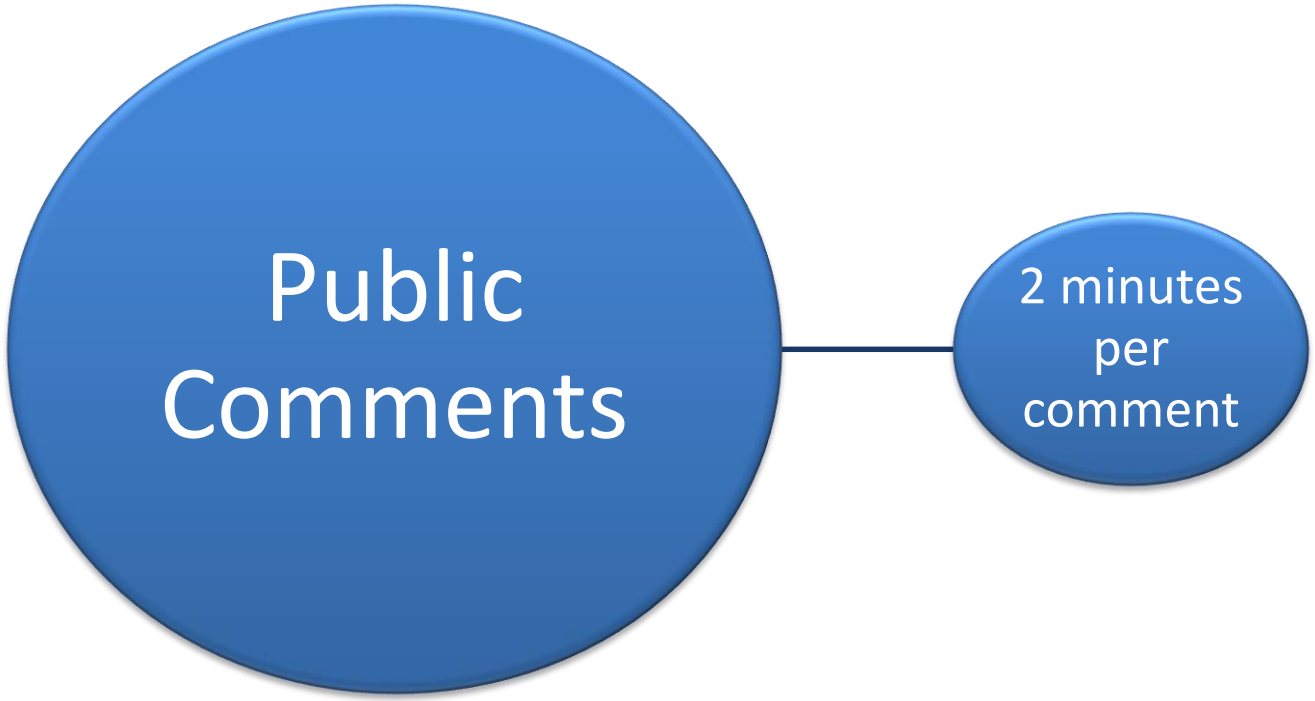
Healthcare Innovation Steering Committee

January 11, 2018

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. Payment Reform/ HEC Planning Strategy	10 min
5. Primary Care Payment Model Report	70 min
6. Population Health Council Charter/Composition (revised)	20 min
7. Adjourn	


Public Comments
2 minutes per comment

Approval of the Minutes

Payment Reform/HEC Planning Strategy

Payment Reform/ HEC Planning Strategy

Primary care payment reform

Health Enhancement Communities

Payment Reform/ HEC Planning Strategy

Medicare Alignment for SIM Models through Customized Models: Medicare alignment with models developed or tested under SIM (hereafter referred to as "SIM models") could be achieved through a new, state-specific APM with Medicare, Medicaid, and private payer participation. In exchange for increased Medicare flexibility, we would hold states accountable for specific quality and cost outcomes. The opportunity for states is more control over improving quality and lowering costs based on population needs of the state with the support of CMS to achieve better results. In order for Medicare to participate in a SIM model under this pathway, the model must meet the set of principles outlined below, and be an Innovation Center test of a novel model under section 1115A authority.

https://innovation.cms.gov/Files/x/sim-medicare-mpmodelsguidance.pdf

Key Principles On Which Proposals are Assessed

1. patient-centered
2. accountable for total cost of care
3. transformative
4. broad-based
5. feasible to implement and
6. feasible to evaluate

Payment Reform/ HEC Planning Strategy

Primary care payment reform

Health Enhancement Communities

State-specific Multi-payer Demonstration

Primary Care Payment Model Report

PCPM White Paper Goals

1. Describe how primary care payment reform supports care delivery transformation
2. Demonstrate why current payment reforms in Connecticut are insufficient to support needed care delivery reform
3. Provide historical background and current examples of primary care payment reforms nationally and in Connecticut
4. Offer three concrete primary care payment model options for consideration in Connecticut
5. Present Connecticut payer, provider, and consumer perspectives on needed primary care payment reform
6. Recommend essential elements of primary care payment models considered for adoption in Connecticut (PTTF key recommendations)

Perspectives on Primary Care Payment Models

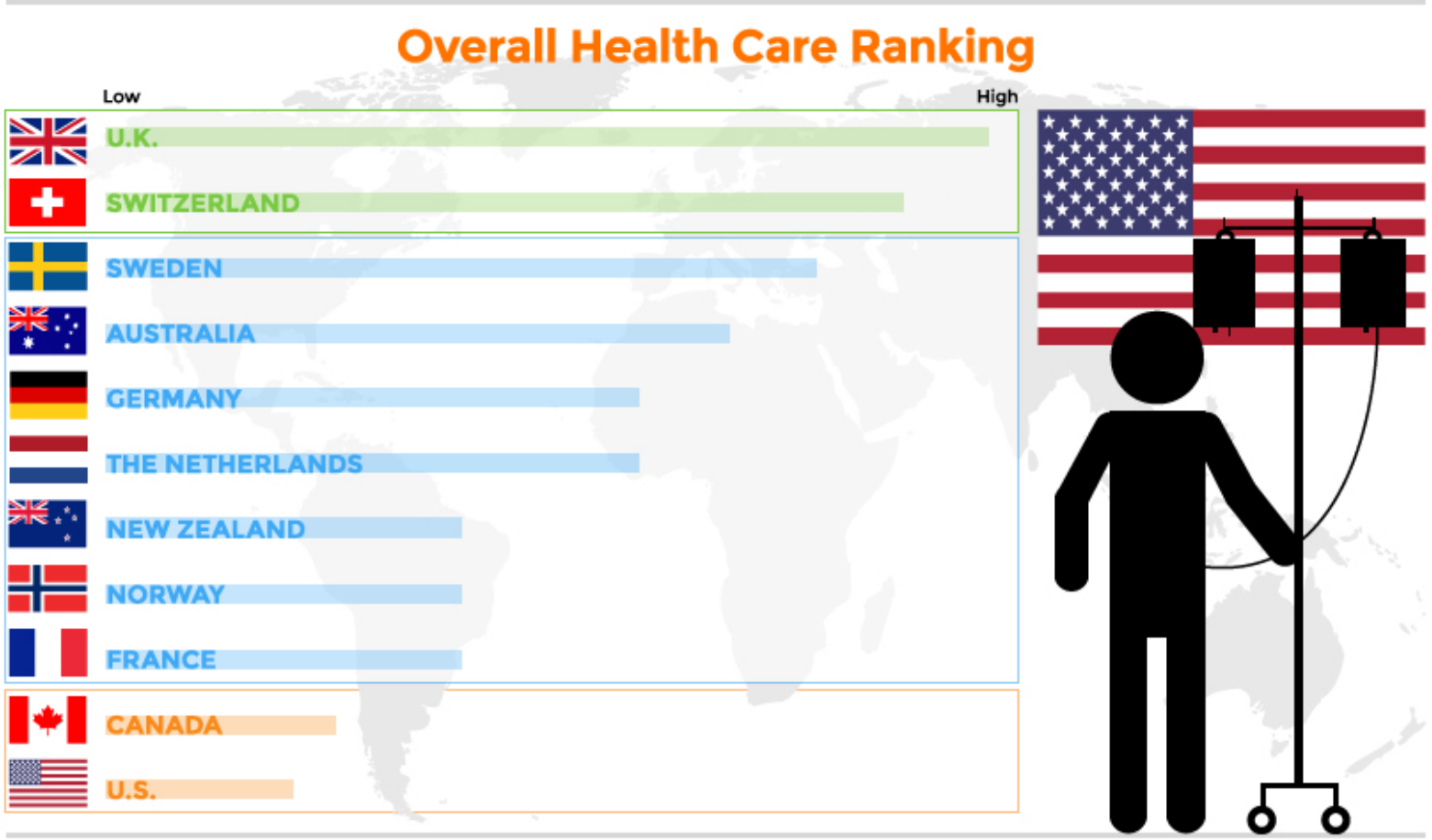
Lesley Bennett, Consumer Advocate

Elsa Stone, MD, Pediatrician

Andrew Selinger, MD, Family Physician, ProHealth Physicians

U.S. Healthcare Ranking

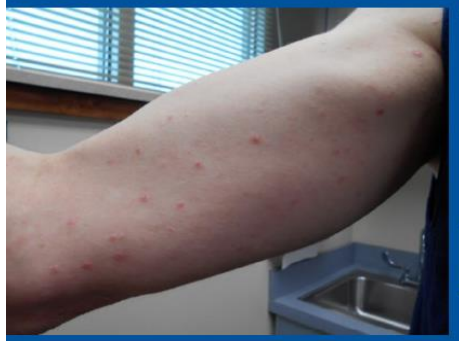
A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

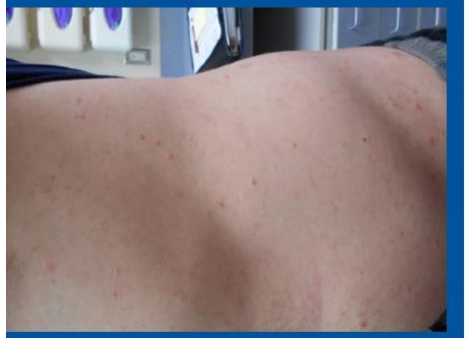


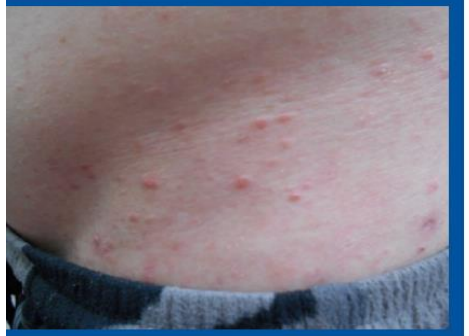
Source: K. Davis, K. Stremikis, D. Squires, and C. Schoen, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update*, The Commonwealth Fund, June 2014.

The COMMONWEALTH FUND

Enabling E-Econsults







Consult Question

E-CONSULT: Are there specific blood tests I should be running? These lesions are scarring his skin. He is concerned about Crohn's disease as well, could this be related to a GI issue? Pictures are uploaded.

Specialist Response

Hello,

This 36 yow male presented with several years hx/o multiple erythematous papules, some with mica-like scaling on the surface on multiple areas of the skin surface. He was seen a dermatologist years ago & told he had Psoriasis. Creams did not seem to help but sunlight was very effective.

This appears to be Guttate Psoriasis. However, Psoriasis doesn't usually scar.

Another remote possibility is Degos Disease, benign variant. However, with his GI symptoms, I would refer to GI for additional testing. No blood test I am aware of is available, but try bxing a fairly fresh lesion. Alert pathologist to previous dx of Psoriasis & R/O Degos Disease.

For Psoriasis, 20 min sunlight exposure/day should help. Also, Dovonex Bid + TMC 0.1% could be useful as could Enstilar Foam.

Thank you for this consultation.
Dermatologist, M.D.

PACT Initiative

Rationale for Post-Acute Program

1. 2014 MSSP post-acute spend = $80M
   - 225 skilled nursing facilities
   - 100 home health agencies
2. Average SNF length of stay = 28 days
3. Average SNF cost/day = $560
4. Shared savings programs revealed the need for an immediate plan to address affordability of services
5. Preparation for global risk agreements, under which ProHealth will be responsible for the total cost of care

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PACT Initiative

Program Expansion

In July 2016, based on 12-month results, the program was expanded to cover additional geographies

Role	Initial Staffing	Current Staffing
ACES	2 at 2 facilities	7 at 10 facilities
SNF UMs	4	8
PACCs	1	4
Pharmacist	Limited access	1
Preferred SNFs	91	38
Preferred HHAs	18	12

LEADERSHIP: In July 2016, 4 interdisciplinary field-based regional teams of RNs, SWs and APCs were added as well as 3 part-time medical directors to oversee new program

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PACT Initiative

6-Month Results

Is the 12 month expected results? Or confirmed?

Metric	Pre-Pilot	6-Month Post-Pilot	12-Month Results
Readmission Rate	18%	3% (engaged patients)	3% (engaged patients) 14.6% (all patients)
Average Length of Stay	28 days	21 days	18 days
Use of Preferred Networks	N/A	90%	90%
SNF Admissions/K	112	104	76
Engagement	N/A	1700 patients	7965 patients
Average Cost per Day	$560	Not measured	$480

PACT Initiative

Year-Over-Year MSSP Key Metrics Comparison

Key Metric	Q4 2015	Q4 2016 (prelim)	Change Rate
Per member per year expense	$10,900	$9,803	-10.1%
30-day readmission rate	16.7%	14.3%	-14.4%
Admissions/k	294	252	-14.3%
SNF admissions/k	104	72	-30.8%
SNF total days/k	2,574	1,431	-44.4%
ED visits/k	664	608	-8.4%

Fall Prevention Courses for Older Adults

In the Netherlands, fall prevention courses are gaining popularity.

Task Force Recommendations

- **Recommendation 1**: Connecticut's payers should implement primary care payment reform to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

- **Recommendation 2**: Payers and providers are encouraged to use prospective bundled payments that reduce or eliminate reliance on visit-based care. Payers should offer entry-level options that limit the risk associated with bundling and an incremental strategy that enables practices to build their capabilities over time.

- **Recommendation 3**: Primary care payment models should use prospective primary care bundles or care management fees to increase by at least double the funding dedicated to primary care as a percentage of the total cost of care.

Task Force Recommendations ctd.

- **Recommendation 4**: Primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care.

- **Recommendation 5**: Primary care payment models should include the cost of new services in prospective primary care bundled payments or care management fees, which should be exempt from cost-sharing.

- **Recommendation 6**: Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.

Task Force Recommendations ctd.

- **Recommendation 7:** Fee-for-service (FFS) payment may play a limited role as part of a blended primary care payment model to incentivize certain services and protect against under-service.

- **Recommendation 8:** Primary care payment models should include a bundled payment option in which primary care practices receive resources to manage mental health and substance use conditions and assume accountability for associated outcomes.

- **Recommendation 9:** Primary care payment models should maximize the flexibility that primary care teams have to expend resources on health promotion and coordination with community services, including the use of community health workers.

Task Force Recommendations ctd.

- **<u>Recommendation 10</u>:** Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change.

- **<u>Recommendation 11</u>:** Primary care payment models should be multi-payer, cover the majority of a practice's patient population, and provide practices with external coaching support and technical assistance.

Population Health Council Charter/Composition (revised)

PARTICIPATION IN THE CT SIM POPULATION HEALTH COUNCIL

Composition

Population Health Council

- Community health improvement strategy and finance expert (1)
- Municipal leadership member (1)
- Advance Network (ACO) Representatives (2)
- Health Plan Representatives (1)
- Large and Small Employer (2)
- Consumers/advocates (5)
- Connecticut Hospital Association (1)
- Health Data Analytics expert (1)
- Health Economist (1)
- Federally Qualified Health Centers (1)
- Urban/Rural school district (1)
- Behavioral Health agency (1)
- Local Public Health agency (1)
- Housing (1)

Support & Technical Assistance Team

- State Agencies: DPH, DCF, DMHAS, DSS, OSC, OHS/APCD (Ex officio)
- PMO staff (1)
- DPH-SIM Staff (2)
- Contractor Facilitator (TBD)

Criteria For Membership

- Direct work experience in the CT public health and healthcare environment
- Knowledge of health related data collection and interpretation
- Experience with outpatient patient care
- Direct experience in regional planning and development organizations.
- Demonstrable experience in community engagement activities related to prevention and health promotion
- Organizational experience in population health management
- Large self-insured organizations/small employers
- Organizational interest in policy advocacy
- Housing
- Consumers representing philanthropic sector; environmental health interest, homeless advocates, non-profit food systems, disabilities, economic support, advocate against violence, chambers of commerce, racial/ethnic/geographically diverse communities

- Expertise in public health and healthcare research, policy and evaluation
- Knowledge of CT SIM
- Experienced supporting communications
- Experience facilitating collaborative activities

Charter:

CT SIM Population Health Council

The Population Health Council is charged by the Healthcare Innovation Steering Committee with recommending strategies to ***improve Total Population Health*** in the context of the State Innovation Model (SIM) implementation.

The Council will recommend an ***innovative and actionable strategy to support and enable Health Enhancement Communities (HECs)*** in Connecticut. HECs shall be accountable for health, health equity, and related costs for all residents in a geographic area; use data, community engagement and cross sector activities to identify and address root causes of poor health; and operate in an economic environment that sustainably funds and rewards such activities by capturing the economic value of improved health.

The Council will ensure that the ***HEC strategy is designed through a community driven cross-sector planning process*** that involves the participation of a diverse set of stakeholders. The HEC strategy recommendation should also be informed by ***problem solving partnerships with selected reference communities***, who jointly with the state will examine barriers and opportunities related to governance, infrastructure, performance measurement and financial sustainability.

The HEC strategy should:

- drive investments that ***focus on prevention of disease and health disparities,***
- include ***methods that reliably capture and quantify the economic opportunity*** associated with health improvements that might be achieved by HECs,
- include a system of ***regional metrics of population health*** and ***community accountability measures***.

In addition, the Council will continuously monitor progress and advise on all aspects of the ***Prevention Services Initiative (PSI),*** including the effectiveness of technical assistance, and progress towards increasing the number of new financial agreements between healthcare organizations and community based organizations.

Adjourn