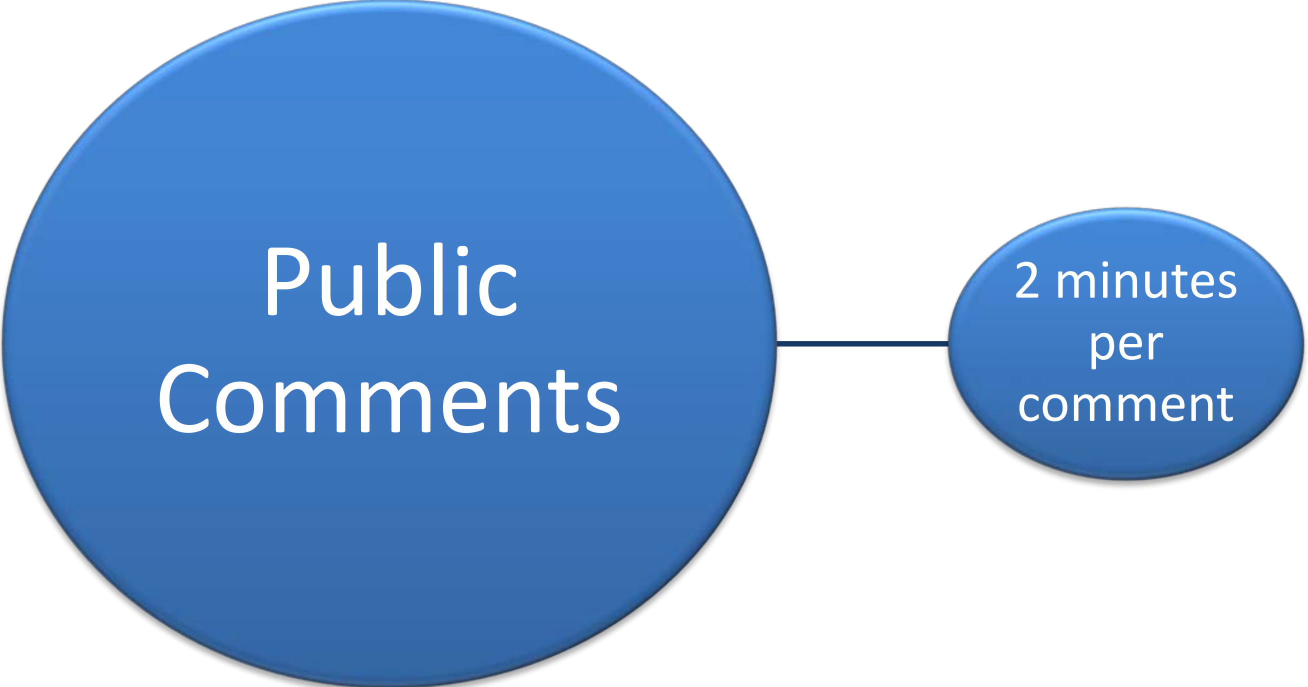
Healthcare Innovation Steering Committee

October 13, 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. VBID Fully-Insured Employer Manual, Pending federal legislation	15 min
5. SIM Alignment Grid Presentation	15 min
6. Operational Plan Update	5 min
7. PCMH+ Update	15 min
8. Work Stream Updates	50 min
10. Adjourn	

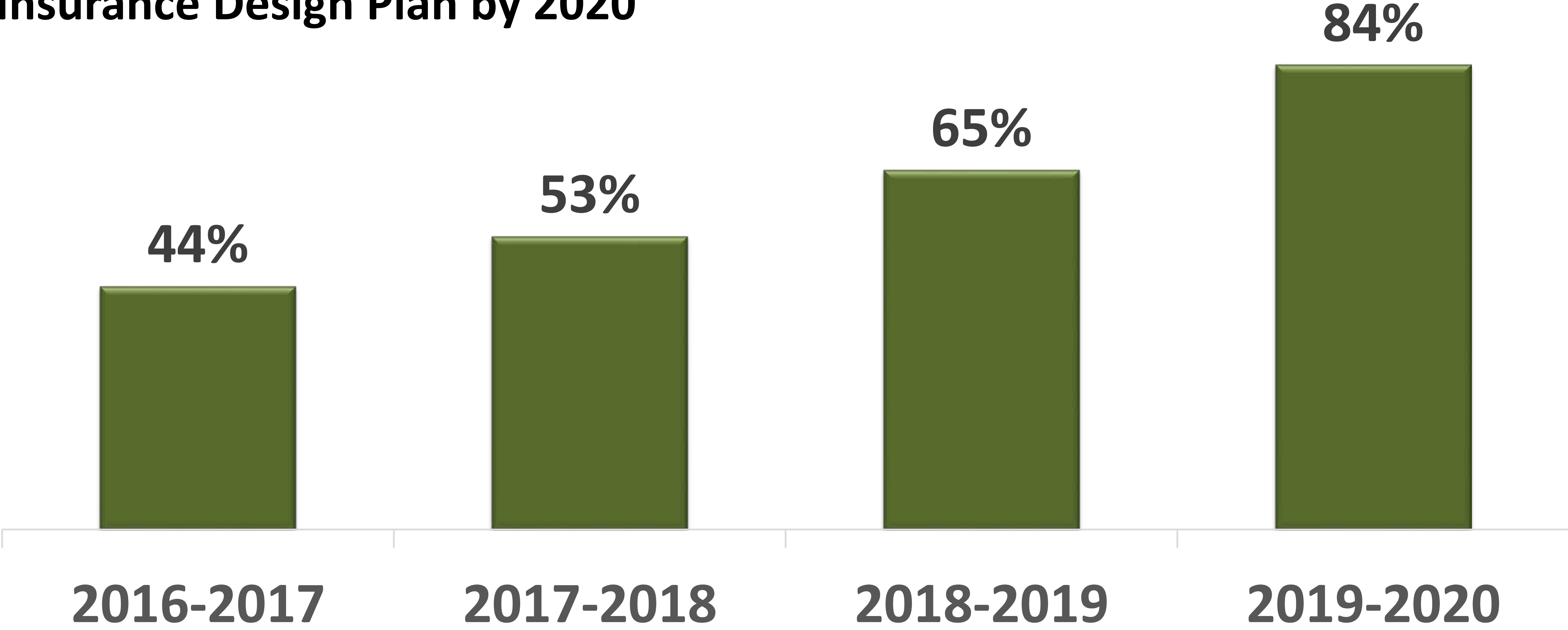

Public Comments
2 minutes per comment

Approval of the Minutes

VBID Fully-Insured Employer Manual, Pending federal legislation

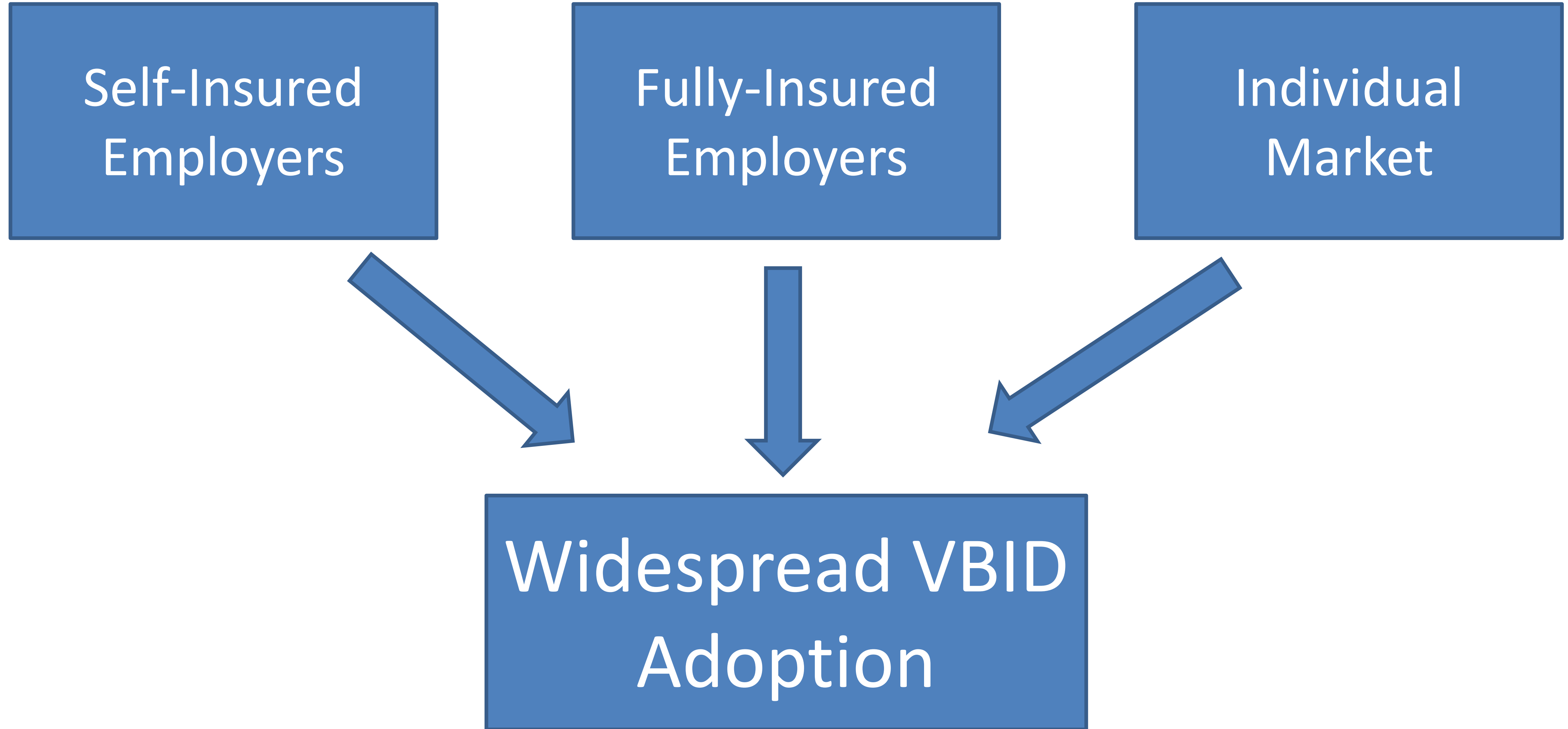
Value Based Insurance Design- Goal

<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

VBID Goal- How do we get there?



VBID Fully-Insured Employer Manual- Walk-Through

- Introduction, Employer Benefits, How to Use Manual, Guiding Principles
- Implementation Strategies
- Best Practices and Lessons Learned
- Communication and Marketing Strategies
- FAQs
- Appendices
  - Recommendation Development
  - Template Worksheets
  - Overcoming Implementation Barriers
  - VBID Toolkit and Resources

VBID Fully-Insured Employer Manual- Highlights

Guide to Implementation

Assess Employee Needs
to identify opportunities for health improvement

Research and Select V-BID Plan
Reach out to health plans to learn more about their V-BID options

Discuss Compliance Measures
to determine which employees are eligible for incentives

Develop a Communication Strategy
to share changes in benefit design with employees

Initiate V-BID Plan
to increase the use of high-value services

VBID Fully-Insured Employer Manual- Highlights

Worksheets for Implementation

<table>
<tr><th>V-BID Basic</th><th>Recommended Core Benefits</th><th>Incentive</th><th>Amount</th></tr>
<tr><td rowspan="9">Component 1
Change Incentives for Specific Services for All Applicable Members</td><td>✓ Blood pressure screening for applicable members depending on age group and gender</td><td rowspan="9">I will provide employees that use any of these services with a:
☐ Contribution to HSA
☐ Contribution to HRA
☐ Bonus Payment
☐ Reduced Premium
☐ Other (e.g. gift card, vacation time, payroll bonus)</td><td rowspan="9">$___________</td></tr>
<tr><td>✓ Cholesterol screening for applicable members depending on age group and gender</td></tr>
<tr><td>✓ Obesity screening for applicable members depending on age group and gender</td></tr>
<tr><td>✓ Depression screening for adolescents over 12 years and adults</td></tr>
<tr><td>✓ Alcohol screening and counseling for all adults</td></tr>
<tr><td>✓ Breast cancer screening for women depending on age group</td></tr>
<tr><td>✓ Cervical cancer screening for women depending on age group</td></tr>
<tr><td>✓ Colorectal cancer screening for applicable members depending on age group and gender</td></tr>
</table>

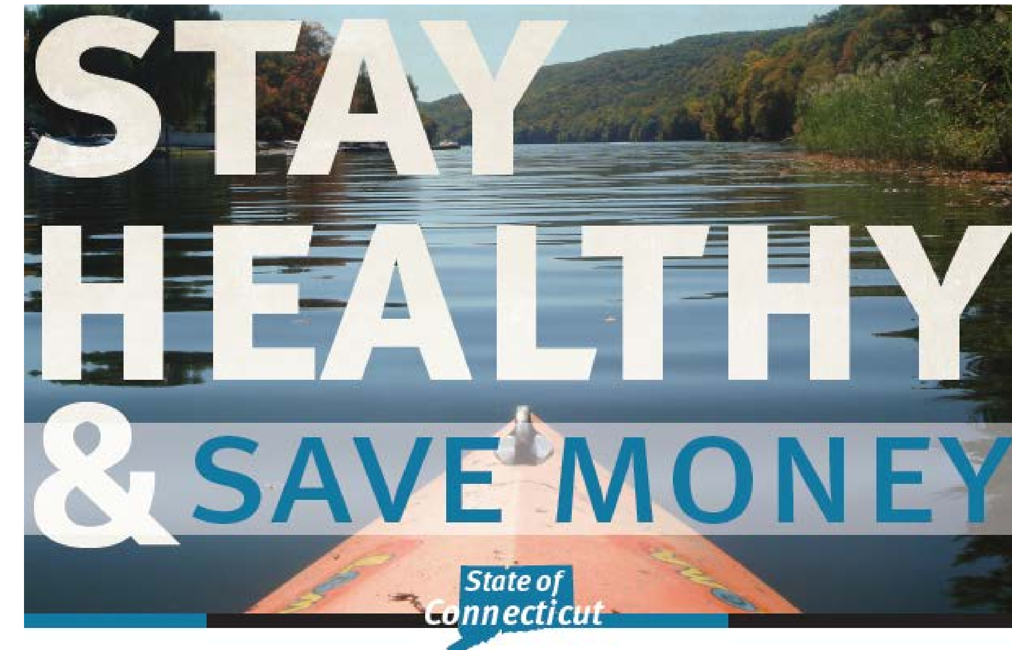
VBID Fully-Insured Employer Manual- Highlights

Communication Guidance

- The importance of messaging from employee leaders
- Who, What, How, and When to Communicate

Communication is Key!

Plan for at least 5 employee touch points to share upcoming changes to health benefits.



HEALTH ENHANCEMENT PROGRAM (HEP)

Requirements

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

Specific Considerations in the Fully Insured Manual

Options for Researching and Selecting a V-BID Plan

Work with your insurance carrier or shop around- The template provides details on these two options

Best Practices

Request a VBID Plan from your Insurance Carrier

This will create market demand

FAQs

How do I know if my insurance carrier offers a VBID Plan?

Ask your Plan or visit the SIM website

VBID Federal Legislative Update

H.R. 5652 Access to Better Care Act: A bipartisan bill recently introduced to change Internal Revenue Service rules to allow plans to better cover clinical services for chronic medical conditions before plan members have met their deductibles.

This would amend section 223(c)(2) of the IRS code: Currently, in health savings account-qualified high deductible health plans (HSA-HDHPs), services meant to treat "an existing illness, injury or condition" are excluded from coverage before the plan deductible is met.

V-BID Next Steps

First VBID LC Meeting 10/20 at Pitney Bowes

Release Fully-Insured Manual for Public Comment

Continue working with business groups on engaging fully-insured employers

Meet with Access HealthCT/health plans/CID to work on VBID adoption

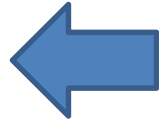
Host 2 additional Consortium meetings by June 2017

Continue work with UConn Evaluation Team on Measuring VBID penetration

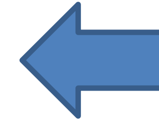
SIM Alignment Grid Presentation

Driver Diagram: Theory of Change

Aims = Clearly articulated goal or objective



Primary Drivers = system components or factors that contribute directly to achieving the aim



Secondary Drivers = actions, interventions, or lower-level components necessary to achieve the primary drivers

Accountability Targets = indicators to track progress towards goals, identify trends in progress and potential best practices and barriers over the period of implementation

SIM Aims

Healthier People and Communities and Improved Health Equity

Reduce the statewide rates of diabetes, obesity, and tobacco use

Better Care and Improved Health Equity

Improve performance on key quality measures, including preventative care and care experience

Smarter Spending

Achieve a 1-2% reduction in the annual rate of healthcare growth

CT SIM: Primary Drivers to achieve Our Aims

$5.8M

Population Health

$8.8M

Payment Reform

$13.5M

Transform Care Delivery

$650K

Empower Consumers

Health Information Technology $10M

Evaluation $3.5M

CT SIM: Primary and Secondary Drivers to achieve Aims

Population Health Plan

- Health Enhancement Communities
- Prevention Service Centers
- Community Health Measures

Transform Care Delivery

- Community & Clinical Integration Program
- Advanced Medical Home
- Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

- Medicare SSP
- Commercial SSP
- Medicaid QISSP
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

CMMI feedback on SIM Operational Plan

- *Enhance focus and synergy*
- *Improve coordination and alignment*
- *Simplify*

SIM Priority Alignment Areas

- *Individuals with Complex Health Needs*
- *Diabetes: prevention and control*
- *Hypertension (HTN): prevention and control*
- *Asthma*
- *Depression*

CT SIM: Alignment Priority Areas and Primary Drivers

- *Individuals with Complex Health Needs*
- *Diabetes: prevention and control*
- *Hypertension (HTN): prevention and control*
- *Asthma*
- *Depression*

Operational Plan Updates

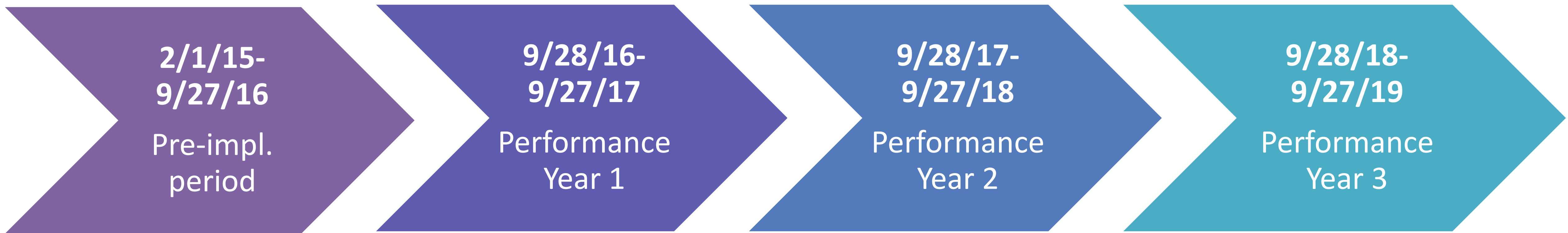
Performance Year 1 Operational Plan

Approved:
Performance Year 1 (PY1) Budget

PY1 Budget Period:
9/28/16-9/27/17

Operational Plan:
Anticipating imminent approval

SIM Timeline



Performance Year 1 Budget Breakdown

$1.7M

Population Health

$2.4M

Payment Reform

$5.3M

Transform Care Delivery

$130K

Empower Consumers

Health Information Technology $2.5M

Evaluation $646K

PCMH+ Updates

Connecticut HUSKY Health:

PCMH+ Update

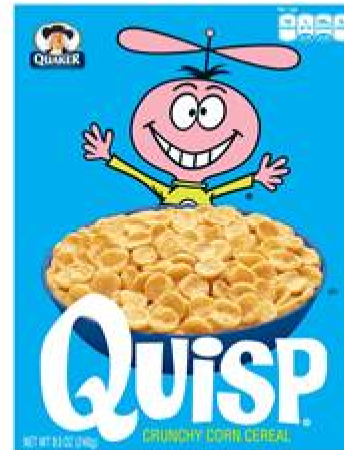
Presentation to the SIM Steering Committee

October 13, 2016

PCMH+

Overview

MQISSP . . .



has been re-christened . . . PCMH+

PCMH+ . . .

- 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 43% 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 PCMH+ 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 PCMH+

- is slated for launch on January 1, 2017

- 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

PCMH+

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

PCMH+ model design process and source material:

- DSS developed PCMH+ 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/

Medicaid Context for PCMH+ Launch

What the current status of access to services?

- **Medical Providers**
  - Overall participation:
    - Primary care providers: **3,454**
    - Specialists: **13,379**
  - Network growth over calendar year 2015: **7.22%**
  - Recruited and enrolled **17 new practices** into DSS' Person-Centered Medical Home (PCMH) program

- **Behavioral Health Providers**
  - Overall participation:
    - Behavioral health providers: **4,537**
  - Network growth over calendar year 2015: **15.94%**

- **Dental Providers**
  - Overall participation:
    - Primary care providers: **1,787**
    - Specialists: **415**
  - Network growth over calendar year 2015: **10.00%**

What outcomes have we achieved through the PCMH initiative?

- As of October, 2016, **108 practices** (representing **435 sites** and **1,518 providers**) were participating

- These practices are serving **328,169 Medicaid members – over 43%** of all members

- PCMH practices achieved better results than non-PCMH practices on measures including, but not limited to, ambulatory ED visits and readmissions within 30 days – physical and behavioral health

- 92.2% of adults, and 95.8% of adults responding for children, surveyed reported immediate access to care

- 92.8% of adults, and 98.6% of adults responding for children, surveyed reported overall positive experience with the program

What relevant results have been produced by Intensive Care Management (ICM) initiatives?

- Over SFY'16, Connecticut Medicaid's medical ASO, CHNCT, has:
  - for those members who received ICM, **reduced emergency department (ED) usage** by **22.28%** and **reduced inpatient admissions by 39.08%**
  - for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 27.18%**

Overall Utilization

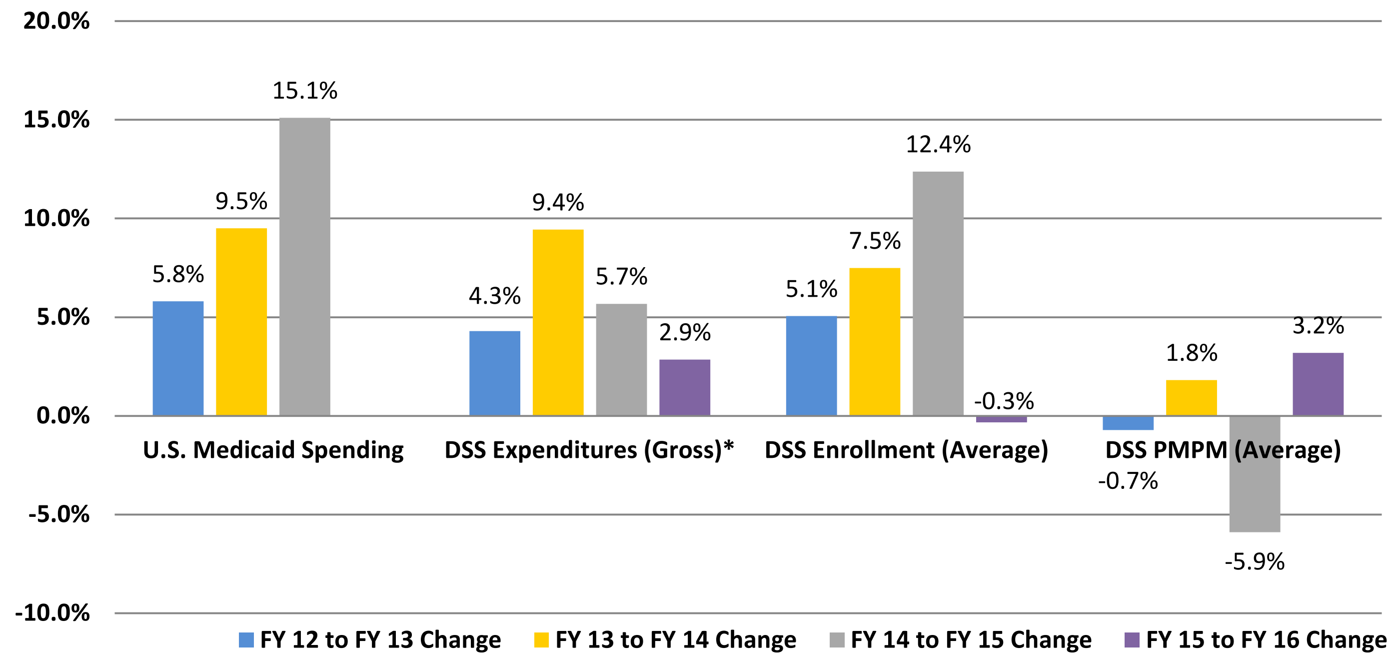
What relevant results do we see in Connecticut, related to overall utilization trends?

- Over SFY'16, through a range of strategies (e.g. Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced** by:
  - **5.80%** for HUSKY A and B
  - **3.10%** for HUSKY C
  - **8.57%** for HUSKY D

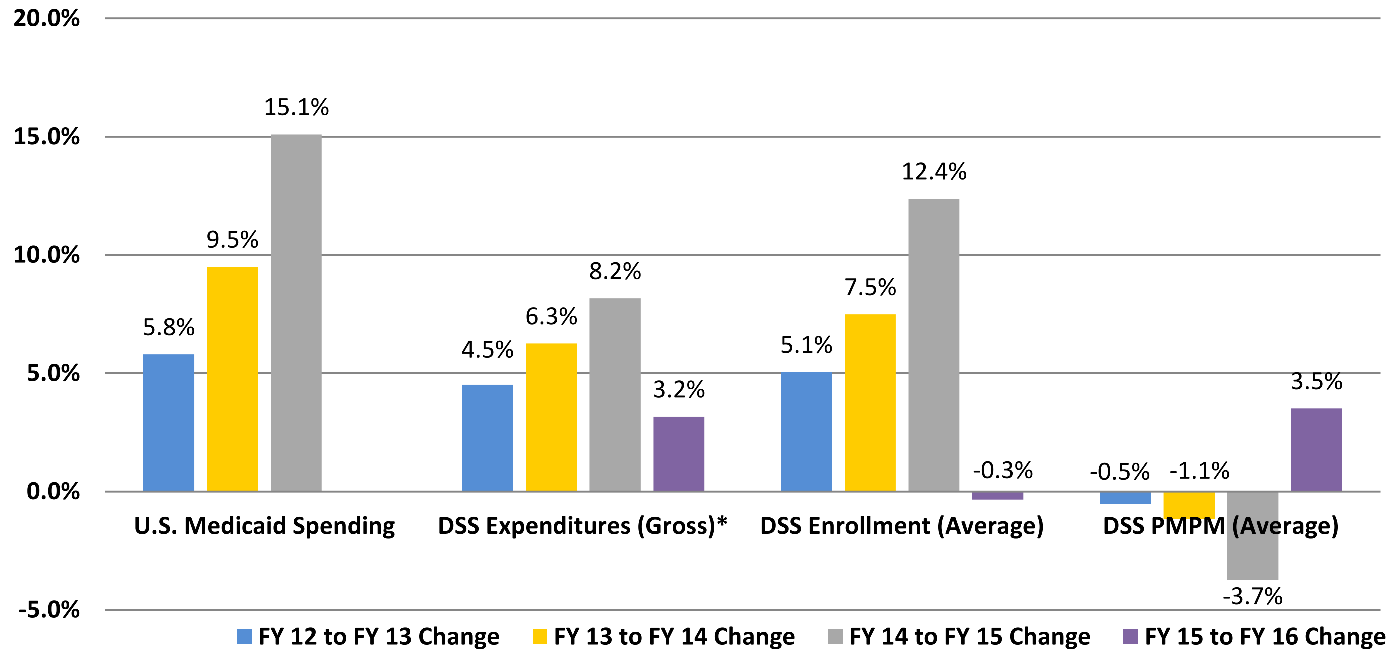
Over SFY'16:

- Overall admissions per 1,000 member months (MM) **decreased by 5.4%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 4.3%**
- Utilization per 1,000 MM for non-emergent medical visits **decreased by 2.7%**

Comparison with National Trends

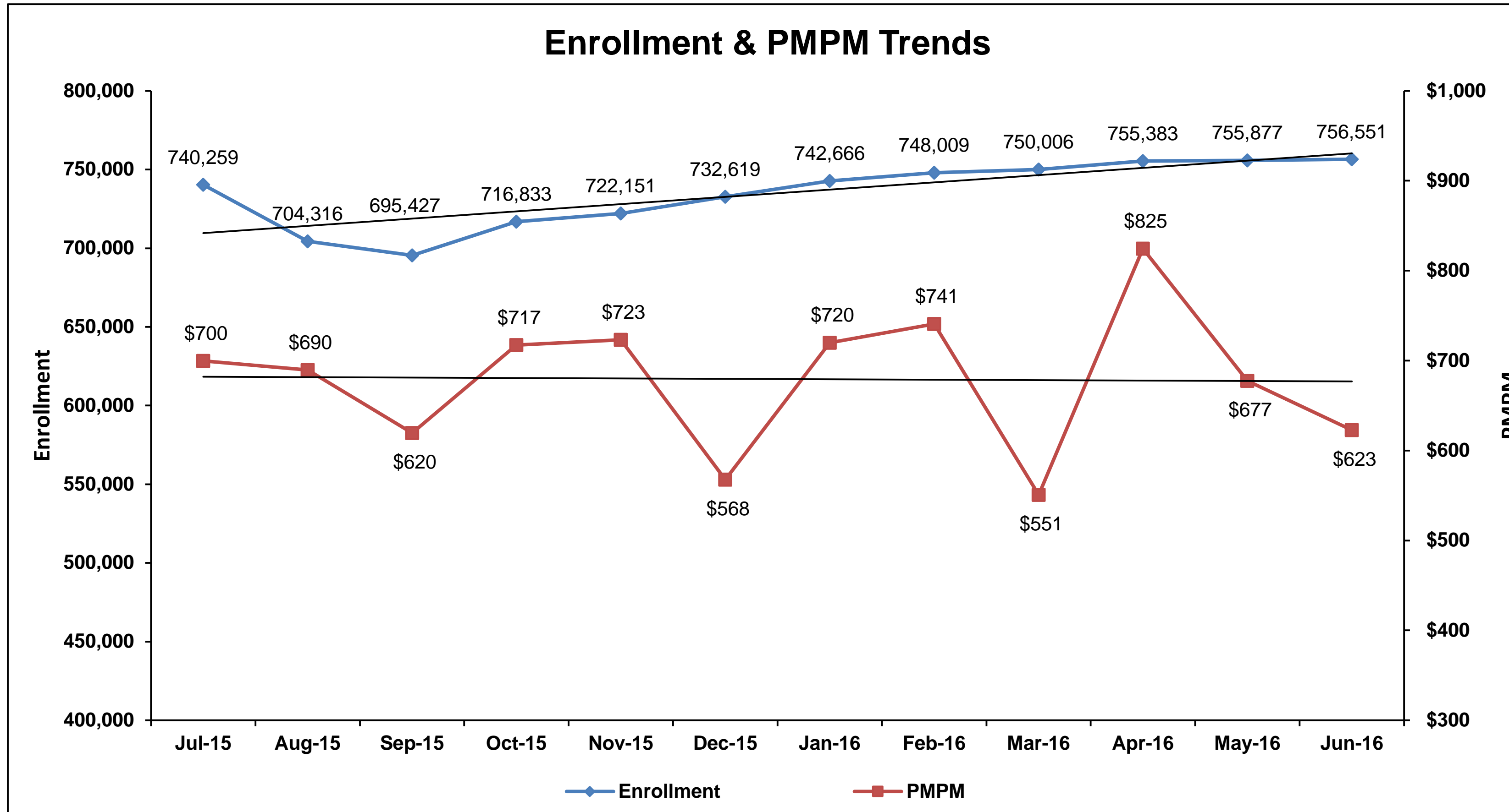


** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **includes** all hospital supplemental and retro payments.*



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

Enrollment and PMPM



Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady.

PCMH+ Operational Update

REFORM PAYMENT & INSURANCE DESIGN	Pre-implementation	Perf. Year 1 (Beg. 10/1/16)			
Initiatives & Work Steps	**May- Sept. 2016**	**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 PCMH+ activities are on track for timely completion:

- **Model design:** In consultation with the Care Management Committee of the MAPOC, DSS has developed all major aspects of PCMH+ 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

- **Issuance of procurement:** DSS' Request for Proposals for PCMH+ Participating Entities was released timely on June 6, 2016

- **Procurement results:** On October 4th, DSS extended invitations to negotiate contracts to the following entities:

Advanced Networks:

- Northeast Medical Group
- St. Vincent's Medical Group

Federally Qualified Health Centers (FQHCs):

- Community Health Center, Inc.
- Cornell Scott-Hill Health Corporation
- Fair Haven Community Health Clinic, Inc.
- Southwest Community Health Center
- Generations Family Health Center, Inc.
- OPTIMUS Health Care, Inc.
- Charter Oak Health Center, Inc.

- **Medicaid authority:** 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" – the focus is on obtaining approval of Medicaid State Plan primary care case management authority under section 1905(a)(25) of the Social Security Act

- **Member and provider engagement:** In consultation with stakeholders, DSS has also developed a member communication, to be sent in mid-November; a supported process for member opt-out; and provider materials and training sessions

- **Procedural updates:** DSS has also submitted to the SIM PMO:
  - **A set of responses to questions from CMMI around mitigation of risks:**
    - Provider participation in procurement
    - Stakeholder engagement
    - Interrelationship with FQHC Practice Transformation Network (PTN) grant
    - Timely approval of authority by CMS
    - Data readiness

- **Revisions to the Operating Plan that detail means through which DSS will review experience and outcomes (health and satisfaction measures, care experience, expenditures) in support of any needed revision in scope or model design of the procurement for Wave 2:**
  - Claims data
  - Results of care experience surveys
  - Mystery shopper
  - Under-service strategies

Appendix
HUSKY Health: Past, Present and Future
At A Glance

Past, Present and Future

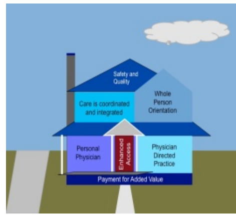
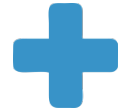
	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods 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

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

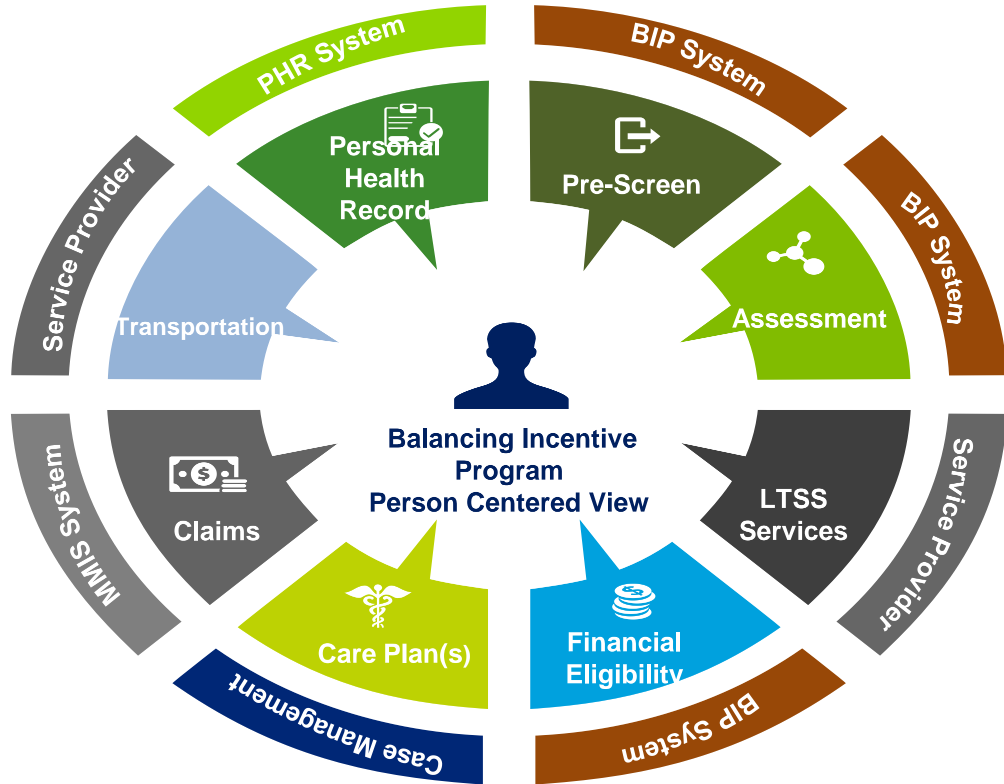
PCMH enhanced fees and performance payments

OB P4P

PCMH+

Shared savings arrangements

Episodes of care



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

Work Stream Updates

CT SIM: Primary and Secondary Drivers to achieve Aims

Population Health Plan

- Health Enhancement Communities
- Prevention Service Centers
- Community Health Measures

Transform Care Delivery

- Community & Clinical Integration Program
- Advanced Medical Home
- Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

- Medicare SSP
- Commercial SSP
- Medicaid QISSP
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

SIM POPULATION HEALTH WORK STREAM TIMELINE

2015-16 | 2016-17 | 2017-18 | 2018-19

Task	Target date
HIRE PROJECT STAFF	
LAUNCH POPULATION HEALTH COUNCIL	9/16
HEALTH STATUS ASSESSMENT	
DATA AND METHODS FOR POPULATION HEALTH METRICS	3/19
ROOT CAUSE AND BARRIER ANALYSIS	
TRENDS AND TARGETS FOR POPULATION HEALTH INDICATORS	9/17
AREAS WITH HIGHEST BURDEN OF DISEASE AND COMMUNITY CAPACITY	12/16
STATEWIDE SCAN COMMUNITY-PREVENTION SERVICES	3/17
DESIGN PREVENTION SERVICE CENTERS AND PRIORITY INTERVENTIONS	12/17
FUNDING OPTIONS & AUTHORITY FOR PSC's AND HEC's	9/18
DEVELOP CONCEPTUAL MODEL OF HEC	12/17
PLANNING TEAM AND GUIDING PRINCIPLES FOR HEC'S	3/18
IMPLEMENT A PSC DEMONSTRATION SITE	9/19
COMMUNITY HEALTH ACCOUNTABILITY MEASURES AND TARGETS	3/19
DETAILED DESIGN AND DESIGNATION STANDARD FOR HEC'S	

POPULATION HEALTH COUNCIL MEETINGS

Topics	Timing
SIM Framework and overarching goals, Teambuilding, Leadership Nomination, Operating Principles, Prevention Concepts, Case studies	First 2 meetings
SHIP/SIM/Population Health Alignment. State Health Assessment Data and Indicators	TODAY
Prevention and Capacity Environmental Scan	OCTOBER
Root Causes and Barriers Analysis. Priority Issues	NOVEMBER
Draft PSC Model. Key Elements and Design Criteria	DECEMBER

PREVENTION SERVICE CENTERS MODEL

MENU OF SERVICES (SIM Priorities)

COMMUNITY HEALTH MEASURES (Indicators)

FINANCIAL SUSTAINABILITY (Pilot/Model)

INFRASTRUCTURE (Consortium)

OWNERSHIP / GOVERNANCE
(Private/Public/Mixed)

CT SIM: Primary and Secondary Drivers to achieve Aims

Population Health Plan

Health Enhancement Communities

Prevention Service Centers

Community Health Measures

Transform Care Delivery

Community & Clinical Integration Program

Advanced Medical Home

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Payment Reform Across Payers

Medicare SSP

Commercial SSP

Medicaid QISSP

Quality Measure Alignment

Empower Consumers

Value Based Insurance Design

Public Quality Scorecard

Consumer Outreach

SIM Health IT Drivers

Driver 1: Coordinate and connect various HIT Initiatives throughout the state

Driver 2: Execute a targeted and time-limited stakeholder engagement process

Driver 3: Leverage technical infrastructure for sending alerts to providers and caregivers

Driver 4: Support Data Analytics

Driver 5: Enable robust statewide health information exchange (Drivers 3 & 4 build initial functionalities)

Driver 6: Deploy health IT Tools for care delivery interventions and quality improvement *(Performance Year 2 & 3)*

HIT Timeline

Health Information Technology	Pre-implementation	Perf. Year 1 (Beg. 9/28/16)			
Activities Planned for Year 1	**May – Sept. 2016**	**Q1** (Oct – Dec)	**Q2** (Jan – Mar)	**Q3** (Apr – Jun)	**Q4** (Jul – Sep)
1. HITO selection process	6/1/16	10/31/16			
2. Engage ONC for Technical Assistance	7/13/16			ongoing	
3. HIT Consulting Services	8/1/16	12/31/16			
4. Expand upon the Medicaid Alert Notification Use Case to support multi-payer participants	9/7/16		12/31/16 1/1/17		12/1/17
5. RFI/RFP for eCQM solutions		11/15/16		4/30/17	
6. IAPD-U to support planning activities for ADT/eCQM		11/1/16	1/1/17		9/27/17
7. Targeted stakeholder engagement		1/1/17			6/30/17

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Practice Transformation- AMH & CCIP

Under Review: CCIP Transformation Award Applications

Under Review: AMH Vendor applications; Vendor should be announced later this month

Under Review: CCIP vendor proposals; Vendor should be announced later this month

Closed: AMH Pilot Application

Total Practices Recruited: **95**

Next Up: AMH Recruitment Event

Details: December 8 @ the Sheraton, Rocky Hill

Interested in PCMH recognition…Save the Date

Advanced Medical Home: Realizing the Vision

Keynote: Marci Nielsen, MD
- Patient Centered Primary Care Collaborative

December 8th, 5:15 to 9pm
Sheraton Hartford South, Rocky Hill

Find out more about medical home and why NCQA recognition makes more sense than ever

Details to follow at: www.healthreform.ct.gov

Community Health Workers

Complete: CHW Definition

Complete: CHW Scope of Work- Roles & Skills

Next Up: CHW Team will be providing technical assistance to CCIP vendor

Next Up: Recommendations on Certification

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- Medicaid QISSP
- Quality Measure Alignment

Empower Consumers

- Value Based Insurance Design
- Public Quality Scorecard
- Consumer Outreach

Consumer Empowerment

Complete: Consumer Engagement Coordinator Survey

Finalized: New Consumer/Advocate Application

Next Up: Recruitment for Vacant Consumer Committee reps

Upcoming event: Young Adult Health Forum tomorrow @ Manchester Community College

Working on it: Public Scorecard approach

CT SIM: Primary and Secondary Drivers to achieve Aims

Population Health Plan

Health Enhancement Communities

Prevention Service Centers

Community Health Measures

Transform Care Delivery

Community & Clinical Integration Program

Advanced Medical Home

Community Health Workers

Stakeholder Engagement

Health IT

Payment Reform Across Payers

Medicare SSP

Commercial SSP

Medicaid QISSP

Quality Measure Alignment

Empower Consumers

Value Based Insurance Design

Public Quality Scorecard

Consumer Outreach

Quality Measure Alignment

Almost there: Quality Council Report nearly complete

Released: CAHPS Vendor RFP

What's CAHPS?: A survey to measure patient experience

More on CAHPS: Finalized CT SIM CAHPS Survey

Even more on CAHPS: Developed Spanish version of Survey

Adjourn