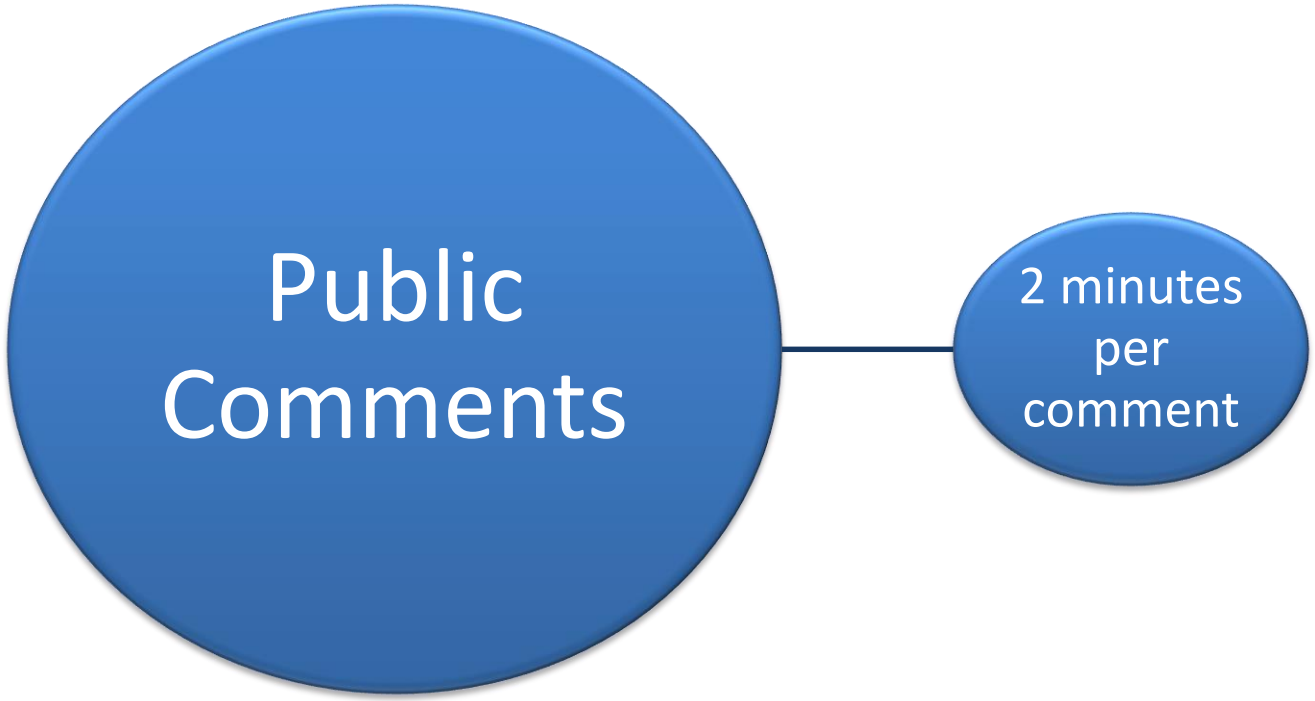
Healthcare Innovation Steering Committee

June 9, 2016

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Approval of the Minutes	5 min
4. HIT Update	10 min
5. Value-Based Insurance Design Templates	35 min
6. Population Health Council Nominations	10 min
7. Quality Council Report	20 min
8. Medicaid Quality Improvement & Shared Savings Program Update	25 min
9. Adjourn	


Public Comments
2 minutes per comment

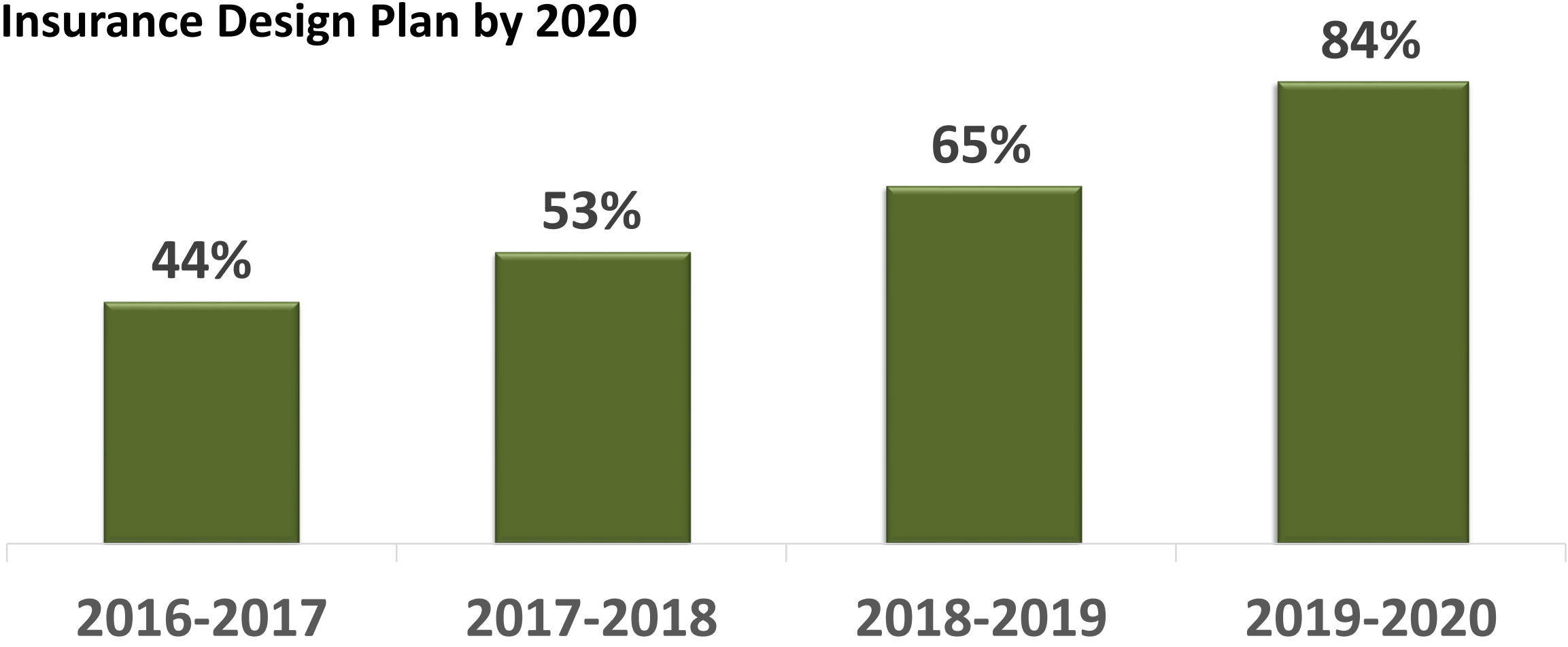
Approval of the Minutes

HIT Update

VBID Templates

Value Based Insurance Design- Goal

<u>Accountability Target</u>: 84% of insured population has a Value-Based Insurance Design Plan by 2020



NOTE: Targets subject to change based on baseline study

Value-Based Insurance Design- How do we reach our target?

1. **Design Insurance Templates for Employer Adoption**
2. Develop employer guidance to accompany templates
3. Host Learning Collaborative kick-off for employers and other stakeholders to learn about VBID implementation
4. Continue Learning Collaborative activities to encourage employer adoption

VBID Consortium- Composition

1 Department of Insurance
1 Access Health CT
5 Providers
5 Health Plans
5 Employer Representatives
5 Consumer Advocates
3 Employer Associations

VBID Consortium- Template Design Process

Consortium Activities:

- 4 Consortium Meetings, 1 Optional Meeting
- 2 Design Group Sessions

Employer and Health Plan Engagement Activities:

- 1 Survey
- 1 Employer Focus Group
- 3 Employer Association Interviews
- 3 National Employer Interviews (2 based in CT)
- 6 Health Plan Interviews

VBID Consortium Outputs- 2 Templates

Basic Template

Target Population: Fully insured Employers with a stable employee base

Expanded Template

Target Population: Self Insured Employers

Recommended Incentive Mechanisms

Plan Type	Incentive Mechanisms
All plans	○ Bonus payment for complying with recommended services ○ Reduced premium for complying with recommended services
Plans with copayment or coinsurance cost-sharing	○ Waived or reduced copayment or coinsurance for recommended services and drugs ○ Waived or reduced copayment or coinsurance for visit to high value provider
Health Savings Account-eligible High Deductible Health Plan (HSA-HDHP)*	○ Contribution to HSA for complying with recommended services or visiting high value provider
Health Reimbursement Account-eligible High Deductible Health Plan (HRA-HDHP)	○ Contribution to HRA for recommended services and drugs ○ Contribution to HRA for visit to high value provider ○ Exclusion of recommended services and drugs from deductible
All plans	○ Financial incentives external to health benefit plan designs, including gift cards, payroll bonuses, and other rewards programs

Incentive Structure

	Participatory	Outcomes-Based
All Members	Incentive for participating in recommended service	Rewards for participation in a program or meeting certain targets, including improving on or maintaining personal targets.
Targeted Members	Incentives for participation in chronic disease management program	Rewards for members with certain clinical conditions that participate in a program or meet certain targets

Basic Template- Recommended Components

1. Change Incentives for **Specific Services** for All Applicable Members, Targeted by Age and Gender

2. Change Cost Sharing for Specific **Prescription Drugs** for All Applicable Members

3. Implement Incentives For Visits To **High-Value Providers**

Expanded Template- Recommended Components

1. Implement incentives for **Specific Services** for All Applicable Members, Targeted by Age and Gender

2. Implement incentives For **Specific Services By Clinical Condition**

Consortium Points of Discussion

1. Disincentives for Low-Value Services- **not included at this time, in favor of a patient-provider education strategy incorporating Choosing Wisely principles.**

2. Outcomes-based incentives- **included as an option, with the understanding that outcomes can be defined as "improving" or "maintaining" certain health measures**

3. Incentives for High-Value providers- **included, with the understanding that "providers" may include hospitals and advanced networks**

Next Steps

1. Design Insurance Templates for Employer Adoption
2. **Develop employer guidance to accompany templates**
3. **Host Learning Collaborative kick-off for employers and other stakeholders to learn about VBID implementation**
4. **Continue Learning Collaborative activities to encourage employer adoption**

Appendix

Basic Template- Recommended Component 1

Change Incentives for **Specific Services** for All Applicable Members, Targeted by Age and Gender *Example: CT State HEP*

	Services	Applicable Members*
Recommended Core Benefit Design	Biometric and Mental Health Screenings	
	Blood Pressure Screening	Applicable members depending on age group and gender
	Cholesterol Screening	Applicable members depending on age group and gender
	Obesity Screening	Applicable members depending on age group and gender
	Depression Screening	Adolescents over 12 years and adults
	Alcohol Screening and Counseling	All adults
	Cancer Screenings	
	Breast Cancer Screening	Women depending on age group
	Cervical Cancer Screening	Women depending on age group
	Colorectal Cancer Screening	Applicable members depending on age group and gender

Basic Template- Recommended Component 2

Change Cost Sharing for Specific **Prescription Drugs** for All Applicable Members *Example: Marriott International decreased copays*

	Prescription Drugs	Applicable Members
Recommended Core Benefit Plan Design: Recommend employers choose at least two drug classes	Beta-blockers	All members prescribed drug for any indication
	ACE inhibitors and ARBs	
	Insulins and oral hypoglycemics	
	Long-acting inhalers	
	Inhaled corticosteroids	
	Statins	
	Anti-hypertensives	
	Anti-depressants	
	Smoking cessation drugs	

Basic Template- Recommended Component 3

Change Incentives For Visits To **High Value Providers**

Example: Pitney Bowes tiered networks

	Provider Type
Recommended Core Benefit Plan Design: Employers choose to incentivize visits to at least one of the following provider types	Network of providers who have been identified as high value based on performance on cost and quality metrics
	Providers who is part of an ACO identified as high value based on performance on cost and quality metrics
	Primary care physician or Patient Centered Medical Home that has been identified as high value based on performance on cost and quality metrics

Basic Template- Optional Component 1

Change Incentives for **Specific Supplemental Services** for **All Applicable Members**

	Supplemental Benefits	Applicable members
Suggested Additional Benefits	Treatment decision support/counseling	Members with conditions that have multiple treatment options with differing risks and benefits, e.g. lung cancer, breast cancer, depression, etc.
	Surgical decision support	Members undergoing elective surgeries that have other treatment alternatives, e.g. low back surgery, hysterectomy, hip or knee replacement, bariatric surgery, breast reduction surgery, etc.
	Chronic Disease Management program	Members with chronic diseases, e.g. diabetes, asthma/COPD, hypertension, depression, substance use disorders, congestive heart failure, coronary artery disease, etc.
	Pain Management	Members with chronic pain
	Healthy pregnancy program	Pregnant women
	Smoking Cessation	All members, as applicable
	Complex Case Management	Members with complex conditions, e.g. cancer

Expanded Template- Recommended Component 2

Change Incentives For **Specific Services By Clinical Condition**

Example: United Healthcare "Diabetes Health Plan"

	Chronic Conditions	Visits	Diagnostics	Drugs
Recommended Core Benefit Plan Design: Recommend employers target at least two conditions	Diabetes	• Office visits related to condition • Nutritional counseling • Smoking cessation	• HbA1c • Eye exams • Foot exams	• Insulin • Diabetic supplies • ACE inhibitors/ARBs
	Pre-diabetes	• Office visits related to condition • Nutritional counseling • Health coach • Smoking cessation	• HbA1c • Glucose test	• Anti-hypertensives • Metformin • Statins
	Asthma/COPD	• Office visits related to condition • Smoking cessation • Home visits	Spirometry	• Long-acting inhalers • Inhaled corticosteroids • Oxygen

Expanded Template- Optional Component 1

Change Incentives for **Supplemental Benefits** for **Members with Clinical Conditions**

Examples of Types of Supplemental Benefits

- Transportation to appointment(s)
- 90-day supply mail-order prescriptions for chronic conditions
- Virtual/audio/telephonic counseling or consultations
- Meals or other nutritional services
- Treatment Decision Support program

Expanded Template- Optional Component 2

Change Incentives for Services for **Members who Participate in Chronic Disease Management Programs**

Examples of Types of Disease Management Programs

- Disease-specific action plan
- Meetings with health coach or health educator for education on condition
- Medication adherence program
- Pharmacist counseling
- Nutritional counseling
- Behavioral health counseling
- Lifestyle change/wellness program specific to condition
- Weight management/weight loss program indicated for condition
- Smoking cessation program

Expanded Template- Optional Component 3

Change Incentives for **Specific Services** only **if delivered by High Value Provider**

	Provider Type	Conditions	Services
Suggested Additional Benefits	Center of Excellence	• Transplant surgery • Knee or hip replacement • Heart surgery • Obesity surgery • Substance use	• All care for specific condition • Medications for specific condition
	Narrow network of high performing providers for specific chronic conditions	• Coronary Artery Disease • Congestive Heart Failure • Diabetes • Hypertension • Cancer	• Office visits for condition • Medications for condition • Procedures for condition

Population Health Council Nominations

Personnel Subcommittee Nomination

- Elizabeth Torres, Bridgeport Neighborhood Trust

Consumer Advisory Board Nominations

- Patricia Baker, Connecticut Health Foundation
- Tekisha Everette, Health Equity Solutions
- Garth Graham, Aetna Foundation
- Lisa Honigfeld, Child Health and Development Institute
- Hyacinth Yennie, Maple Avenue Neighborhood Revitalization Group

Quality Council Report

Objectives of Today's Presentation

- Present a brief overview of:
  - Purpose
  - Quality Council membership
  - Process for selecting measures and timeline
  - Proposed core quality measure set
  - Implementation strategy
- Discussion
- Seek approval from Steering Committee to proceed with public comment

Purpose

Aligning Quality Measures & Promoting Meaningful Measures

Problem:

1. Too many measures
2. Little alignment on measures
3. Focus is on process rather than outcomes

Burdensome and ineffective for quality improvement efforts and performance transparency

SIM Quality Measure Alignment Initiative:

Work with payers to promote alignment across measures used in Alternative Payment Models in Connecticut, including promoting the use of electronic clinical Quality Measures

Participants

SIM Quality Council

Rohit Bhalla *Stamford Hospital*	Karin Haberlin *Dept. of Mental Health & Addiction Services*
Stacy Beck (replaced Aileen Broderick) *Anthem Blue Cross & Blue Shield*	Kathleen Harding *Community Health Center, Inc.*
Mehul Dalal *Department of Public Health*	Gigi Hunt *Cigna*
Mark DeFrancesco *Westwood Women's Health*	Elizabeth Krause *Connecticut Health Foundation*
Leigh Anne Neal (rep. Deb Dauser Forrest) *ConnectiCare*	Kathy Lavorgna *General Surgeon*
Steve Frayne *Connecticut Hospital Association*	Steve Levine *ENT & Allergy Associates, LLC*
Amy Gagliardi *Community Health Center, Inc.*	Arlene Murphy *Consumer Advisory Board*
Daniela Giordano *NAMI Connecticut*	Robert Nardino *American College of Physicians – CT Chapter*

SIM Quality Council

Thomas Wilson (replaced Donna O'Shea) *United Healthcare*	
Robert Zavoski *Department of Social Services*	
Jean Rexford *CT Center for Patient Safety*	
Rebecca Santiago *Saint Francis Center for Health Equity*	
Andrew Selinger *ProHealth Physicians*	
Todd Varricchio *Aetna*	
Steve Wolfson *Cardiology Associates of New Haven PC*	
Thomas Woodruff *Office of the State Comptroller*	

Break Out Groups

- Created three sub-groups in order to:
  - Provide the opportunity for in depth review outside of the full council meetings
  - Consolidate perspectives from 20+ individual members to 3 sub-group perspectives

Consumer Advocates

Physicians

Payers

Design Groups & Care Management Committee

Pediatric Design Group

Health Equity Design Group

Behavioral Health Design Group

Care Experience Design Group

Obstetrics Design Group

MAPOC
Care Management Committee

Technical assistance

- CMMI – National Opinion Research Center (NORC) at the University of Chicago, State Health Data Assistance Center (SHADAC) Center for Healthcare Strategies
  - CT comparison to other SIM states, readmission, care experience
- Yale – CORE (Center for Outcomes Research and Evaluation)
  - Readmission, hospital admission, avoidable ED, cardiac
- National Committee for Quality Assurance
  - Readmission, admission, ED use, base rates
- Leora Horwitz, MD, NYU
  - Readmission measures
- Other SIM states
  - Vermont, Delaware, Maine

Process

Timeline

December 2014

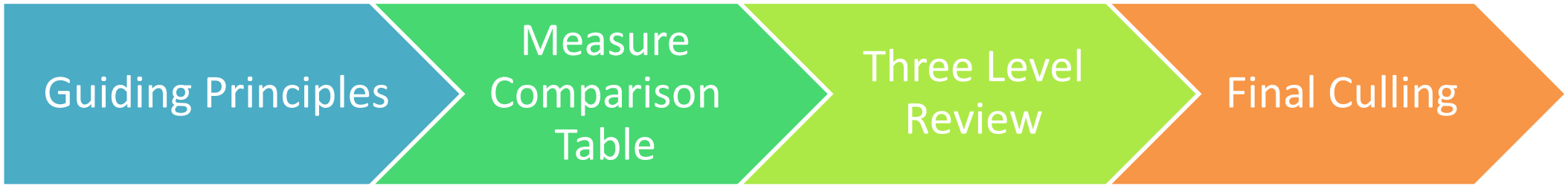
Planning Phase

June 2016

Alignment Process

2016 – September 2019 ➔

Key Activities



Considerations in choosing measures: Three Level Review

Level 1

- Is the measure part of the Medicare ACO SSP set?
- Does the measure address a significant population health concern based on prevalence?
- Does the measure address a health disparity concern?
- Is there another compelling reason that the measure should be used for SSP, e.g., the measure represents a known patient safety, quality, or resource efficiency/cost concern?

Level 2 (review all measures that pass level 1)

- Is the measure appropriate for VBP for Advanced network, FQHC, and/or ACO (e.g., eliminate measures recommended for individual clinicians, home health agencies, hospitals, etc.)
- Is the measure easily tied to QI efforts at the level of the Advanced Network/FQHC/ACO?
- If the measures within a performance domain or sub-domain (e.g., diabetes care) are in excess of what is necessary to demonstrate improved performance, retain those measures which serve as the best indicators of improvement.
- De-duplication
    - Is the measure the same or similar to another measure (e.g., “hospital admissions for asthma among older adults” is subsumed within “hospital admissions for COPD or asthma among older adults”)

Considerations in choosing measures: Three Level Review

Level 3 (for all measures that pass level 2)

- Culling
  - Is the measure a process measure for which an available outcome measure would better serve?
  - Is there an opportunity for improvement or does the measure represent an area where the state is already performing well (consider for significant sub-populations if known)
  - Is there likely to be sufficient variation among provider organizations?
  - Does measure meet feasibility, usability, accuracy and reliability standards (e.g., can the measure be reliably produced with available or SIM proposed technology?, is the data sufficiently complete and accurate to be tied to payment?, will the measure be useful for quality improvement?, are base rates likely to be sufficient?
  - If the number of performance areas or measures (e.g., diabetes care, epilepsy care) is too high, such that organizational focus and improvement would be compromised, Council will rank and retain the highest ranked areas.
- Check for conflicts w guiding principles
- Reconsider previously rejected measures if necessary

Action: Accept those that remain.

Considerations in choosing measures

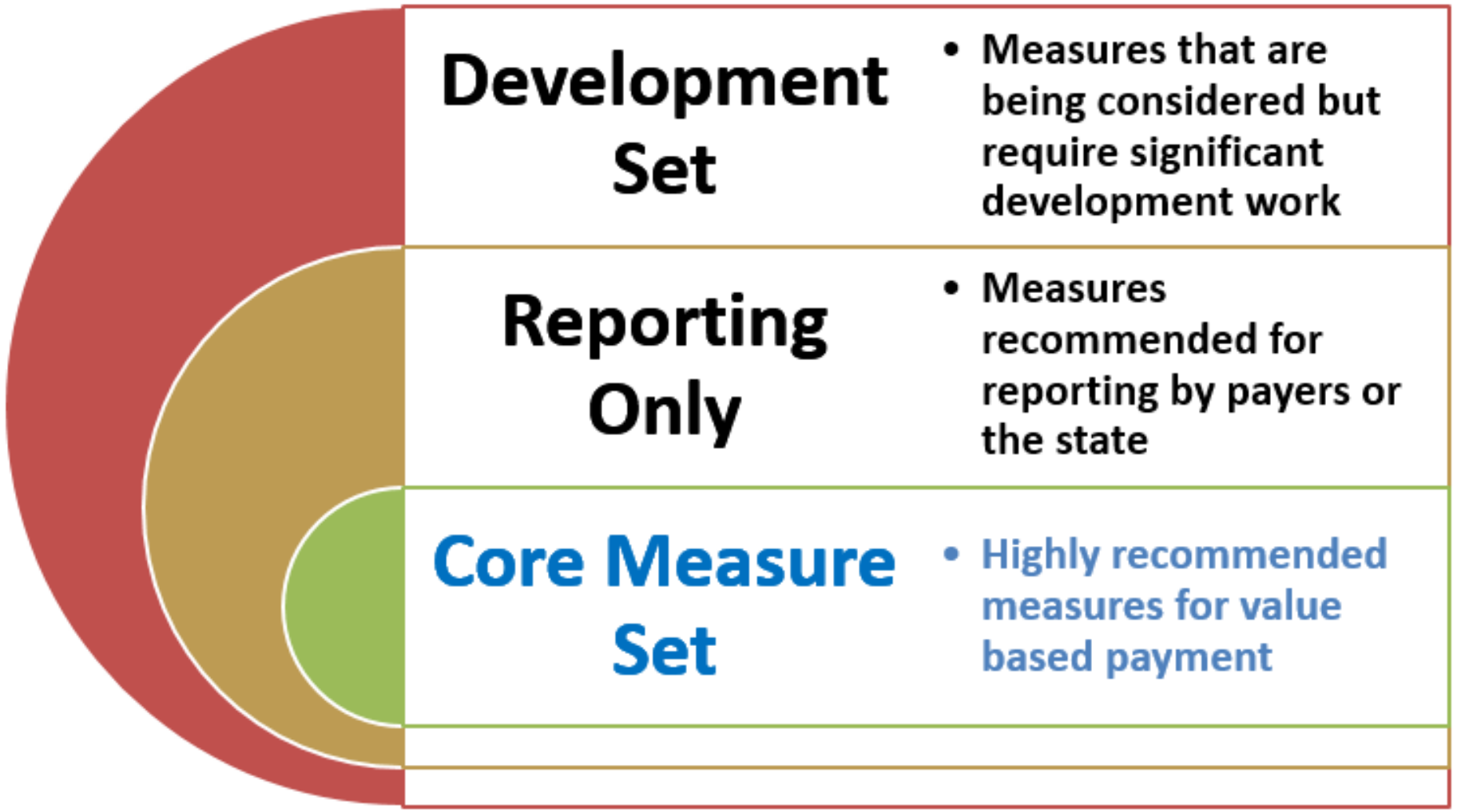
Used Robert Wood Johnson Foundation “Buying Value Tool” to rank measures based on criteria:

- Base rate sufficiency
- NQF endorsement
- Availability of an appropriate benchmark
- Opportunity for improvement
- Outcome vs. process measure
- Health Equity value

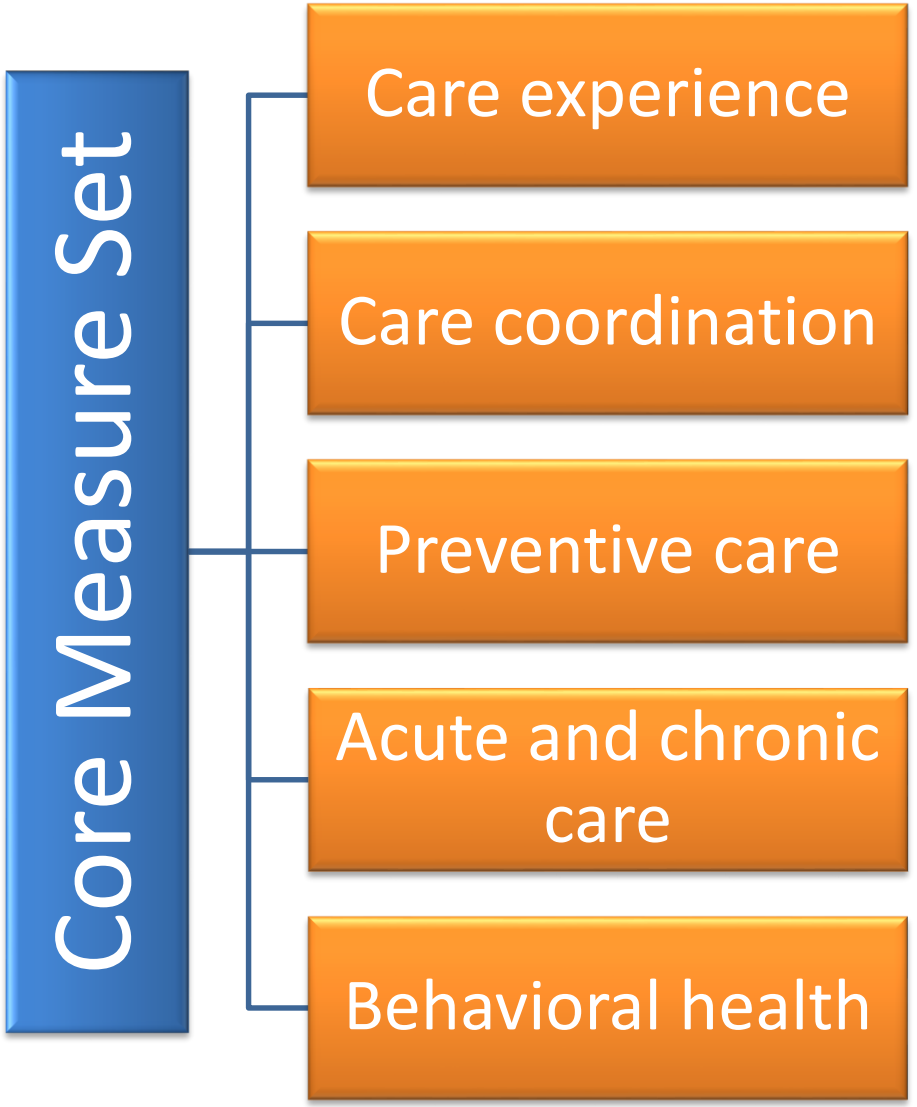
Special issues

- Care coordination measures and base rates
- OB/GYN measures
- HIV measures
- Oral health measures
- Meaningful use
- Cardiology measures
- Diabetes measures
- Core Quality Measures Collaborative

Three categories of measures



Quality Measure Alignment



QC Provisional Core Measure Set

Consumer Engagement
PCMH - CAHPS care experience measure
Care Coordination
Plan all-cause readmission
Annual monitoring for persistent medications
Prevention
Breast cancer screening
Cervical cancer screening
Chlamydia screening in women
Colorectal cancer screening
Adolescent female immunizations HPV
Weight assessment and counseling for nutrition and physical activity for children/adolescents
BMI screening and follow up
Developmental screening in first 3 years of life
Well-child visits in the first 15 months of life
Adolescent well-care visits
Tobacco use screening and cessation intervention
Prenatal Care & Postpartum care
Screening for clinical depression and follow-up plan
Behavioral health screening (Medicaid only)

Acute & Chronic Care
Medication management for people w/ asthma
DM: Hemoglobin A1c Poor Control (>9%)
DM: HbA1c Testing
DM: Diabetes eye exam
DM: Diabetes: medical attention for nephropathy
HTN: Controlling high blood pressure
Use of imaging studies for low back pain
Avoidance of antibiotic treatment in adults with acute bronchitis
Appropriate treatment for children with upper respiratory infection
Behavioral Health
Follow-up for children prescribed ADHD medication
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only)
Depression Remission at 12 Twelve Months
Progress towards depression remission
Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment
Unhealthy Alcohol Use – Screening

Provisional Core Measure Set

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Consumer Engagement						
1	PCMH – CAHPS measure**	0005		NCQA		✓	✓
	Care Coordination						
2	Plan all-cause readmission	1768		NCQA	Claims	✓	
3	Annual monitoring for persistent medications (roll-up)	2371		NCQA	Claims		
	Prevention						
4	Breast cancer screening	2372	20	NCQA	Claims		
5	Cervical cancer screening	0032		NCQA	Claims		
6	Chlamydia screening in women	0033		NCQA	Claims		
7	Colorectal cancer screening	0034	19	NCQA	EHR	✓	
8	Adolescent female immunizations HPV	1959		NCQA	Claims		
9	Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024		NCQA	EHR		
10	Preventative care and screening: BMI screening and follow up	0421	16	CMMC	EHR		
11	Developmental screening in the first three years of life	1448		OHSU	EHR		✓
12	Well-child visits in the first 15 months of life	1392		NCQA	Claims		✓
13	Adolescent well-care visits			NCQA	Claims		✓
14	Tobacco use screening and cessation intervention	0028	17	AMA/ PCPI	EHR		
15	Prenatal Care & Postpartum care***	1517		NCQA	EHR		✓
16	Screening for clinical depression and follow-up plan	418	18	CMS	EHR	✓	
17	Behavioral health screening (pediatric, Medicaid only, custom measure)			Custom	Claims		✓

Provisional Core Measure Set

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Acute & Chronic Care						
18	Medication management for people w/ asthma	1799		NCQA	Claims	✓	✓
19	DM: Hemoglobin A1c Poor Control (>9%)	0059	27	NCQA	EHR	✓	
20	DM: HbA1c Screening****	0057		NCQA	Claims		✓
21	DM: Diabetes eye exam	0055	41	NCQA	EHR		
22	DM: Diabetes: medical attention for nephropathy	0062		NCQA	Claims		
23	HTN: Controlling high blood pressure	0018	28	NCQA	EHR	✓	
24	Use of imaging studies for low back pain	0052		NCQA	Claims		
25	Avoidance of antibiotic treatment in adults with acute bronchitis	0058		NCQA	Claims		✓
26	Appr. treatment for children with upper respiratory infection	0069		NCQA	Claims		
	Behavioral Health						
27	Follow-up care for children prescribed ADHD medication	0108		NCQA	Claims		
28	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only)	2800		NCQA	Claims		✓
29	Depression Remission at 12 Twelve Months	0710	40	MNCM	EHR		
30	Depression Remission at 12 months – Progress Towards Remission	1885		MNCM	EHR		
31	Child & Adlscnt MDD: Suicide Risk Assessment	1365		AMA/ PCPI	EHR		
32	Unhealthy Alcohol Use – Screening			AMA/ PCPI	EHR		

Implementation

Implementation phase

- The State is encouraging public and private payers to consider adopting recommended measures in one of two ways:
  - as part of a standard measure set for all value-based payment contracts or
  - as part of a suite of measures that are included in value-based payment contracts when there is an opportunity for performance improvement. The State recognizes that there are measures in the core set that may not be applicable to all plans or all providers.
- Encourage payers to use measure set as a reference when negotiating or re-negotiating value-based payment contracts
- Care experience and Claims-based measures will be the initial focus of alignment. Measures that require collection of clinical data will require additional lead time
- Monitor the pace of quality measure alignment

Questions?

Approval to proceed with public comment

Appendix

Development Set

#	Development Set	NQF	ACO	Steward	Source
	Care Coordination				
1	ASC admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults	0275	9	AHRQ	Claims
2	ASC: heart failure (HF)	0277	10	AHRQ	Claims
3	All-cause unplanned admission for MCC		38	CMS	Claims
4	All-cause unplanned admissions for patients with heart failure		37	CMS	Claims
5	All-cause unplanned admissions for patients with DM		36	CMS	Claims
6	Asthma in younger adults admission rate	0283		AHRQ	Claims
7	Preventable hospitalization composite (NCQA)/Ambulatory Care Sensitive Condition composite (AHRQ)			NCQA/ AHRQ	Claims
8	Asthma admission rate (child)	0728			Claims
9	Pediatric ambulatory care sensitive condition admission composite			Anthem	Claims
10	ED Use (observed to expected) – New			NCQA	Claims
11	Annual % asthma patients (2-20) with 1 or more asthma-related ED visits				Claims
	Prevention				
12	Oral health: Primary Caries Prevention	~~1419~~		None	Claims
	Acute and Chronic Care				
13	*Gap in HIV medical visits*	2080		HRSA	EHR
14	*HIV/AIDS: Screening for Chlamydia, Gonorrhea, and Syphilis*	0409		NCQA	EHR
15	*HIV viral load suppression*	2082		HRSA	EHR

Reporting Set

#	Reporting Only	NQF	ACO	Steward	Source	Equity
	Coordination of Care					
1	30 day readmission			MMDLN	Claims	
2	% PCPs that meet Meaningful Use		11	CMS	EHR	
	Prevention					
3	Non-recommended Cervical Cancer Screening in Adolescent Female			NCQA	Claims	
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516		NCQA	Claims	
5	Frequency of Ongoing Prenatal Care (FPC)	1391		NCQA	EHR	
6	Oral Evaluation, Dental Services (Medicaid only)	2517		ADA	Claims	✓
	Acute and Chronic Care					
7	Cardiac strss img: Testing in asymptomatic low risk patients	0672		ACC	EHR	
	Behavioral Health					
8	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions			APA	EHR	
9	Anti-Depressant Medication Management	0105		NCQA	Claims	
10	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004		NCQA	Claims	
11	Follow up after hospitalization for mental illness, 7 & 30 days			NCQA	Claims	

Medicaid Quality Improvement & Shared Savings Program- Update

Connecticut HUSKY Health:

MQISSP in Context of the Overall Connecticut Medicaid Reform Agenda

Presentation to the SIM Steering Committee

June 9, 2016

Medicaid Quality Improvement and Shared Savings Program (MQISSP) Overview

MQISSP . . .

- is a Connecticut Medicaid upside-only shared savings initiative whose aim is to build on the successes of the current Medicaid reform agenda and further improve health and satisfaction outcomes for Medicaid beneficiaries who are served by Federally Qualified Health Centers (FQHCs) and “advanced networks”

- will use the existing Connecticut Medicaid Person-Centered Medical Home (PCMH) initiative, under which 40% of Medicaid members are being served, as an essential building block to expand upon current practice transformation work

- will build on existing supports for members (ASO-based member services and Intensive Care Management, ICM) and providers (primary care rate increase, PCMH payments, EHR payments, ICM)

- will use the Department's current Person-Centered Medical Home attribution model to identify where beneficiaries have sought care, and prospectively assign beneficiaries to MQISSP Participating Entities

- will continue to ensure that Medicaid members have the right to seek care from any Medicaid provider, and will give them the option to decline to participate in MQISSP

- is expected to launch on January 1, 2017 and to serve between 200,000 and 215,000 Medicaid members

- will incorporate new care coordination requirements related to integration of primary care and behavioral health care, development of disability and cultural competence, and linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits

- will further the Department's interests in preventative health and begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence

- Will include a package of strategies designed to prevent, detect and remedy under-service

- will make supplemental payments to Participating Entities that are Federally Qualified Health Centers (FQHCs) in support of enhanced care coordination activities (e.g. behavioral health integration, cultural competency, disability competency)

- will make shared savings payments to all Participating Entities (both FQHCs and “advanced networks”) that achieve benchmarks on a core set of measures of quality and care experience

MQISSP

Enhanced Care Coordination Activities

Upside-Only Shared Savings Arrangements

Use of Medicaid claims data to perform predictive modeling

Administrative Services Organization-Based Intensive Care Management

Person-Centered Medical Home Practice Transformation

MQISSP model design process and source material:

- DSS developed MQISSP model design through monthly meetings and work group sessions, as well as subject specific webinars, with the Care Management Committee of the Medical Assistance Program Oversight Council (MAPOC)
- All source documents are available on the face page of the MAPOC website at:

  https://www.cga.ct.gov/med/

Connecticut Medicaid Reform Context

HUSKY Health at a Glance

Critical source of economic security and well-being to over 750,000 individuals (21% of the population of Connecticut).

- Serves adults, working families, their children, their parents and their loved ones with disabilities.
- Covers an extensive array of preventative services (primary care through Person-Centered Medical Homes, dental and behavioral health coverage) as well as care coordination.
- Successful in improving quality, satisfaction and independence through prevention and integration.

Data driven.

- Maintains a fully integrated set of claims data for all covered individuals and all covered services.
- Uses data analytics to direct policy-making, program development and operations.
- Employs predictive modeling to identify both those in present need of care coordination, and those who will need it in the future.

Already doing more with less.

- Administrative costs are 5.2%. Total staffing (131 individuals) has held relatively constant while the number of individuals served has dramatically increased.
- 59% of Connecticut Medicaid and 88% of CHIP (HUSKY B) expenditures are federally reimbursed.
- Health expenditures (70.7% of department budget) are increasing based on caseload growth, but trends in per person costs are stable and quality outcomes have improved.

HUSKY Health touches **everyone**.

Children. Working families and individuals.

Older adults. People with disabilities.

Your neighbor. Your cousin.

One in five CT citizens is served by HUSKY Health.

HUSKY Health . . .

- extends financial security from the catastrophic costs of a serious health condition
- enables people to stay well, through prevention, and to work
- promotes the health, well-being and school readiness of children
- supports independence in the community

HUSKY Health is **mission-driven.**

DSS works in partnership with stakeholders across the health care delivery system to ensure that **eligible people** in Connecticut **receive the supports and services they need** to promote **self-sufficiency, improved well-being and positive health outcomes**. We ensure that the **delivery of these services is consistent with federal and state policies**.

HUSKY Health is **person-centered**.

HUSKY Health is **improving outcomes while controlling costs.**

Health outcomes and care experience are improving. We are **enabling independence and choice** for people who need long-term services and supports.

Provider participation has increased.

Enrollment is up, but **per member per month costs are stable**.

The **federal share** of HUSKY Health costs **has increased.**

HUSKY Health has **maximized benefits under the Affordable Care Act.**

- 100% federal coverage for expansion of Medicaid eligibility (HUSKY D)
- coverage of new preventative services including smoking cessation and family planning
- new resources for behavioral health integration
- $77 million in funding under the State Balancing Incentive Program for home and community-based long-term services and supports (LTSS)

Conceptual framework

DSS is motivated and guided by the Centers for Medicare and Medicaid Services (CMS) "Triple Aim":

- improving the patient experience of care (including quality and satisfaction)
- improving the health of populations
- reducing the per capita cost of health care

We are also influenced by a value-based purchasing orientation. The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Hypotheses

We have two critical reform hypotheses:

Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, will yield improved health outcomes and beneficiary experience, and will help to control the rate of increase in Medicaid spending.

Building on current preventative and coordinative interventions (e.g. PCMH, ASO-based Intensive Care Management) by migrating such efforts to a more community-based approach and building in appropriate value-based payment strategies (e.g. pay-for-performance, bundled payments, episodes, shared savings arrangements) will yield further improvements in health outcomes and beneficiary experience, and will continue to control the rate of increase in Medicaid spending.

Key Terms

Term	Acronym	Detail
Administrative Services Organization	ASO	DSS has contracted with four organizations (CHN, Beacon, Benecare and Logisticare) to act as statewide ASOs. The ASOs perform many traditional member support functions , but are also responsible for data analytics and ICM.
Behavioral health home	BHH	DMHAS and DSS have partnered to implement this new means of integrating behavioral health, medical care and social service supports for individuals with Serious & Persistent Mental Illness.
Expansion group	HUSKY D	Connecticut's Medicaid expansion group includes adults at 18-64 who are not otherwise eligible for another Medicaid coverage group.
Fee for Service	FFS	A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
Intensive Care Management	ICM	A set of services that help people with complex health care needs to better understand and manage their care.
Long-term services and supports	LTSS	Long-term services and supports (LTSS) are a spectrum of health and social services that support elders or people with disabilities who need help with daily living tasks.
Medicaid Quality Improvement and Shared Savings Program	MQISSP	MQISSP is a Connecticut Medicaid initiative under which DSS will enter into shared savings arrangements with FQHCs and advanced networks.
Pay-for-performance	P4P	P4P rewards health care providers for attaining targeted service goals, like meeting health care quality or efficiency standards.
Person-Centered Medical Home	PCMH	PCMH is a model for the organization of primary care that ensures effective delivery of the core functions of primary health care.
Value-Based Payment	VBP	VBP links provider payments to improved performance on quality measures.

HUSKY Health: Past, Present and Future

At A Glance

Past, Present and Future

	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods and Value-Based Payment (VBP) approaches
Financial trends	Double digit year-over-year increases were typical	Overall expenditures are increasing proportionate to enrollment; per member per month spending is trending down	Quality-premised VBP strategies will enable further progress on trends
Data	Limited encounter data from managed care organizations	Fully integrated set of claims data; program employs data analytics to risk stratify and to make policy decisions	Data match across human services and corrections data sets will enable more intelligent policy making

	Past	Present	Future
Member experience	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies	ASOs provide streamlined, statewide access points and Intensive Care Management; PCMH practices enable coordination of primary and specialty care; health homes enable integration of medical, behavioral health and social services	Health neighborhoods will address both health needs and social determinants of health (e.g. housing stability)
Provider experience	Provider experience varied across MCOs; payment was often slow or incomplete	ASOs provide uniform, statewide utilization management and ICM; providers can bill on a bi-weekly basis	Consideration of migration to health neighborhood self-management of provider relationships

Context Setting: The Past

HUSKY Health prior to 2012

- Families and children were served under capitated managed care arrangements
- Other than those served by waivers, older adults and people with disabilities did not have care coordination
- In many areas there was relatively poor access to providers
- Beneficiaries and providers experienced many challenges in working with the MCOs
- Double digit year-over-year cost increases were typical
- DSS had inadequate data on which to base policy decisions or risk stratify

Context Setting: The Present

HUSKY Health 2012 to present

	Families & Children	Older Adults and People with Disabilities	Eligible Individuals
Current census	459,839	93,731	196,436
Administrative structure	Self-insured managed FFS; contracts with ASOs	Self-insured managed FFS contracts with ASOs	Self-insured managed FFS; contracts with ASOs
Interventions	Risk stratification using CareAnalyzer; ASO-based member supports and ICM; dental outreach; PCMH; BHH, MQISSP	Governor's LTSS rebalancing plan, ASO-based member supports and ICM; PCMH, BHH	Launch of expansion group (HUSKY D), risk stratification using CareAnalyzer; ASO-based member supports and ICM; PCMH, BHH, MQISSP
Results	Improved HEDIS and care experience results, stable PMPM	Improved HEDIS and care experience results, stable PMPM	Improved HEDIS and care experience results, downward trending PMPM

Providers now have the benefit of:

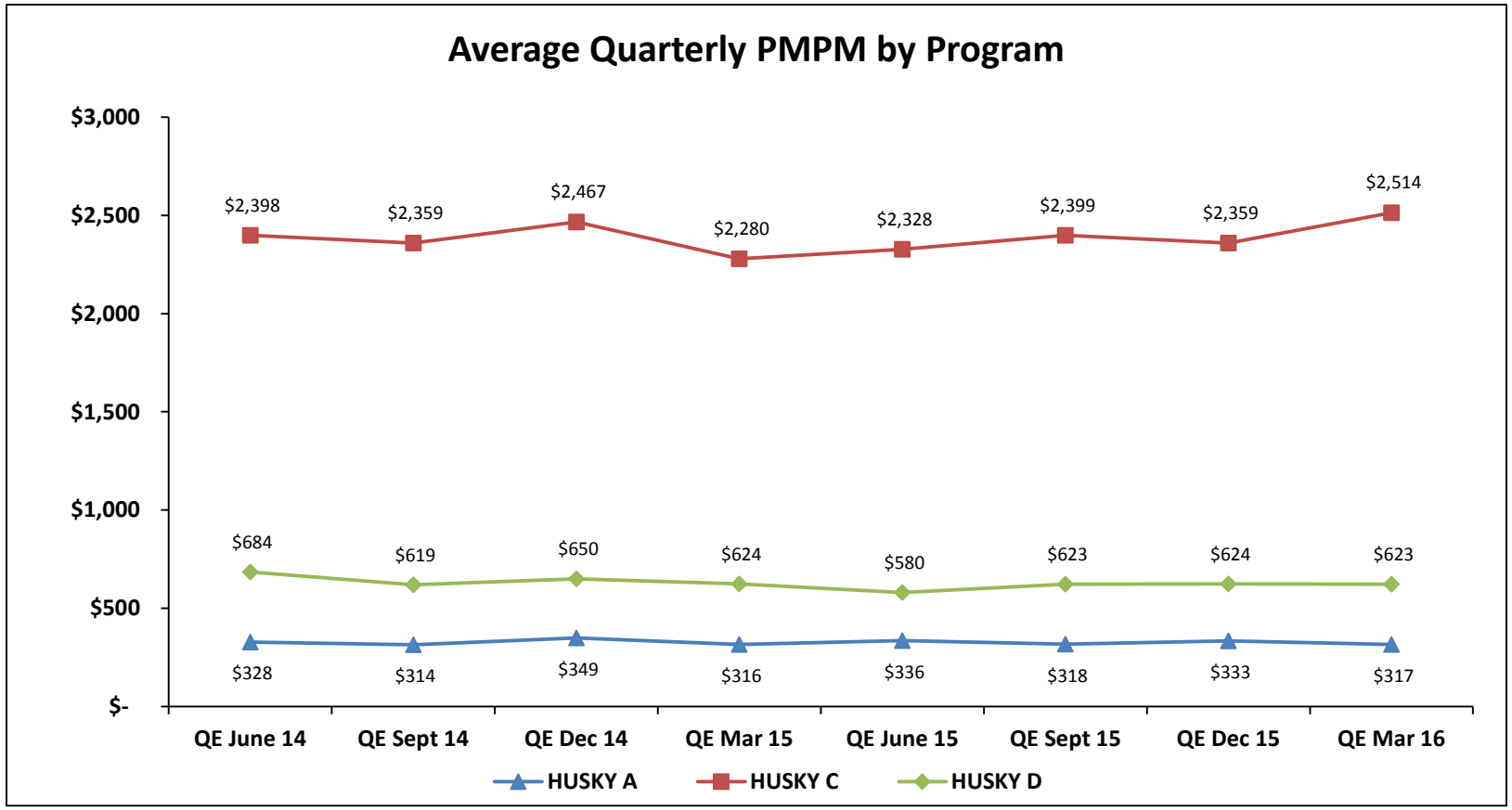
- A streamlined electronic provider enrollment process
- Standard, statewide utilization requirements and rate schedules for HUSKY Health-covered services
- Support with patients with complex needs through ICM
- PCMH practice supports, enhanced fees and performance/improvement payments
- A claims process through which providers can bill every two weeks and receive full payment on all clean claims

What is the result?

A significant increase in participation of both primary care providers and specialists

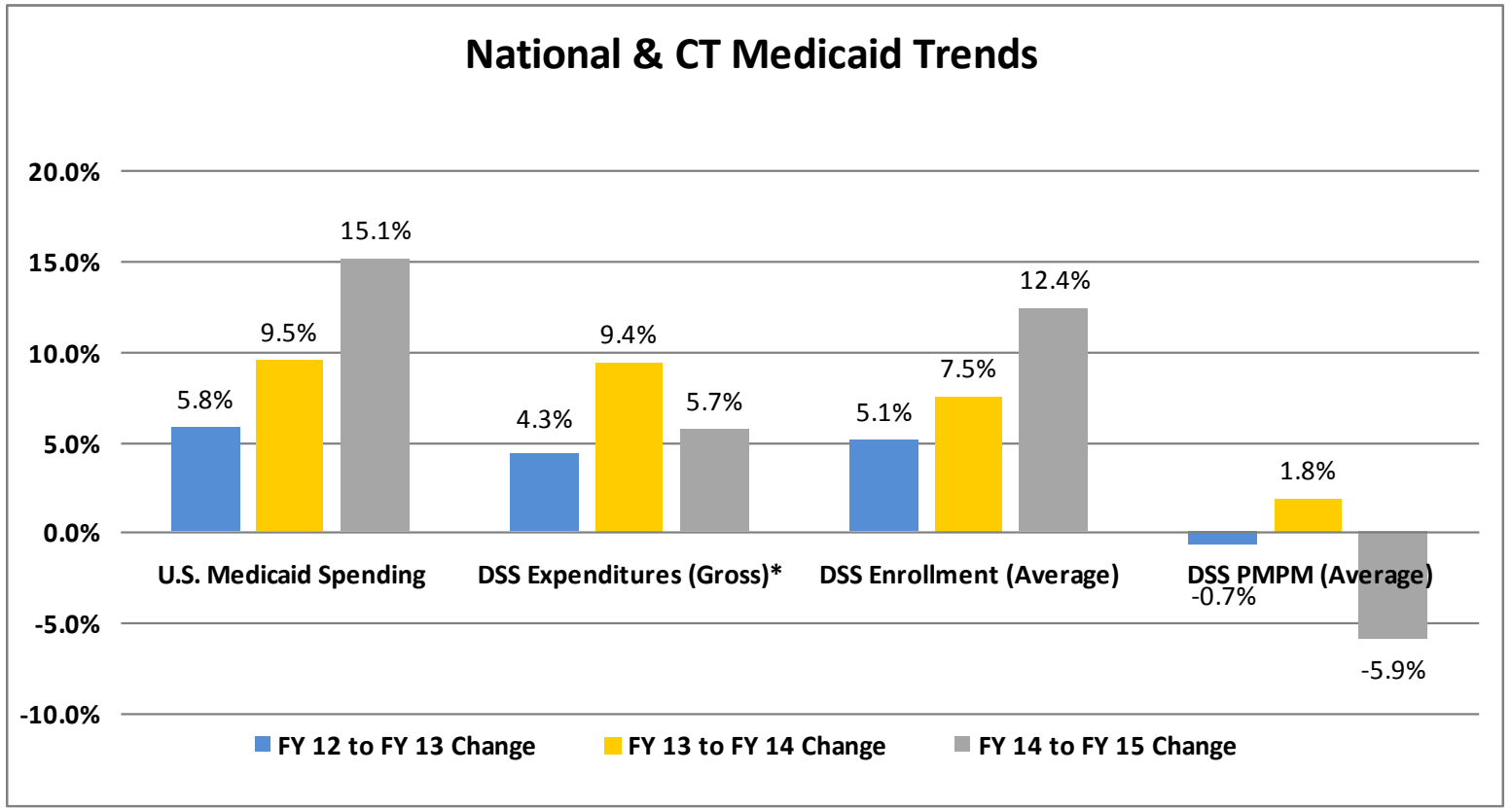



PMPM Trends

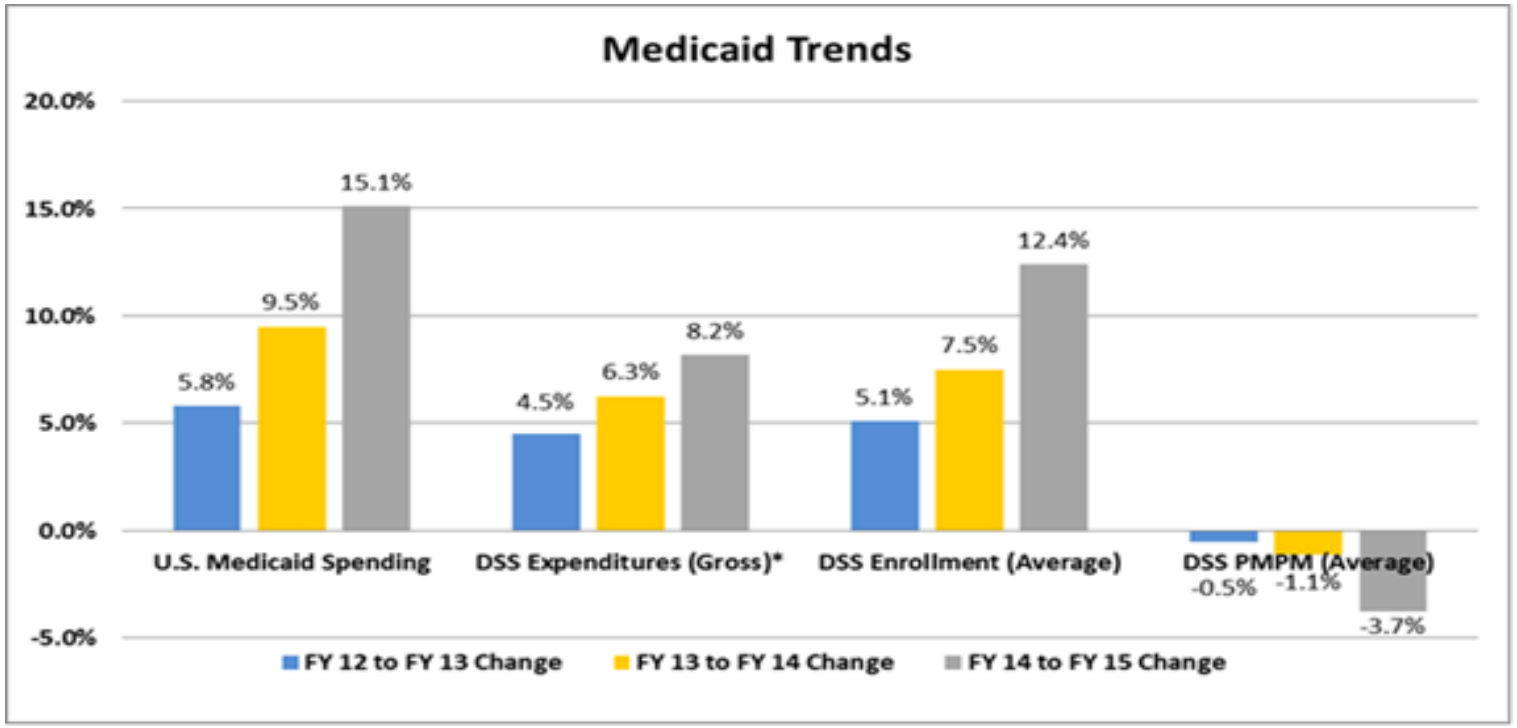


PMPM for HUSKY D is trending down over time; PMPM for HUSKY A & C has been stable over time.

Comparison with National Trends



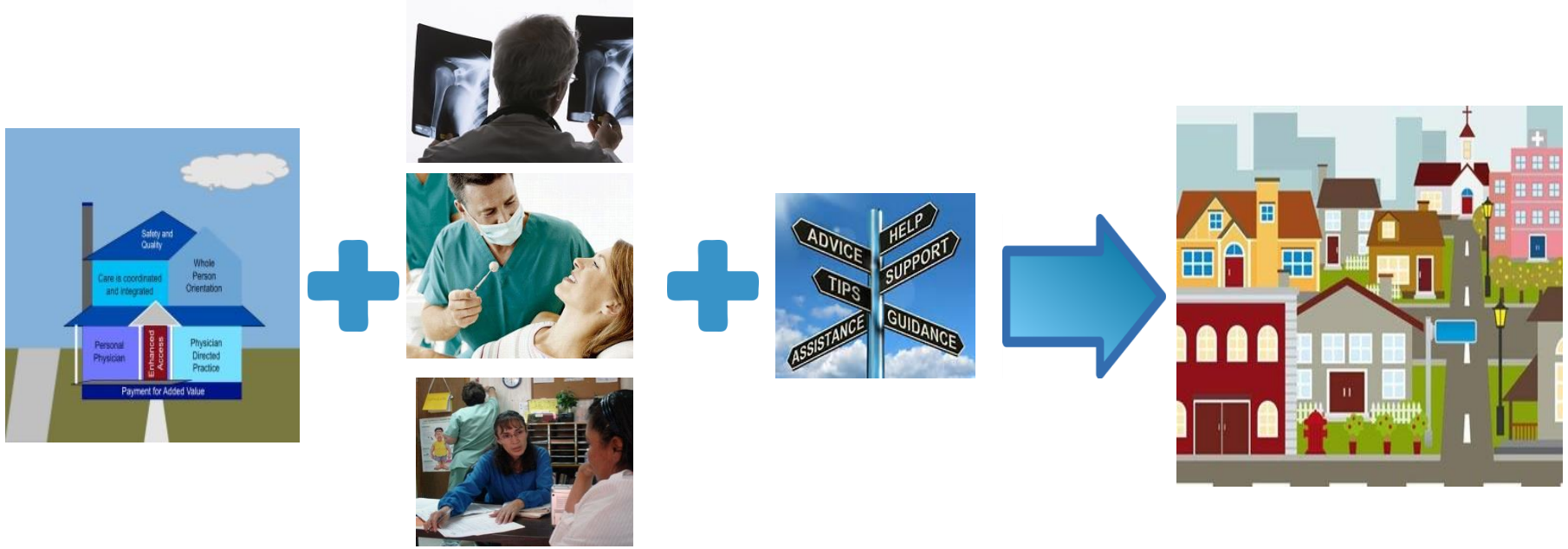
** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction includes all hospital supplemental and retro payments.*



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.* ***This depiction excludes all hospital supplemental and retro payments.***

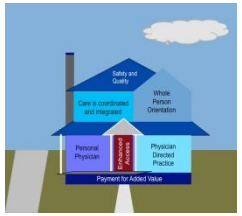
The Future State

HUSKY Health 2017 and ongoing



Health neighborhoods composed of PCMH practices, specialties, CHWs and non-medical services and supports

Development of additional value-based payment strategies



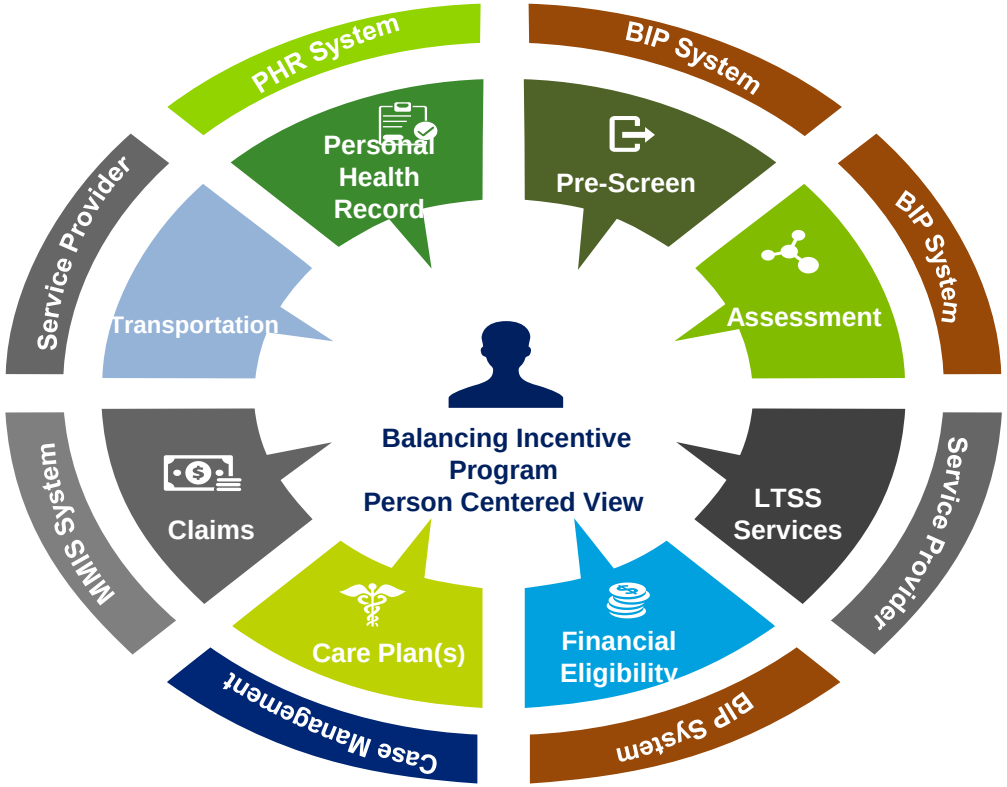
PCMH enhanced fees and performance payments

OB P4P

MQISSP

Shared savings arrangements

Episodes of care



Achievement of a person-centered, integrative, rebalanced system of long-term services and supports

MQISSP Operational Update

REFORM PAYMENT & INSURANCE DESIGN

Initiatives & Work Steps	Pre-implementation May- Sept. 2016	Perf. Year 1 (Beg. 10/1/16) Q1 (Oct-Dec)	Q2 (Jan-Mar)	Q3 (Apr-Jun)	Q4 (Jul-Sep)
MQISSP					
Develop SSP for Medicaid, and engage stakeholders		10/31			
Finalize Wave 1 RFP for Advanced Network and FQHC entry	6/6				
Execute Wave 1 provider contracts		10/31			
Go live with Wave 1, targeting 200,000-215,000 beneficiaries			1/1		
Commence on-going TTA to providers			1/31		
Receive, clean, and validate data related to the target population (all sources). Develop expenditure benchmark with calculation. Link quality score and shared saving loss percentages.	6/6				
Commence under-service monitoring				4/30	
Prepare baseline reports for comparison of utilization changes occurring after the implementation of the SIM program for Medicaid beneficiaries				1/31	

MQISSP Operational Update

All MQISSP activities are on track for timely completion:

- In consultation with the Care Management Committee of the MAPOC, DSS has developed all major aspects of MQISSP model design, including, but not limited to: provider qualifications, care coordination standards, quality measures, shared savings methodology, and a range of strategies designed to prevent, as well as to identify and remedy, under-service to Medicaid members

- DSS' Request for Proposals for MQISSP Participating Entities is slated to be released timely on June 6, 2016

- DSS is in active dialogue with CMS on Medicaid authority needed to make supplemental payments (to FQHCs) and shared savings payments to eligible FQHCs and "advanced networks"

- Next steps will focus upon further development of the package of strategies around under-service, as well as development of a multi-media communications package on MQISSP for Medicaid members and providers

Accountability Targets:

- 89% of Medicaid beneficiaries receive their care from MQISSP-participating healthcare entities by 2020:
- 2017 (Wave 1): 200,000 – 215,000 beneficiaries – after Wave 1 DSS will evaluate outcomes and consider additional wave of participation
- 2018 (Wave 2): additional 200,000 – 215,000 beneficiaries

Adjourn