HEALTH MANAGEMENT ASSOCIATES:
HEALTH ENHANCEMENT COMMUNITY INITIATVE
SCOPE OF SERVICES

1.1 HEC STRATEGY DEVELOPMENT

A. The CONTRACTOR shall develop an innovative, logical, clear and actionable strategy to support and enable HECs in Connecticut's communities. In support of these efforts, the CONTRACTOR shall:

1) Synthesize the Connecticut-specific problems the initiative addresses and what success looks like.
2) Recommend the role of key sectors in enabling HECs to succeed, including potential governance structures, sources of infrastructure support, management resources, fiduciary functions and coordinating activities. This includes identifying the respective role and functions of the State and participating communities.
3) Recommend community-wide process and outcome measures and methods for producing such measures as a means to monitor HEC performance; such measures must be sufficiently reliable and valid to serve as the basis for accountability agreements and the distribution of financial rewards. The recommendation should include a solution for community-wide attribution (i.e., the population with regard to which the HEC performance will be measured).
4) Recommend one or more financial models and develop a plan with stakeholder input for implementing such models that would provide financial resources up-front to plan and implement cross-sector activities and sustain such activities ongoing. Such models should, at a minimum:
    i) Enable near term investments in infrastructure and cross-sector activities;
    ii) Rely primarily on public and private sector investments and contributions, rather than grants;
    iii) Provide rewards to HECs and other contributors/investors:
        (1) proportionate to the economic value of health improved considering the tangible and intangible value produced in the healthcare sector as well as other sectors such as private and public sector employers, municipalities, and state agencies such as corrections and child welfare;
        (2) taking into consideration the extended return on investment timeframes characteristic of root cause preventive interventions.
5) In support of #4 above, consider promising options for financing root cause solutions such as those identified in the RWJF report and CDC report. The examination shall, at a minimum, include but is not limited to the following:
    - Capture and reinvest
    - Blending and braiding federal, state and local funds
    - Community benefit financial institutions
    - Hospital Community Benefit
    - Prevention escrow account
    - Low-income housing tax credits
    - New Markets Tax Credit
    - Pay for Success/Social Impact Bonds
    - Wellness Trust
    - Captive insurance
6) Identify and review the range of existing value-based payment models, with special attention to existing Connecticut models, and recommend adjustments to such models that would promote investments in prevention.
    i) Propose models of community-wide attribution;
    ii) Outline short and long-term benefits to all sectors;

iii) Align fiscal incentives consistent with CMS guidance.

7) Recommend statutory and regulatory levers and various federal authorities (e.g., Medicare or Medicaid waivers) that would be required to implement the solutions recommended in #3, 4, 5, and 6 above.

8) Recommend health information technology enablers that would support the success of HECs and federal opportunities to finance such enablers, in consultation with the State's Health Information Technology Officer (HITO).

   i) Recommend HIT enablers that are premised on successful programs adopted in other states;

9) Recommend levers regarding workforce.

   i) Build on ongoing CT work, such as training and advancement recommendations for the Community Health Workers initiative.

1.2 COMMUNITY AND STAKEHOLDER ENGAGEMENT

A. The CONTRACTOR shall use a community-driven process to design the HEC strategy that is relevant to and has strong buy-in from a diverse set of stakeholders. In support of these efforts, the CONTRACTOR shall:

1) Implement ongoing stakeholder engagement and a bi-directional communication strategy. This strategy should, at a minimum:
   i. Convene in-person meetings, regularly scheduled follow-up meetings, emails and public posting of information.
   ii. Allow for community members, existing collaboratives, healthcare providers, employers, community organizations, municipal government representatives, and others to be active participants and co-creators of the ultimate HEC approach.
   iii. Special emphasis should be placed on garnering the input and engagement of individuals and organizations that represent or serve populations with demonstrated health disparities.
   iv. Engage state experts in insurance and health economics and private and public universities.
   v. Engage federal officials such as at CMS, CMMI, and HRSA as needed.
   vi. Communicate progress on a periodic basis, translating complex ideas into simple, clear messages for broad dissemination.
   vii. Propose a feedback process where HEC components and recommendations are continuously vetted and adjusted as part of the stakeholder input process.

2) Support the State in engaging state agencies and statewide organizations (e.g., foundations) in the planning process. This may include preparing background materials, organizing meetings, preparing summaries, and serving as subject matter experts.

3) Work with a cohort of no less than three reference community health collaboratives that meet a minimum state of readiness in order to engage in a problem-solving partnership for designing the HEC strategy and to illustrate how the recommendations from Objective 1 might be realized in a Connecticut-specific community. Jointly, with the reference communities as planning partners, the CONTRACTOR shall:

   i. Perform initial introductions that include clearly defined goals and objectives from the State perspective, reference community responsibilities, and a detailed timeline for planning to ensure that all deliverables are met in a timely manner.

ii. Facilitate meetings to promote decision making during planning sessions and help reference communities organized and assess information that will be used to for planning.

iii. Prepare materials and agendas, provide training and technical assistance and any other supports needed to identify and assess reference communities' strengths, resources, financing, gaps, preferences, priorities, etc. that are critical to inform recommendations and guidance that will ensure both HEC development and long-term sustainability.

iv. Utilize the Stanford Social Innovation Review Collective Impact Framework and leverage experience working with community partnership models in other states to foster openness, transparency and inclusiveness to ensure meaningful participation across diverse stakeholder communities.

v. Establish a clearly delineated planning framework that outlines and sequences decisions that will be required to assure complete and comprehensive input on, and recommendations regarding, HEC governance and management structure, analytics, finance and strategy. Additionally, the planning framework shall ensure sufficient time for engagement, discourse and collaboration to result in detailed recommendations to guide future policy. The framework shall address the topics and questions detailed in **Appendix A, as adjusted by mutual agreement of the STATE, the CONTRACTOR and the Reference Communities.**

vi. Bring the necessary inputs to the planning process and ensure the development of corresponding outputs:

a. Facilitate decision making during the planning sessions;
b. Provide tools, facilitation, and technical assistance, to address topics outlined in Appendix A;
c. Provide information and subject matter expertise on key options and evidence from the field as well as tools for assessing and prioritizing options;
d. Develop written documents and financial models to support the iterative planning process and codify decisions;
e. Provide coaching to collaborative leaders and staff to help them keep the process moving forward effectively and resolve issues that arise.

1.3 FINANCIAL MODELING AND ACTUARIAL ANALYSIS

A. The CONTRACTOR shall conduct financial modeling and analysis that will enable the STATE to quantify the magnitude of the economic opportunity associated with health improvements that may be undertaken by HECs as described in subsections B through E below.

B. The CONTRACTOR shall undertake the following in support of quantifying the economic value to Medicare:

1) Build a detailed, multi-year financial model using Medicare data contained in the Connecticut All Payer Claims Database to project the potential savings associated with various health improvement scenarios over a 3, 5, 10, 15 and 20-year timeframe.

2) Focus primarily on the economic benefits of health problems avoided (i.e., a reduction in the incidence and prevalence of acute and chronic illness and injury) as a result of primary and upstream secondary prevention.

3) Examine non-disease specific approaches to quantifying value creation such as impact on population risk trend as reflected in agreed-upon risk scoring models.

4) Avoid focusing primarily on near term savings that accrue from improvements in clinical management, as is typical of most value-based payment models.

5) Collect, review and validate available Medicare data from the all-payer claims database;

6) Identify additional data sources, such as self-reported health status, functional impairments, and living arrangements;

7) Identify key inputs and outputs for the model;

8) Review and analyze data by population groups (elderly, disabled, Medicare/Medicaid dually eligible) and disease categories (acute, chronic, mental health, substance use disorders, and injury-related diagnosis)

9) Develop a multi-year projection model segmented by population groups and disease categories;

10) Develop short and long-term trend estimates with and without intervention;

11) Review research to assess the impact on Medicare expenditures due to prevention strategies, payment and care delivery interventions and non-medical interventions targeted to social conditions and other factors.

12) Produce an Excel-based flexible financial modeling tool using Medicare data that enables state planners to modify assumptions, assess associated economic impact, and calculate return on investment that reflects changes in health status over time. This includes but is not limited to:

    i. Provide instructions that explain how to vary key assumptions to support sensitivity testing;

    ii. Estimate Medicare cost impacts across three levels including the incidence of disease, early detection, and better management of diseases.

B. Recommend companion analyses that may be undertaken by the STATE and its private partner payers with respect to Medicaid, state employees, and commercially insured populations in order to produce a complete, statewide view of the potential economic value of health improved.

C. Propose and conduct analyses with respect to other state agency service expenditures to which health improvement benefits would likely accrue in corrections, juvenile justice, education, housing, and child welfare. This includes but is not limited to, researching social determinants of health evidence to guide the development of key inputs and outputs for other downstream benefits to public services.

D. Work with 2-3 employers to model the potential value of prevention efforts as it relates to productivity (e.g., presenteeism & absenteeism). This includes but is not limited to summarizing the literature on the causes and effects of healthcare-related issues on the workforce; and, the evidence of greater productivity when people are at work, savings for employers, reduced State expenditures for benefit programs and higher State tax collections.

E. The CONTRACTOR shall submit an Analytic Plan for acceptance and approval by the STATE before undertaking the financial modeling and analysis.

F. The ability of the CONTRACTOR to conduct the Medicare analysis specified in A of this Section is predicated on the STATE's provision of the necessary Medicare data.

1.4 MEETING FACILITATION AND ENGAGEMENT

A. The CONTRACTOR shall engage the HISC and Population Health Council in the formulation of an HEC vision and execution of the Population Health Council charter, which shall serve as a frame for the advisory process.

    1) Utilize the Collective Impact Model as a guide to:

        i. Identify stakeholders' shared interests;
        ii. Identify critical decision points in the design process;
        iii. Assure continuous communication
        iv. Define mutually reinforcing activities
        v. Review the policy, financial and potential outcomes of proposed alternatives;
        vi. Gather information and data that is needed to effectively evaluate proposals and alternatives.

B. The CONTRACTOR shall organized and facilitate up to10 in-person Population Health Council meetings that include the following:

    1) Preparing meeting agendas, presentation and support materials, conducting presentations that include clear action steps and defined team responsibilities; meeting minutes; bi-directional communication tools and by creating a structured and logically sequenced timetable.

    2) Arranging for subject matter expert (SME) presentations and/or illustrating local experiences that feature related work in Connecticut and in other states.

C. The CONTRACTOR shall provide up to four presentations to and solicit input from the HISC periodically through the conclusion of the planning process. The CONTRACTOR shall do so noting that the HISC usually requires two meetings to review and approve a final plan including a period of public comment.

1.5 SUMMARY REPORT AND PLAN

A. Produce a concise, clear and comprehensive report including, at a minimum, background, key findings, and recommended HEC initiative strategy consistent with the advice of the Population Health Council and HISC.

    1) The report shall document community engagement and offer tangible strategies to ensure community-wide multi-sector collaboration and accountability to promote healthier people, better care, smarter spending, and health equity.

    2) The report shall describe the current state and future state and an *applied view* of the proposed strategy, for the state as a whole and for each of the three reference communities as separate sections, chapters or exhibits.

    3) The report shall note potential challenges, detailing the overarching strategy and anticipated outcomes, as well as presenting alternatives should the environmental context change.

    4) The report shall include a detailed plan that operationalizes key components of the HEC initiative.

    5) Recommendations shall be reflected in an implementation roadmap with timelines to achieve measurable goals and objectives, including milestones to assess progress of the proposed strategy and adjustments over time, as necessary.

Table 1. High-Level Project Timeline

Key Outputs	Timeline
Guidance and subject matter expertise regarding HEC design and operational strategy provided	Ongoing
Population Health Council meeting facilitation	Monthly through contract end date
Periodic presentations to the Healthcare Innovation Steering Committee provided	Bi-monthly
Description of communication and stakeholder Engagement Strategy complete	First 30 days
Multi-sector stakeholders engaged	Contract start - ongoing
Synthesize the Connecticut-specific problems being solved and what success looks like	By 4/15/18
Recommend the role of key sectors in enabling HECs to succeed	By 4/15/18
Recommend community-wide measures and methods	By 5/15/18
Recommend financial models	By 5/15/18
Review existing value-based payment models and recommend adjustments	By 5/15/18
Recommend statutory and regulatory levers	By 6/15/18
Recommend health information technology enablers	By 6/15/18
Recommend levers regarding workforce	By 6/15/18
Conduct financial modeling using Medicare data	By 7/15/18
Produce a flexible financial modeling tool using Medicare data	By 7/15/18
Conduct analyses with respect to other state agency service expenditures to which health improvement benefits would likely accrue	By 6/15/18
Work with 2-3 employers to model the potential value of prevention efforts	By 6/15/18
Partial Draft 1 of report detailing the HEC initiative strategy	By 6/30/18
Presentation to Healthcare Innovation Steering Committee – Review and discussion	By 7/13/18
Engage HISC and release HEC Report and Recommendations for public comment	By 8/15/18
Final draft of report detailing the HEC initiative strategy	By 9/15/18
Final Draft of report disseminated to Healthcare Innovation Steering Committee	By 9/15/18
Presentation to Healthcare Innovation Steering Committee – Final Review and Approval	By 10/18/18