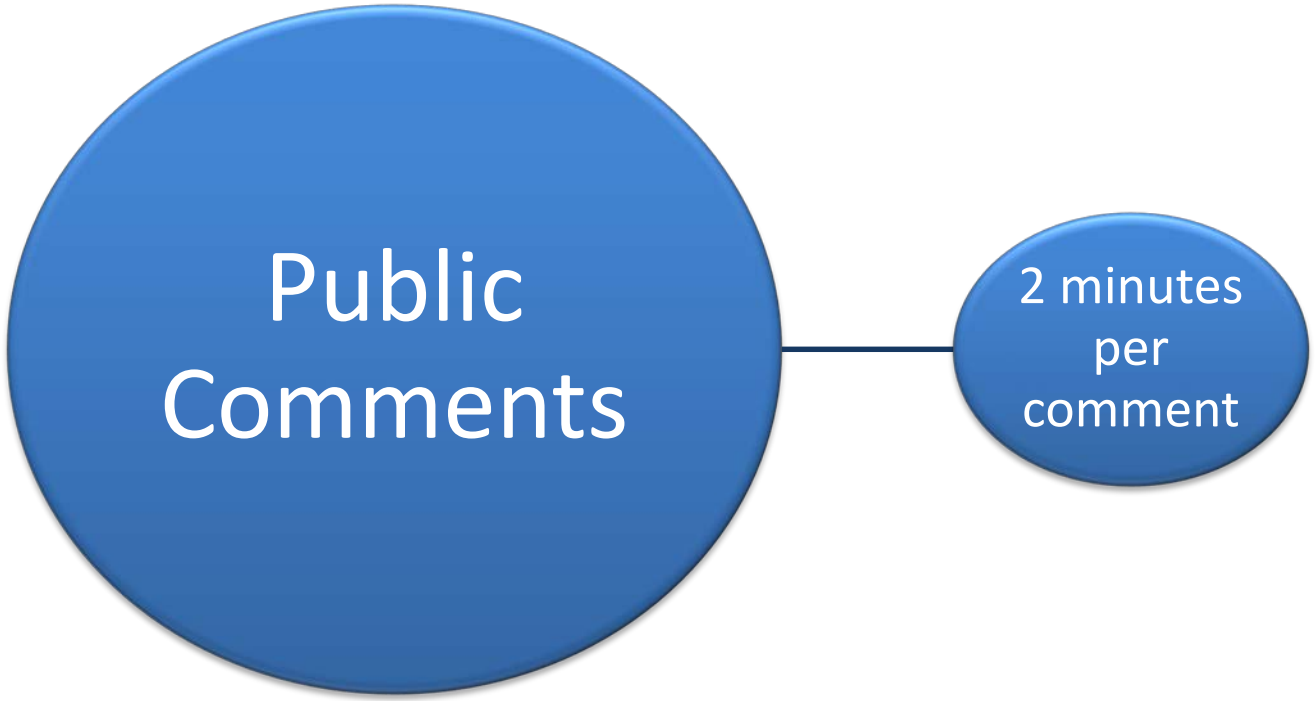
Healthcare Innovation Steering Committee

January 12, 2017

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. CAB Member Appointments	5 min
5. Population Health Council FQHC Representative Appointment	5 min
6. VBID Fully-Insured Employer Manual	10 min
7. CCIP and AMH Updates	20 min
8. Primary Care Payment Reform	50 min
9. Work Stream Updates	10 min
10. Adjourn	


Public Comments
2 minutes per comment

Approval of the Minutes

Consumer Advisory Board Member Nominees

- **Loretta Ebron**, Senior Community Health Worker, OPTIMUS Health Care, Inc. & Housatonic Community College
- **Linda Guzzo**, Dean of the School of Workforce & Continuing Education, Capital Community College
- **Velandy Manohar, MD**, Medical Director, Aware Recovery Care

Population Health Council- FQHC Representative Nominee

- **Craig Glover,** CEO, Norwalk Community Health Center, Inc.

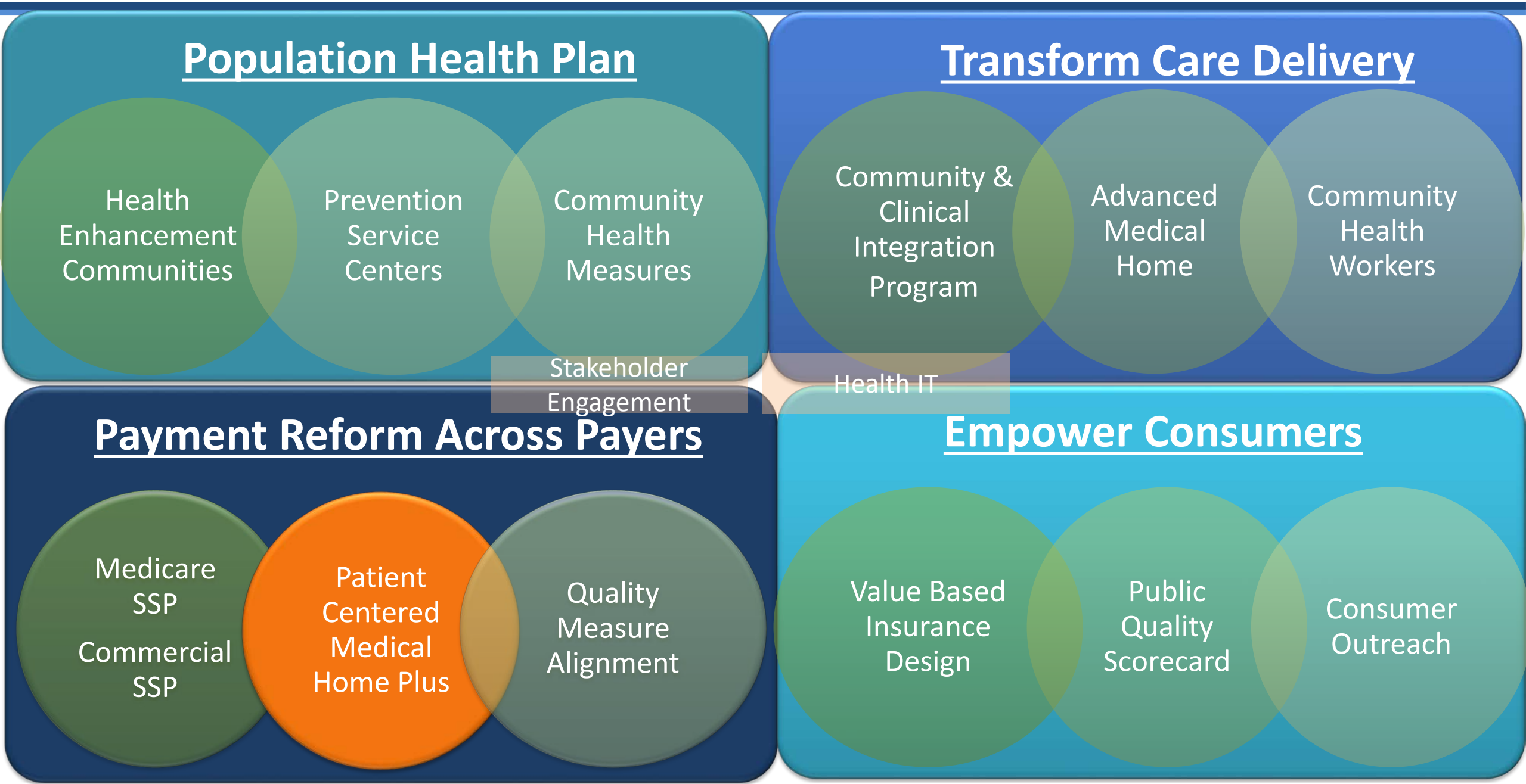
VBID Fully Insured Employer Manual

Summary of VBID Public Comments

- Defining Value: The Committee should continue working with progressive payers on guidelines to define value iteratively.
- Patient Engagement: Engage patients through quality shared decision making tools or health advocacy campaigns. Meeting patients/plan members where they are is essential.
- Support for Value Based Contracting: Consider ways to expedite value-based reimbursement.
- VBID plans should be offered to fully-insured employees as an option, not as a mandate.

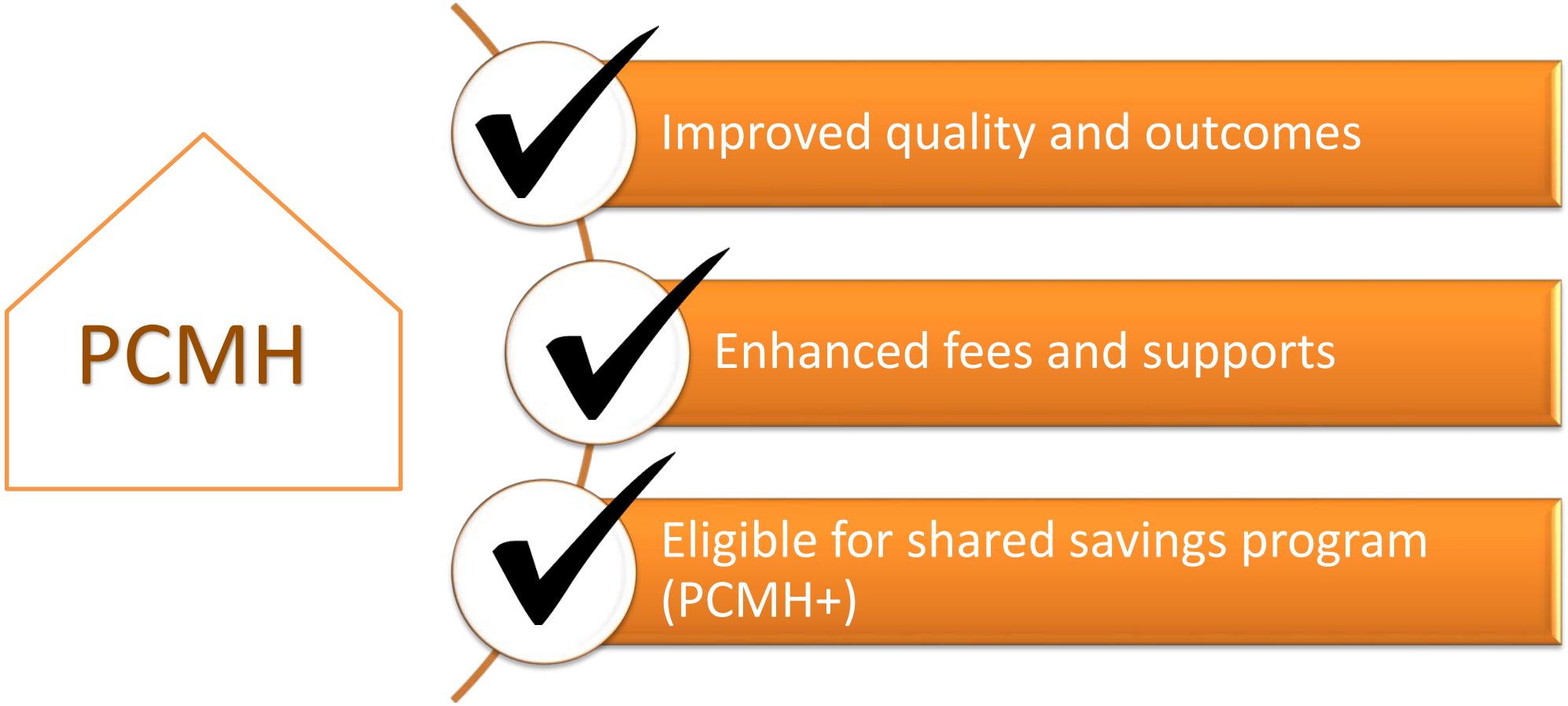
PCMH+, AMH, and CCIP Updates

CT SIM: Primary and Secondary Drivers to achieve Aims

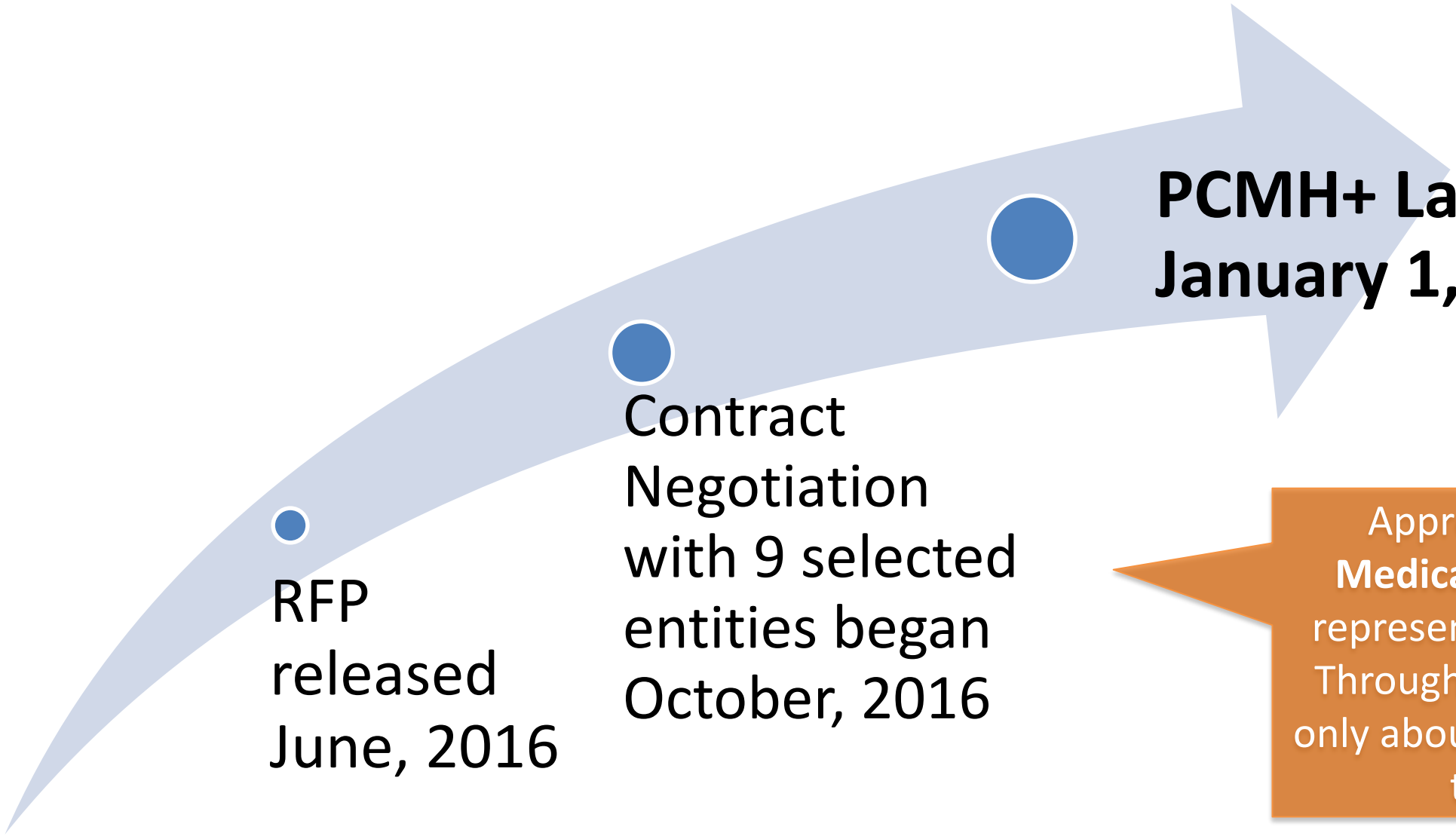


What is PCMH+?

- PCMH+ is the **Medicaid Shared Savings opportunity** (formerly MQISSP) offered to Primary Care Practices who are designated as Patient Centered Medical Homes by DSS
- PCMH+ builds on the Medicaid PCMH program:



PCMH+ Participant Selection Process



Approximately **160,000 Medicaid beneficiaries** are represented by the 9 entities. Through the opt-out process, only about 2,000 requested not to participate.

PCMH+ Participating Entities

Advanced Networks

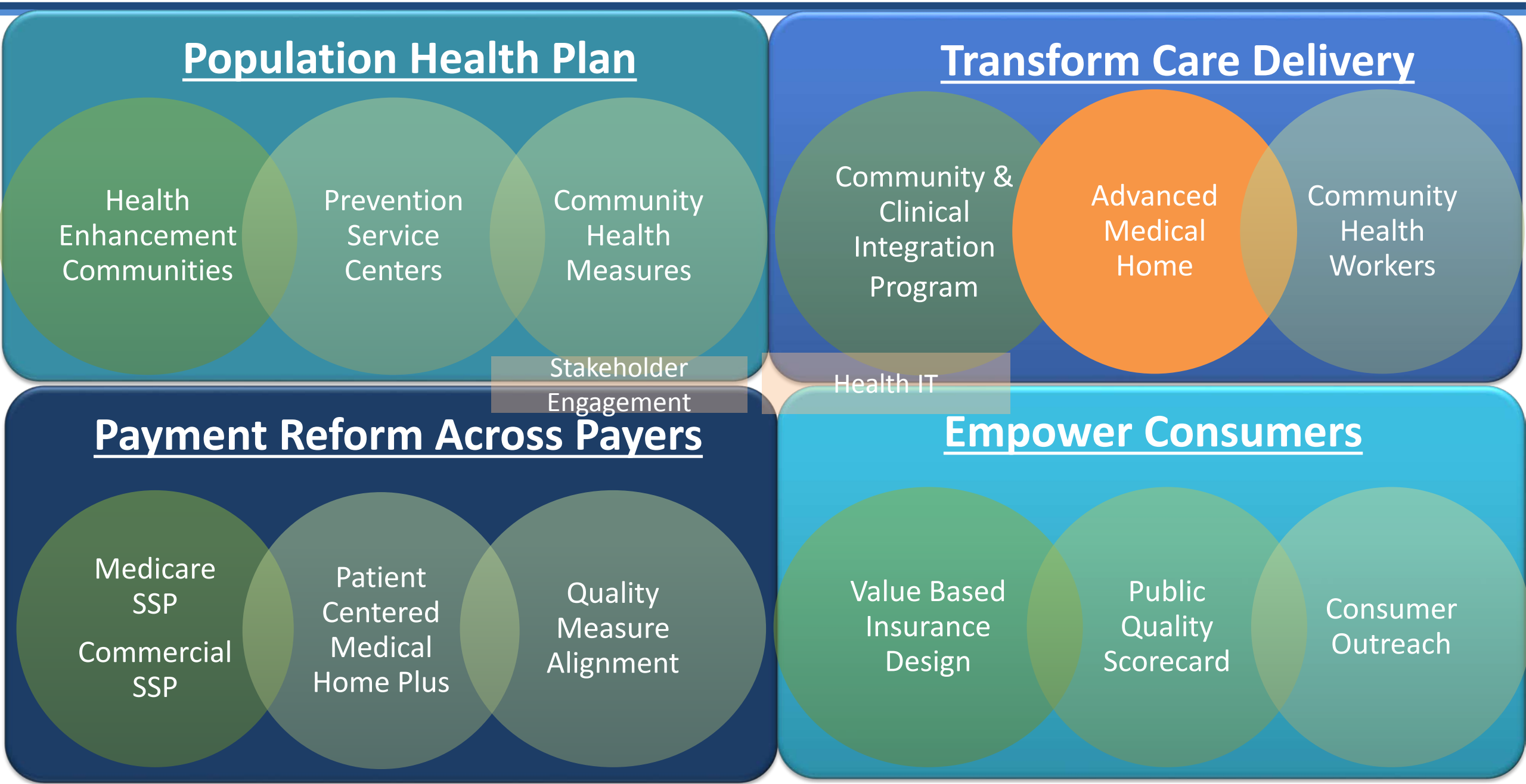
- St. Vincent's Medical Center (acting as lead for Value Care Alliance)
- Northeast Medical Group

Federally Qualified Health Centers

- 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.

Update on
Advanced Medical Home Program

CT SIM: Primary and Secondary Drivers to achieve Aims



Advanced Medical Home (AMH) Program Update

- SIM Office is actively recruiting AMH participants
- NCQA PCMH 2017 standards soon to be released

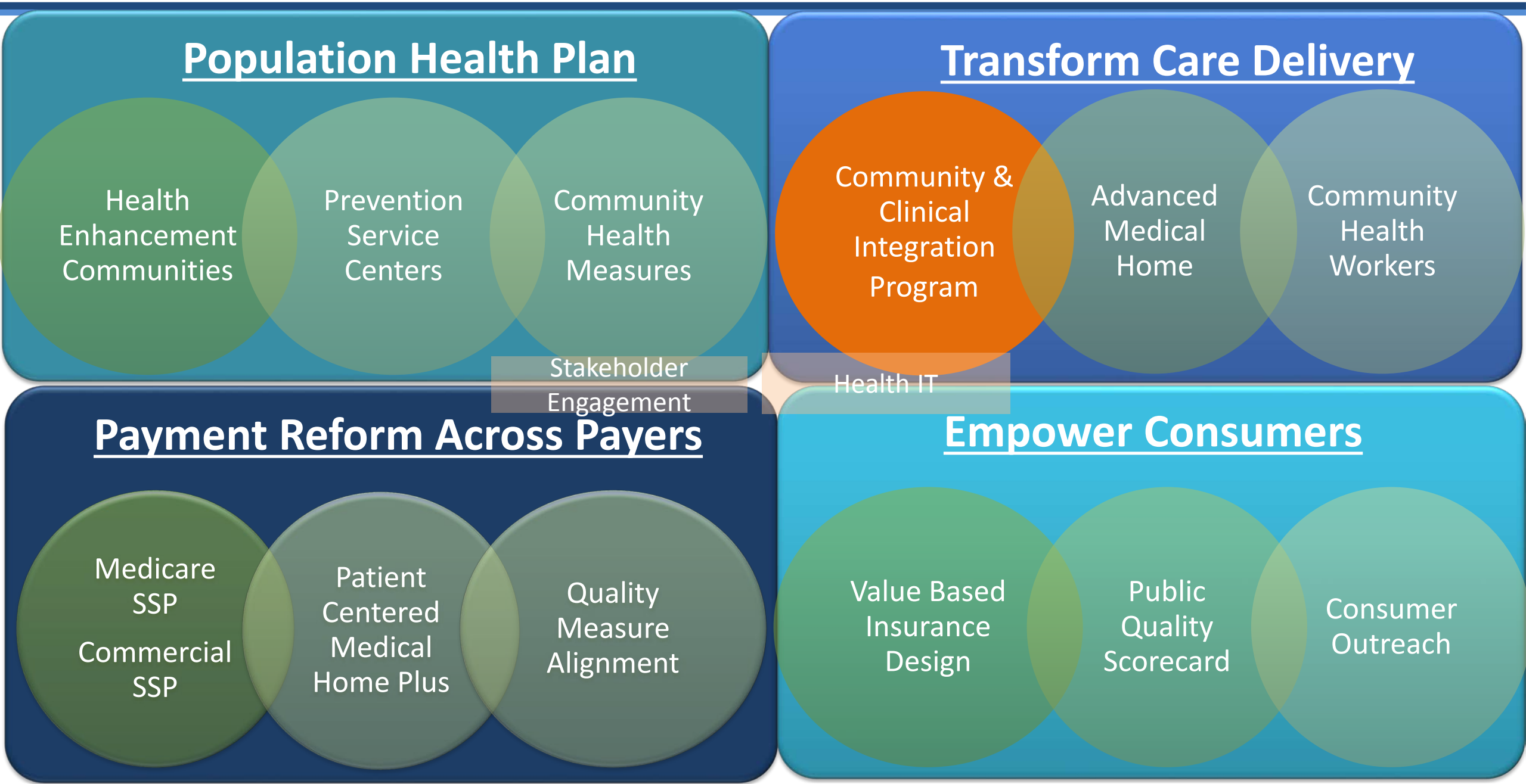
Phase 1: Recruitment
Months 1-3

Phase 2: Transformation
Months 4-12

Phase 3: Evaluation
Months 13-16

Update on Community & Clinical Integration Program (CCIP)

CT SIM: Primary and Secondary Drivers to achieve Aims



What is CCIP?

CCIP provides:

•**Technical Assistance & Peer Learning**

AND

•**Transformation Awards**

To Advanced Networks and FQHCs to help them achieve the **CCIP Standards**

Comprehensive Care Management

Comprehensive care team, Community Health Worker , Community linkages

Health Equity Improvement

Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Behavioral Health Integration

Network wide screening tools, assessment, linkage, follow-up

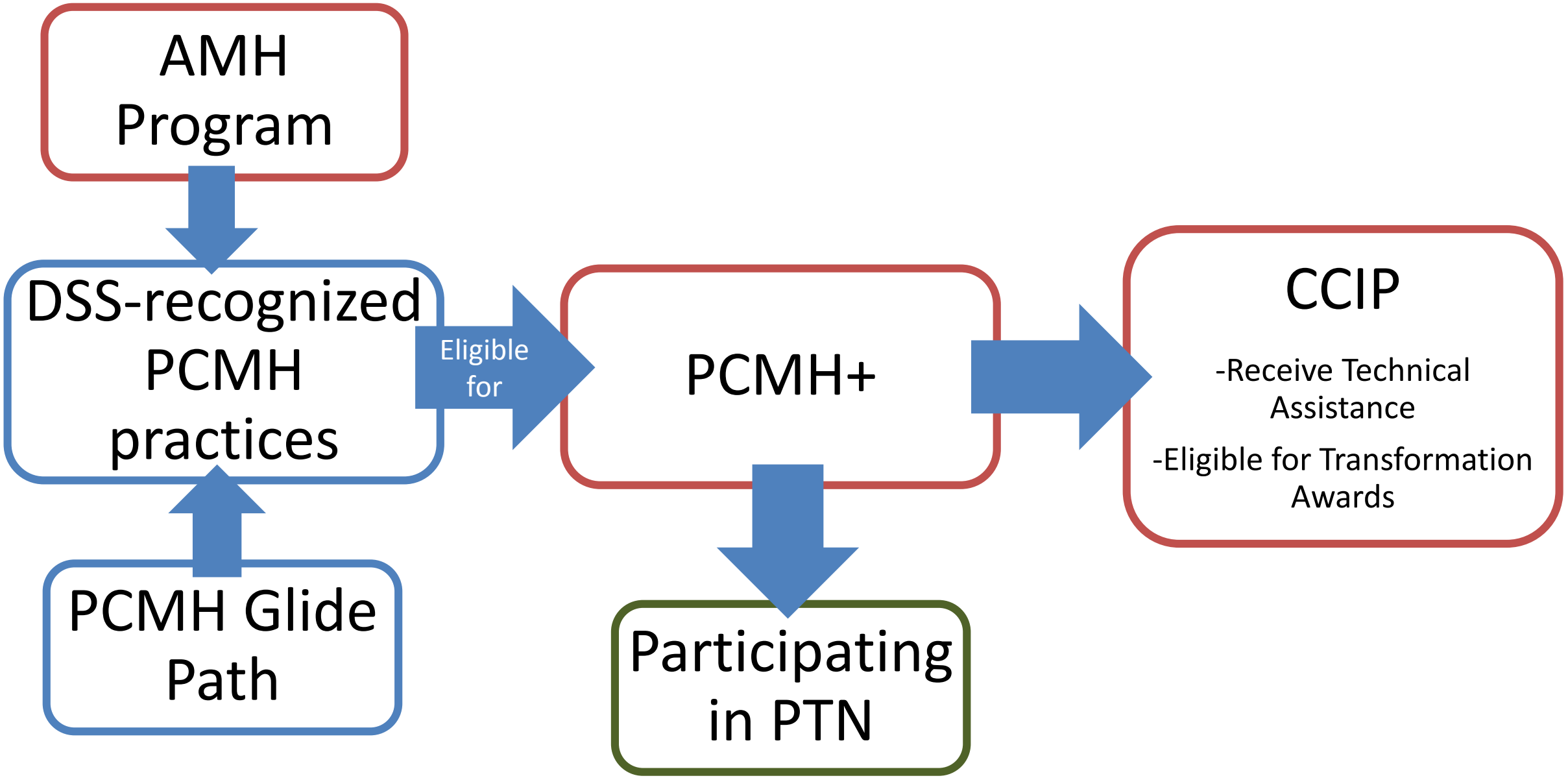
Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

CCIP, AMH, and PCMH+: What is the connection?



CCIP Participating Entities

Advanced Networks

- St. Vincent's Medical Center (acting as lead for Value Care Alliance, which also includes Middlesex Hospital, Griffin Hospital and Western Connecticut Health Network)
- Northeast Medical Group

Federally Qualified Health Centers

- Community Health Center, Inc.

Transformation Awards: Selection Process

All 3 CCIP PEs were awarded Transformation Awards

RFA released August, 2016

Evaluation Team reviewed and scored 6 proposals September, 2016

Evaluation Team awarded 3 PEs based on PCMH+ Participant Selection, December, 2016

SIM PMO negotiating Contract Agreements, January 2017

Transformation Awards release date anticipated February 1, 2017

How will the Transformation Awards be used?

Each transformation award is approximately **$500,000**

The awards will be used for:

Community Health Workers

Behavioral Health specialists

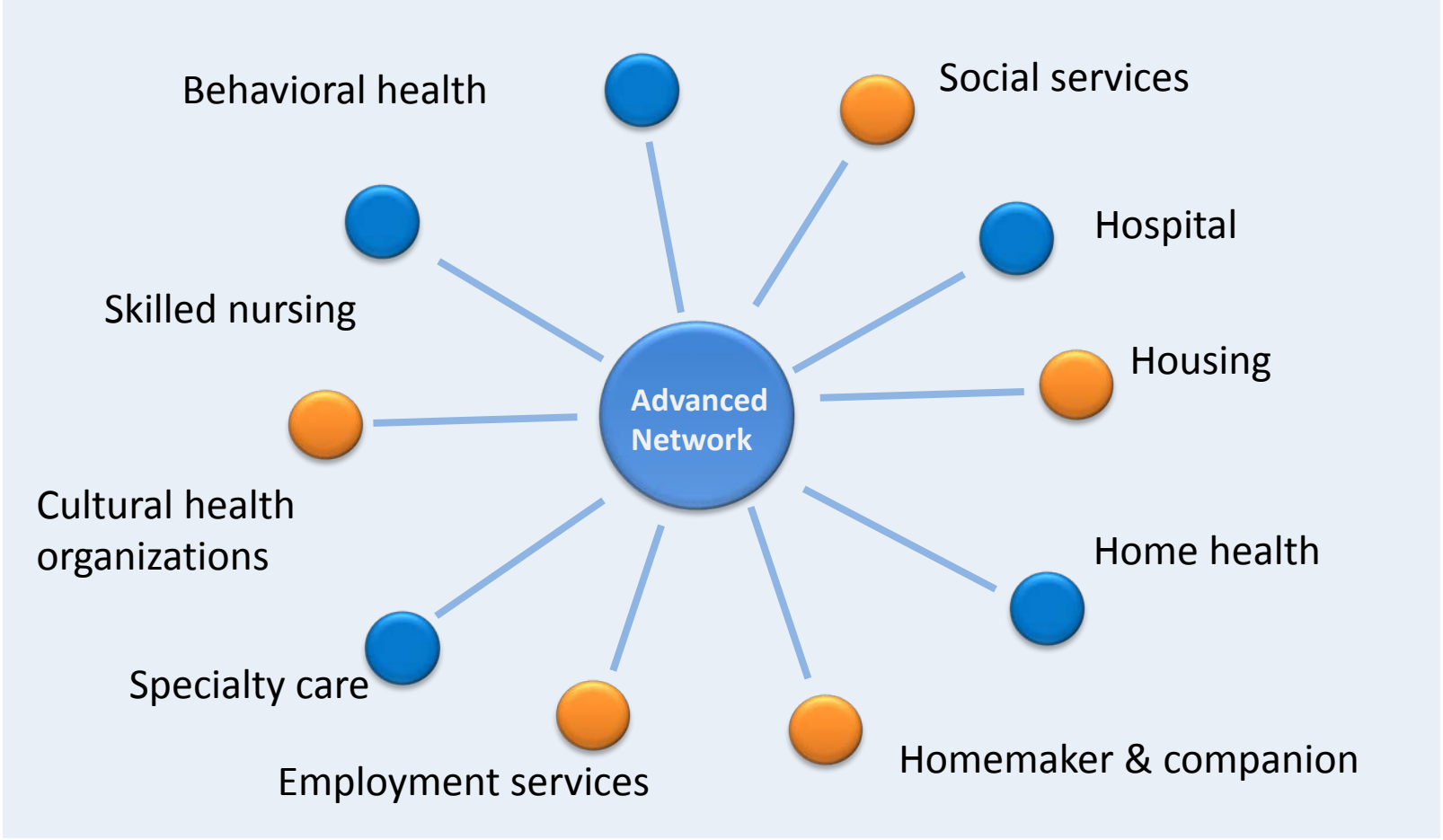
Data analytics and IT support

Program Coordinators and
Administrative support staff

Staff time/consulting dedicated
to process/system redesign

Community Health Collaboratives

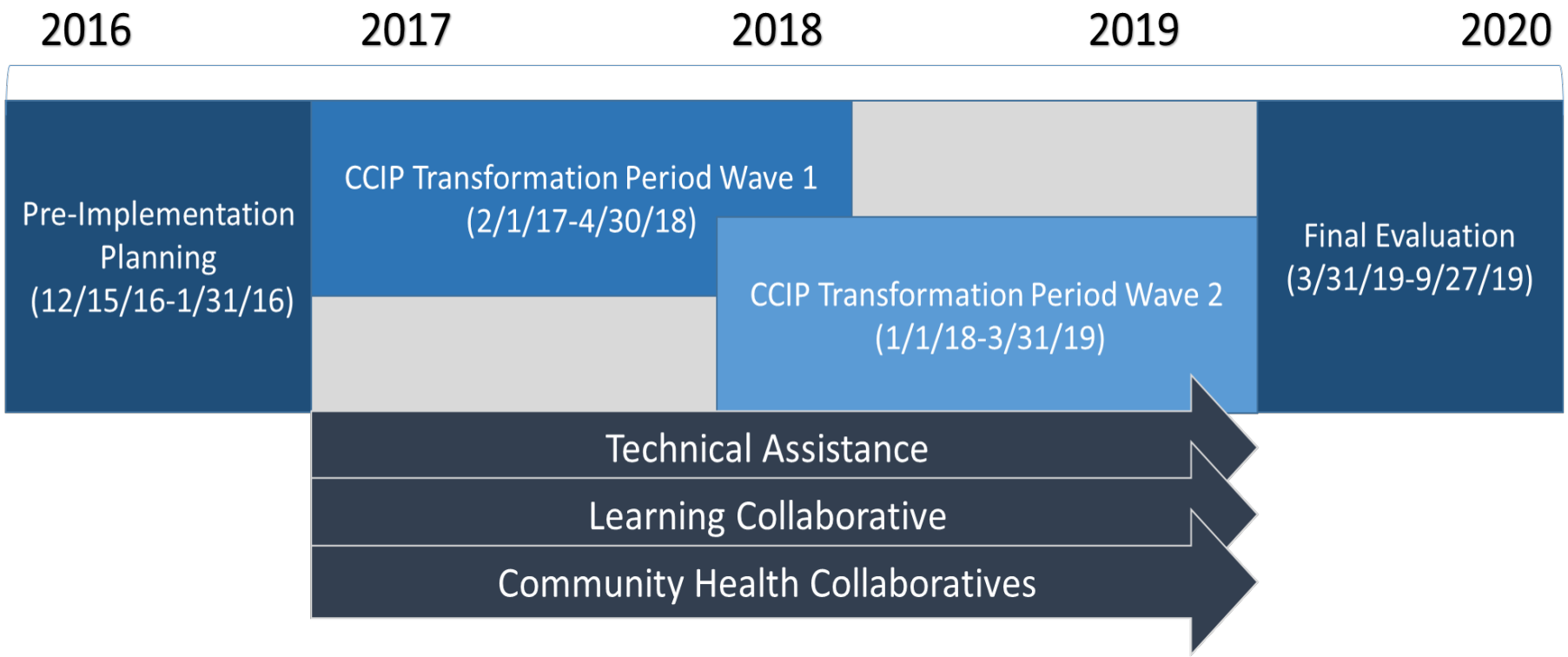
- CCIP PEs are required to participate in a **Community Health Collaborative** to promote coordination between clinical and community organizations
- The PMO will work with DSS and DPH to weigh criteria for selecting the regions for Collaboratives. Criteria may include:



- Percent of region covered by a value-based payment arrangement
- Existing Infrastructure for Collaboratives
- High-risk regions based on population health data

Technical Assistance Vendor: Qualidigm

- Technical Assistance and Peer Learning opportunities through a Learning Collaborative will be provided by the Technical Assistance vendor, Qualidigm
- Qualidigm was selected through a competitive procurement process and includes a fully Connecticut-based team



Primary Care Payment Reform

Integrating and Sustaining CCIP Capabilities: Our Biggest Challenge

More time with patients

Community Health Workers

Behavioral Health specialists

Acting on data about patient needs

Care Planning

Non-billable services (e-consults, phone-calls, email)

Shared Savings: Opportunities and Limitations

Opportunities

- Provides an incentive to invest in services like care management
- Provides a first step toward value-based care focused on quality and cost efficiency

Limitations

- Savings are uncertain
- Savings are far-off
- Limits investments to activities with substantial ROI in 1-3 years

PCPM – Scope of Work

- Literature Review including summary and analysis of primary care payment models that have been implemented in other states/regions
- Key informant interviews/case studies – national models
- Interviews and/or focus groups with CT stakeholders including payers, providers and consumers to inform the analysis and recommendations
- Examination of practice readiness assessment models
- Final report and recommendations and presentation to the Healthcare Innovation Steering Committee

PCPM – Meet the Team

- ***Ken Lalime***

  Ken is a Registered Pharmacist with over 35 years of experience in a wide variety of health care settings, including, Pharmacy, Hospital Management, Physician Organization Management and most recently as CEO of HealthyCT, a non-profit health plan that focused on an evidence based patient centered delivery model.

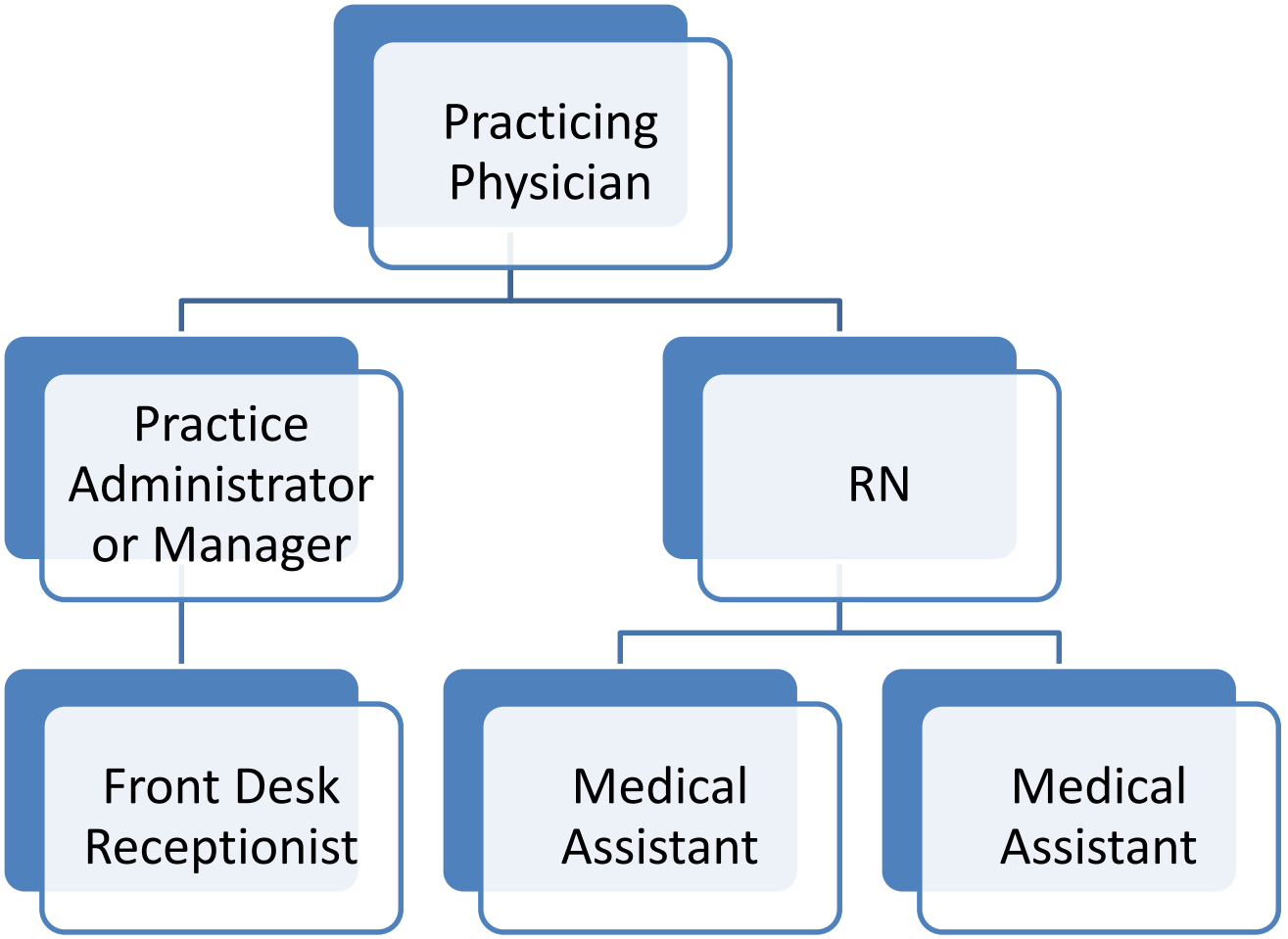
- ***Lauren Williams***

  After a 24-year career at ConnectiCare, Lauren launched her Consulting company in 2016. Her focus has been on leadership and subject matter expertise in all aspects of care and utilization management. During her tenure at ConnectiCare, Lauren, an RN, co-lead the implementation of the State of CT Employee Health Enhancement Program as well as securing grant funding for a research study related to care of vulnerable older adults.

- ***Russ Munson, MD***

  Dr. Munson spent 20 years as a family physician in Chester, CT before pursuing a physician executive career focused on population health and the triple aim. This included hospital and managed care positions in CT and MA over the past 15 years. He recently accepted a position with Harvard Pilgrim in their Hartford office.

Standard Primary Care Practice Organizational Chart



Financial Model of a Single Practice

Practice Revenue Overview - Base case		
Revenue Estimate		
Panel Size	2,500	2,500
$ / Visit	$95.00	$95.00
PCP visit/day	25	20
Total Revenue	$513,000	$410,400
Expenses		
Core Staff (Admin, Billing, Med Assist X2, Benefits)	$200,000	$200,000
Other Overhead (Rent, Insurances, Fees, etc)	$100,000	$100,000
Physician Take Home Compensation	**$213,000**	**$110,400**

This example demonstrates basic compensation for a single practice

Financial Model of a Single Practice with Care Management Investments

Practice Revenue Overview - Base case + Care Management Investments

Revenue Estimate		
Panel Size	2,500	
Advanced payment	**$0.00**	
$ / PCP Visit	$95.00	
PCP visit/day	25	
Total Revenue	$513,000	
Expenses		
Staff (Admin, Billing, Med Assist X2, Benefits)	$200,000	
Other Overhead (Rent, Insurances, Fees, etc)	$100,000	
Care management staff, services, resources		**($150,000)**
Physician Take Home Compensation	**$213,000**	

Financial Model of a Practice with CCIP Services

Practice Revenue Overview w/CCIP Services		
Revenue Estimate		
Panel Size	2,500	
Advanced payment	**$0.00**	
$ / PCP Visit	$95.00	
PCP visit/day	20	
Non-billable pt interactions (phone, e-mail, video, text)	1 hour	
Supervision/huddles/home visit	.5 hours	
Total Revenue	**$410,400**	
Expenses		
Core Staff (Admin, Billing, Med Assist X2, Benefits)	$200,000	
Other Overhead (Rent, Insurances, Fees, etc)	$100,000	
Care management staff, services, technology		**($150,000)**
Additional CCIP Related Staff and Services		
Community Health Workers	**$15,000**	
Behavioral health worker	**$10,000**	
Pharmacist	**$15,000**	
Other	**$7,500**	
Subtotal CCIP Services	**$47,500**	
Physician Take Home Compensation	**$62,900**	

*Dollar figures are hypothetical; model assumes shared CCIP related staff across network

PCPM – Continuum of Options

Comprehensive Primary Care +

Iora Health

Case Study 1: The Iora Health Model

Unique Model of Care

- Non-physician coaches advocate for patients and deliver care
- In-home, text, video, email, etc.
- Fully integrated behavioral health

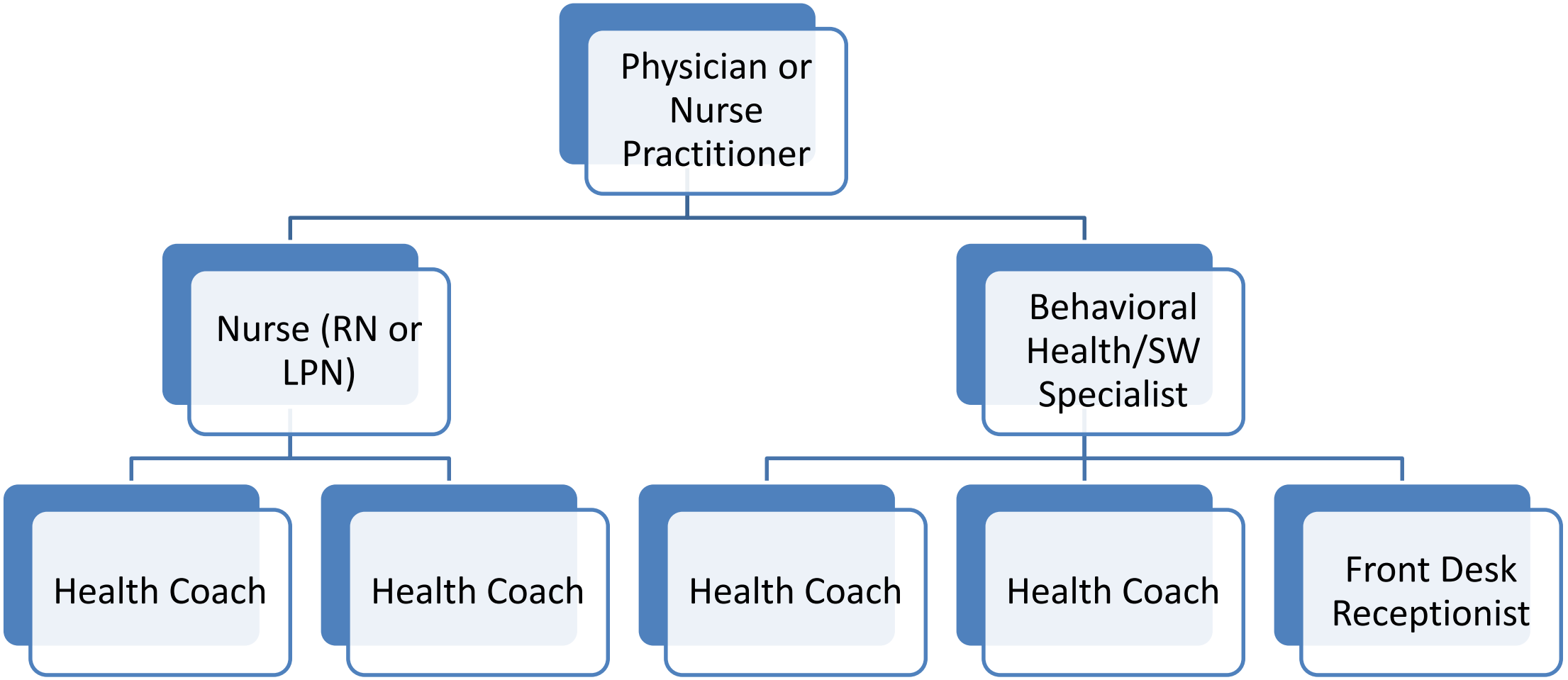
Better Outcomes

- Improved quality and satisfaction
- Improved patient and physician experience
- Reductions in unnecessary and downstream care

Comprehensive PCPM

- Risk adjustment
- Incentives for meeting patient experience, quality and utilization targets
- Shared savings

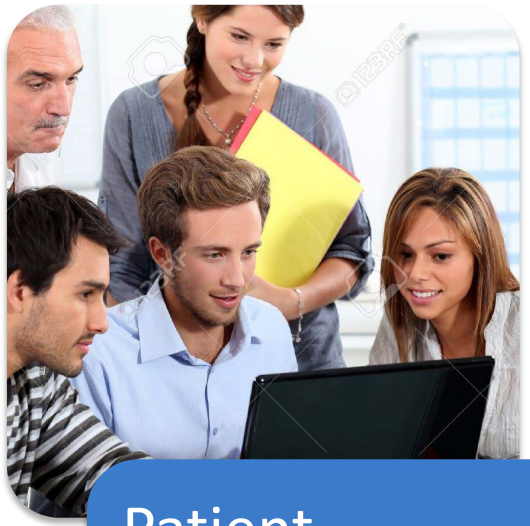
Iora Primary Care Practice Organizational Chart



Iora Health Care Model

Unique Care Teams

- Physician
- Nurses
- Health Coaches



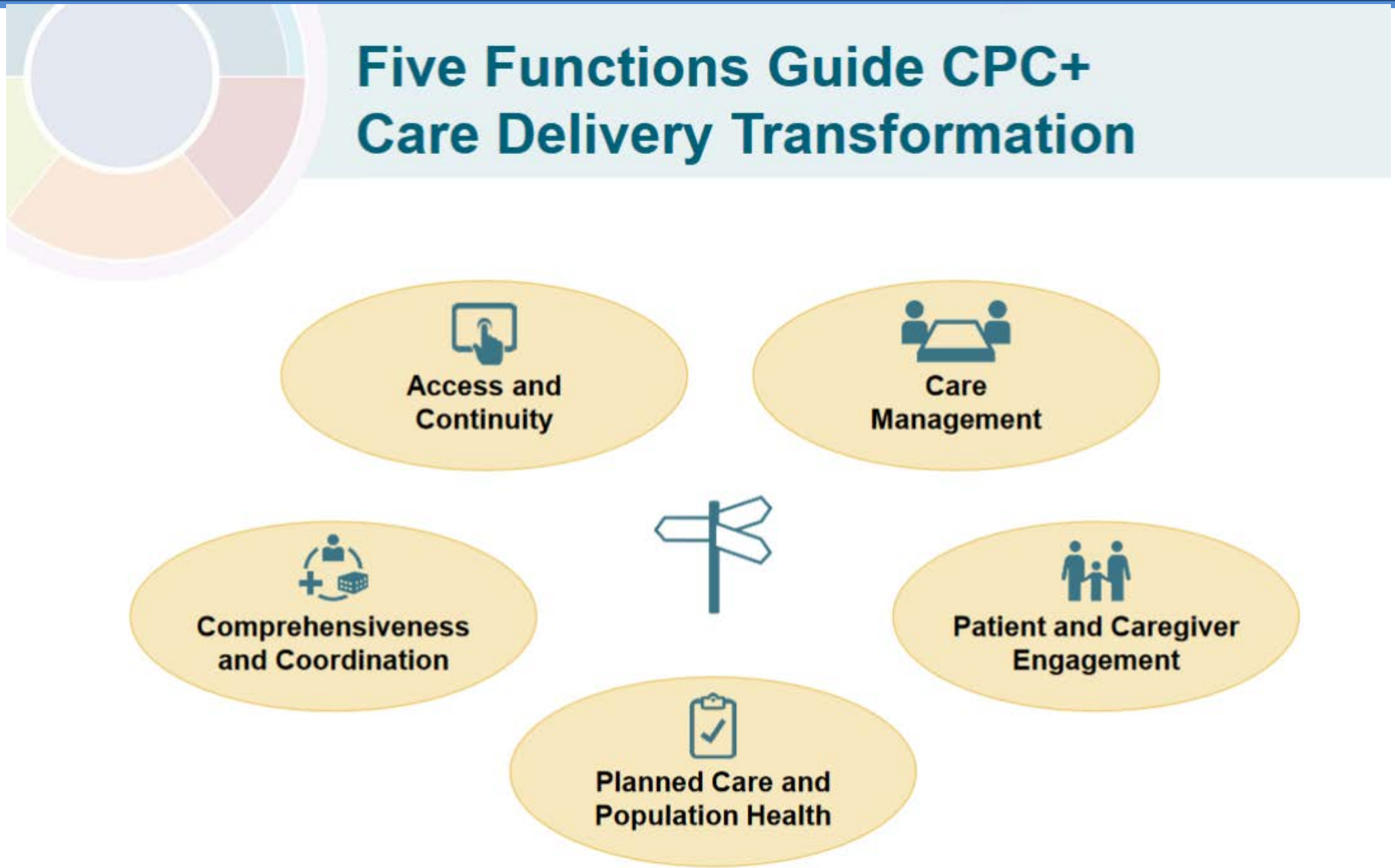
Patient-Centered EMR

- focused on care plan vs. codes

Different Reimbursement Model

- comprehensive bundled payment

Case Study 2– Comprehensive Primary Care + Initiative (CPC+)



Three Payment Components Support CPC+ Practice Transformation

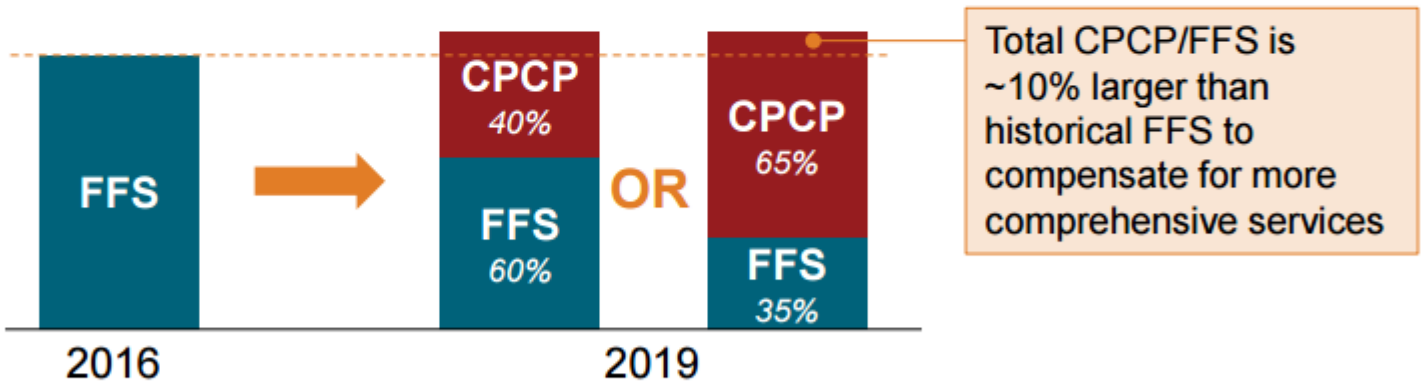
	1 Care Management Fee (PBPM)	2 Performance-Based Incentive Payment (PBPM)	3 Payment Structure Redesign
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (Standard FFS)
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

Comprehensive Primary Care Payment

Track 2 Reimbursement Redesign Offers Flexibility in Care Delivery

Designed to Promote Population Health Beyond Office Visits

Hybrid of FFS and Upfront "Comprehensive Primary Care Payment" (CPCP) for Evaluation & Management



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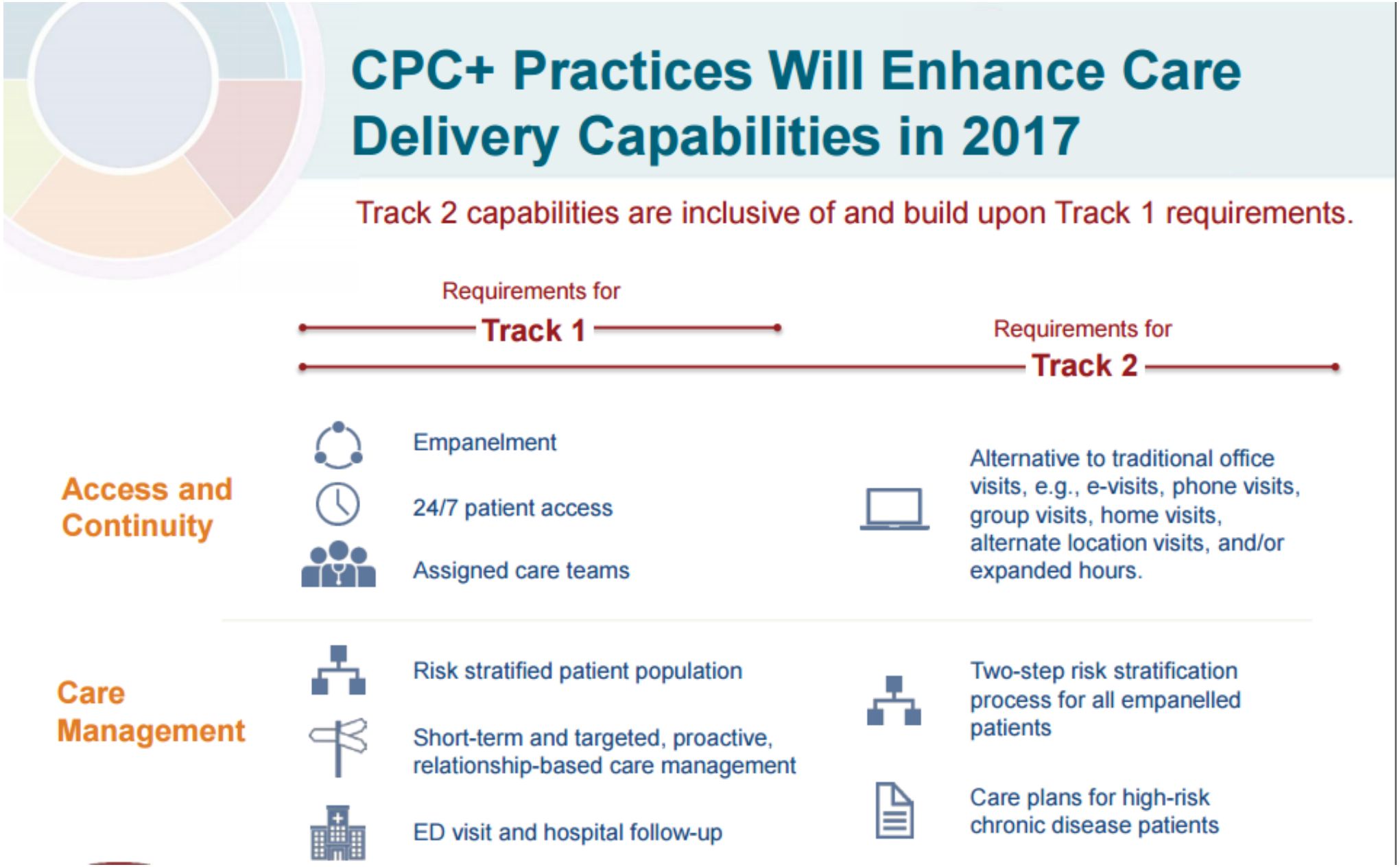
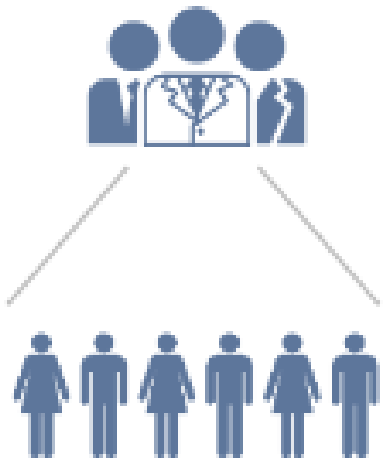
- Practices receive enhanced fees with roughly half of expected FFS payments upfront and subsequent FFS billings reduced by the prepaid amount
- CPCP reduces incentive to bring patients into the office for a visit but maintenance of some FFS allows for flexibility to treat patients in accordance with their preferences

Care Delivery Capabilities



CPC+: An Example (1 of 3)



3
practitioners

250
attributed
beneficiaries
(Medicare)

- Practice B is a small practice
- CPC+ Track 2
- Large number of high risk patients, including several that have been diagnosed with dementia
- Hires a nurse practitioner to do home visits, targeted at high-risk patients

CPC+: An Example (2 of 3)

- Receives:
  1. Care management fee
  2. Performance Incentive Payment
  3. CPC Payment (CPCP) and commensurately reduced fee-for-service payment.
- The CPCP allows practices to provide clinical care outside of the office, which is particularly helpful to high risk patients and those with dementia
- Finds home visits are particularly useful in uncovering patients' unmet social needs, so they spend time building relationships with social service providers in the community to better support

CPC+: An Example (3 of 3)

- Practice B would receive the following CPC+ Medicare payments for program year 1:

Care Management Fees

Based on risk score for attributed beneficiaries, practice receives an average of **$32 PBPM**

Total: $96,000

Performance-Based Incentive Payment**

Practice receives an at-risk incentive payment of **$4 PBPM**

Total: $12,000

Underlying Payment Structure

Practice elects to receive 65% prospective CPCP (plus an additional 6.5% bump), based on historic E&M revenue of $35,000

Total: $24,228

Work Stream Updates

Adjourn