchasing component. After consulting with the Advisory Board and considering the results of the family focus groups, we decided upon a one-time distribution of $500 for 100 patients/families. It was determined that $500 was a large enough amount of money for a family to make a meaningful purchase of nonclinical goods or services that might have a positive impact on their child's health or health care but not so large that they might incur additional taxes or risk losing Medicaid eligibility. The accounts were offered to all families in the target population with children ages 10 to 19, as they may need to more quickly become more experienced purchasers of nonclinical goods and services than other families with younger children who will not be transitioning out of Medicaid in the near term. Also, these older children/youth may themselves be able to participate in decisions about how to use the funds.

Step 6.D: Set up processes for implementing consumer-directed purchases

In the UPMC *for You* demonstration project, planning for the consumer-directed component of the value-based payment model began in fall 2013. There was considerable discussion with the Leadership Team, providers, and our Advisory Board about how funds should be used and administered. We wanted the decisions to be family-driven and the actual use of the accounts to be non-bureaucratic and family friendly. Therefore, we did not restrict what the families could purchase with their $500 account.

Our Advisory Board recommended three key principles that we incorporated into our design:

1. Families receive guidance and support on how to spend the funds.

2. Transparency so that information about their spending is available to learn how the accounts helped families.

3. Internal checks and balances to ensure that families did not spend the funds on something already reimbursable or available through Medicaid.

After exploring multiple options for paying families, including checks, Visa gift cards, setting up a new process with a vendor similar to a flexible spending account, and reimbursing families for expenses, we decided to use the WePay™ card payment system, a Web-based system that enables authorized University of Pittsburgh and UPMC personnel to disburse payments to participants. WePay™ cards are anonymous, instant issue, MasterCard® branded, stored-value debit cards. This system allowed us to mail cards with zero balances and add funds once received by participants. WePay™ also provides some reporting functions about where and when funds were spent. Our primary source of data about the specific items purchased with the consumer-directed accounts, however, was that we asked families to send us their receipts along with a Purchase History Forms that described what they purchased, how it helped

improve their child's health and well-being and several other questions about their overall project experience.

A practice flow diagram illustrating the final overall implementation process is provided in **Section V, Toolkit II.B.1.** The sequence of steps to be conducted collaboratively by the practice-based care coordinators, UPMC *for You* administrators, and patients/ families was as follows:

- Care coordinators call families and introduce them to the consumer-directed purchasing component of the project;
- UPMC *for You* administrators send a follow-up outreach mailing with materials explaining the program (**Section V, Toolkit II.B.2**);
- Families meet with their care coordinators in-person or by phone to develop their spending plan for their $500 consumer-directed account and to answer some questions about their spending plans on a Participation Form (**Section V, Toolkit II.B.3**);
- Families or care coordinator mail the Participation Form to UPMC *for You*;
- UPMC *for You* administrators mail WePay™ cards to families that completed the Participation Form and the spending plan meeting with the care coordinators;
- Families call the care coordinator to activate the card;
- Card is activated and loaded with $500 electronically via WePay™ system;
- Families complete their purchase(s) and mail a Purchase History Form (**Section V, Toolkit II.B.4**) and receipts for their purchases by set deadline.

Step 6.E: Develop plan for evaluation and quality assurance

In order to ensure quality and to learn from the consumer-directed purchasing process, we created a tracking spreadsheet that included all of the touch points between families, care coordinators, UPMC *for You* staff, and the WePay™ system. Information was added to the spreadsheet by care coordinators at each practice and UPMC *for You* administrators. Informational categories included dates for key steps in the process (e.g., when letters were mailed to families) and outcomes associated with each of those steps (e.g., letter was returned to sender). This information was password-protected and backed up on a regular basis to ensure that the data entered and analyzed would be as accurate as possible. In addition, monthly phone calls were planned with care coordinators in order to troubleshoot, answer questions, and ensure adherence to the process and timeline.

Step 7: Develop Process for Monitoring and Reporting Performance

In order to ensure the delivery of appropriate, high-quality, and cost-efficient care under any type of payment model, agreed-upon processes must be established for monitoring and reporting on quality and cost outcomes at both the patient and population levels. Ideally, these

processes should be minimally burdensome and maximally transparent for providers and incorporate outcomes that are relevant to all key stakeholders. In some cases, the achievement of a certain level of performance will be set as a condition for providers' earning financial incentive payments under total cost of care arrangements. Some arrangements may also include bonus incentives beyond the shared savings if high levels of performance levels are achieved.

Step 7.A: Select measures for evaluating performance and supporting quality improvement

In the UPMC *for You* demonstration project, the Outcomes Subgroup identified a number of potential quality and cost measures that would provide meaningful information for all stakeholder groups – including some for which data is readily available to payers, such as service utilization and costs and Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, and others that would require additional data collection. The recommended list of measures is provided in **Section V, Toolkit II.C.1**. In order to allow for a formal evaluation of the payment model, the Leadership Team decided to focus primarily on quality and cost measures for which data are readily available for both the target population and a matched comparison group. These measures are listed in Table II.C. Related care measures were used to support service delivery improvements for individual patients at the provider and practice levels. These measures are listed in Table II.D.

Table II.C: Quality and Cost Measures (Based on Existing UPMC *for You* Data) for Evaluating the UPMC *for You* Demonstration Project and Determining Shared Savings Under the New Payment Model

Quality Measures	Cost Measures by Service Category
Screening Childhood blood lead levels **Immunizations** HPV for female adolescents Immunization for adolescents Childhood immunization status **Medication Management** Use of appropriate medications for people with asthma **Testing** Appropriate testing for children with pharyngitis **Treatment and Follow-Up Care** Appropriate treatment for children with upper respiratory infection Follow-up care for children prescribed ADHD medication (initiation) Follow-up care for children prescribed ADHD medication (continuation and maintenance) **Primary Care and Prevention** Children and adolescents' access to primary care Annual dental visit Well-child visits in the first 15 months of life Well-child visits in the 3rd, 4th, 5th, 6th years of life Adolescents well-child care visits	**Inpatient** Inpatient facility—acute Catastrophic Skilled nursing facility Total Inpatient **Outpatient** Observations Outpatient surgery—hospital Outpatient surgery—ambulatory Urgent care center Other Total Outpatient **Primary Care** **Specialty Care** **Behavioral Health** Inpatient Outpatient Total Behavioral Health **Diagnostic Testing** Low tech radiology technical Low tech radiology professional High tech radiology technical High tech radiology professional Radiation therapy Laboratory Total Diagnostic Testing **Emergency Room** Facility Professional Total Emergency Room **All Other Medical Expenses** Therapy services Durable medical equipment Medical supplies Medical transportation Home and hospice care Dialysis Injectables, chemo and infusion Total All Other Medical Expenses

	Average Monthly Medical Expense **Pharmacy** Brand Generic Pharmacy rebates **Average Monthly Pharmacy Expense** **OVERALL Average Monthly EXPENSE**

Table II.D: Related Care Measures for Supporting Service Delivery Improvements at the Provider and Practice Levels

Services	Data Elements
Chronic Condition Indicators	Asthma, diabetes, depression, COPD, CAD, CHF
Last Five Emergency Room Visits	Date, allowed amount, facility, diagnosis ID, primary diagnosis description
Last Five Acute Inpatient Admits	Date, allowed amount, facility, DRG code, DRG description
Last Five PCP Visits	Date, allowed amount, PCP provider name, primary diagnosis, primary diagnosis description
Last Five Specialist Services	Date, allowed amount, specialist name, diagnosis ID, primary diagnosis description
Last Five Radiology Services	Date, allowed amount, CPT code, CPT procedure description
Last Five Urgent Care Visits	Date, allowed amount, facility, diagnosis ID, primary diagnosis description
Last 10 DME Services	Date, allowed amount, facility, diagnosis ID, primary diagnosis description
Last 10 Home Care/Hospice Visits	Date, allowed amount, facility, diagnosis ID, primary diagnosis description
Last 10 Medical Supply Services	Date, allowed amount, facility, diagnosis ID, primary diagnosis description
Last 25 Medications Filled	Date, drug label name, prescriber name

Step 7.B: Establish ongoing and transparent reporting processes

UPMC *for You* developed three reports for this demonstration project which were shared electronically via secure file transfer on a monthly or quarterly basis with participating physicians and care coordinators.

1. **Patient Profiles** —This report provided a snapshot of the care received by each patient in the target population over the past 12 months, including a breakdown of specific service use categories as listed in Table II.D. The profiles were compiled in alphabetical order by patient last name and sent to the four participating practices on the 20th of each month between March 2013 and December 2014.

2. **HEDIS Quality Reports** —This report provided HEDIS gaps in care for the quality measures listed in Table II.C. The report identified gaps in recommended visits, screenings and tests for the population as well as for each individual patient and by practice. The reports were sent quarterly to the four participating practices on the 20th of the month beginning in March 2013 and ending in December 2014.

3. **Financial Reports**—This report compared the total cost of care for the target population at baseline and bi-annually for the payment reform demonstration project. It included costs for traditional service categories, as well as additional costs incurred under the new payment model (i.e., prospective payments for care coordinators, reimbursements for non face-to-face care coordination, and consumer-directed account costs). The reports were sent twice a year to the four participating practices on the 20th of the month beginning November 2013 and ending in May 2015.

   The first financial report was accompanied by a physician-friendly report that included graphs and text that explained the findings of the financial report in layman's language and highlighted clinically-meaningful results, such as which type of medical services changed the most over time. This report was reviewed over the phone with physicians, care coordinators, and office administrators in order to answer questions and help to make the reports more actionable.

All reports were modified over time based on feedback from the providers. Copies of the final reporting templates are provided in **Section V, Toolkit II.C.2, Toolkit II.C.3, Toolkit II.C.4 and Toolkit II.C.5.**

Step 7.C: Create opportunities to discuss results among all key stakeholders

Since many providers are not accustomed to using quality and cost information from payers to improve service delivery, it is important to create opportunities for discussing the results and identifying actionable areas for improvement. In the UPMC *for You* demonstration project, the Leadership Team asked the providers how they would like to communicate with and be supported by the project team. As a result, three of the four practices organized monthly calls and invited UPMC *for You* team members to participate and give updates. The fourth practice held its own separate monthly meeting, which was attended by one of the UPMC *for You* project leaders. For important and timely updates with all practices, ad hoc conference calls were also organized.

Examples of topics and issues addressed on these calls include:

- Interpretation of patient profiles, HEDIS reports and financial reports – understanding terminology, such as a "catastrophic" claim or a HEDIS gap in care; understanding how different costs are categorized;

- Issues with flagging patients in the electronic medical record system.
- Billing and coding issues with the new reimbursements.
- Creation and monitoring of care plans for patients.
- Difficult or challenging patient situations.
- Success stories about improved care coordination with subspecialists and connections to behavioral health resources.
- Medical home and care coordination best practices.
- Reminders of key project deadlines and events.

III. Implementing a Value-Based Payment Model

Step 8: Set Up Payment Mechanisms for Reimbursing Providers/Practices

Appropriate mechanisms for reimbursing providers and/or practices under a new payment model will depend on the nature of the model to be implemented. Important issues to consider are:

- Timing of payments (prospective, retrospective).
- Precise activities to be performed.
- Duration of the activity per encounter.
- Type of provider that can perform the activity.
- Appropriate rates for the services.
- Transactional systems that will be required to reimburse for the new services.

In cases where the new payment model components will be implemented under the existing FFS system, at least initially, stakeholders may use unique Current Procedural Terminology (CPT) codes that have been created by the payer to reimburse for a specific set of services or universal CPT codes with a claim modifier indicating that the service delivered is different from what is outlined under the universal code description.

The UPMC *for You* demonstration project required setting up payment mechanisms for supporting practice-based care coordinators and reimbursements for care coordination services provided by both billing and non-billing providers (see Step 5) that are not currently reimbursable through Medicaid. Below we detail how this setup process was handled and the types of operational/technical support that were needed.

Step 8.A: Set up prospective payments for care coordinators

As the practices participating in the UPMC *for You* demonstration project did not have care coordinators on staff who could dedicate time to serving the target population, the payer agreed to provide prospective payments to cover the salary and benefits of such staff for the duration of model implementation. These arrangements were made under a formal contract between the payer and participating practices, requiring review of the practice's proposed plan for program care coordination including, but not limited to, practice's job descriptions for staff providing care coordination services. Upon approval of the practice's plan, UPMC *for You* authorized monthly payments to the practices to support dedicated care coordinators through December 2014.

Altogether, support for two full-time equivalents (FTE) was used to hire and identify nurse care coordinators at each of the four participating practices. There was one FTE at Practice A and four to seven part-time care coordinators (this changed over time) totaling one FTE at the three remaining practices. Payments were made on the first business day of each month directly from

the payer to the business unit/cost center of the participating practice starting July 1, 2013 and ending December 2014.

To maintain eligibility for care coordination services, the practices were required to fulfill a clearly defined set of responsibilities and obligations (**Section V, Toolkit III.A.1**) and to submit to UPMC *for You* documentation of care coordination services provided to members of the target population monthly (**Section V, Toolkit III.A.2**). This monthly documentation had to substantiate that 160 hours (on average) per FTE per month were spent by the practice on care coordination services and/or program-related meetings or initiatives.

Step 8.B: Set up enhanced FFS payments for physicians and other clinical staff

Arrangements for reimbursements for physicians and other clinical staff were also made under a formal contract between the payer and participating practices. Reimbursements for non face-to-face care coordination services provided by billing providers (i.e., physicians or physician extenders) were set up to occur through standard billing procedures as described in Table III.A. Non-billing providers (i.e., other non-physician staff such as nurses, dieticians, etc.) could also be reimbursed for these enhanced services by submitting documentation with monthly invoices to the payer. These activities were designated as part of our value-based payment model as a result of input from the practices and hospital administrators on the Payment Design Work Group who felt that these activities would add the most value to this population but are often not conducted because of pressure to focus on billable time and activities.

Because UPMC *for You* was already paying for the salaries of the two FTE care coordinators, those care coordinators were not to invoice for these enhanced payments. Practice administrators were instrumental in coordinating the EHR changes and preparing instructions for non-billing providers. Invoices were sent by the participating practices to the payer by the 10th day of each month for reimbursement.

Services were billable from the start of model implementation on March 1, 2013, using the codes as specified in Table III.A. The rates were established jointly by the payer and providers and set up through UPMC *for You*'s claims system to only be paid to participating practices for the target population. The UPMC Health Plan Quality Audit department committed to review a sample of submitted claims against EHR documentation periodically and monthly reports were monitored to ensure that practices were correctly billing and that payments were being correctly applied. The invoice template used for non-billing providers is provided in **Section V, Toolkit III.B.**

Table III.A: Reimbursements for Value-Based Payment Model Components

Description of Care Coordination Service	Modification	Physician or Physician Extender Billing Code	Care Coordinator Tracking Code	Other Clinical Staff Billing Code
Chart review, creation of a treatment plan, and/or consult w/ other care providers	Billable in 15-minute increments multiple times per month	9948701-52 Reimbursement rate: $30.00	9948702-52	9948703-52 Reimbursement rate: $10.00
Transition of care management services (moderate complexity)	N/A	9949501 Reimbursement rate: $240.00	9949502	N/A
Transition of care management services (high complexity)	N/A	9949601 Reimbursement rate: $360.00	9949602	N/A
Medical team conference	Billable in increments of 30 minutes or more	9963701-52 Reimbursement rate: $60.00	9963702-52	9963703-52 Reimbursement rate: $20.00

Step 8.C: Provide other operational/technical support as needed

In order to facilitate implementation of the provider payment changes as quickly as possible, the Leadership Team created “ramp-up” goals for providers based on the number of patients in the target population at each practice. (Table III.B) During the first six to seven months of payment model implementation, the goal was for physicians at these practices to incrementally target a certain number of patients for service delivery changes supported by the new model, including chart review to identify opportunities for improvement, development of a long-term care plan, care coordination, and medical team conferences with or without the patient/caregiver. Progress was reported by each practice during monthly calls with the Implementation Task Force and through a chart review tracking spreadsheet see Step 10.A). Other activities for supporting service delivery improvements linked to payment and purchasing reform were undertaken throughout the course of the demonstration project as described in Step 10.

Table III.B: Ramp-Up Goals for Participating Practices: Number of Patient Charts to be Reviewed (Monthly/Cumulative Total)

2013	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Practice C	5/5	5/10	5/15	5/20	5/25	5/30	30	30	30	30
Practice B	5/5	5/10	5/15	5/20	5/25	5/30	30	30	30	30
Practice D	5/5	7/12	9/21	11/32	12/44	13/57	57	57	57	57
Practice A	10/10	15/25	20/45	25/70	25/95	25/120	26/146	146	146	146
Total # Patients	25	57	96	142	189	230	263	263	263	263

Since the reimbursements codes used in the UPMC *for You* demonstration project were not part of standard FFS billing procedures, additional support was needed to resolve both upstream and downstream issues in the billing and reimbursement processes.

First, when physicians began to use billing code 9948701-52 for chart review, creation of a treatment plan, and/or consultation with other care providers (universal CPT code + the 52 modifier indicating that the activity to be reimbursed was a modification of the activity typically reimbursed for this code), the claims were denied. After extensive investigation, it was found that this problem was due to a practice-based business rule that suppressed the 52 modifier before electronic submission of the claim, even if the provider initially coded the 52 modifier. To troubleshoot this issue, participating practices were able to change their billing rules to permit use of the 52 modifier for the specific billing codes relevant to the UPMC *for You* demonstration project.

Second, when physicians began submitting for new reimbursements for some children, they were automatically denied because UPMC *for You* was not the *primary* insurer, but the secondary insurer. To circumvent this problem, a "hold for review" process was set up in the claims database for these codes and this target population. If the UPMC *for You* Claims Department determined that there was another primary insurer present, rather than deny the claim, they proceeded to pay as if UPMC *for You* were the primary insurer. We note that this was the case only for the new reimbursements; participating practices were required to bill primary insurance appropriately for all other services.

Third, some unexpected complications were encountered with regard to the units billed. UPMC *for You* was denying claims that billed for more than one unit (15 minutes), even though it was set up to allow for multiple units. Follow up with the UPMC for You Claims Department was needed to correct this denial.

Fourth, keeping the active participant list up to date was challenging. The effort required to accurately account for participants who changed insurance plans, moved, aged out of their coverage, or changed physicians – and to communicate these changes to the practices and with the project team members in a timely fashion – was considerable.

Finally, although efforts were made to streamline the billing process for participating practices and physicians by building the new codes into the existing Children's Hospital of Pittsburgh of

UPMC EHR, this process was not completed until fall 2013. In the meantime, practices were required to independently document their activities and then retroactively bill once the billing and claims system was ready. Significant time and effort were also invested in informing the practices of appropriate billing procedures under the new payment model (i.e. who can bill, services included and not included in care coordination, why claims denied). A portion of the monthly calls with practices (see Step 7.C) was regularly devoted to addressing billing issues, particularly during the early months of EHR billing/claims system implementation.

Step 9: Activate Consumer-Directed Purchasing of Nonclinical Goods and Services

In the UPMC *for You* demonstration project, a subgroup of families with children ages 10 to 19 (n=87) were eligible to participate in consumer-directed purchasing, receiving $500 each to spend on items deemed likely to improve the health and quality of life of their child. Key milestones and dates for this process were as follows:

- June 24, 2014—Initial mailing of program materials.
- July 1, 2014—First Participation Forms received from families.
- July 23, 2014—First set of WePay™ cards mailed to families.
- September 30, 2014—Deadline for families submitting Participation Forms.
- December 31, 2014—Deadline for spending funds on WePay™ cards.

Care coordinators were a critical part of the activation and implementation process. Their role was to help engage families in the program and to provide support and ideas to families for how to most effectively use the $500. Written materials (**Section V, Toolkit II.B.5**) were developed for care coordinators to help them brainstorm creative uses of the money that would help to improve the care and quality of life for the child. Care coordinators were also supported through care coordination and medical home resources (**Section V, Toolkit III.C.1-9, Clinical Resource Toolkit for Providers**), monthly phone calls, on-site visits, and direct access to a number of UPMC *for You* administrators and care managers. Other steps associated with activating the consumer-directed accounts are described below.

Step 9.A: Obtain legal and Medicaid approval

Because our payment reform was conducted within a Medicaid managed care program, there were additional funding considerations and approvals required. The UPMC *for You* Legal and Compliance Departments reviewed the program and member materials. Then all printed member materials had to be reviewed and approved by the Pennsylvania Department of Human Services (PA DHS, formerly called the Department of Public Welfare). UPMC *for You* did not use Medicaid dollars to fund the consumer-directed accounts.

Step 9.B: Outreach to and engage families/children

Immediately after receiving the necessary approvals from DPW, practices were informed that outreach could begin. All consumer-directed account materials, workflows, and training

materials were shared with the practice-based care coordinators and reviewed with UPMC *for You* administrators over the phone.

Care coordinators were at the center of all communication to families about the consumer-directed accounts. They called families prior to and following the mailing of the program materials (see Step 6.D). The mailing to families included a letter that explained the opportunity and requirements for participation as well as the Participation Form (see Step 6.D) and a self-addressed return envelope. After the letters were mailed, care coordinators made follow up calls and sent additional letters to families to encourage and remind them to participate in this unique opportunity. Every outreach attempt, including date and outcome, was documented in the secure tracking spreadsheet described in Step 6.E.

Monthly calls with care coordinators (as described above) were used to discuss barriers to family engagement, commonly requested items, community resources that might help families with some of the needs identified on the Participation Forms, and other ways to improve participation with the consumer-directed accounts and to build relationships with care coordinators.

Step 9.C: Document consumer purchases and monitor progress

A master tracking spreadsheet listed all patients who were invited to participate in the consumer-directed account program. This master spreadsheet was monitored and maintained by UPMC *for You*. Each practice had its own version of the spreadsheet that listed patients at that practice. All of the spreadsheets were password-protected and linked back and forth with the master spreadsheet, so that updates to either the master or the practice spreadsheet would be seen as soon as either one was saved.

Members of UPMC *for You*'s pediatric clinical team entered all data from the Participation Forms and monitored the tracking spreadsheet for progress (e.g., who talked to their care coordinator but did not submit a Participation Form, who received a WePay™ card, etc.).

Step 9.D: Assess/evaluate value of consumer-directed purchasing for patients and families

After members finished spending the $500 on their WePay™ card, they were instructed to complete and mail a Purchase History Form and receipts from their purchases. The Purchase History Form asked what they spent the $500 on and how it helped their child. They were also asked some additional questions to assess the perceived value of the consumer-directed accounts and their satisfaction with services provided by the care coordinators.

Care coordinators were again critical in these outreach efforts to follow up with patients and families and remind them to return their Purchase History Form and receipts, as well as to get direct feedback about the family's experience and how they benefited from the $500.

Step 9.E: Provide other operational/technical support as needed

UPMC *for You* provided extensive written documentation to the care coordinators about the consumer-directed accounts, as the care coordinators were the sole source of contact with families about this program. Supportive documents included:

- **General information**—Explanations about the purpose of the $500 consumer-directed account, key deadlines in the program, criteria and restrictions for purchases, and participation requirements; contact information for practices (not parents) of specific individuals at UPMC *for You* who could help with different types of questions.

- **Workflow documents**—Program workflow step-by-step instructions for how the program should ideally run and additional steps that must be taken in circumstances that are outside of the "ideal " (i.e., family does not contact care coordinator after a specific date or milestone); visual program workflow, including a breakout by person (care coordinator, UPMC *for You*, patient/family).

- **PA DHS-approved mailings from UPMC *for You***—Participation Form, Purchase History Form, program letter, WePay™ brochure and card sleeve.

- **Mailings from practices**—"Unable to reach" letter on practice letterhead.

Copies of most of these documents are provided in **Section V, Toolkit II.B.1-5**, **Planning for Consumer-Directed Accounts.**

Step 10: Support Service Delivery Improvements Linked to Payment and Purchasing Reform

While payment and purchasing reform can serve as a powerful lever for enhancing care value, the disruptive nature of such changes can trigger a high level of uncertainty about "what to do next" among both providers and consumers. Additional efforts should be taken to ensure that all stakeholders are suitably informed and equipped to take full advantage of the new service opportunities supported through the payment and purchasing changes. Ideally, these efforts should be focused specifically on core components of the service delivery process that are directly linked to the new payment model.

Step 10.A: Educate and train stakeholders on core components of service delivery supported through payment model

In the context of the UPMC *for You* demonstration project, payment reform success hinged on the ability of care coordinators, physicians, and other clinical staff to provide comprehensive care coordination at the practice level, including the development and implementation of individual care plans in close partnership with patients and families. Therefore, several activities were undertaken to support education and training in these areas.

First, the Leadership Team, with input from the Implementation Task Force, developed a supplemental clinical resource toolkit for participating practices and providers that was available via the secure shared drive. Informational materials, tools, and resources were added to the toolkit as needed throughout the various phases of model implementation. Items in the final toolkit included specific community and health plan resources, names and contact information, plus more general information about clinical best practices that were adopted for this project. Some of those documents are listed below and provided in **Section V:**

- Chart review tips (**Toolkit III.C.1**).

- Tip sheet for getting started (**Toolkit III.C.2**).
- Patient chart review tracking tool (**Toolkit III.C.3**).
- Set up instructions for clinical team phone and video conferencing (**Toolkit III.C.4**).
- Information on automatic prescription refills (**Toolkit III.C.5**).
- Subspecialist case conference sample letter (**Toolkit III.C.6**).
- Provider FAQ about payment reform (**Toolkit III.C.7**).
- "Care Coordination for Children with Special Health Care Needs," *Pediatrics* 2008 (**Toolkit III.C.8**).
- Preamble Patient-Centered Principles (**Toolkit III.C.9**).

Second, at the request of the participating practices, the Leadership Team organized two one-hour trainings (via teleconference) in October 2013 focused specifically on care coordination. One training was designed for physicians and the other for care coordinators, although some physicians and practice managers attended this second training as well. General topics covered in both trainings included:

- Definition, goals and processes.
- Role clarification.
- Relevance to the patient-centered medical home model.
- Use of individual care plans as a shared tool for care planning and care coordination, including the medical summary, emergency plans (medical and home), and family-directed goals (long- and short-term) and strategies.

The care coordinators' training also included review of potential care planning tools and discussion about how to develop an optimal tool that is comprehensive, easy to update, and able to be shared among all relevant team members and printed for patients and families.

Step 10.B: Solicit input from patients and families to inform implementation of core service delivery components

The Leadership Team and the Implementation Task Force also facilitated efforts to solicit input from patients and families to inform the practices' overall approach to care coordination as well as aspects of coordination that are specifically important to subgroups of the target population (e.g., individuals transitioning from pediatric to adult primary care providers). This input was obtained as part of the focus group discussions described in Step 6.A as well as additional questionnaires sent to patients and families by the participating practices.

The Leadership Team initiated and conducted (facilitated by the family engagement specialist) focus groups, which identified several reoccurring themes specific to patient and family experiences with care coordination as follows:

- Challenges coordinating/managing numerous and ongoing care-related activities, including:
    - Integrating medical care and advice from multiple specialists;
    - Obtaining medications, supplies, and equipment;
    - Working with insurance companies and nursing agencies;
    - Exploring educational and recreational options; and
    - Advocating for their children.
- Lack of a systematic process for learning about available resources.
- Variable experiences (both positive and negative) working with health plan-based care managers.
- Preference for continuous contact with a single care manager who can assist children and families over the long term.
- Concerns about added time associated with developing individual care plans.
- Recommendation that care coordinators have access to parent advisors who can share their real-life experiences and expertise.

A summary report of these discussions is provided in **Section V, Toolkit II.A.1, Toolkit II.A.2, and Toolkit II.A.3.**

Participating practices, with support and guidance from members of the UPMC *for You* leadership team, conducted patient and family surveys.

First, the Barriers to Care survey, which asks parents to identify the kinds of things that make it difficult to get health care for their children, was divided into two shorter parts to decrease respondent burden and allow for distribution by the practices to different patient groups at different time points. Second, the Pediatric Primary Care survey, which focuses on issues related to access, service utilization, and unmet needs, was designed to fit on one page for easier distribution and completion; there were no changes made to the original survey items. Copies of both instruments are provided in **Section V, Toolkit III.D.1 and Toolkit III.D.2.** The participating practices mailed one or more of the surveys to families in the target population at varying time points and offered them on iPads in their waiting rooms. Respondents completed the surveys anonymously and returned the hard copies to a central administrative office of the Children's Hospital of Pittsburgh of UPMC for tabulation and reporting of the results to each practice.

Step 10.C: Provide operational and technical support as needed for service delivery changes

Both the UPMC health system and the UPMC Health Plan provided operational and technical support as needed to facilitate the practices' care coordination activities. Most of the health system support focused on modifying the existing EHR to help identify or "flag" patients in the target population and to automate key components of care coordination process, such as incorporating progress notes into portable medical summaries and adding a complex condition template to the patient's record. The health system also helped to support patient/family use of MyUPMC, a secure online health management system through which UPMC members 18 years old and older (or individuals functioning as a proxy) can get advice from their doctor's office, review their medical history and test results, renew prescriptions, request appointments, ask billing questions, and have an online doctor's visit.

UPMC *for You* identified a practice-based care coordinator to serve as a direct liaison for answering questions or addressing issues raised by the practice-based care managers. Staff also flagged members of the target population in the health plan care management system and sent real-time updates to the practices regarding emergency room visits, hospital admissions, and upcoming specialist visits. Members were also checked monthly for ongoing Medicaid enrollment status and assisted as needed in keeping their enrollment up to date.

IV. Lessons Learned

Stakeholder Engagement

1. Successful payment reform requires bringing together many different stakeholders with varied needs, perspectives, and priorities. It takes time to learn how to speak a common language and build the foundation of trust that is critical for success.

2. Not all stakeholder groups need or should be involved in all components of the change process. However, it is extremely valuable for continuity and relationship building if some stakeholders participate in more than one component or group.

3. Patient and family engagement is best facilitated by working through physicians and other stakeholders who have established relationships with them.

4. Even in our technology-driven world, the most effective means of communicating with lead physicians, administrators, care coordinators, and office managers from primary care practices on an ongoing basis is via a standing phone call.

5. Creating additional shared learning opportunities for stakeholders, outside of the formal work of payment reform, can serve as an important motivator for engagement; these opportunities appeal to individual interests in continual learning, being a part of a cutting-edge initiative, and advancing self-knowledge related to payment reform in particular.

Designing Payment Model

6. Because patients with high health care expenditures have a variety of medical conditions, it was not feasible to develop and test condition-adjusted per child payments as originally proposed. Rather, our revised approach, which is based on historic health care expenditures for the entire target population, fosters the development of an acuity-adjusted global payment model for children with medically complex conditions.

7. Using total health care expenditures to represent medical complexity, we identified a subgroup of patients for whom service delivery changes are most likely to result in cost savings; however, more work is needed to determine specific factors that could improve the medical management of these children, both individually and as an important subgroup. The unique circumstances of certain patients (e.g., those transitioning across care and/or payment systems, “loophole” kids) must also be considered and addressed.

8. It is important for participating providers and payers to agree on and understand the metrics of performance evaluation up front; for the purposes of evaluation, inclusion and exclusion criteria should also be clearly defined at the start of the demonstration project and consistently adhered to throughout.

9. As the demonstration project progressed, some physicians and care coordinators expressed interest in adding more patients and in being more directly involved in selecting the patients whom they believed were the most complex or would benefit most from the model. The

decision not to add additional patients or allow providers to select participants may have had unintended consequences on the ability of providers to engage successfully with some families.

10. Gathering input from patients and families regarding consumer-directed purchasing in particular, and service delivery improvements in general, is critical to any successful reform effort. However, finding times that will work for several families can be challenging, especially for those with children who have 24-hour care needs. We found that most parents in two-parent households worked opposite shifts, and nursing care is only provided during their work hours.

Implementing Payment Model

11. Although we chose a virtual accounting approach to ease the payment change process and minimalize downside risk for providers, numerous technical issues related to aligning the proposed payment modifications with internal business processes took considerable time to resolve.

12. Changing the way providers are paid does not automatically lead to different or better service delivery. There are many additional steps in this process that take time, effort, and resources, including:

    a. Obtaining buy-in, particularly of physicians and administrators.

    b. Identifying additional staff to coordinate care across multiple providers.

    c. Developing and disseminating tools, tips, and information to support service delivery improvements.

    d. Coordinating efforts to directly engage patients and families in the service delivery change process.

13. Developing incremental strategies for moving forward with service delivery changes as practices identify, hire, and/or train the staff required is essential for the timely implementation of payment reform.

14. Consumer-directed purchasing can serve as an important incentive for increased engagement and collaboration between practice-based care coordinators and families. Discussions about consumer-directed accounts can open the door to sharing important information about aspects of families' daily lives that may not otherwise occur, such as transportation barriers or educational needs for the child.

15. Our efforts to enhance the value of care for children with medically complex conditions through payment reform revealed other opportunities for system improvement. Staying focused on the task at hand was a continual challenge.

Implementing Different Clinical Practices
(Lessons Learned by Providers)

16. Practice-based care coordination has improved the care that families receive (e.g., the pediatric practice has a deeper and broader understanding of unique child and family circumstances and can tailor care accordingly, families get important assistance with making appointments with specialists and receive reminders and preparation assistance in advance of visits).

17. Continuity with families has deepened care coordinators' appreciation of the challenges that families face in pursuing things their child needs. Not only do families have one person to call who they know will respond, but care coordinators are more able to advocate and support in ways that fit each child uniquely.

18. While challenging and time-intensive, care coordination may be more satisfying to families and care coordinators than typical triage, where providers respond to a series of individual problems and concerns that may appear unrelated.

19. Primary care practices value practice-based care coordination as evidenced by their plans to continue and expand this role for more families. Care coordination strengthens PCP-care coordinator partnerships and can lead to more efficient, effective visits.

20. Care coordination is enhanced when care coordinators are well-trained and supported, and have access to key individuals in insurance companies, health care settings, and community resources.

21. Care coordination assistance to families may be further enhanced if families receive an orientation as to what it is and how it can help through a face-to-face intake process.

22. The project overall and the consumer-directed accounts may have had a greater impact if the participating families had been identified by PCPs and nurses at the practice level.

23. Electronic medical records can be adapted to serve care coordination purposes.

24. Tracking tools are helpful for proactive engagement with families.

25. Comprehensive care planning and interdisciplinary conferencing is a challenge. Persistence is required to arrange meetings, and develop relationships and contacts with subspecialists.

Overall

26. The infrastructure, data systems, relationships, and implementation mechanisms/strategies that are built as part of payment reform demonstration projects can serve as the groundwork for successful transition to accountable care models involving a wide range of providers and payers.

27. Sustaining and replicating improvements achieved as part of such demonstration projects will require maintaining and expanding the infrastructure, promoting ongoing payer-provider

dialogue, and working to systematically disseminate the results among other stakeholder groups, both within our region and beyond.

V. Toolkit

I. Startup

A. Operational plan template

B. UPMC Population DIVe (Dynamic Interactive View) tool
1. UPMC Population DIVe tool
2. UPMC Population DIVe tool usage instructions

II. Payment Model Design

A. Family focus groups for designing consumer-directed accounts
1. Discussion guide for parental focus groups
2. Discussion guide for transition-age focus groups with parents and adolescents
3. Summary of discussions

B. Planning for consumer-directed accounts
1. Practice flow diagram
2. Outreach letter
3. Participation form
4. Purchase history form
5. Guidance for care coordinators

C. Ongoing performance review
1. Potential quality and cost outcome measures
2. Patient profile template
3. HEDIS quality report template
4. Financial pro forma sample
5. Provider friendly financial summary sample

III. Payment Model Implementation

A. Practice-based care coordinators
1. Description of care coordinators' responsibilities and obligations
2. Templates for documenting care coordination services

B. Invoice template for reimbursement payments to non-billing providers

C. Clinical resource toolkit for providers
1. Chart review tips
2. Tip sheet for getting started
3. Patient chart review tracking tool
4. Set up instructions for clinical team phone and video conferencing
5. Information on automatic prescription refills
6. Subspecialist case conference sample letter
7. Provider FAQ about payment reform
8. Care Coordination for Children with Special Health Care Needs – Pediatrics 2008

9. Preamble: Patient-Centered Principles

D. Patient/family input on service delivery components supported through payment model

1. Barriers to Care survey (adapted)
2. Pediatric Primary Care survey (reformatted)

VI. Glossary

Term	Definition
Comprehensive care coordination within the medical home	A direct, family/youth-centered, team-oriented, outcomes-focused process designed to facilitate the provision of comprehensive health promotion and chronic condition care; ensure a locus of ongoing, proactive, planned care activities; build and use effective communication strategies among family, the medical home, schools, specialists, and community professionals, and community connections; and help improve, measure, monitor and sustain quality outcomes (clinical, functional, satisfaction and cost).
Consumer-directed accounts	Individual purchasing arrangements that enable patients and/or families to exercise choice and control over some nonclinical goods and services related to basic aspects of their day-to-day lives that impact their overall health and well-being.
Current Procedural Terminology (CPT) codes	Numbers assigned to every task and service a medical practitioner may provide for a non-Medicare patient, including medical, surgical, and diagnostic services, and used by insurers to determine the amount of reimbursement that the practitioner will receive.
Diagnostic related group (DRG)	A billing code used in a larger medical billing and tracking system that identifies a doctor's diagnosis and allows hospitals to bill insurers and Medicare for inpatient services. DRG codes are combined with a CPT code and the length of the hospital stay to decipher the total claim payment and reimbursement required.
Fee for service (FFS)	A health care payment model in which doctors and other health care professionals receive a retrospective fee for each service (e.g., office visit, test, procedure) provided.
High-value health care	Commonly defined as a process through which physicians provide the best possible quality of care to their patients while simultaneously reducing unnecessary costs to the health care system.
Individual care plans	A document or tool that formalizes the plan of support for patients with complex health care needs based on information from the medical practitioner provided by the patient/family; the plan should include a description of the patient's needs, actions to be taken to meet these needs, and detailed procedures to be followed if an emergency arises.
Integrated delivery and financing system (IDFS)	A network of health care provider and payer organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served.
Managed care organization (MCO)	Health industry professionals that work together to deliver high quality health care when it is medically necessary, render the services by the most appropriate health care professional, and oversee how health care professionals are reimbursed for their services.

Medicaid	A public health insurance program jointly financed by the federal and state governments and administered at the state level that provides coverage for many low-income individuals, offers long-term care assistance to people over the age of 65 and individuals with disabilities, covers gaps in the Medicare program, and funds institutions that serve a disproportionate number of low-income patients with special needs.
Medicaid waiver programs	Federal authorization allowing states to cover home and community-based services for specific populations to avoid institutionalization; waivers may increase optional and additional Medicaid services, such as respite care, environmental modifications, and family training.
Medically complex conditions	Chronic physical, developmental, behavioral, or emotional conditions requiring health and related services of a type or amount beyond that generally required.
Patient-centered medical home	A team-based health care delivery model led by a physician, physician's assistant, or nurse practitioner that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.
Payment reform	Changing the way health care is paid for in order to improve outcomes, enhance the patient experience, and reduce cost.
Total cost of care (TCOC)	A method of measuring health care affordability that includes all relevant care costs (professional, inpatient, outpatient, pharmacy, ancillary, etc.).
Value-based payment models	New models for reimbursing providers that emphasize fulfilling the needs of the patient in the best manner possible, while also lowering costs; examples include Pay for Coordination, Comprehensive Care Payment, and Pay for Performance.

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