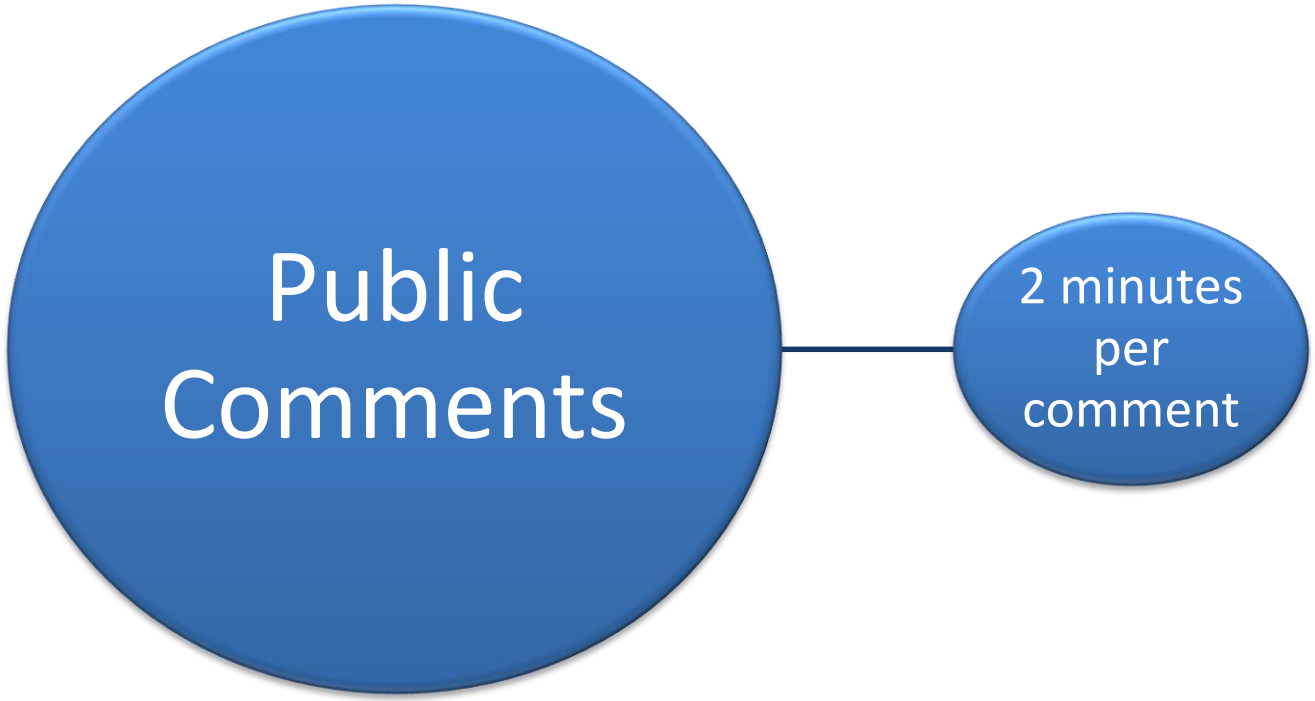
Community Health Worker Advisory Committee

June 1, 2017

Meeting Agenda

Item	Allotted Time
1. Call to Order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. C3 Roles and Skills Endorsement- Discussion and Approval	5 min
5. Sustainable Funding for CHWs through Global Budgets	90 min
7. Next Steps and Adjourn	5 min

Call to Order


Public Comments
2 minutes per comment

Approval of the Minutes

C3 Roles and Skills Endorsement- Discussion and Approval

Sustainable Funding for CHWs through APMS/Global Budgets

Sustainable Funding for CHWs- How do we get there?

1. How are payment and care delivery changing?
2. How do CHWs fit into these changes?
3. What's missing and where can we go next?

How are payment and care delivery changing?

Health system reform includes

- Organizing the health care system differently using Accountable Care Organizations (We refer to as Advanced Networks)
- Paying for health care services differently using Alternative Payment Models

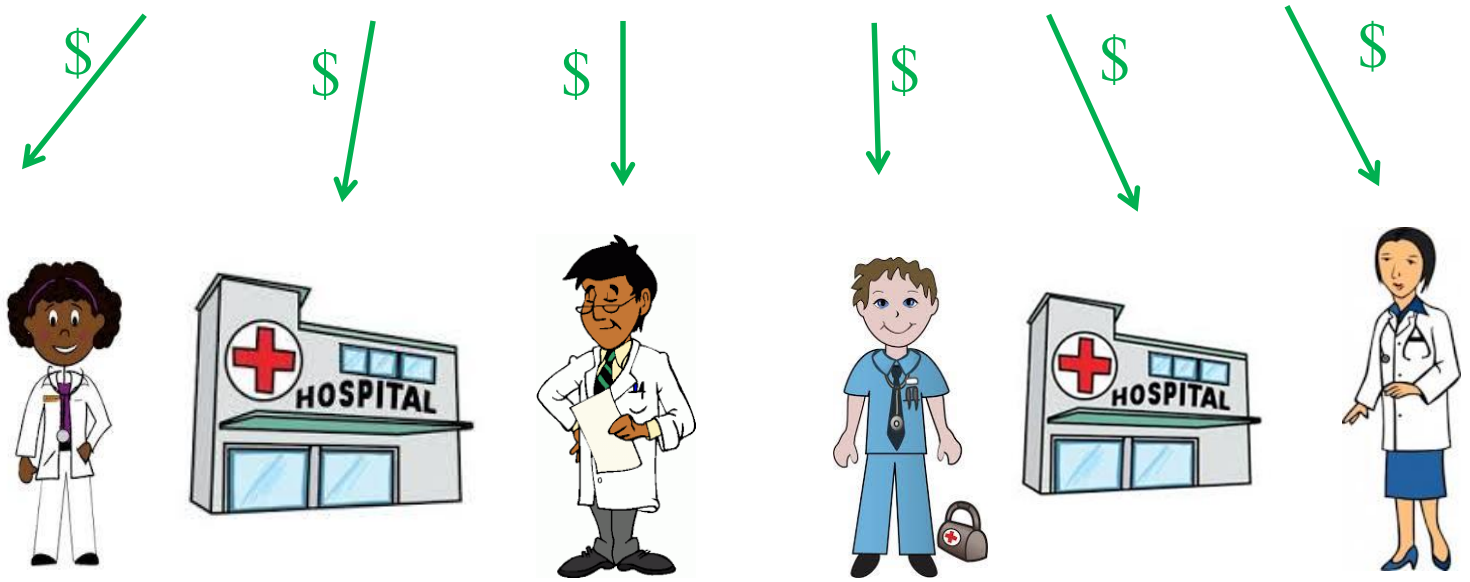
➢ *Each approach can support CHW services*

Care Delivery Reform- Overview

- Traditional payment and delivery system
- Fee for service
- Paying for volume vs. paying for value
- Accountable care organizations (Advanced Networks)

Traditional payment & delivery system

Payer (Medicare, Medicaid, Anthem, etc.)
pays each provider a fee for each service



Payment Method: Fee for Service

Definition: Health care providers receive a separate fee for each service they deliver

Payers often establish a fee for each service code, for example:

- Physician visit, new patient
- Physical therapy 15 minutes
- Hospital stay for asthma

- ➢ Providers only paid for covered services
- ➢ There are codes for CHW services, but most payers won't pay for them
- ➢ MN & PA Medicaid pay FFS for CHW services

Pay for volume vs. pay for value

Pay for volume: Traditional payment and delivery system rewards providers for providing more services and more expensive services

- Health care costs rising
- Payers hesitate to cover new services because of cost

Pay for value: Reward providers for providing high quality care (evidence-based practices, healthier patients, better patient experience) and containing costs

- Hold provider organizations **accountable** for quality and cost
- *Can pay for new services that improve quality and contain cost*

Accountable Care Organizations/ Advanced Networks (ACOs/ANs)

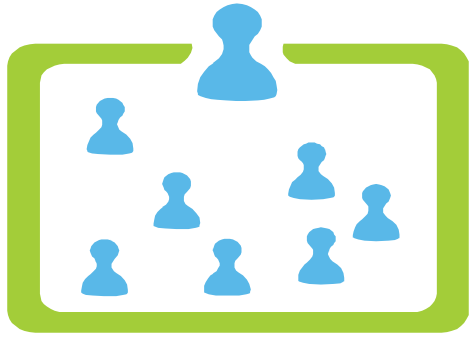
Payer (Medicare, Medicaid, Anthem, etc.) pays ACO through accountable payment arrangements

$ $

In Connecticut, **Advanced Networks** are groups of providers that have entered into at least one accountable payment arrangement.

Providers join together into ACOs

Accountable Care Organizations (ACOs)



CMS/Medicare definition:

"**Accountable Care Organizations (ACOs)** are:

- groups of doctors, hospitals, and other health care providers,
- who come together voluntarily
- to give coordinated high quality care

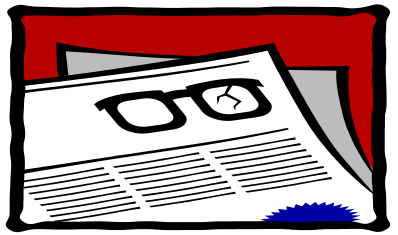
"The goal of **coordinated care** is to ensure that

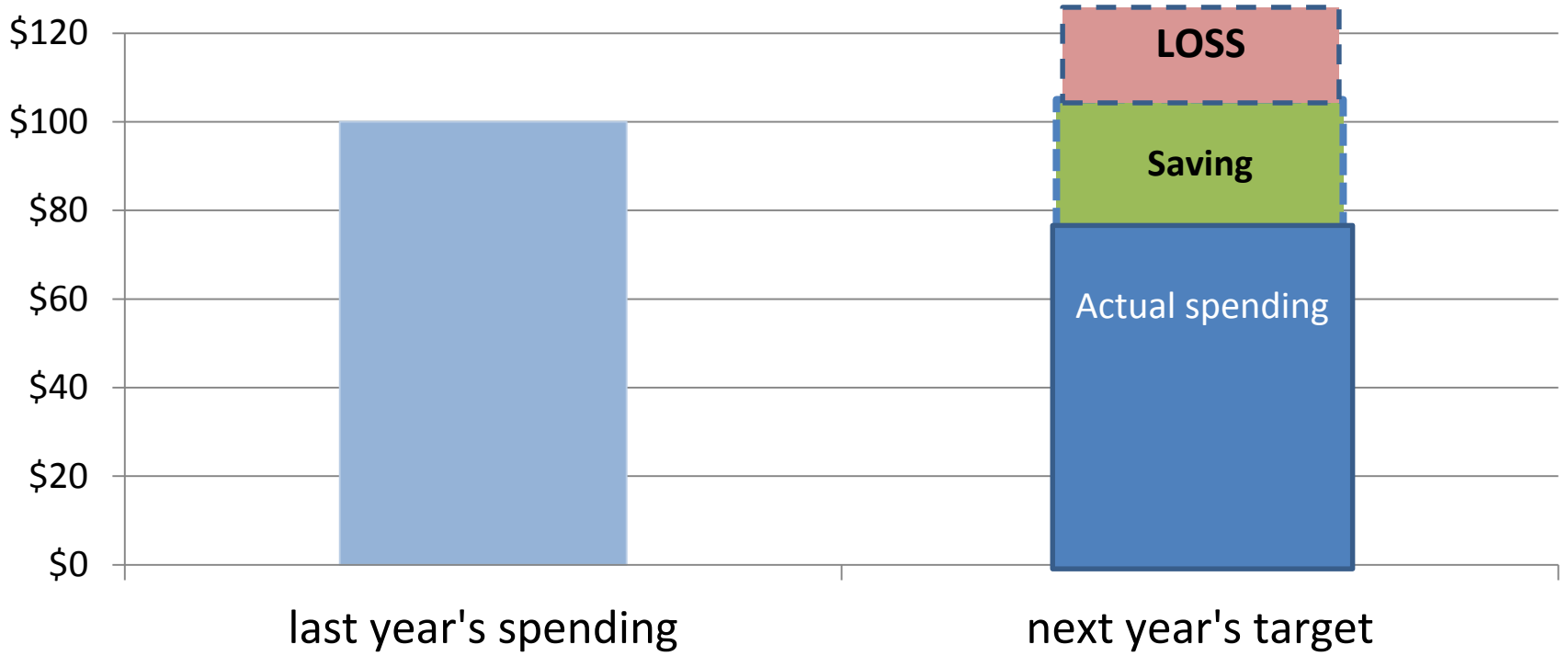
- patients, especially the chronically ill,
- get the right care at the right time,
- while avoiding unnecessary duplication of services and preventing medical errors."

Source: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

Key Terms: Financial Risk

Financial risk: Assuming liability for the financial loss that could occur if actual costs exceed expected costs (shared savings and losses)





Alternative Payment Models: Overview

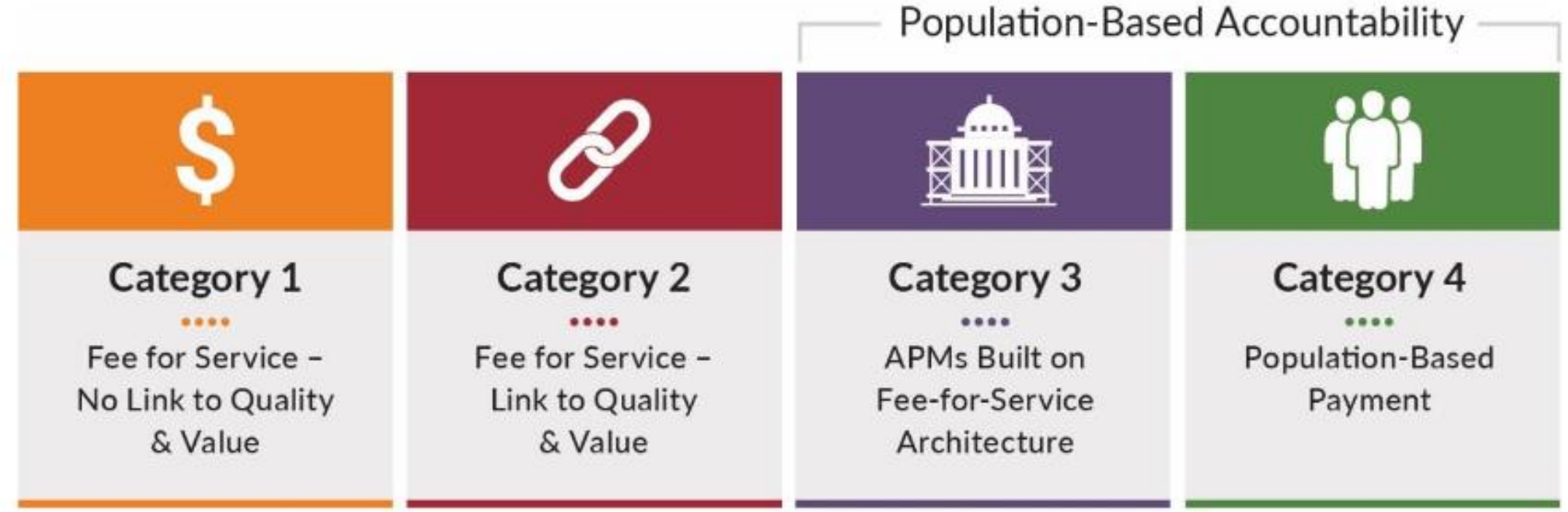
1. Pay for Performance (P4P)
2. Shared Savings
3. Primary Care Payment Bundle
4. Global Payment

Opportunity

Alternative payment models:

- Aim to reward providers for outcomes rather than volume of service provided
- Give providers flexibility to provide care that best meets patients' needs
- Support preventive care that helps to contain total health care costs

HCP LAN Alternative Payment Model Framework



Alternative Payment Model (APM) Framework and Progress Tracking Work Group

Payment Method 1: Fee for Service

Definition: Health care providers receive a separate fee for each service they deliver

Payers often establish a fee for each service code, for example:

- Physician visit, new patient
- Physical therapy 15 minutes
- Hospital stay for asthma

- ➢ Providers only paid for covered services
- ➢ There are codes for CHW services, but most payers won't pay for them
- ➢ MN & PA Medicaid pay FFS for CHW services

Payment Method 2: Pay for Performance

Definition: Providers receive bonus payments for meeting specific quality improvement goals or targets

Category 2

Fee for Service – Link to Quality & Value

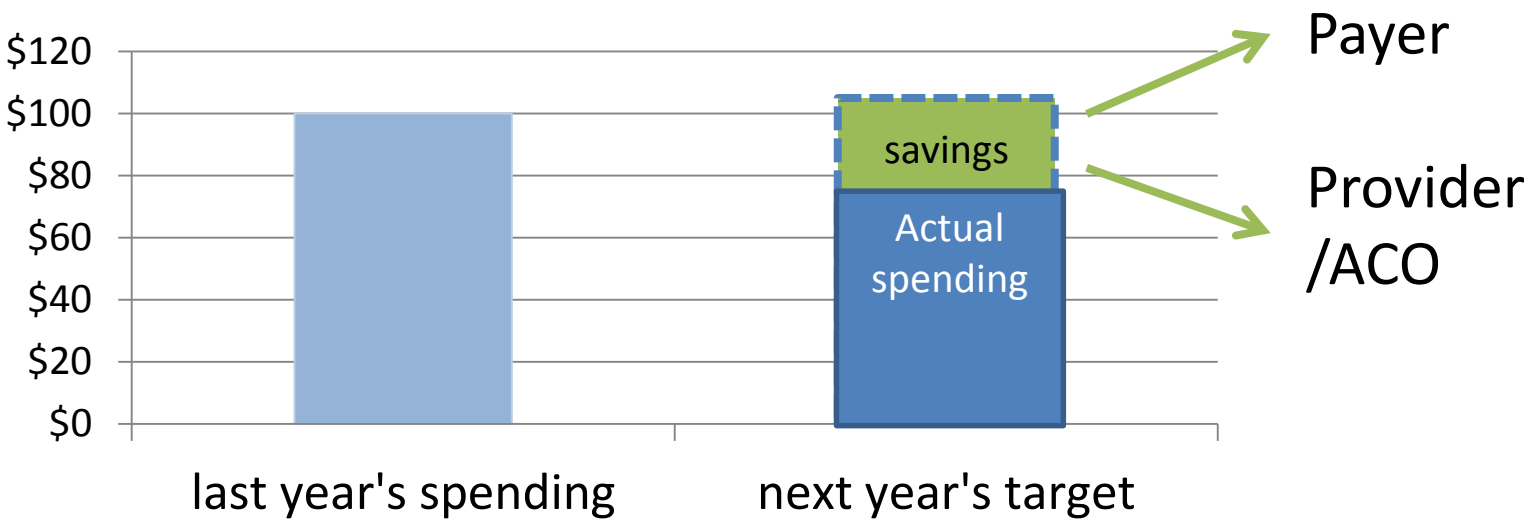
For example, a provider might receive a bonus for:

- Increasing by 10% the share of patients with diabetes who have good glycemic control (HbA1c < 7%)
- Ensuring 95% of patients with asthma have an Asthma Action Plan

- *Providers can invest in services that help achieve these outcomes and bonus payments can pay for those services*
- Providers receive bonus after end of year
- **Connecticut Example: Medicaid PCMH Program**

Payment Method 3: Shared Savings

Definition: Savings that accrue - when actual spending for a population is less than a target amount - are shared between the payer and the provider/ACO



Category 3

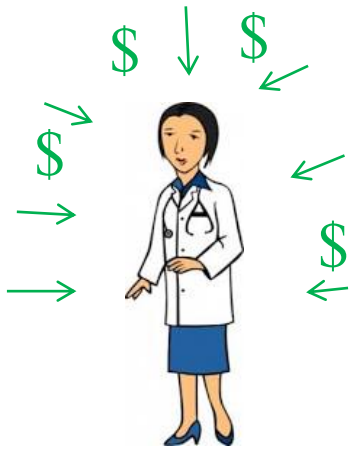
APMs Built on Fee-for-Service Architecture

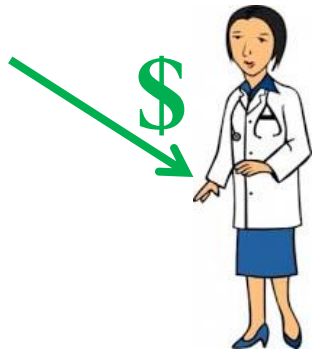
- *Providers can invest in services that produce savings*
- Providers receive savings after end of year
- **Connecticut example: PCMH+**

Payment Method 4: Primary Care Bundled Payment

Definition: A portion or all primary care payments are bundled into one payment to cover primary care services.

- *Provider has flexibility to invest in CHW and other services to support primary care needs.*
- Only provides flexibility for care delivery changes in primary care.
- May be administratively difficult depending on portion of primary care that is bundled.





Category 3

APMs Built on Fee-for-Service Architecture

Category 4

Population-Based Payment

Payment Method 5: Global Payment

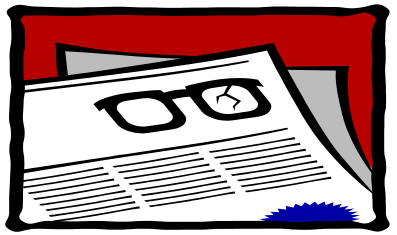
Definition: a fixed-dollar payment for **all** the care that a group of patients receive in a given time period, such as a month or year.

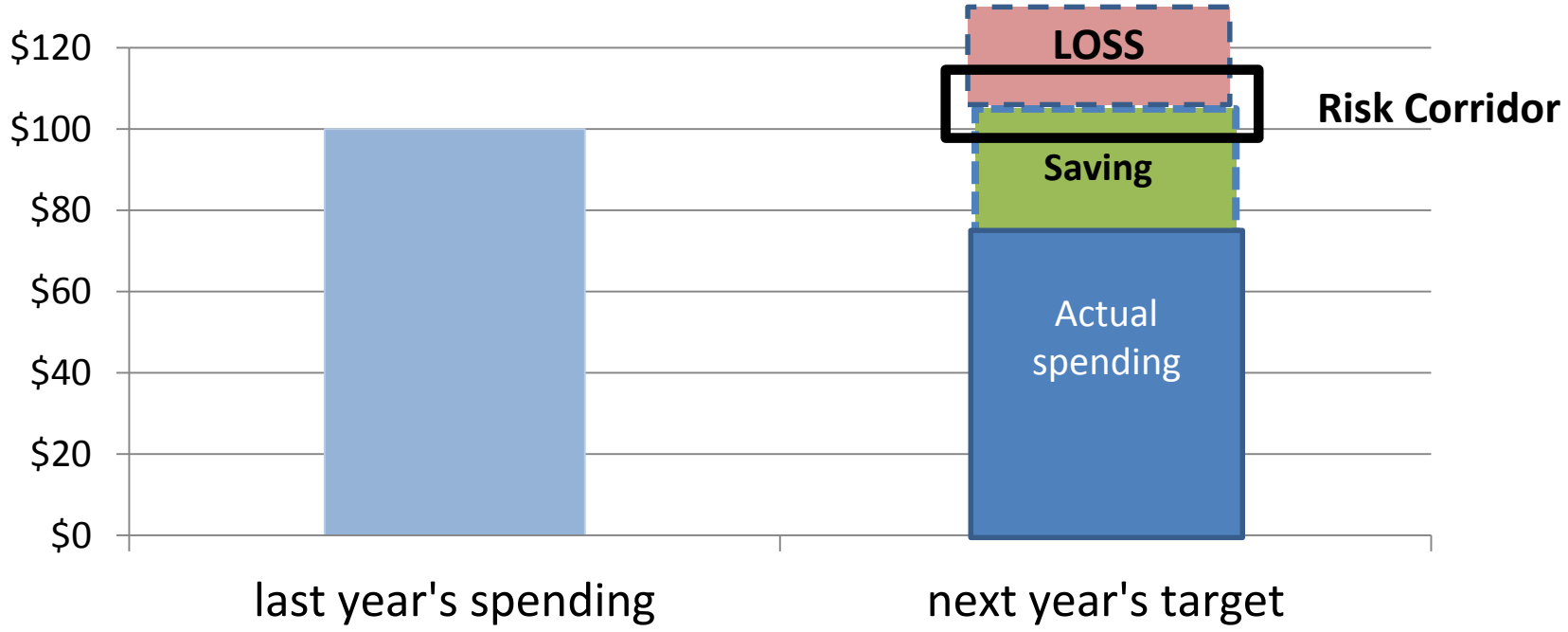
- Providers are at **financial risk** for both the occurrence of medical conditions (whether people get sick) as well as the management of those conditions (providing services)
- Because of financial risk, usually paid to a large organization like an ACO/AN
- *Flexibility to provide services that best meet patients' needs*

Source: Adapted from "Payment Reform: Bundled Episodes vs. Global Payments: A debate between Francois de Brantes and Robert Berenson." Timely Analysis of Immediate Health Policy Issues, September 2012.

Key Terms: Risk Corridor

Risk corridor: A provision that limits a provider's financial losses or profits to a specified percentage above and below its break-even point, to prevent the provider from experiencing excessive profits or catastrophic losses.

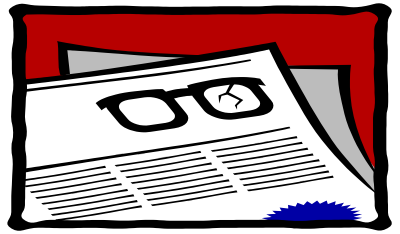


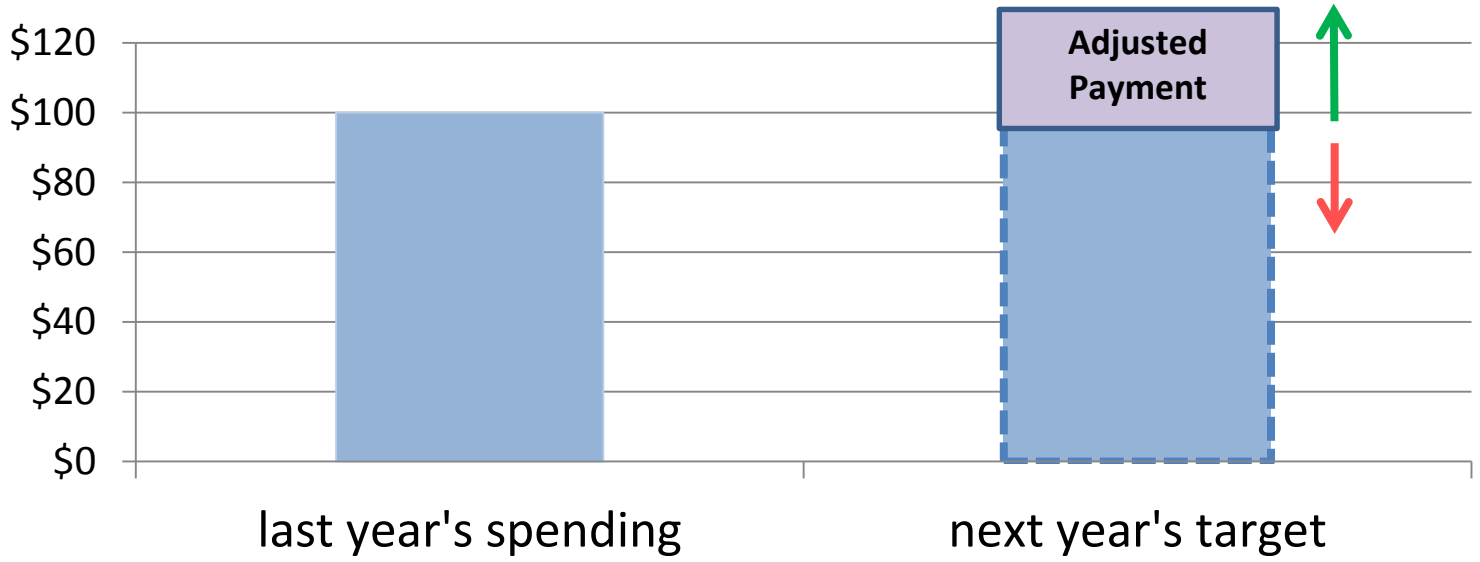


Source: Adapted from "Payment Reform: Bundled Episodes vs. Global Payments: A debate between Francois de Brantes and Robert Berenson." Timely Analysis of Immediate Health Policy Issues, September 2012.

Key Term: Risk Adjustment

Risk adjustment: A process of adjusting payments to providers (up or down) to reflect patient characteristics, especially health status, age, sex, and other demographic characteristics.

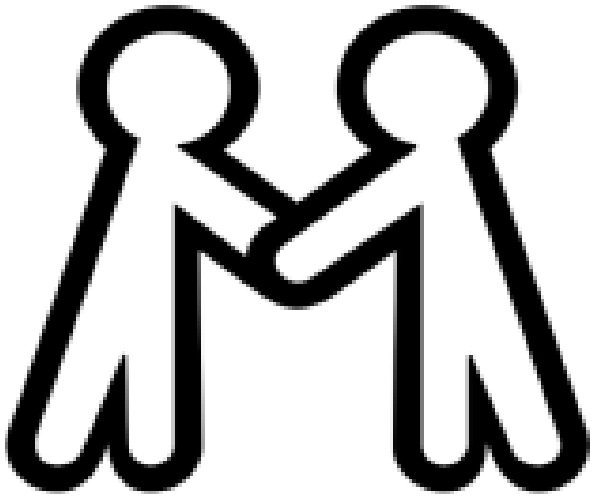




Source: Adapted from "Payment Reform: Bundled Episodes vs. Global Payments: A debate between Francois de Brantes and Robert Berenson." Timely Analysis of Immediate Health Policy Issues, September 2012.

How do CHWs fit into these changes?

- Accountable Care means that providers are responsible for quality and outcomes. CHWs can provide the needed services to help achieve those outcomes.
- More flexible payment methods allow providers to pay for CHW services.



Connecticut Landscape- Healthcare Reform

- 17-18 Advanced Networks
- About 85% of patients from the largest payer are in accountable payment arrangements
- Shared Savings is the alternative payment model being used in most cases
  - Medicare Shared Savings (MSSP)
  - Commercial Shared Savings
  - Medicaid Shared Savings (PCMH+)

Beyond Shared Savings- Where can we go next?

1. Shared Savings plus Advance Payments
2. Shared Savings with Primary Care Bundles (and Advance Payments)
3. Global Budgets

Alternative Payment Models: Beyond Shared Savings

Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings

Shared Savings plus Advance Payments

Shared Savings with Primary Care Bundles and Advance Payments

Global Budgets

CHW Advisory Committee Recommended (CPC+)

Dr. Neil’s Primary Care Practice

What does Dr. Neil want to do?

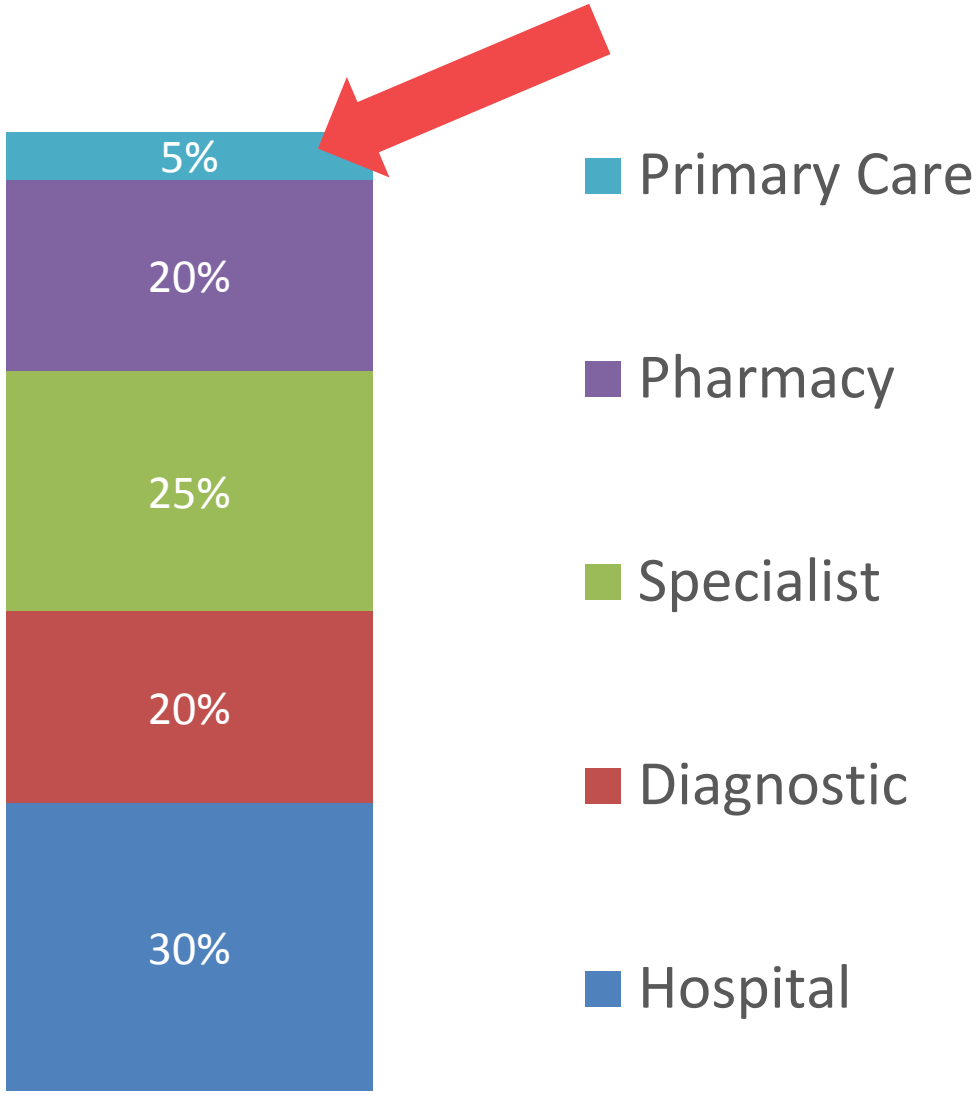
Patient Engagement and Support	Care Team Diversity
Phone contact	Community Health Worker
E-mail/text support	Social Worker
Telemedicine visits	Licensed BH clinician
Home visits	Pharmacists
E-consult	Nutritionist/dietician
Remote monitoring	Care coordinator
Group visits (illness self-management, prevention, lifestyle enhancement)	Health coach
Tweet/chats/on-line support groups	Patient navigator
Patient/family advisory council	Nurse Care Manager
Communication with child care/school	
Transportation	

Why can’t Dr. Neil deliver care in the way she would like?

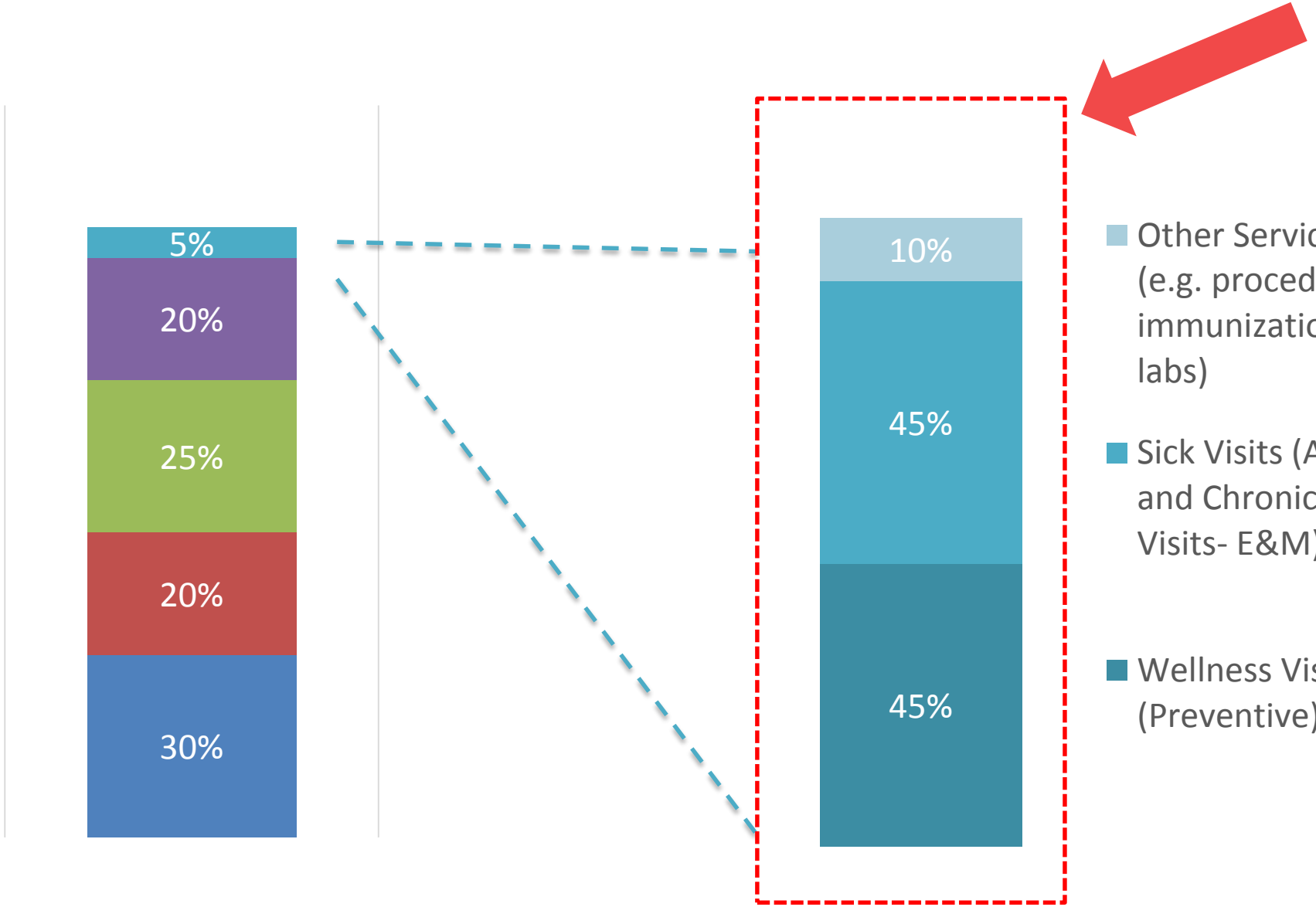
Primary Care Providers are limited in the way they can deliver care due to:

- **Low investment** compared to other areas of healthcare
- **Low flexibility** on payments – only paid for each billable services

What % of healthcare spending goes into Primary Care?



How do Primary Care Providers typically get paid?



QUALIDIGM

Alternative Payment Models: Beyond Shared Savings

Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings

Shared Savings plus Advance Payments

Shared Savings with Primary Care Bundles and Advance Payments

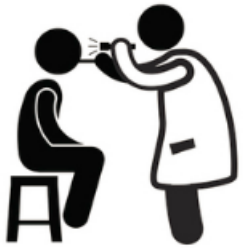
Global Budgets

How has Dr. Neil gotten paid for most of her career?

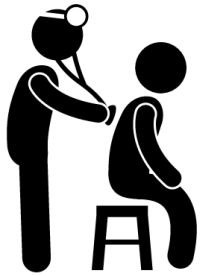
SIM connecticut state innovation model

Payment Method 1: Fee for Service

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

Opportunities and Limitations

No risk of under-service

Only paid for visit-based services

Alternative Payment Models: Beyond Shared Savings

SIM connecticut state innovation model

Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings

Shared Savings plus Advance Payments

Shared Savings with Primary Care Bundles and Advance Payments

Global Budgets

How does Dr. Neil currently get paid?

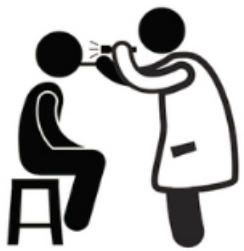
SIM connecticut state innovation model

Category 2

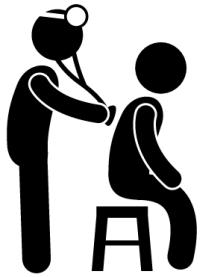
Fee for Service – Link to Quality & Value

Payment Method 2: Pay for Performance

Types of Payment



Each Sick Visit



Each Wellness Visit

Each service like Immunizations

Bonus Payments for Quality Care- **received after end of the year**

Opportunities and Limitations

Bonus Payments can support non-visit based activities and care coordination staff.

Bonuses typically limited in amount, long wait, and not guaranteed.

Alternative Payment Models: Beyond Shared Savings

SIM connecticut state innovation model

Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings

Shared Savings plus Advance Payments

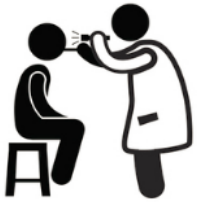
Shared Savings with Primary Care Bundles and Advance Payments

Global Budgets

How might Dr. Neil get paid?

Payment Method 3: Shared Savings

Types of Payment



Each Sick Visit

Each Wellness Visit

Each service like Immunizations

Shared Savings Payments for Quality & Cost- **Received after end of the year**

Shared Savings: Opportunities and Limitations

+ Opportunities
  - Return on Investment for improved healthcare outcomes
  - Limited financial risk for the provider
  - Minimal risk of under-service
  - First step toward value-based care

− Limitations
  - Providers may not invest, because savings are uncertain and take a long time
  - Lack of capital for up-front investments needed to improve care
  - Only supports practice changes that yield substantial ROI in 1-3 years
  - Limited flexibility to make substantial care delivery changes due to fee-for-service infrastructure
  - Not sustainable- limitations on how much can be saved over time
  - Does not address rising healthcare costs due to fee-for-service infrastructure
  - Only supports care delivery changes in the primary care office

Alternative Payment Models: Beyond Shared Savings

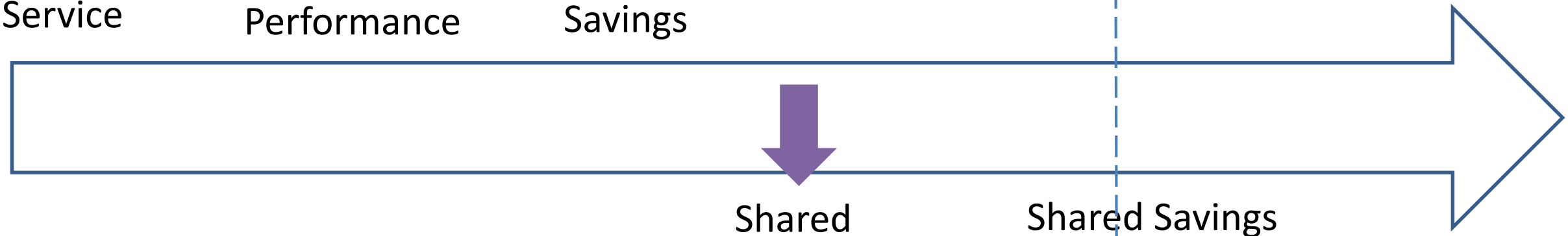
Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings



Shared Savings plus Advance Payments

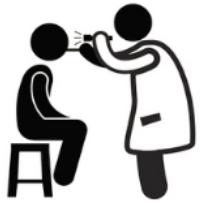
Shared Savings with Primary Care Bundles and Advance Payments

Global Budgets

How might Dr. Neil get paid?

Payment Method 3.1: Shared Savings with Advance Payments

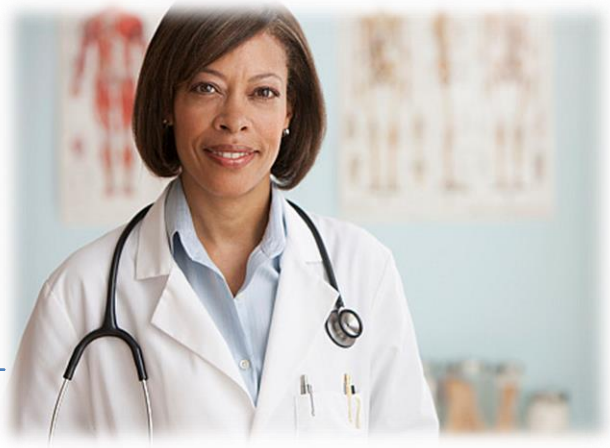
Types of Payment



Each Sick Visit

Each Wellness Visit

Each service like Immunizations



Shared Savings Payments for Quality & Cost- **Received after end of the year**

Enhanced Payment, i.e. Care Management Fee

Shared Savings with Advance Payments: Opportunities and Limitations

+ Opportunities

- Return on Investment for improved healthcare outcomes
- Limited financial risk for the provider
- Limited risk of under-service
- First step toward value-based care
- Some capital to make up-front investments needed to improve care

– Limitations

- Savings are difficult to predict so ROI is uncertain
- Only supports practice changes that yield substantial ROI in 1-3 years
- Limited flexibility to make substantial care delivery changes due to fee-for-service infrastructure
- Not sustainable- limitations on how much can be saved over time
- Does not address rising healthcare costs due to fee-for-service infrastructure
- Only supports care delivery changes in the primary care office

Alternative Payment Models: Beyond Shared Savings

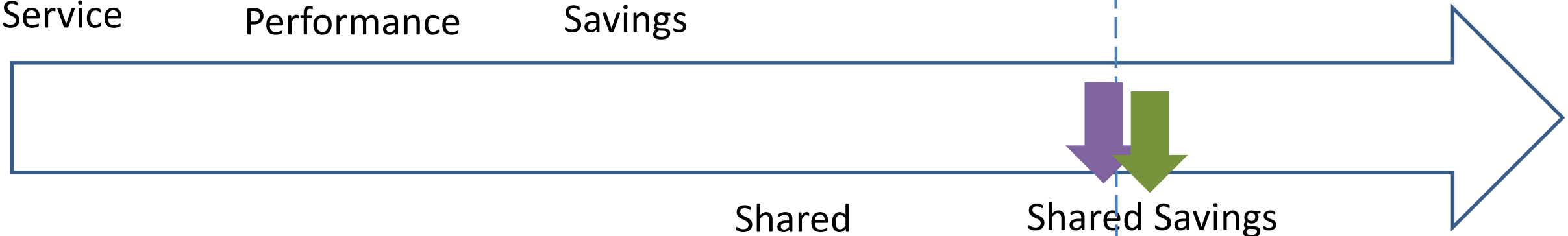
Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings



Shared Savings plus Advance Payments

Shared Savings with Primary Care Bundles and Advance Payments

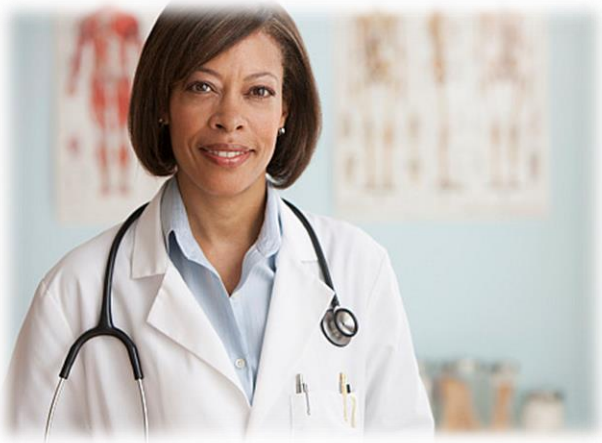
Global Budgets

How might Dr. Neil get paid?

Payment Method 4: Shared Savings with Primary Care Bundles & Enhanced Payments

Types of Payment

Primary Care Bundle



Shared Savings Payments for Quality & Cost- for services not included in bundle

Enhanced Payment, i.e. Care Management Fee

Shared Savings with Primary Care Payment Bundles & Advance Payments

+ Benefits

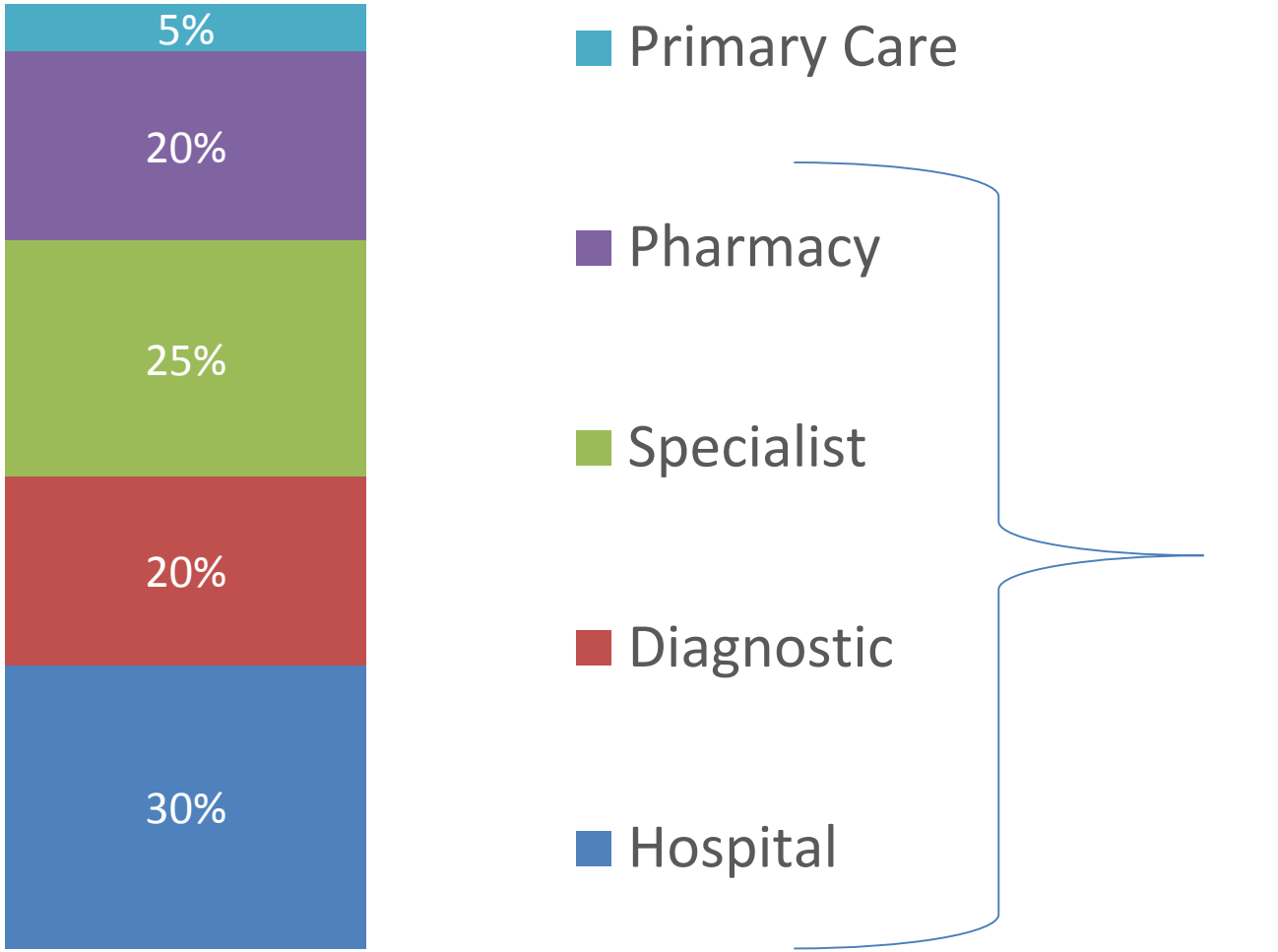
- Return on Investment for improved healthcare outcomes
- Some capital to make up-front investments needed to improve care
- More flexibility to make needed changes to delivery of primary care services
- Less dependency on shared savings
- May provide incentive for changes that yield longer-term ROI

– Limitations

- Limited flexibility *outside of primary care* to make substantial care delivery changes due to fee-for-service infrastructure
- Not sustainable- limitations on how much can be saved over time
- Does not address rising healthcare costs due to fee-for-service infrastructure
- Only supports care delivery changes in the primary care office
- Some financial risk for the provider
- Some risk of under-service
- Can be administratively complex

~~What % of healthcare spending goes into Primary Care?~~

What about the rest of our healthcare spending?



How can we change other areas of healthcare spending to improve care delivery?

Alternative Payment Models: Beyond Shared Savings

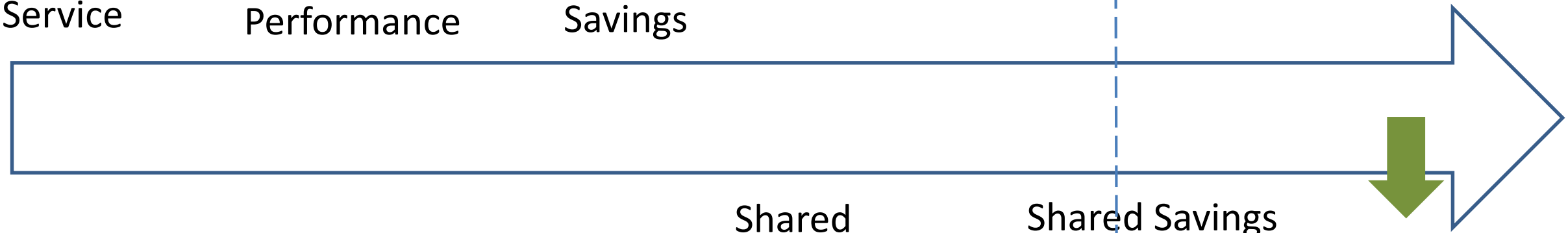
Built on Fee-for-Service Infrastructure

Population-based Payments

Fee-for-Service

Pay for Performance

Shared Savings



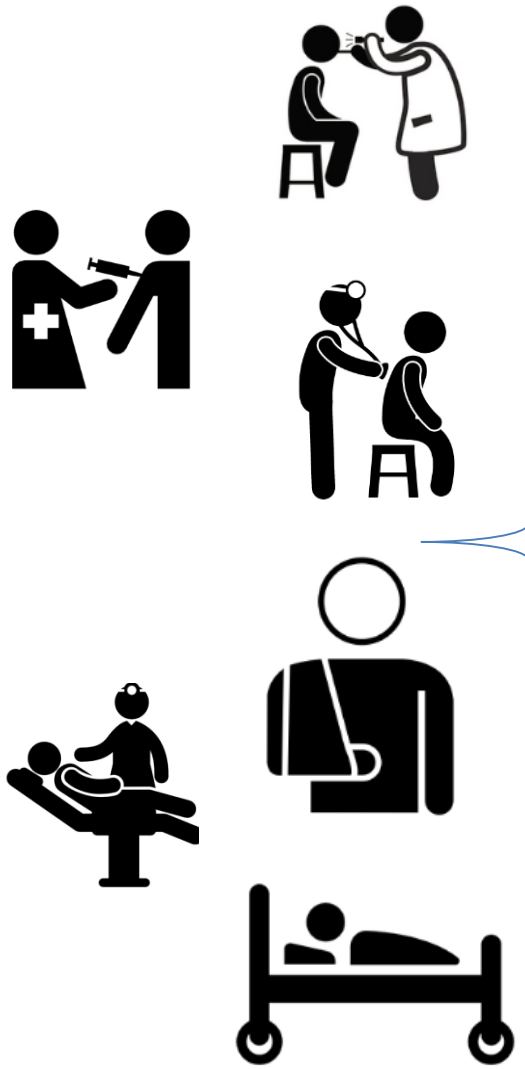
Shared Savings plus Advance Payments

Shared Savings with Primary Care Bundles and Advance Payments

Global Budgets

How might Dr. Neil get paid?

Payment Method 5: Global Payments



Types of Payment

Global Payment for all care provided for a patient, within defined scope. Shared across provider network.

Global Budgets

Benefits

- Return on Investment for improved healthcare outcomes
- Prospective payments allow for needed investments
- Most autonomy and flexibility for hospitals to make needed care delivery changes due to global payment
- Incentivizes changes that yield longer-term ROI
- Sustainable- ROI does not depend on savings
- Addresses rising healthcare costs
- Supports care delivery changes across all healthcare settings
- Not administratively complex

Limitations

- Significant financial risk for the provider network
- More potential for under-service
- Can reinforce poor care delivery processes if the budget is based on historical trends
- To achieve maximum benefit, requires multi-payer participation or single-payer model

CHW Recommendations on Primary Care Payment Models

The CHW Advisory Committee recommends the following related to Primary Care Payment Models in Connecticut.

- Primary care payment reform models can provide an opportunity to sustainably finance CHWs as members of the care team.
- Primary care payment reform should include a requirement that providers incorporate Community Health Workers into their care teams.
- During the course of the Advisory Committee's work, the Centers for Medicare and Medicaid Innovation (CMMI) released a solicitation for the Comprehensive Primary Care + (CPC+) initiative, in which public and private payers were invited to participate with Medicare in a value-based primary care payment reform arrangement. Recognizing the merits of the CPC+ model and the significance of this opportunity to engage Medicare in primary care payment reform arrangement, the Committee recommended that Connecticut's payers apply. This recommendation was ultimately narrowed to include commercial payers only in light of the administration's position on Medicaid participation.

Question for Discussion

Do global budgets offer an opportunity for sustainable funding for Community Health Workers?

Next Steps

Next Steps

- The CHW Team will distribute the Report of the CHW Advisory Committee containing Recommendations on:
  - Definition
  - Scope of Practice
  - Certification
  - Sustainable Funding
- The Committee will share feedback and recommended edits to the Report and discuss changes during the June 28 Meeting.
- The Report will be shared with the Steering Committee on July 13, and released for public comment if approved.

Adjourn

Appendices

Appendix A. CT Health Care Cabinet CCO Recommendation

Global Budgets: Health Care Cabinet Recommendations

- Establish Consumer Care Organizations
- CCOs would be responsible for the Total Cost of Care of Medicaid beneficiaries and State employees
- CCOs would be required to meet a minimum set of standards demonstrating the quality and cost effectiveness of their care delivery efforts
- CCOs would be paid through value-based payment arrangements that would progressively move further along the continuum of global, population-based payments

Appendix B. Massachusetts Payment Models

CHW services can provide benefits to a variety of stakeholders

Individuals

- Better experience
- Better quality of life
- Lower out-of-pocket costs
- Fewer missed work days

Providers

- Improved patient communication
- Better patient outcomes
- Meet quality targets

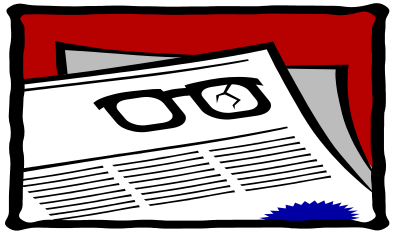
Society

- Lower health care costs
- Increased work productivity and school attendance
- CHW jobs created

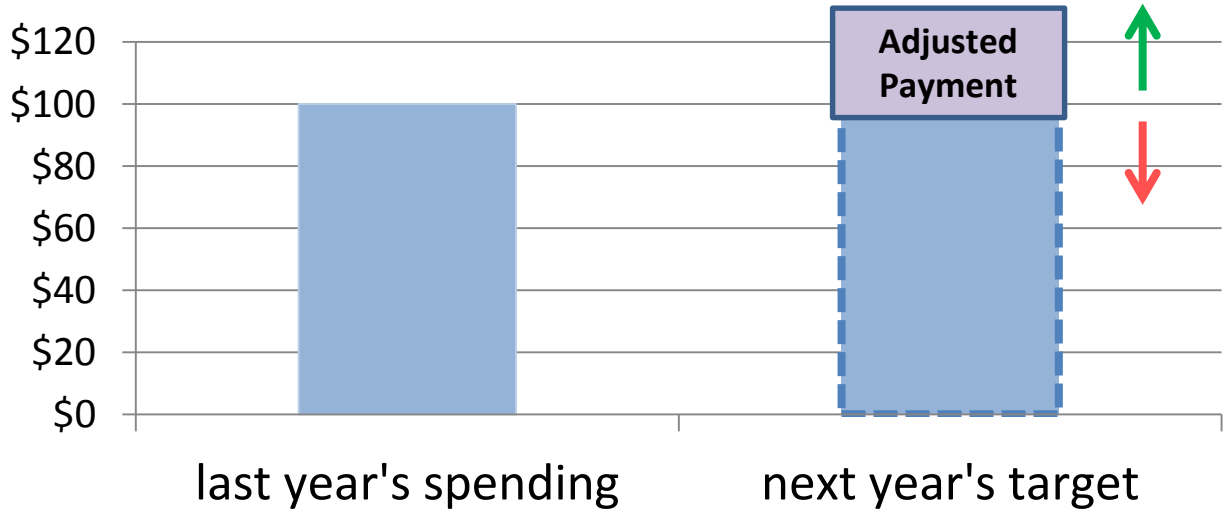
Payers

- Improved quality scores
- Positive ROI

Risk Adjustment



MassHealth adjusts payments to each MCO and ACO (up or down) to meet its members' expected need for health care resources



MassHealth risk adjustment - new method

New method adjusts payments to address social determinants of health, avoid penalizing providers in disadvantaged neighborhoods

Variables included in risk adjustment	Sample additional payment per member
All Managed Care	$5000
[adjustments for age, sex, geography, diagnoses]	varies
DMH client	$13,650
DDS client (not DMH)	$2,550
All other disabled	$1,400
Serious mental illness (SMI)	$2,250
Substance use disorder (SUD)	$2,000
Homeless (coded in claims) or Unstable housing (3+ addresses)	$550
Neighborhood stress score*	$50

* Neighborhood Stress Score is a measure of how stressed a neighborhood (census block) is relative to other neighborhoods in terms of share of adults who have low income, are unemployed, receive public assistance, have no car, are a single parent, have less than a HS education

Risk adjustment – hypothetical example

ACOs that serve different populations would receive different payments

	ACO 1: lower risk patient pool	ACO 2: higher risk patient pool
Number of patients	1000	1000
Base payment	$5,000,000	$5,000,000
Adjustments		
All BH	$293,000	$1,171,900
Unstable housing	$31,700	$126,700
Neighborhood stress	($100,000)	$100,000
Total payment	$5,224,700	$6,398,600

- *ACO 2 could use its additional revenues to pay for services to address its patients' special challenges*

Flexible Services

- ACOs may provide community goods/services that address health-related social needs
- Includes services not otherwise covered under Massachusetts' Medicaid benefits
- Must be pre-approved by MassHealth
- Different ACOs may choose to address different needs
- Address social determinants of health in the following areas:

1. Transition services for individuals transitioning from institutional settings into community settings	**4. Home and Community-Based Services to divert individuals from institutional placements**
2. Services to maintain a safe and healthy living environment	**5. Physical activity and nutrition**
3. Experience of violence support	**6. Other individual goods and services**

➢ *Flexible services may include CHW services*

Source: EOHHS, MassHealth Delivery System Restructuring Open Meeting, March 2017, Boston, MA and Springfield, MA.

Community Partners (CPs)

"Certified Community Partners (CPs)
are **community-based organizations**
that offer members linkages and support
to **community resources** that facilitate
a coordinated, holistic approach to care"

- Waiver Extension, STC 63

Community Partner Functions

BH CP Functions

1. **Outreach and active engagement;**
2. **Facilitate access and referrals to social services, including following-up on flexible services;**
3. **Provide health and wellness coaching;**
4. Conduct comprehensive assessment and person-centered treatment planning;
5. Identify, engage, and facilitate member's care team;
6. Coordinate services across continuum of care; and
7. Support transitions of care between settings

LTSS CPs Functions

1. **Outreach and engagement;**
2. **Facilitate access and referrals to social services, including following-up on flexible services;**
3. **Provide health and wellness coaching;**
4. Perform LTSS care planning and choice counseling;
5. Participate on enrollee's care management team, as directed by the member; and
6. LTSS care coordination and support during transitions of care

➢ *CPs can use CHWs to provide some of these functions*

Source: EOHHS, MassHealth Delivery System Restructuring Open Meeting, March 2017, Boston, MA and Springfield, MA.

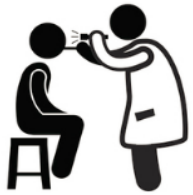
Appendix C. Primary Care Payment Bundle Options

Option 1: Partial E&M (Sick Visit) Bundle

Types of Payment

Care Management Fee– **Up front, flexible**

Other Services like Immunizations



E&M (Sick Visit) Partial Bundle- **Up front, flexible**

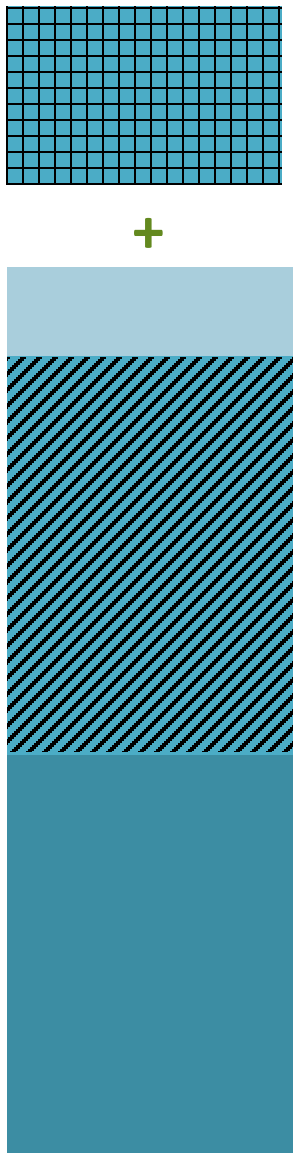
E&M- Each Sick Visit- lower amount

Each Wellness Visit

How flexible?

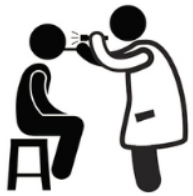
Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Some flexibility to support non-visit based care.

Option 2: Full E&M (Sick Visit) Bundle



Care Management Fee– **Up front, Flexible**

Other Services like Immunizations



E&M (Sick Visit) Bundle- **Up front, Flexible**

~~E&M Each Sick Visit lower amount~~

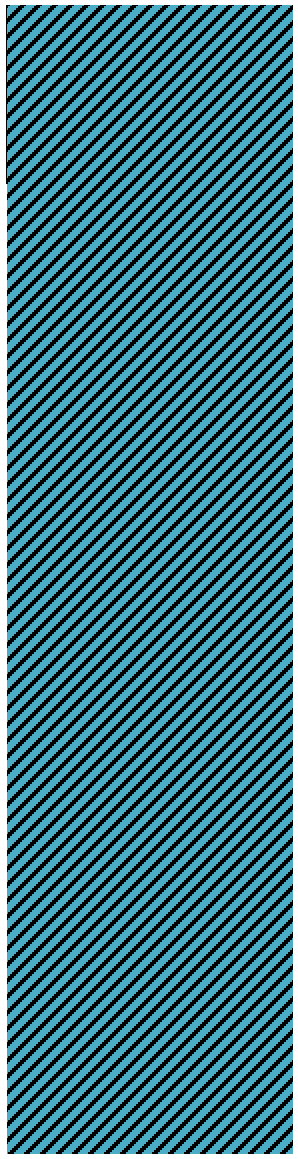
Each Wellness Visit

Types of Payment

How flexible?

Up-front, flexible payments can support email, telephone, video & group visits; home visits; CHWs, BH specialists, and other staff. Even more flexibility to support non-visit based care. Potential for visit under-service.

Option 3: Full Primary Care Bundle



Types of Payment

Full Primary Care Bundled Payment- Up Front, Most Flexible

How flexible?

Payments can support any services, activities or staff to support patients. This is the most flexible model. Potential for under-service