



CT SIM: SHIP steering committee meeting

Discussion document
September 17, 2013

Agenda

210 Capitol Avenue, Room 410

Tuesday, September 17

2:30-4:00p US ET

Objective	Timing
▪ Review developments in Connecticut's proposed Advanced Medical Home (AMH) model and strategy	30 min
▪ Proposed governance and operating model	30 min
▪ Connecticut SIM savings and investment assumptions	30 min

Context for today's discussion

- Drafting State Healthcare Innovation Plan (SHIP)
 - Synthesized work group recommendations and information on Connecticut's health care context
 - Resolving design issues and addressing design gaps
 - Incorporating insights from Medicaid claims and other data analysis into plan narrative
 - Analyzing state employee data and value-based payment models; in discussion on replicating Medicaid data analysis with state employee data
 - Preparing to share SHIP draft in October
- Engaging in individual conversations to inform development of technical design
- Today, we will
 - Share the latest developments of the care delivery reform design and strategy for your feedback
 - Solicit input on areas under consideration

We have defined Connecticut's model as the Advanced Medical Home (AMH) model

ADVANCED MEDICAL HOME – Core Elements

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-informed clinical decision making

**Consumer
activation**

**Performance
transparency**

**Health
information
technology**

**Value-based
payment**

**Workforce
development**

ENABLING INITIATIVES

OUR ASPIRATIONS

- **Better health for all**
- **Improved quality and consumer experience**
- **Reduced costs and improved affordability**

Advanced Medical Home – Core Elements

Prioritized interventions

1 Whole-person-centered care

- Whole person and family assessments that identify strengths and capacities, risk factors¹, behavioral health, oral health and other co-occurring conditions, and ability to self-manage care
- Person centered care plan and shared decision making tools
- Address cultural, linguistic, health literacy barriers to care

2 Population health management

- Gather and analyze information about patient population
- Gain insight into health patterns and improvement opportunities for particular patient sub-populations (e.g., by health risk, condition, or race/ethnicity)
- Apply these insights strategically in the continuous improvement of care delivery processes.
- Translate population health trends and statistics to individual patients
- Maintain a disease registry

¹ Including history of trauma, housing instability, access to preventive oral health services

Advanced Medical Home – Core Elements

3

Enhanced access to care (structural and cultural)

Prioritized interventions

- Improve access to primary care through
 - a) extended hours (evenings/weekends),
 - b) convenient, timely appointment availability including same day (advanced) access,
 - c) non-visit-based options for consumers including telephone, email, text, and video communication
 - Enhance specialty care access through non-visit-based consultations: e.g., e-Consult
 - Raise consumer awareness regarding most appropriate options for accessing care to meet routine and urgent health needs
-

Advanced Medical Home – Core Elements

4

**Team-based,
coordinated care**

Prioritized interventions

- Provide team-based care from a prepared, proactive, and diverse team
 - Integrate behavioral health and primary care with “warm hand-offs” between behavioral health and primary care practitioners (on-site if possible)
 - Develop and execute against a whole-person-centered care plan
 - Coordinate across all elements of a consumer’s care and support needs
-

5

**Evidence-
informed clinical
decision making**

- Apply clinical evidence and health economic data to target care and interventions to those for whom they will be most effective
 - Leverage tools at the point of care to include the most up-to-date clinical evidence
 - Promote new methods for rapid adoption and application of evidence at the point of care
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Multi-payer Alignment

ADVANCED MEDICAL HOME – Core Elements

Whole-person centered care

Enhanced access

Population health management

Team-based coordinated care

Evidence-informed clinical decision making

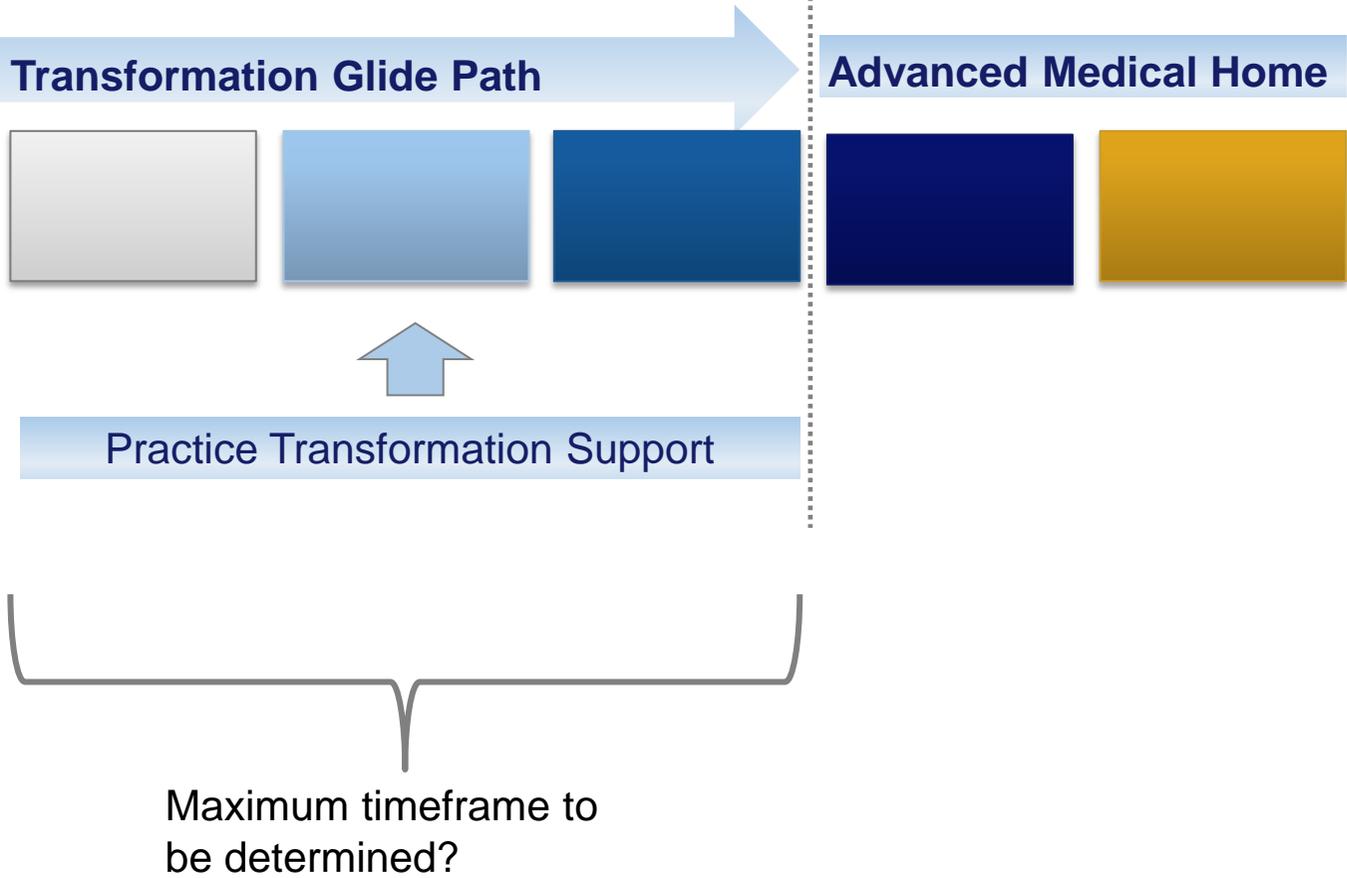
How to Develop and Administer a Common Set of Standards Endorsed by All Payers?

Alignment on Advanced Medical Home Standards

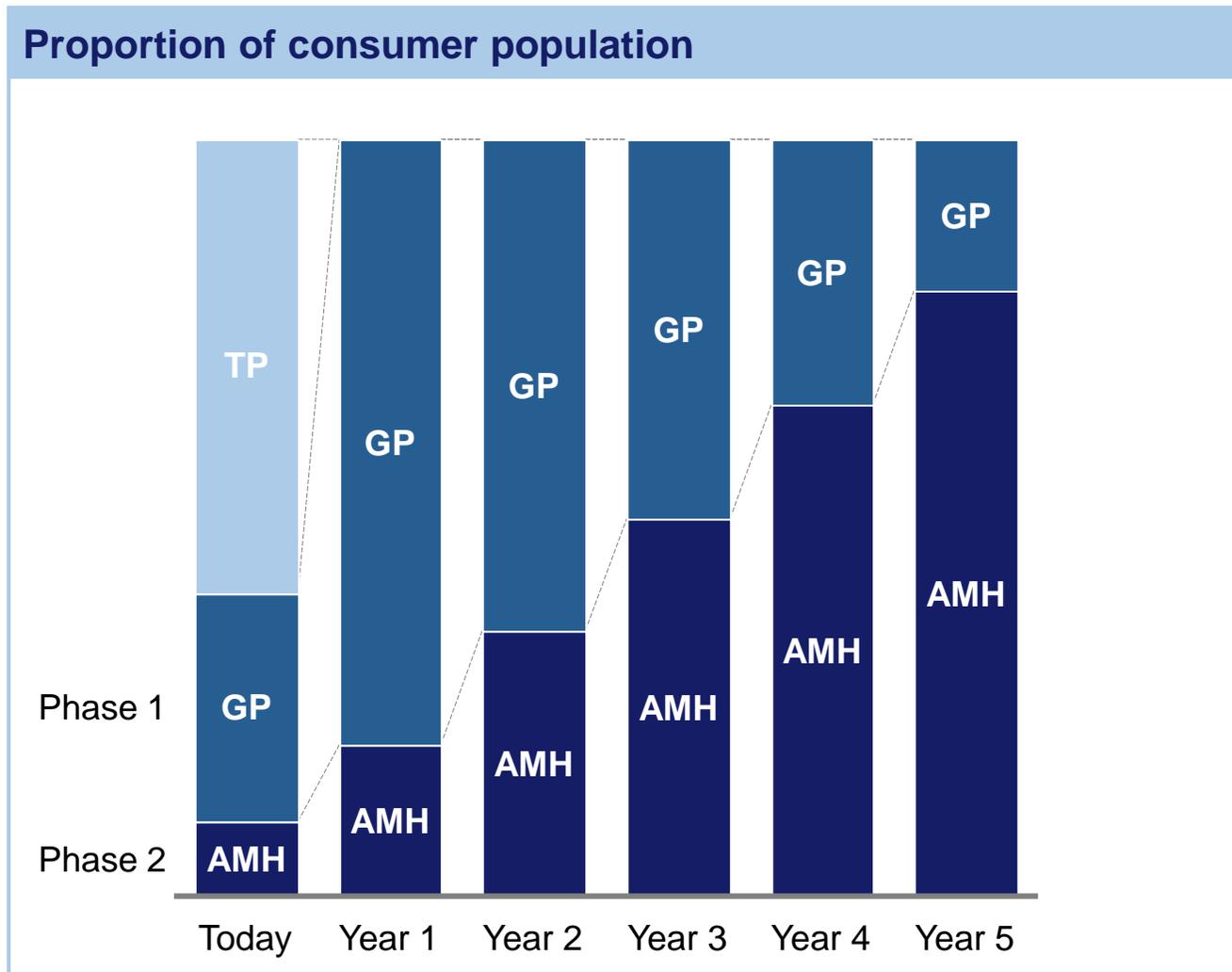
■ Recommendations

- Provider Transformation Workgroup defines AMH standards and element
- Payers participate in workgroup and voluntarily adopt standards
 - Possibly subject to attestation and verification
- Reciprocity with national medical home accreditation bodies (i.e., NCQA, Joint Commission)
- On-site validation survey conducted by common vendor

Transformation Support – Helping Practices Meet AMH Standards



Advanced Medical Home Phase-in as Providers Complete Glide Path



TP = Traditional practice
GP = Glide Path

AMH = Advanced Medical Home

Enabling Initiatives

Consumer Activation

- Securely share health data on consumer portal
- Self-management programs
- Shared decision making tools
- Provider quality and cost performance to inform consumer choices
- Promote Community outreach programs
- Value-based Insurance Design

Performance Transparency

- Collection, integration, analysis and dissemination of data for performance reporting on health, health care quality and cost
- Statewide performance metrics to demonstrate improvement over time
- Track AMH performance on quality, care experience, and equity measures on common scorecard
 - For use by payers to determine whether providers qualify for value-based incentive payments
- Track broader array of providers on quality, outcome and cost measure for use by consumers and providers in deciding where and from whom to obtain services
- Establish rapid cycle analysis of quality and consumer experience data to support continuous improvement

HIT - Four Categories of HIT Capabilities to Support Reforms

Category	Description
Payer analytics (complemented by provider analytics)	<ul style="list-style-type: none">Tools for payers to analyze claims and clinical data to produce payment-related analytics, assess quality / outcome / performance metrics
Provider - payer - patient connectivity	<ul style="list-style-type: none">Channels (e.g., portal) for providers and patients to access and submit information, data and analytics required to support care delivery and payment models
Care management tools	<ul style="list-style-type: none">Provider tools (e.g., workflow, event management) and analytics to coordinate the medical services for a patient (focus on highest risk sub-populations)
Provider to provider connectivity	<ul style="list-style-type: none">Integrated clinical data exchange among healthcare stakeholders (e.g, direct messaging), including the longitudinal patient registry that can be enabled by HIE

HIT - Strategy to Develop Required HIT Capabilities

Category

Strategy



Payer Analytics
(complemented by
provider analytics)

- Begin with building on **payer's own population-health analytics** and continue to establish the full set of tools required in end state
- In the longer term, look to **leverage APCD** for system level analytics that informs public health policy and consumer facing cost/quality transparency



**Provider-payer-patient
connectivity**

- **Select and scale a single existing provider portal** for use across multiple payers
- Leverage AccessHealth CT/APCD for **consumer engagement**
- Potentially form relationships with 3rd party **patient tool vendors**



**Provider-patient care
mgmt. tools**

- **Near term:** Educate providers on process and technology adoption
- **Medium term:** Simplify procurement through creating a marketplace or pre-qualifying vendors
- **Longer term:** Host shared service for providers to access basic care management capabilities



**Provider-provider
connectivity**

- Ensure alignment with **eHealthConnecticut** and **HITE-CT** strategies to accelerate EHR adoption and enable connectivity between providers (ongoing effort)

Value-Based Payment

- **Glide path (GP)**

- Physicians responsible for achieving practice transformation milestones
- Pay-for-performance (P4P) rewards for providers that meet quality standards¹
- 500+ attributed consumers
- Care coordination payments?

¹Provider groups with sufficient attributed consumers may elect to negotiate a shared savings program arrangement with individual payers in advance of achieving AMH status.

Value-Based Payment

- **Advanced Medical Home (AMH)**
 - Practices have met initial quality metrics and progressing on AMH standards
 - 5,000+ attributed consumers
 - Care coordination payments?
 - Shared savings arrangement
 - Share in savings if provider meets minimum quality standards
 - Payer and providers negotiate whether to share in losses

Linkage Between Care Delivery and Payment Reform

- More than half of Connecticut's primary care physicians in contracts or negotiating contracts with one or more payers that move toward shared savings program (SSP) arrangements.
- These primary care physicians are distributed among at least a dozen IPAs, clinician integrated networks, or ACOs. Others are emerging.
- In many cases, the practices that comprise these groups do not have medical home recognition by one of the national accrediting bodies.
- Requiring AMH certification as a condition for migrating to shared savings arrangement could slow the pace of value-based payment reform
- Questions:
 - Should timing of migration to SSP arrangement be decided by each payer and provider, without regard to progress on standards or AMH status?
 - Should there be a validation survey that all existing and future providers system would be required to meet as a condition for remaining in SSP arrangements?

Workforce Development

- Improved health workforce data collection and analyses
- Connecticut Service Track: inter-professional training for team & population health approaches to health services
- Training program and certification standards for Community Health Workers,
- Development of core STEM (Science Technology Engineering Mathematics) curricula for baccalaureate degrees in the health field, and career ladders and career flexibility through comprehensive articulation agreements among schools that train health care professionals and allied health professionals
- Assistance for practicing primary care clinicians in adapting to care delivery models that emphasize teamwork, best practices, population health, patient engagement, learning collaboration, continuous improvement and the meaningful use of Health Information Technology (HIT)
- Assistance in developing primary care clinical skills for primary care clinicians who have been away from direct patient care and for specialists interested in primary care
- More innovative and compelling primary care GME programs

Certified Community-Based Entity

- Support local primary care practices with a specified package of evidence-based community services.
- Responsible for delivery of a core set of evidence-based community interventions.
- Enter into formal affiliations with primary care practices and share accountability for quality and outcomes.
- Have a unique understanding of the community and population served and be able to deliver high quality, culturally and linguistically appropriate services.
- Meet specified standards pertaining to the type, quality, scope and reach of services.
- Employ and utilize community health workers for their services
- Have IT-enabled integrated communication protocols. Collect and report data and evaluate performance and relevant outcomes.

Certified Community-Based Entity

Illustrative Core Services

- Asthma Home Environmental Assessments (putting on AIRS)
- Diabetes Prevention Program (DPP)
- Chronic Disease Self-Management Programs
- Falls Prevention Program
- Core Services foundational framework includes: DPH's State Health Assessment, CDC's four-domain framework on chronic disease prevention and health promotion, proven effectiveness, reduction of health disparities and return on investment potential.

Primary care practices will be able to draw on support from certified community based entities

Certified community based entities (both state wide and local)

Certification, training, technical assistance, and sharing of best practices

Department of health and other state agencies



Reporting and sharing of best practices

Funding and patient referrals

Programs

Programs, services and patient referrals

Primary care

Independent practitioners



Clinically integrated networks



Reporting and data sharing

5 YEAR LOGIC MODEL: CERTIFIED ENTITY

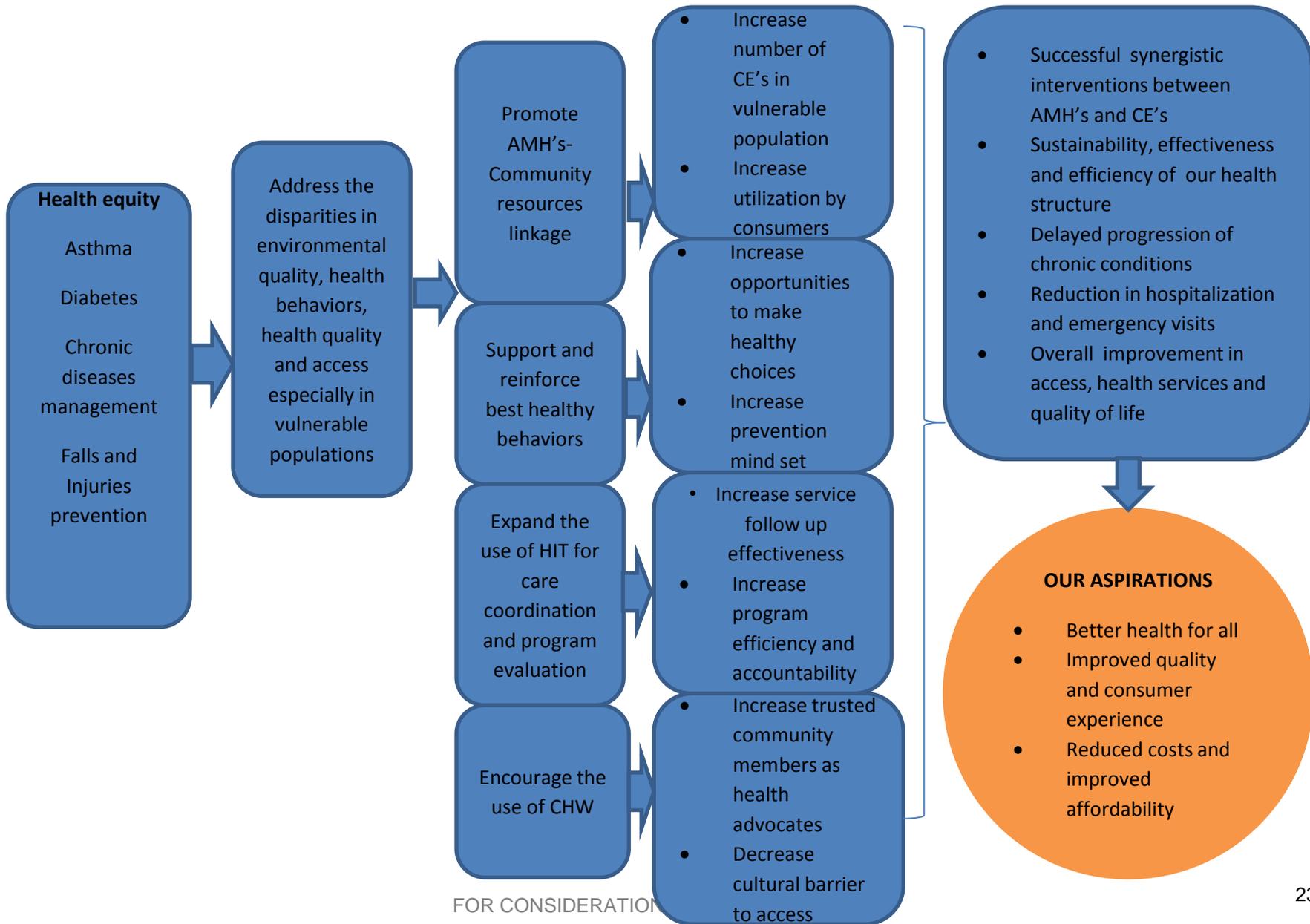
Priority Areas

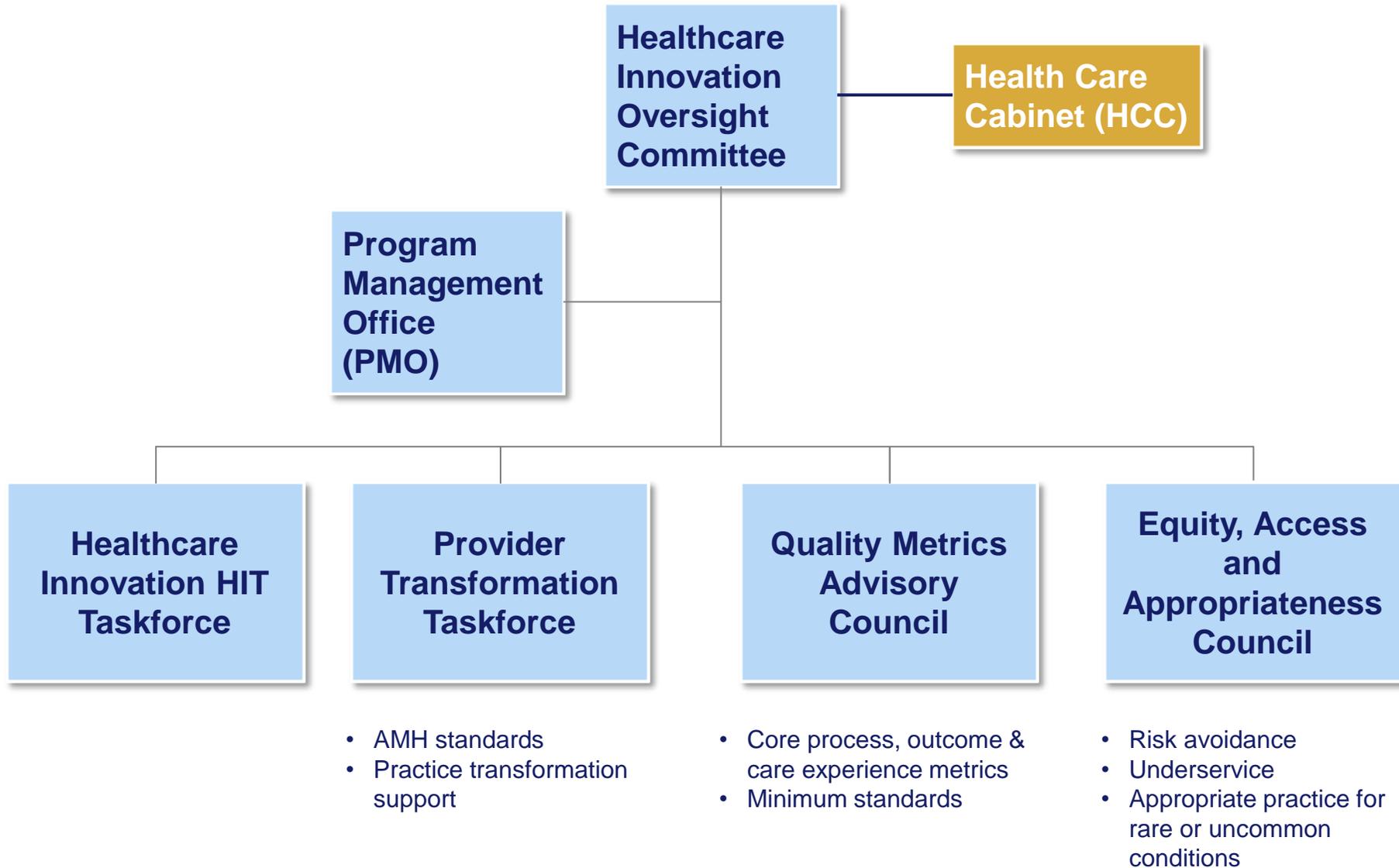
Plan Goals

Strategies

Objectives

Outcomes-Impact





Quality Metrics Advisory Council

- **Provider Quality and Care Experience Metrics**
 - Process (e.g., HBA1C)
 - Outcome (e.g, fewer hospitals stays for ambulatory care sensitive conditions)
 - Care experience
 - Health equity

Equity Access & Appropriateness Council

- **Medicare/Medicaid/private payers – special divisions focused on risks inherent to volume based payment**
- **Special SIM council – focus on methods for identifying and addressing concerns related to payment reforms that reward economy and efficiency, e.g.,**
 - **Avoiding/discharging higher risk clients**
 - **Systematic under-service (e.g., tests, procedures)**
 - **Appropriate care for rare or uncommon conditions**

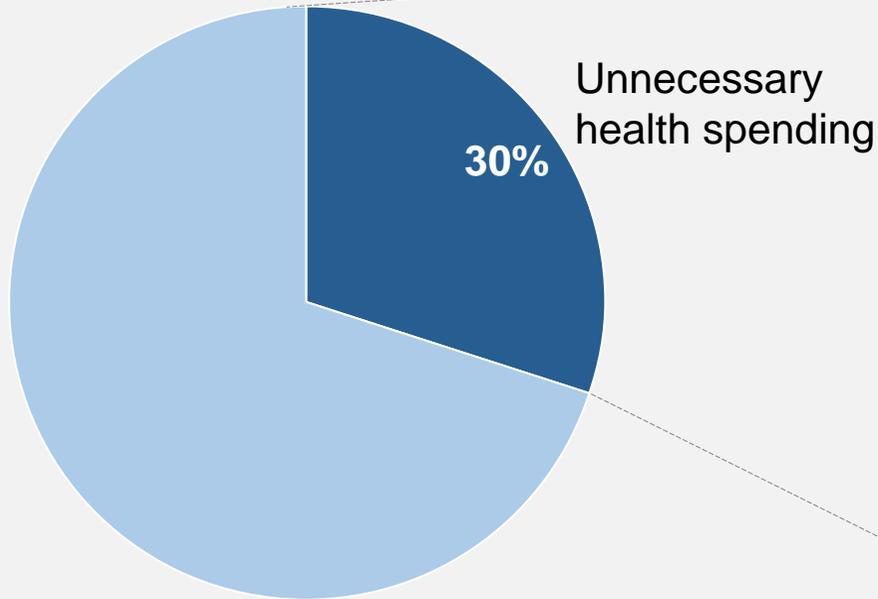
Composition and high-level criteria for participation

	Composition	Criteria for participation
Oversight Committee	<ul style="list-style-type: none"> ▪ Similar to existing SHIP, plus additional provider, consumer, and/or consumer advocate 	<ul style="list-style-type: none"> ▪ Commitment to shared aspirations ▪ Formal authority or ability to influence ▪ Awareness of related initiatives
PMO	<ul style="list-style-type: none"> ▪ Program Director ▪ 3-5 dedicated staff initially ▪ Increase as necessary over time (10-15) ▪ External consulting support as needed 	<ul style="list-style-type: none"> ▪ Aspirational mindset and bias for action ▪ Analytic problem solving skills ▪ Ability to influence without authority ▪ Experience with transformational change
HIT Taskforce	<ul style="list-style-type: none"> ▪ Similar to composition of SIM HIT Workgroup 	<ul style="list-style-type: none"> ▪ Formal authority or ability to influence ▪ Technical expertise with HIT
Provider Transformation	<ul style="list-style-type: none"> ▪ 2-3 consumers or advocates ▪ 2-3 physicians ▪ 1-2 behavioral health providers ▪ 1-2 hospital executives ▪ 2-3 payer medical directors ▪ 1 self-insured employer representative 	<ul style="list-style-type: none"> ▪ Direct experience with provider transformation
Quality Advisory Council	<ul style="list-style-type: none"> ▪ 2-3 consumers or advocates ▪ 3-5 physicians ▪ 2-3 behavioral health providers ▪ 2-3 hospital medical directors ▪ 2-3 payor medical directors ▪ 1-2 statisticians from private payers ▪ 1 epidemiologist from DPH 	<ul style="list-style-type: none"> ▪ Technical expertise and experience with measurement of health, quality, and consumer experience
Equity Access and Appropriateness Council	<ul style="list-style-type: none"> ▪ 1-2 statisticians ▪ 2-3 representatives from academic schools ▪ 3-4 consumer advocates ▪ 4-5 payer representatives from program integrity, fraud & abuse, and/or audit division ▪ 4-5 providers 	<ul style="list-style-type: none"> ▪ Relevant experience and technical experience with audit methodologies ▪ Expertise in standards of practice and evidence based practice

National research indicates that waste and inefficiencies comprise ~30% of health care spending

Health care spending

% of health care dollars



Sources of waste

% of health care dollars

30%



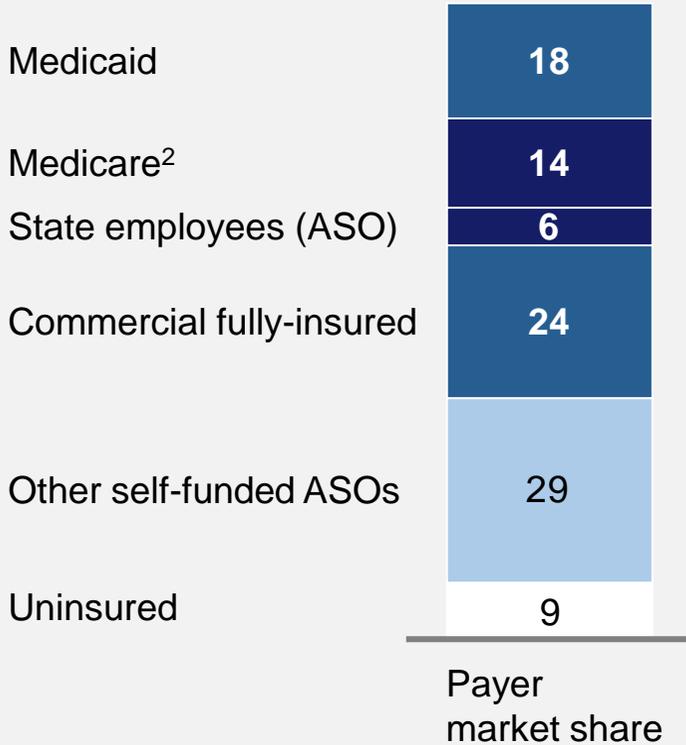
Population-based models of care delivery have demonstrated the ability to reduce complications and waste and thereby generate cost savings

Illustrative example	Savings	Drivers
<p>BCBS Mass. AQC Model emphasizes payment reform: risk adjusted capitated payments and P4P incentives</p>	<p>3% decrease in health care spending growth rate in 2012 (1.9% in 2011)</p>	<ul style="list-style-type: none"> ▪ Reduced readmission rates ▪ Decreased non-emergent ER use ▪ Shifted lab procedures, imaging, and tests to lower cost facilities
<p>CareFirst Providers paid an Outcome Incentive Award based on savings relative to global budget and quality</p>	<p>2.7% lower costs than total projected 2012 health care costs for (1.5% in 2011)</p>	<ul style="list-style-type: none"> ▪ Reduced unnecessary hospital admissions ▪ Reduced ER utilization
<p>Sacramento ACO Model emphasizes care coordination, pooled upside/downside risk between payer and provider</p>	<p>2% reduction in PMPM in Year 1</p>	<ul style="list-style-type: none"> ▪ Reduced hospitalization ▪ Reduced preventable readmissions ▪ Reduced costly out-of-network care ▪ New drug purchasing strategies ▪ Lowered administrative costs with electronic record-keeping

The pace of transformation depends on both payer participation and provider capabilities

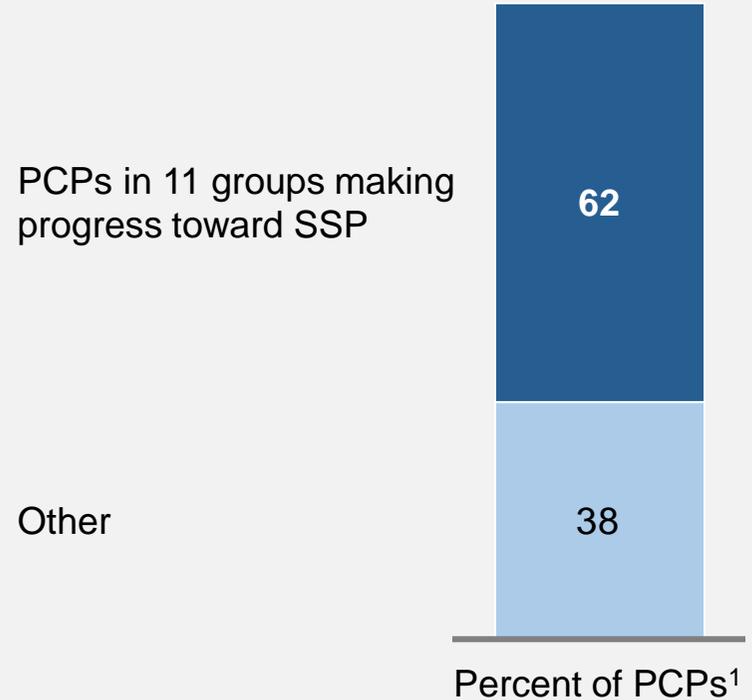
Insurance status of individual lives (2012)
 % of individuals in Connecticut

100% = ~3.6M



PCPs with groups making progress toward SSP
 % of PCPs in Connecticut (As of Sept 2013)

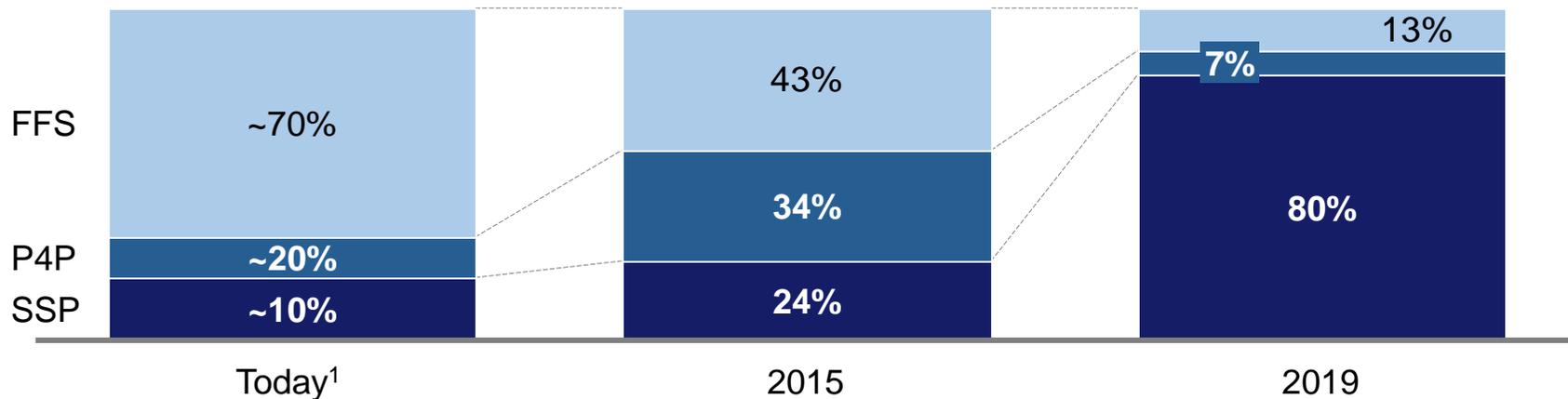
100% = ~2600



1 PCP includes internal practice, general practice, family medicine, OB/GYN, and pediatrics, 2 Excludes dual eligibles

The pace of payment reform adoption is a key driver of savings (2 of 2)

% of lives cared for by primary care providers in Shared Savings (SSP), Pay for Performance (P4P), or purely Fee-for-Service (FFS) arrangements



WHAT YOU WOULD HAVE TO BELIEVE

- Broad payer participation
 - Medicaid, Medicare, OSC participate
 - 4 largest payers participate for fully-insured
 - 30% of self-funded employers participating
- Adoption of SSP by two-thirds of PCPs in the 11 “key” groups
- Adoption of P4P by remainder of “key” groups, plus half of other PCPs not affiliated with 11 “key” groups
- Near-universal payer participation
 - 95% of self-insured employers
 - Smaller payers for fully-insured
- PCPs for all 11 “key” groups participating in SSP
- More than half of remaining PCPs have aggregated to participate in SSP model

¹ Of the 62% of PCPs moving toward SSP today, assumes SSP arrangements are in place today only with 20% of their patient panel;

SOURCE: CT Office of the State Comptroller, CHNCT for average Medicaid enrollees AMA Physician Masterfile via CT SIM workforce taskforce report, literature review

System-wide investment in practice transformation support and care coordination depends on payment rate and availability to providers

PRELIMINARY

Options

Practice transformation support

(Ranges from \$1-3 PMPM)¹

- A** Available to all non-AMH² providers without limitation (\$25-75M per year, tapering significantly after 2 years)
- B** Fixed capacity available to all non-AMH² providers on a first-come first-served basis (\$15-45M per year, tapering significantly after 3 years)
- C** A or B, but with means test, i.e., limited to providers without scale or scope to self-fund (\$10-30M per year, tapering significantly after 3 years)

Care coordination

(Ranges from 0.5-2% of covered spend)¹

- A** Available to AMH providers only (\$80-320M total investment³ over first two years prior to reaching breakeven in year 3)
- B** Available to all providers (\$300M-1.2B total investment prior to reaching breakeven in year 3)

¹ Ranges are meant to be purely descriptive of findings of market research into examples within and outside Connecticut, and are used for planning assumptions, and are not meant to prescribe the funding levels that payers will choose to provide, to be arrived at independently by each payer

² Non-AMH providers include all providers in P4P or in SSP who do not meet AMH standards

³ Assuming that all SSP providers can meet AMH standards

Size of HIT and PMO investment is based on state's aspiration for integration of HIT systems and size/ complexity of transformation program

HIT investment

HIT investment ranges from a one-time cost of \$20-30M over 3 years, with \$3-5M per year ongoing thereafter

Variability in HIT investment driven by:

- Level of integration with HIE
- Number of payers
- Integration of payer systems

Program management office (PMO)

Program management investments range from \$5-30M for each of the first 3 years and \$3-4M per year ongoing thereafter

Variability in PMO investment driven by:

- Complexity and size of state's plan for transformation
 - Number of programs
 - Integration across programs (e.g., AMH, DMHAS Behavioral Health Homes, ICI Duals Demonstration)
- Internal expertise and capacity

¹ Covered spend is the spend attributed to patients who are participating in the program. Covered spend is calculated as the product of the total number of patients participating in the program and the spend associated with those patients.

Options for funding investments

Grant funding

- CT SIM testing grant funds estimated at \$20-60M
- Optimal for one-time investments

In-kind investments

- Personnel and staff from state agencies and participating payers
- Most applicable to expert input on task forces, program mgmt. & performance analytics/reporting

Premium tax/ access fee flow into central fund

- Participating payers are assessed a premium tax/ access fee that is pooled into a central fund for direct investments
- Optimal for ongoing investments

Payer payments to providers

- Individual payers fund providers with upfront investment in expectation of back-end savings
- Optimal where provider adoption is required

“ACO self-funding”

- Providers invest upfront for ability to share in savings on the back-end
- Optimal where provider adoption is required