OHS CONNECTICUT Office of Health Strategy

Healthcare Innovation Steering Committee

July 12, 2018

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of the Minutes	5 min
4. Health Enhancement Community Planning	80 min
5. Primary Care Modernization Planning Update	20 min
6. Adjourn	

Introductions/Call to Order

Public Comment

2 minutes per comment

Approval of the Minutes

Primary Care Modernization Planning Update

Health Enhancement Community Planning

OHS CONNECTICUT Office of Health Strategy

Keeping Connecticut Healthy DPH Connecticut Department of Public Health

SIM connecticut state innovation model

Health Enhancement Community Initiative

Medicare Impact Model: Baseline Projections & Potential Savings Opportunity

Healthcare Innovation Steering Committee (HISC)
July 12, 2018
3:00 pm – 5:00 pm

Version #	Purpose/Change	Date
1.0	Initial Draft	07/06/2018
2.0	HISC Meeting	07/12/2018

Today's Objectives

Orient HISC members about a critical potential source of Health Enhancement Community (HEC) financing related to improving health status and generating savings as a result of HEC activities.

I. **Contextualize:** Discuss the Medicare Impact Model analysis in the context of the broader HEC work

II. **Inform:** Provide an overview of the Medicare Impact Model, including data, methodology, assumptions, and baseline projections

III. **Size the Opportunity:** Share hypothetical scenarios that attempt to size the potential for Medicare savings

Part I

Contextualize

Discuss the Medicare Impact Model analysis in the context of the broader HEC work

Health Enhancement Community Initiative

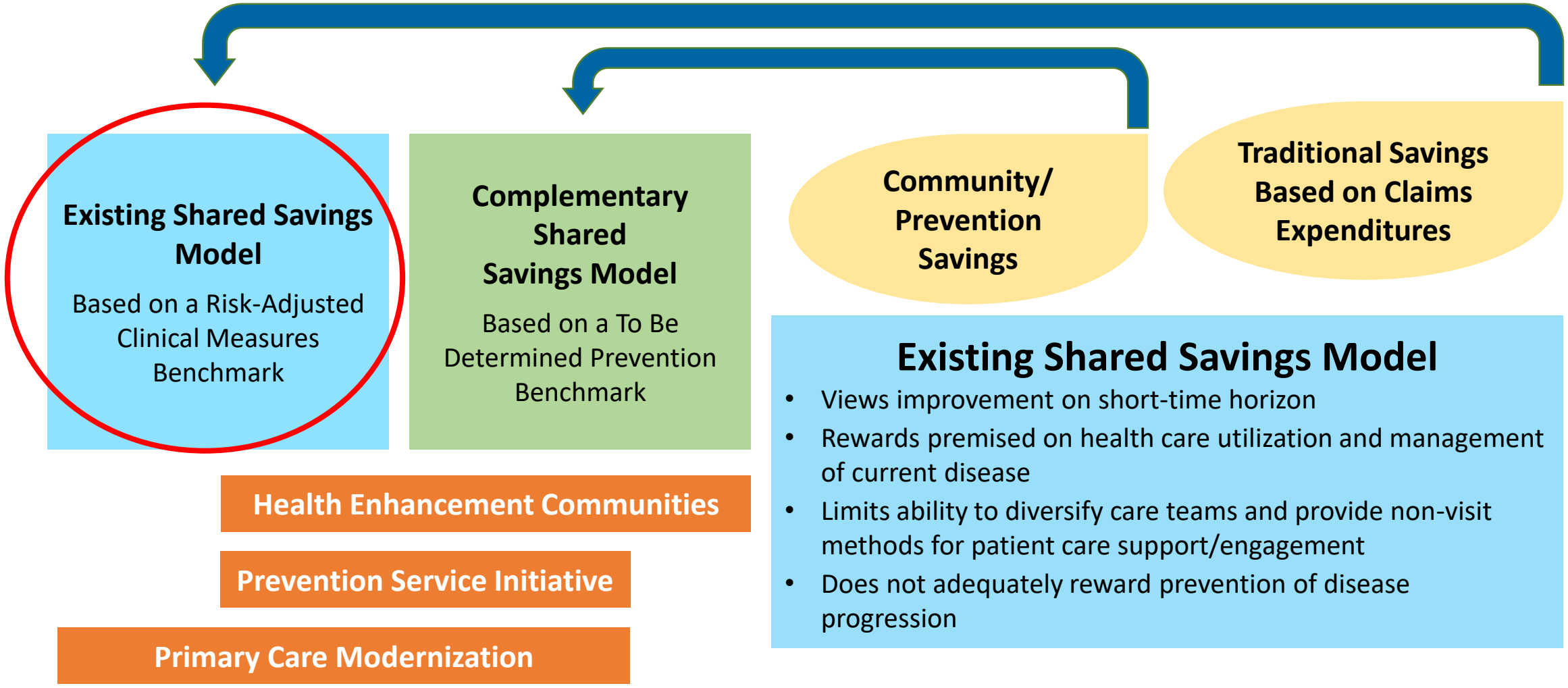
- Focuses on creating the conditions that **promote and sustain cross-sector community-led strategies focused on prevention**.
- **Aligns with health improvement work underway** in communities, previous and current SIM work, and adds sustainability and scale focus.
- Intentionally leverages thoughtful, **community-driven planning processes** to refine the HEC definition through further input.

PROVISIONAL DEFINITION

A Health Enhancement Community (HEC) is:

- ❑ Accountable for health, health equity, and related costs for all residents in a geographic area
- ❑ Uses data, community engagement, and cross sector activities to identify and address root causes
- ❑ Operates in an economic environment that is sustainable and rewards communities for health improvement by capturing the economic value of Improved health

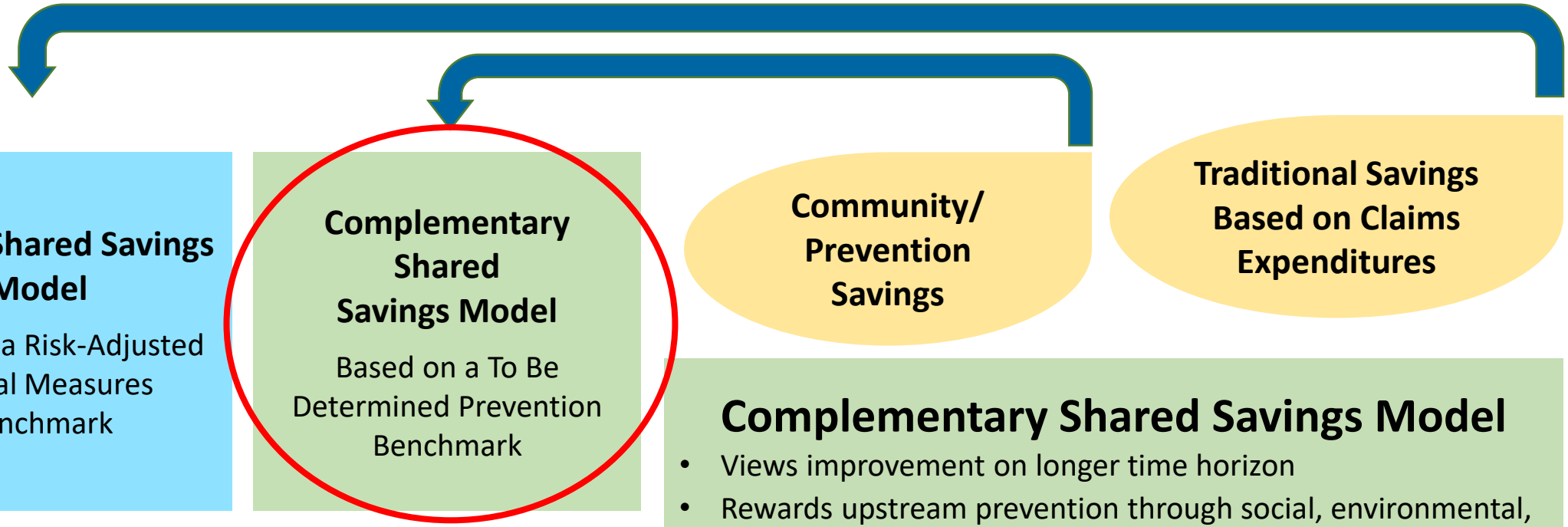
Existing Shared Savings Models Do Not Adequately Reward Prevention



Existing Shared Savings Model

- Views improvement on short-time horizon
- Rewards premised on health care utilization and management of current disease
- Limits ability to diversify care teams and provide non-visit methods for patient care support/engagement
- Does not adequately reward prevention of disease progression

Existing Shared Savings Models Do Not Adequately Reward Prevention



Health Enhancement Communities

Prevention Service Initiative

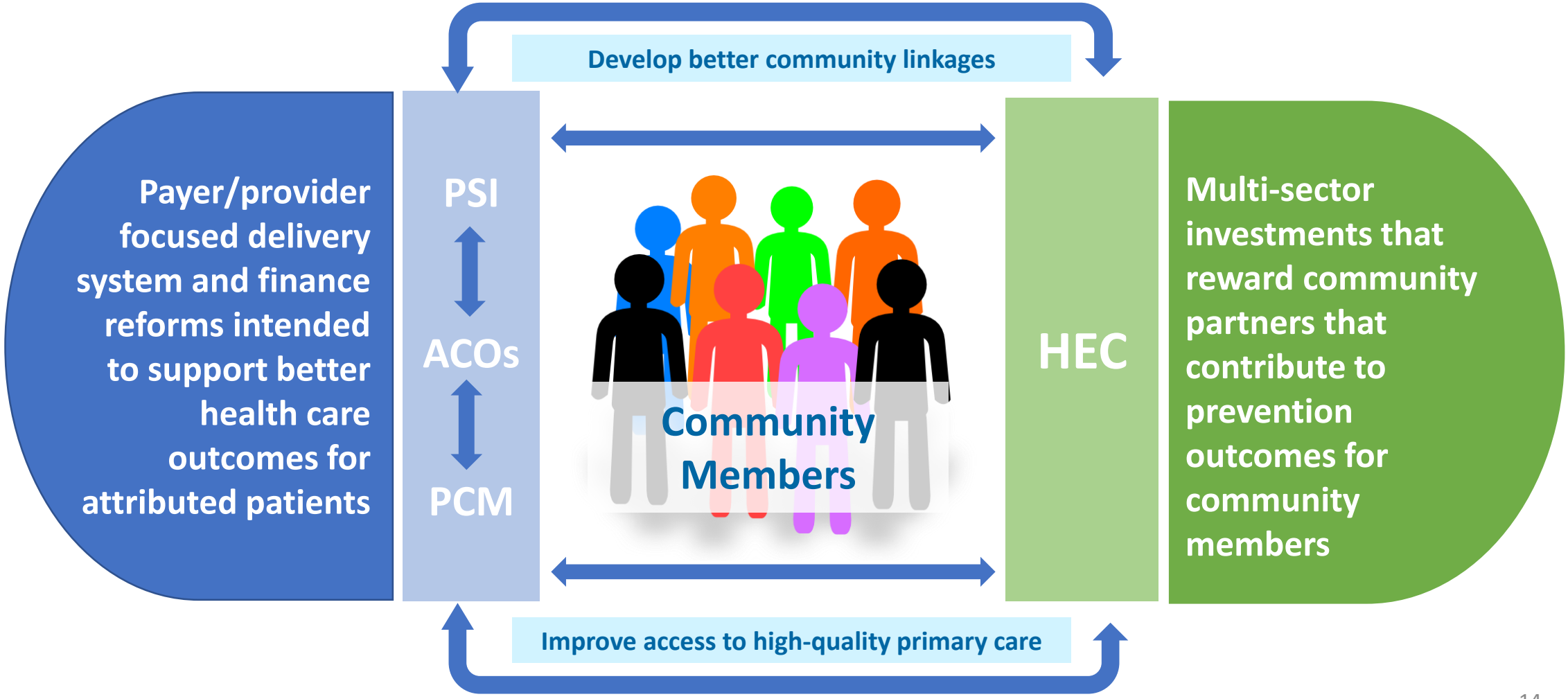
Primary Care Modernization

Complementary Shared Savings Model

- Views improvement on longer time horizon
- Rewards upstream prevention through social, environmental, and genomic interventions
- Creates need for new measures for quantifying long-term impacts of health/wellness improvement activities
- Opportunity to harness non-traditional and private investments

Alternative Payment Models and Prevention:

The need for an augmented strategy and potentially a new model altogether



Sustainability and the Medicare Impact Model

A critical component of securing long-term financing for HECs is developing **prevention-oriented shared savings arrangement with Medicare**

- Prevention-oriented shared savings arrangement would complement the existing Medicare Shared Savings Program (MSSP) with Accountable Care Organizations (ACOs)
- HECs will also work on pursuing additional sustainability strategies including with other payers and state agencies

Part II

Inform

Provide an overview of the Medicare Impact Model, including data, methodology, assumptions, and baseline projections

Overview: Medicare Impact Model

- HMA, in partnership with Airam Actuarial Consulting, is quantifying the potential **short-term and long-term savings impact of the HECs on Medicare** with consideration for how to modify the analysis for other payers; and perform financial analyses to inform key design decisions.
- Using publicly available Medicare data, we are building a model to examine **per capita costs for the Medicare population** with and without HEC interventions.

Quantifying Baseline Conditions

- Medicare Impact Model begins by **quantifying baseline conditions** (without HEC interventions)
- Using the Medicare Public Use File and spending growth projections informed by the CMS Office of the Actuary, we are **modeling future Connecticut Medicare spending**
- This can be done by statewide, by county/Hospital Referral Region, age group (under 65 and 65+), and by other variables.

Modeling Interventions

- Working from an estimated Medicare baseline trend, the Medicare Impact Model will **apply adjustments to future spending estimates** based on evidence-based population health interventions identified in collaboration with the Population Health Council
- Will use evidence base and evolving practice to model assumptions about the degree and nature of impacts on Medicare spending and population health outcomes.

EXAMPLE

- **Evidence may suggest a particular population health intervention may ultimately reduce the prevalence of certain disease conditions (e.g., diabetes).**
- **The financial model will attempt to quantify the impacts over time.**

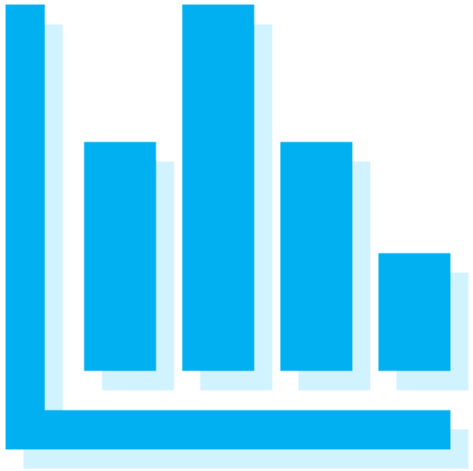
Questions the Medicare Impact Model will Explore

- How will the HECs improve the **trajectory of health risk, health outcomes, and costs** over time?
  - How is this different from what Accountable Care Organizations (ACOs) are expected to achieve?
- What are the current **baseline costs** and trajectory of spending?
- Which **population groups are of interest**, defined by medical and social characteristics?
- Which HEC **interventions** do we think will be most effective in driving the change in the health risk and achieving savings based on the latest research?

Primary Data Source

Medicare Geographic Variation Public Use File:

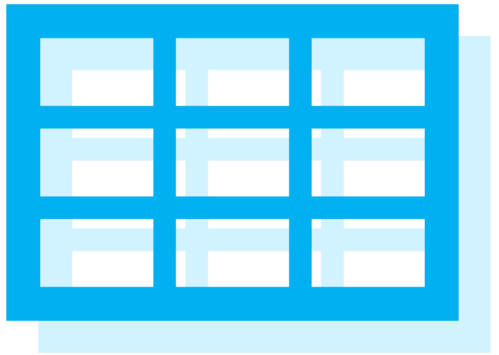
- The Centers for Medicare & Medicaid Services (CMS) has developed a public use file (PUF) that enables researchers and policymakers to **evaluate variation in the utilization and quality of health care services for the Medicare fee-for-service population by geographic area**.
- The file includes demographic, spending, utilization, and quality indicators at the state level, hospital referral region (HRR) level, and county level.
- **10 years of data** are available (2007 - 2016).



Sample of Date File Elements

The Medicare Geographic Variation Public Use File includes the following kinds of **indicators and metrics**:

- Count of Medicare fee-for-service beneficiaries
- Age, gender, and race/ethnicity
- Average Hierarchical Condition Category (HCC) Risk Score*
- Medicare Cost data: actual, per capita, and risk-adjusted
- Prevention quality indicators (e.g., hospital readmission rates and emergency room visits)



**Note: HCC risk scores discussed in subsequent slides.*

Data Limitations and Strengths

Limitations

- The Medicare Public Use File is **summary level data** and is not provided at the beneficiary level. This constrains the ability to "cut" the data into more granular views of narrowly-defined population segments.
- File **only includes Medicare Fee for Service (FFS) data** and does not include Medicare Advantage (coverage via a private health plan), Medicare Part D (pharmacy) or other payers (i.e. commercial carriers, Medicaid). *(*)*
- File does not include non-health sector spending

Strengths

- Enables national and state comparisons and **benchmarking**

(*) Note: See Appendix for list of supplemental data sources.

Projecting Health Care Cost Growth

Key drivers of health care cost increases include:

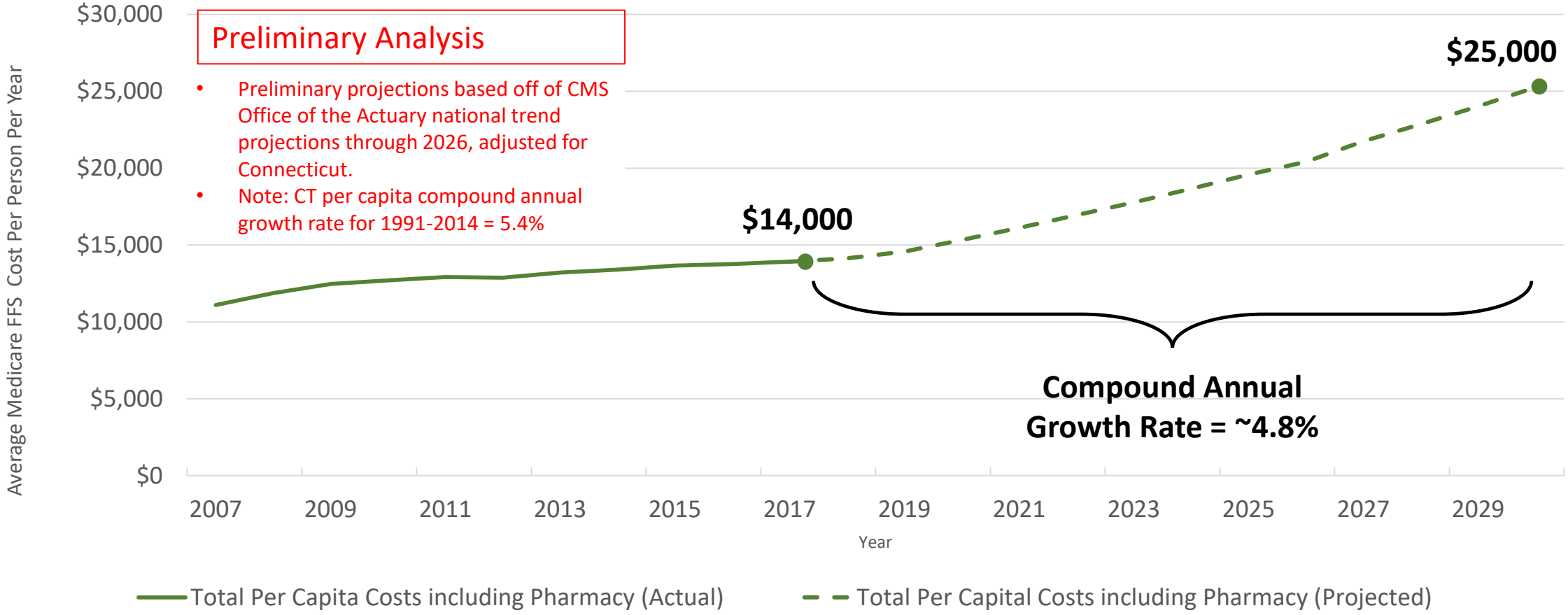
- **Price:** Cost per unit of service
- **Utilization:** Number of services used
- **Morbidity:** Risk score*
  - Age/Demographic shifts
  - Intensity/Case Mix

Focus on per capita costs controls for changes in population size

**Note: Risk scores discussed in subsequent slides.*

Connecticut Medicare Baseline Projections

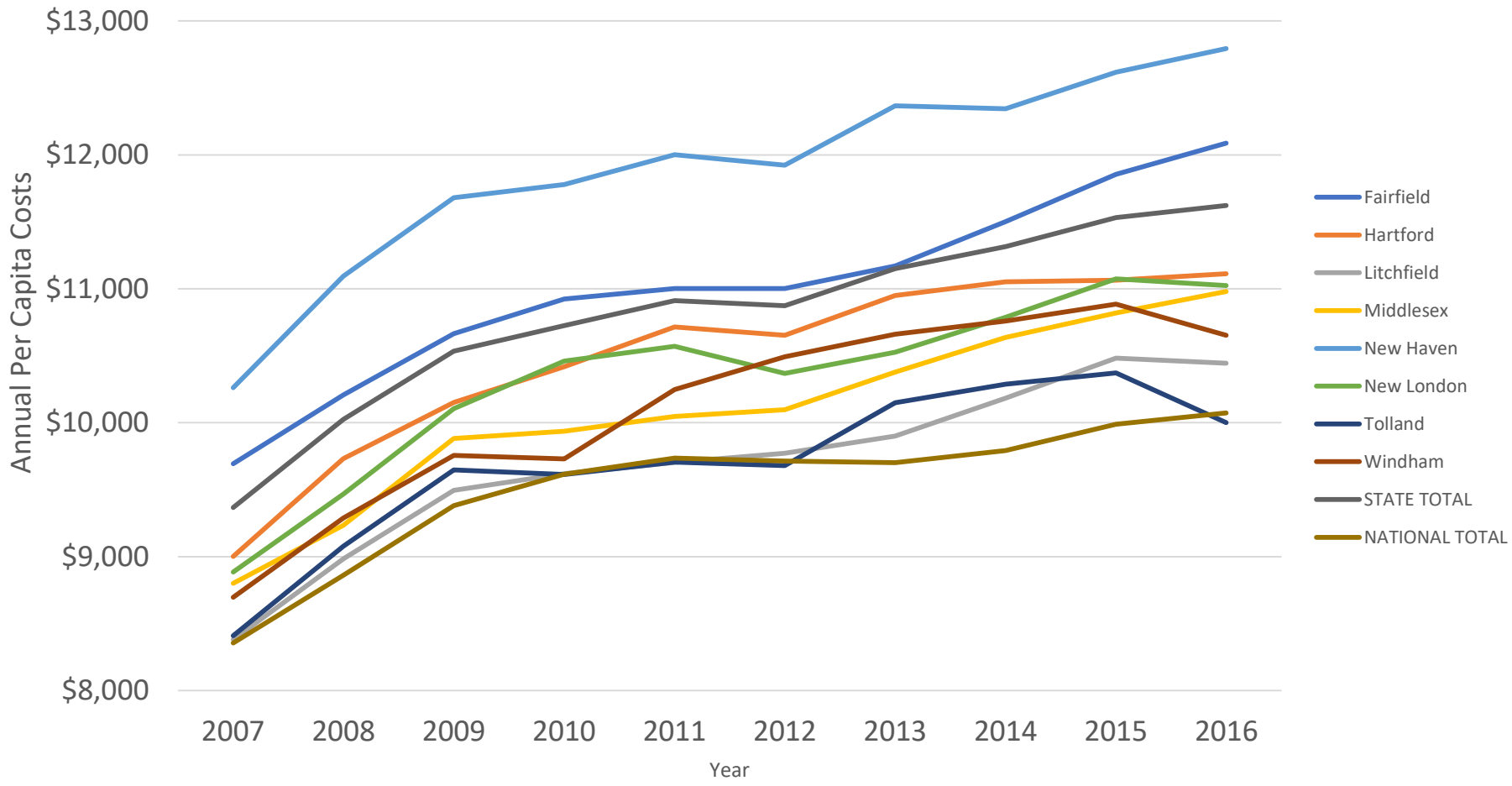
Connecticut Medicare Per Capita Fee For Service costs are expected to nearly double by 2030



Connecticut Medicare FFS Per Capita Costs by County

2007 - 2016

Annual Medicare FFS Per Capita Costs (Excluding Pharmacy)



Key Observations

- In 2016, per capita costs in CT were 15% above the national average
- Average annual historical trend has been 2.4% in CT compared to 2.1% nationally
- New Haven has the highest per capita costs of all counties in CT, 10% above statewide average in 2016
- Per capita costs in all CT counties have been higher than the national average

Hierarchical Condition Category (HCC) Score

- Risk adjustment uses a patient's demographics and diagnoses to determine a **risk score**, which is a relative measure of how costly that patient is anticipated to be.
- CMS uses **HCC risk scores** to pay Medicare Advantage plans and set cost benchmarks/budgets for ACOs
- HCCs are **useful information in comparing the risk and predicted cost of different populations** (e.g., by geography, health condition)
- **Nationwide risk score = 1.0**, recalibrated each year

Medicare HCC Risk Score: Illustrative Example

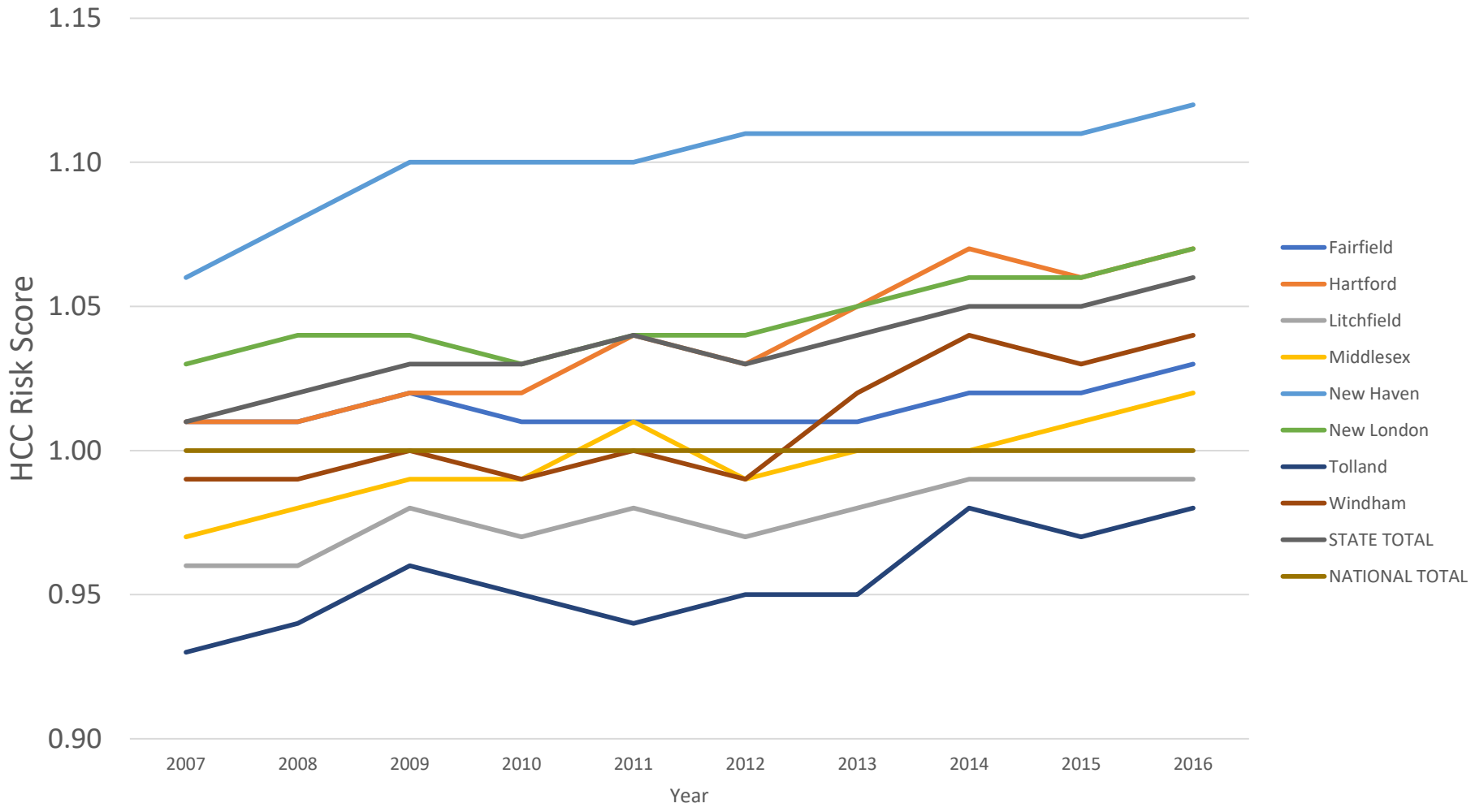
	Person A CHF, diabetes, and morbid obesity	Person B CHF, no diabetes, normal weight
76 year old female living in the community, no Medicaid	.452	.452
Congestive Heart Failure (CHF)	.310	.310
Diabetes with complications	.307	--
Morbid obesity	.262	--
Interaction (Diabetes + CHF)	.152	--
Total HCC Risk Score	1.483	.762
Average Annual Per Capita Medicare FFS Costs	x $15,000	x $15,000
Total Annual Medicare Cost Per Capita	**$22,245**	**$11,430**

Source: CMS-HCC Relative Factors from CY 2019 Medicare Advantage Final Call Letter, April 2, 2018, Table VI-1.

Connecticut Medicare HCC Risk Score by County

2007 - 2016

HCC Risk Scores – Medicare Fee for Service Population

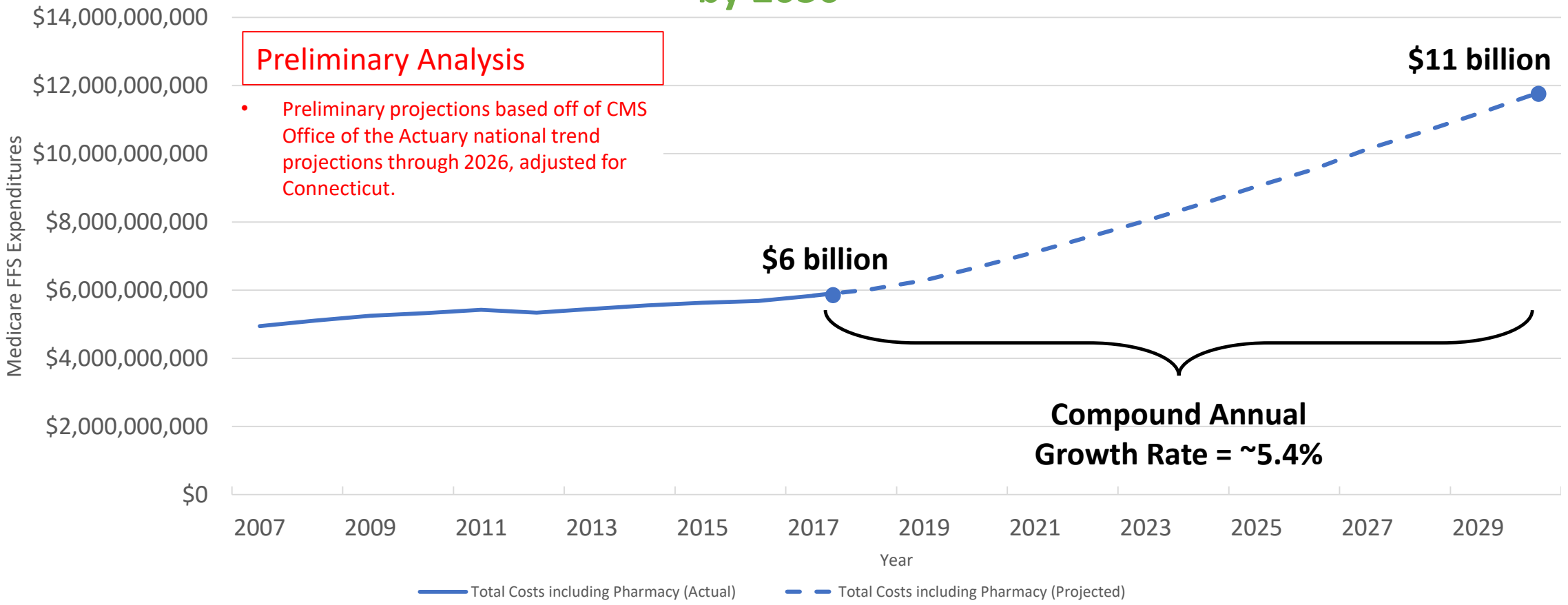


Key Observations

- HCC risk scores in CT have steadily increased from 1.01 to 1.06 over the last 10 years
- In 2016, 6 of the 8 counties in CT had HCC risk scores higher than the national average
- New Haven has the highest HCC risk score of all counties in CT
- Tolland and Litchfield have the lowest HCC risk scores in CT

Connecticut Medicare FFS Baseline Projections

Connecticut FFS Medicare Expenditures are expected to exceed $11B by 2030



Part III

Size the Opportunity

Share hypothetical scenarios that attempt to size the potential for Medicare savings

Opportunity to Bend the Cost Curve

- Connecticut Medicare FFS costs are expected to **nearly double to $11 billion in by 2030**
- An annual reduction in the HCC risk score from 2021 through 2030 in Connecticut would generate billions in savings over the 10-year period.
- However, the **total savings would be dependent on statewide prevention strategies and success of HECs interventions**

Scenarios	
Connecticut HCC Risk Score in 2030:	**Cumulative Savings 2021-2030 (*)**
1.17 (**)	$0
1.03	$4.58 billion
1.00	$5.55 billion
0.97	$6.55 billion

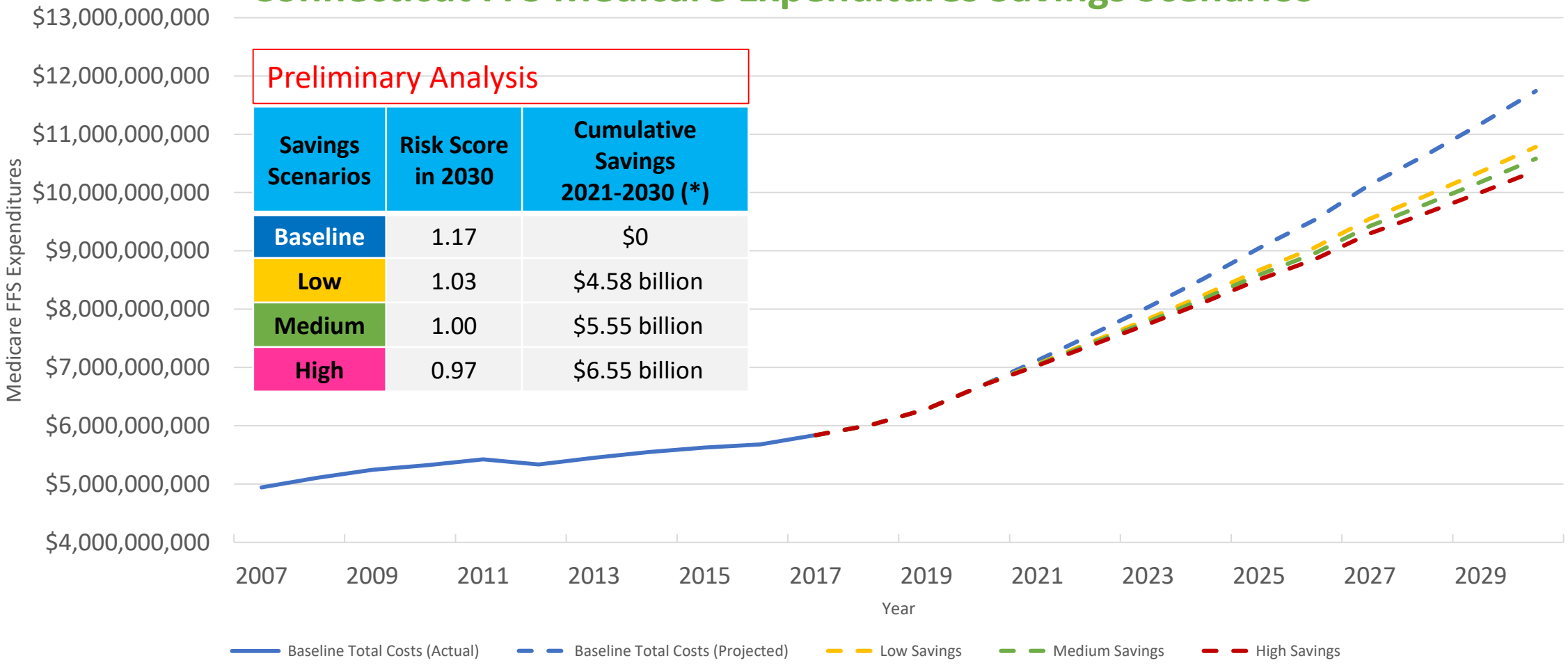
**Preliminary savings estimates based on Medicare Fee for Service population only. Excludes beneficiaries enrolled in Medicare Advantage Plans. (**) CT HCC risk score increased from 1.01 to 1.06 from 2007 to 2016. This trend, if continued, suggests an HCC risk score equal to 1.17 by approximately 2030. Projected growth in HCC risk score subject to further analysis.*

Connecticut Medicare FFS Baseline Projections

Connecticut FFS Medicare Expenditures Savings Scenarios

Preliminary Analysis

Savings Scenarios	Risk Score in 2030	Cumulative Savings 2021-2030 (*)
Baseline	1.17	$0
Low	1.03	$4.58 billion
Medium	1.00	$5.55 billion
High	0.97	$6.55 billion



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SIM connecticut state innovation model

Health Enhancement Community Initiative

HEC Model Elements: Health Condition Priorities and Interventions | *Focus + Flexibility*

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DISCUSSION: Strawperson Design for HEC Focus and Activities

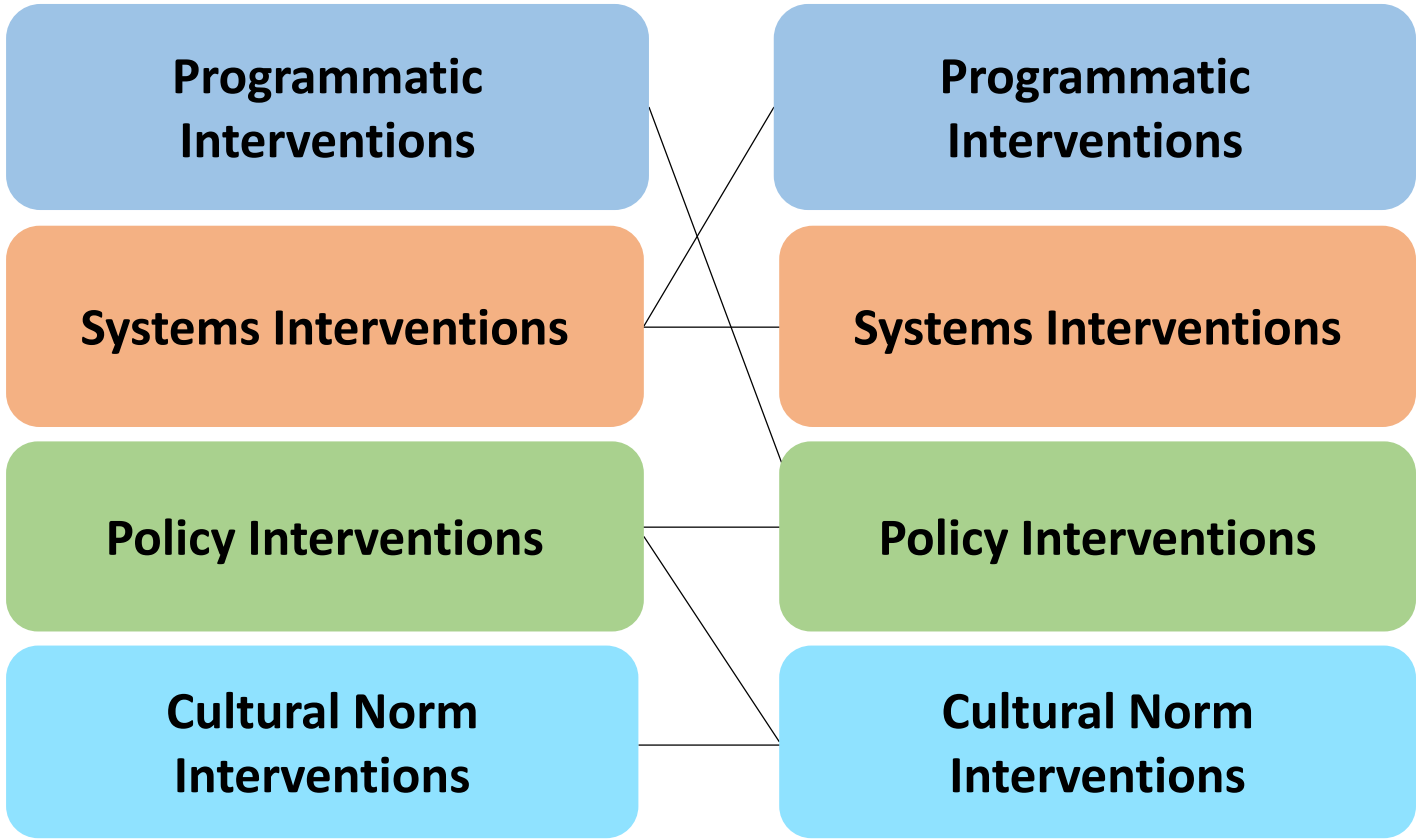
- With some interventions deliberately for more than one health condition
- Populations could be targeted (e.g., people in "hot spot" areas within the geography or people with mental health or substance use disorders)

CHILD WELL-BEING

HEALTHY WEIGHT

Root Causes – Social Determinants of Health

"Upstream" Interventions to Prevent Conditions and Poor Outcomes



For discussion: HEALTH PRIORITIES FOCUS AREAS

For discussion: FOCUSED CATEGORIES

- Evidence-based/ informed and cross-generation interventions selected by HECs
- Complementary statewide interventions

Appendix

Other Supplemental Data Sources

- **MMLEADS:** CMS public use file that includes Medicare and Medicaid FFS eligibility and cost data and chronic condition prevalence rates
- **2018 Medicare Trustees Report:** Medicare Part D (pharmacy) per capita costs estimates and long term trend projections
- **DPH Data:** Population estimates and survey data that includes disease and chronic condition prevalence rates, mortality rates for Connecticut
- **All Payer Claims Database (APCD):** Detailed claims and eligibility file at the beneficiary level that includes Medicare FFS, Medicare Advantage, and commercial payer data for Connecticut

Connecticut Medicare FFS Per Capita Costs by County

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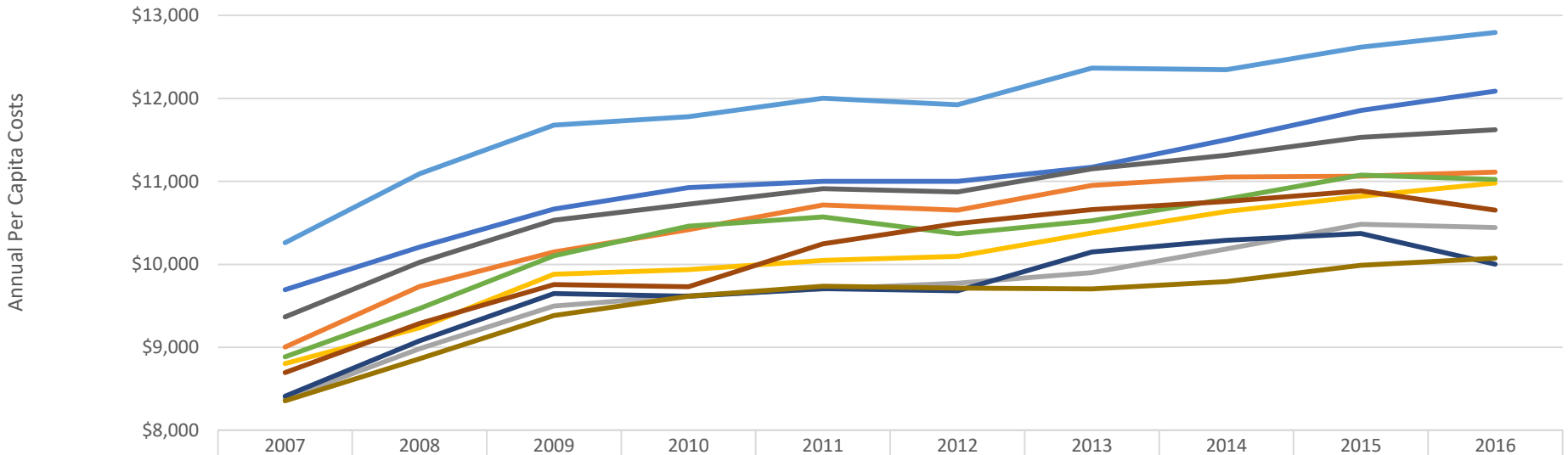

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Fairfield	9,694.32	10,208.10	10,665.25	10,924.00	11,001.39	11,001.75	11,171.23	11,502.52	11,855.13	12,086.87
Hartford	9,002.37	9,732.18	10,150.73	10,417.42	10,715.13	10,651.97	10,950.77	11,051.86	11,063.60	11,112.00
Litchfield	8,381.96	8,983.59	9,496.25	9,620.69	9,703.47	9,772.02	9,900.01	10,184.01	10,482.76	10,443.98
Middlesex	8,802.13	9,234.18	9,881.77	9,936.99	10,048.04	10,097.58	10,378.87	10,637.07	10,819.40	10,980.20
New Haven	10,261.52	11,093.70	11,679.78	11,778.74	12,000.80	11,923.65	12,367.02	12,344.93	12,617.71	12,793.23
New London	8,885.28	9,467.86	10,104.32	10,460.21	10,571.26	10,369.02	10,525.99	10,787.91	11,074.44	11,024.66
Tolland	8,409.61	9,078.37	9,647.93	9,614.70	9,706.62	9,680.17	10,149.70	10,288.80	10,371.37	10,001.48
Windham	8,696.32	9,288.61	9,755.93	9,730.15	10,247.29	10,492.75	10,661.51	10,758.81	10,885.60	10,653.84
STATE TOTAL	9,366.74	10,024.11	10,533.69	10,724.23	10,911.93	10,872.84	11,150.62	11,315.89	11,531.02	11,621.24
NATIONAL TOTAL	8,356.41	8,861.42	9,381.50	9,615.88	9,737.03	9,713.10	9,702.52	9,791.53	9,988.67	10,072.38

Year

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Connecticut Medicare HCC Risk Score by County

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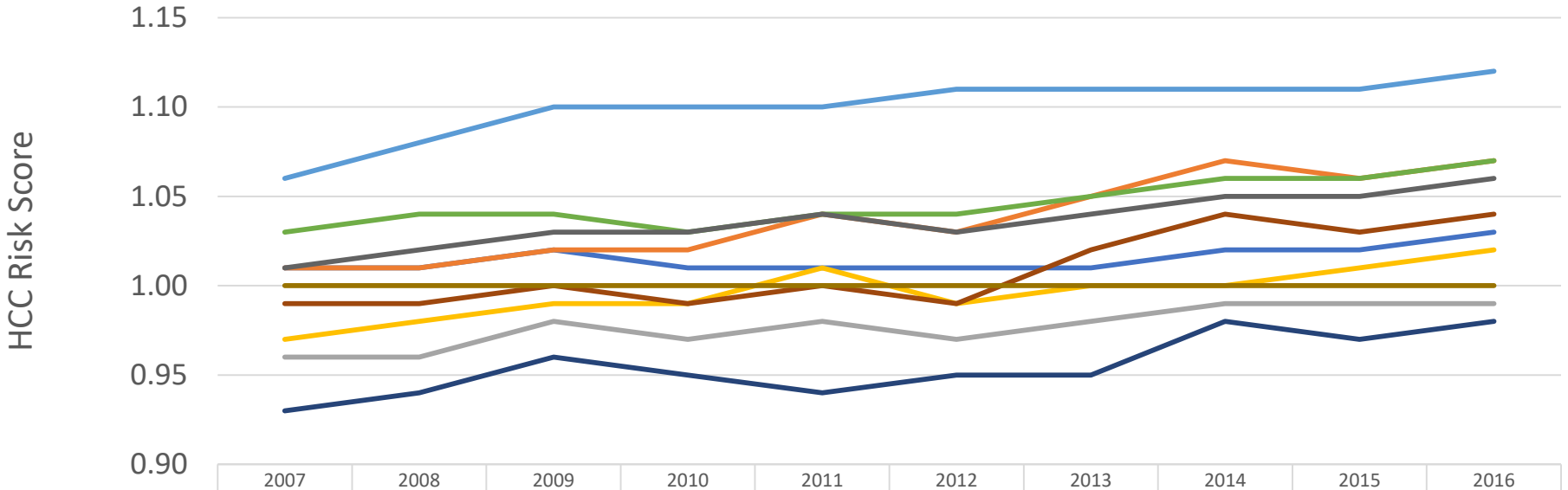
HCC Risk Scores – Medicare Fee for Service Population



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Fairfield	1.01	1.01	1.02	1.01	1.01	1.01	1.01	1.02	1.02	1.03
Hartford	1.01	1.01	1.02	1.02	1.04	1.03	1.05	1.07	1.06	1.07
Litchfield	0.96	0.96	0.98	0.97	0.98	0.97	0.98	0.99	0.99	0.99
Middlesex	0.97	0.98	0.99	0.99	1.01	0.99	1.00	1.00	1.01	1.02
New Haven	1.06	1.08	1.10	1.10	1.10	1.11	1.11	1.11	1.11	1.12
New London	1.03	1.04	1.04	1.03	1.04	1.04	1.05	1.06	1.06	1.07
Tolland	0.93	0.94	0.96	0.95	0.94	0.95	0.95	0.98	0.97	0.98
Windham	0.99	0.99	1.00	0.99	1.00	0.99	1.02	1.04	1.03	1.04
STATE TOTAL	1.01	1.02	1.03	1.03	1.04	1.03	1.04	1.05	1.05	1.06
NATIONAL TOTAL	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Year

Key Observations

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Primary Care Modernization Design Process

Primary Care Modernization Model Design

Primary Care Modernization – High Level Aim: Create a primary care payment reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement.

The program model is intended to double primary care spending over a period of five years so that doctors can provide patients with more support. It will also introduce new payment methods that increase flexibility to make care more convenient, community-based and responsive to the needs of patients. Together, these changes must improve outcomes and health equity while reducing the total cost of care and increasing the joy of practice.

Primary Care Modernization Model Design

Project Goals

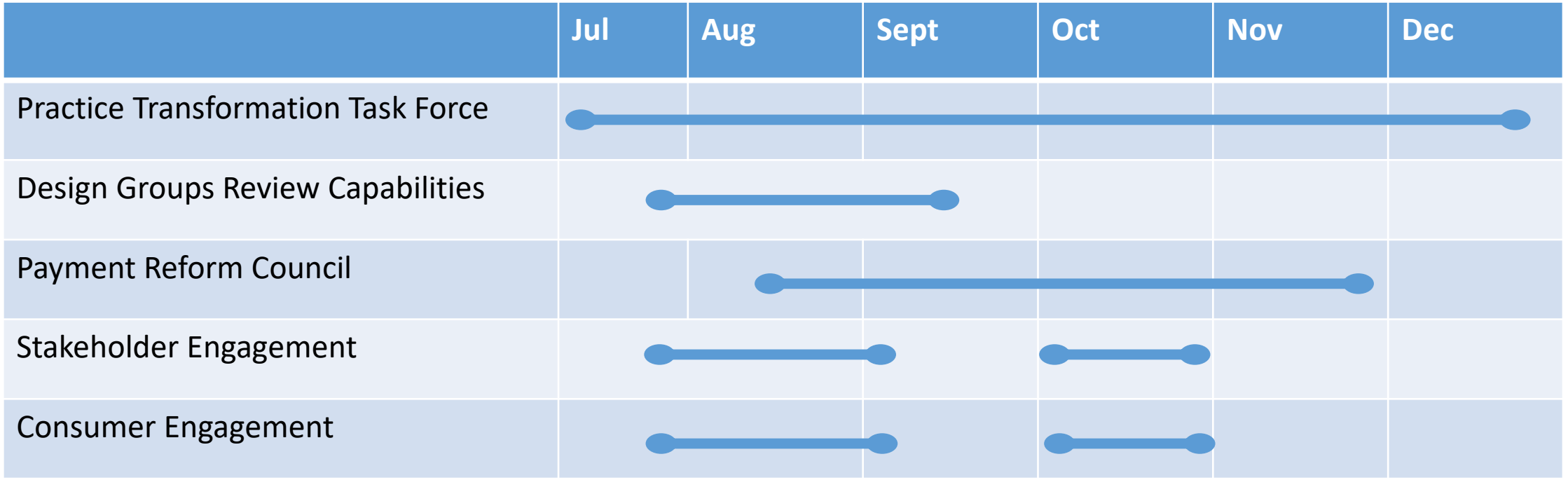
- Develop Primary Care Modernization program model that defines practice capabilities and payment model options that support them
- Collaborate with leadership and support from providers, payers and consumers as partners in the payment reform design and promotion process
- Complete the model design for consideration by the Governor-elect following the Nov. 2018 election

Freedman HealthCare Project Team

- Facilitation and Support
  - Alyssa Harrington, Project Director and Facilitator
  - Mary Jo Condon, Consumer Engagement Facilitator
  - Linda Green, PTTF Facilitator
  - Laurie Doran, Payment Reform Council Facilitator/SME
  - Vinayak Sinha, Coordination and Scheduling

- Subject Matter Experts
  - Quality Improvement: John Freedman, MD, MBA
  - Pediatrics: Jeffrey Lasker, MD, MMM
  - Population Health: Judy Levy, RN, CPHQ
  - HIT: Danny Sands MD, MPH
  - ACO: Gail Sillman, JD, MPH
  - PCMH and CPC+: Pano Yeracaris, MD, MPH

PCM Work Plan



Communications about project to broader healthcare community will be ongoing

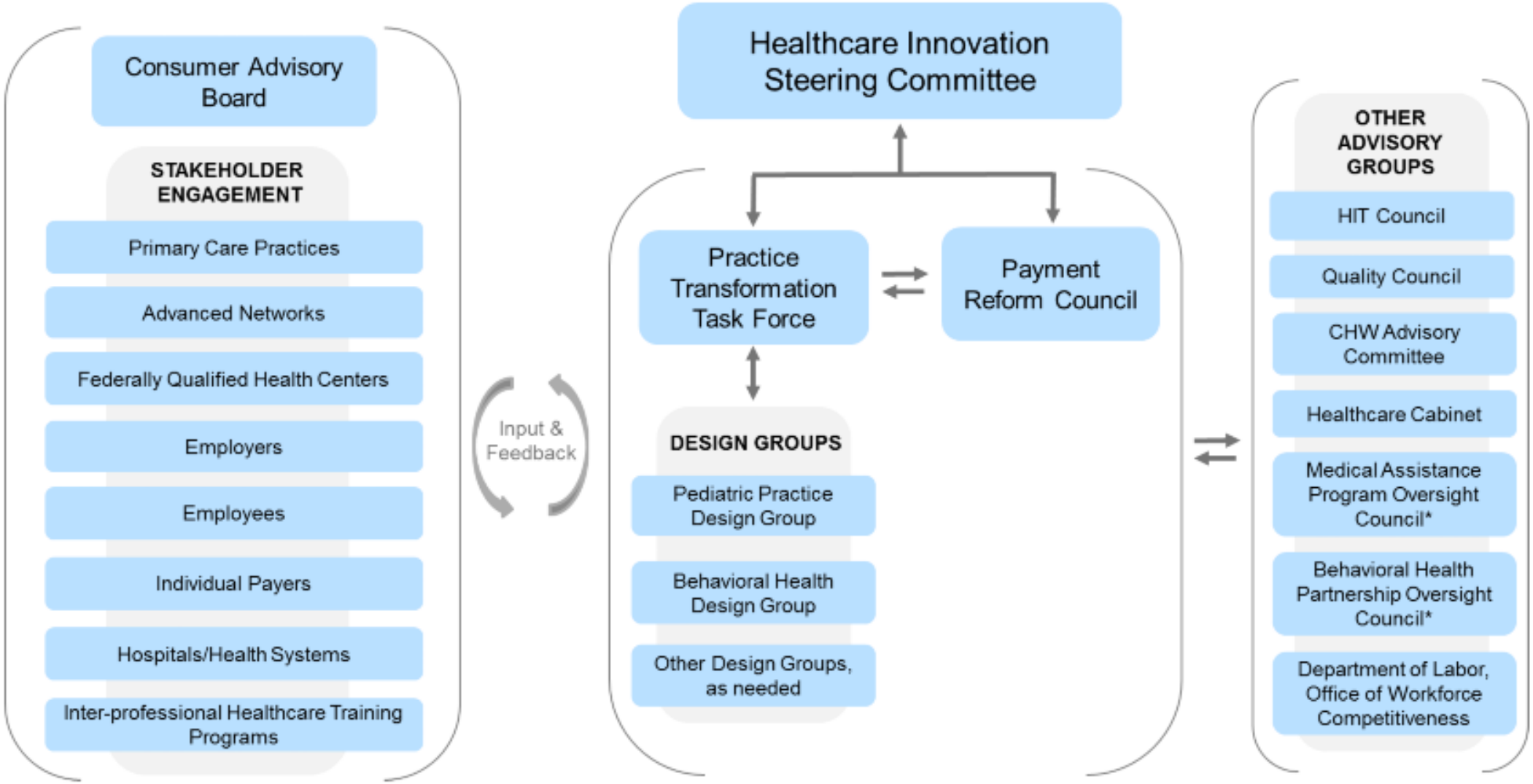
PCM High Level Timetable

January 2017 – June 2019

July 2018 – December 2018

January 2019 – July 2019

Primary Care Modernization Advisory Process



SIM connecticut state innovation model

*Pending DSS initiated collaboration agreement

Guiding Principles for all Meetings

- **Sessions generate focused, actionable feedback**
  - Guided discussions focus on the PCM concepts most applicable to the specific participants and leave some time for general dialogue

- **Content is accessible and meaningful to participants**
  - The same topic may have very different content and facilitation approach, depending on the audience

- **Participants, facilitators respect each other and the process**
  - Agenda overview & consent, parking lot for off-topic ideas, rules of the road for stakeholder and consumer meetings

- **Participants, except consumers, bring their stakeholder perspective, not an individual or organizational agenda**

Stakeholder Workgroup Approach

- Initial meeting with each stakeholder group end of July – early September to gather input
- Follow up meeting(s) in October/November to gather feedback on model

Initial Meetings	Follow up Meetings

Overview of PCM Project
• What capabilities are being considered?
• How might a more flexible payment model support the capabilities?
 	
Hearing from You
• What are your goals?
• What changes would you like to see? What would have the most impact?
• What should not change?
• What's missing? Any concerns?
 	
Deeper Dive Into a Few Specific Areas
• Targeted questions depending on stakeholder group
	Recap of Work to Date and Goals
	
	What's Moving Forward, What's Not and Why
	• From your perspective, anything you wish could be reconsidered?
	
	Decision Points on Specific Areas
	• If you had to vote, could you support this?
	  • If no, what could change your mind?
	  • If yes, would you be willing to advocate for this in your org? Among peers?
	• What will be important for us to highlight as we share this with your stakeholders?
	• Do you expect we will hear concerns? If so, what?

Targeted Approach for Each Stakeholder Group

Partnership with CAB

- Consumers Advocate Organizations
- Consumers Representing Various Perspectives, including Employees
- Primary Care Practices
- Advanced Networks
- Federally Qualified Health Centers
- Employers
- Individual Payers
- Hospitals/Health Systems
- Inter-professional Healthcare Training Programs

Initial Stakeholder Sessions

Approaches and Sample Questions

- **Providers: Separate meetings with executives, and frontline providers**
  - Separate meetings with FQHCs, ANs, and Training Programs
  - What functions of an expanded care team would provide the most benefit to your patients? What's most critical to your routine practice? What could smooth the workflow transition? Potential barriers?
- **Employers: Group of interested employers identified, mix of local and national**
  - Start with business case – how PCM can benefit employers and employees
  - If your health plan/TPA offered a modernized primary care network, would you use it? What would it need to include? Potential barriers? Demonstrated use of funds (What kind of proof do you need to invest in these capabilities?)
- **Individual Payers: Individual meetings with commercial payers, Medicaid***
  - Similar to employers: what would it take for you be able to administer a payment model with bundles, care management fees, bonuses? Demonstrated use of funds (What kind of proof do you need to invest in these capabilities?)
- **Consumers: In development in collaboration with CAB**
  - Key informant interviews with consumer advocacy organizations, consumer listening sessions developed in collaboration with CAB

SIM connecticut state innovation model

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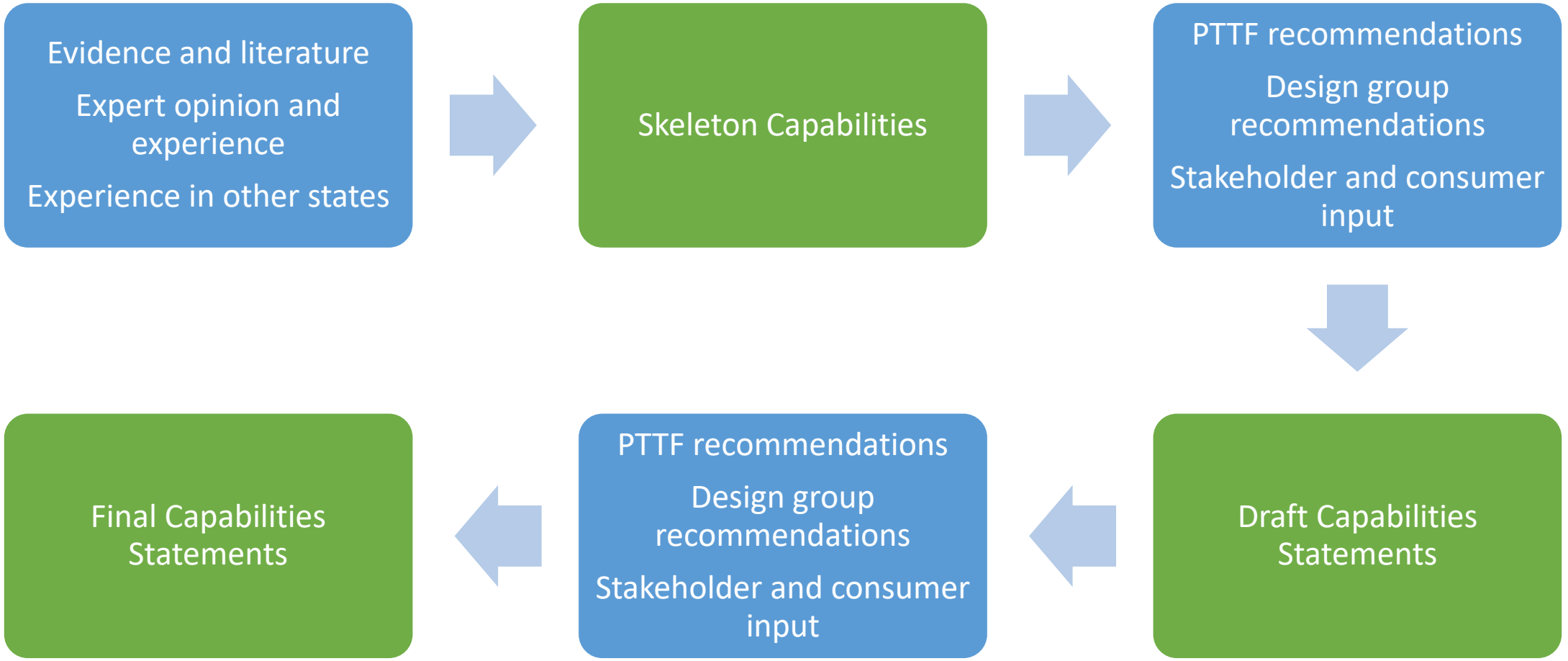
Approach to Developing Capabilities



Plan for Reviewing PCM Capabilities

PTTF Meeting	Capability
July 24th	Phone/text/email, Home Visits, Shared Visits
	Practice specialization: Pain management, MAT, Infectious Diseases
	E-consults, Remote patient monitoring/patient generated data
Sept. 4th	Telemedicine
	Diverse care teams: Community health workers, pharmacists, nurses, care coordinators, navigators, health coaches, nutritionists, interpreters
	Practice specialization: Genomic medicine, older adults, persons with disabilities
Sept. 25th	Adult and Pediatric Behavioral Health integration
	Community integration: Community linkages, purchased community services, social determinants of health assessments
	Oral health integration
	Sub-specialists as PCPs

Social determinants of health and health equity will be considered across capabilities

PTTF Design Group Process

Design Groups will review certain capabilities prior to PTTF when:

- Multiple proven models with distinct ways to accomplish capability
- Capability is emerging role in primary care

Design groups will include at least one PTTF member, consumers, and subject matter experts

- Diverse care teams
- Genomic medicine
- Behavioral health integration (adults)
- Community integration
- Pediatrics: Collaborating with Pediatric Study Reform Group
- Behavioral health integration (pediatrics): Collaborating with Yale Pediatrics Child Study Center

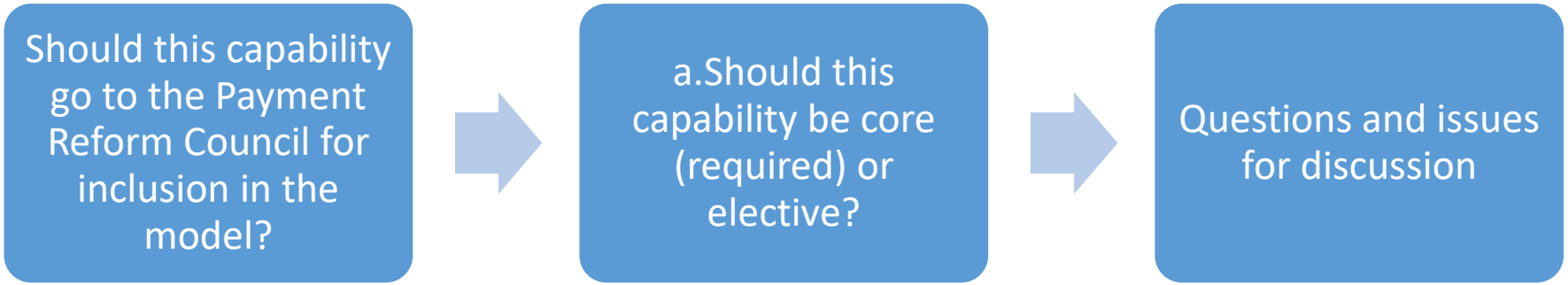
Capabilities Statement Development

- Begins with “skeleton” created by PCM Project Team, in consultation with subject matter experts
- Outline
  - Problem statement and contributing factors
  - Proven strategy
    - *Consumer needs*: Incorporates feedback from CAB consumer listening sessions and other consumer engagements
    - *Health Equity Lens*: Perspectives on how capability might address health disparities
    - *Intended Outcomes*
  - Implementation
    - *Example clinical scenario*
    - *HIT Requirements*
    - *Implementation Concerns*
  - Impact: Health promotion, quality of care and outcomes, patient experience, provider satisfaction, costs
  - State and National Scan: CT and national case studies, results and lessons learned
  - Additional Reading and Bibliography

PTTF Review Process

Pre-work and design groups prior to meetings will identify areas of consensus and discussion to focus PTTF meeting discussion

- PTTF members review skeletons in advance and complete survey
- Key Questions to PTTF: Based on review of evidence of impact presented in skeleton:



Next Steps

- PTTF meets July 24th to begin reviewing capabilities skeletons
- Scheduling stakeholder engagement and consumer meetings
- Forming Payment Reform Council to develop payment model options
- Communications plan in collaboration with OHS

Adjourn