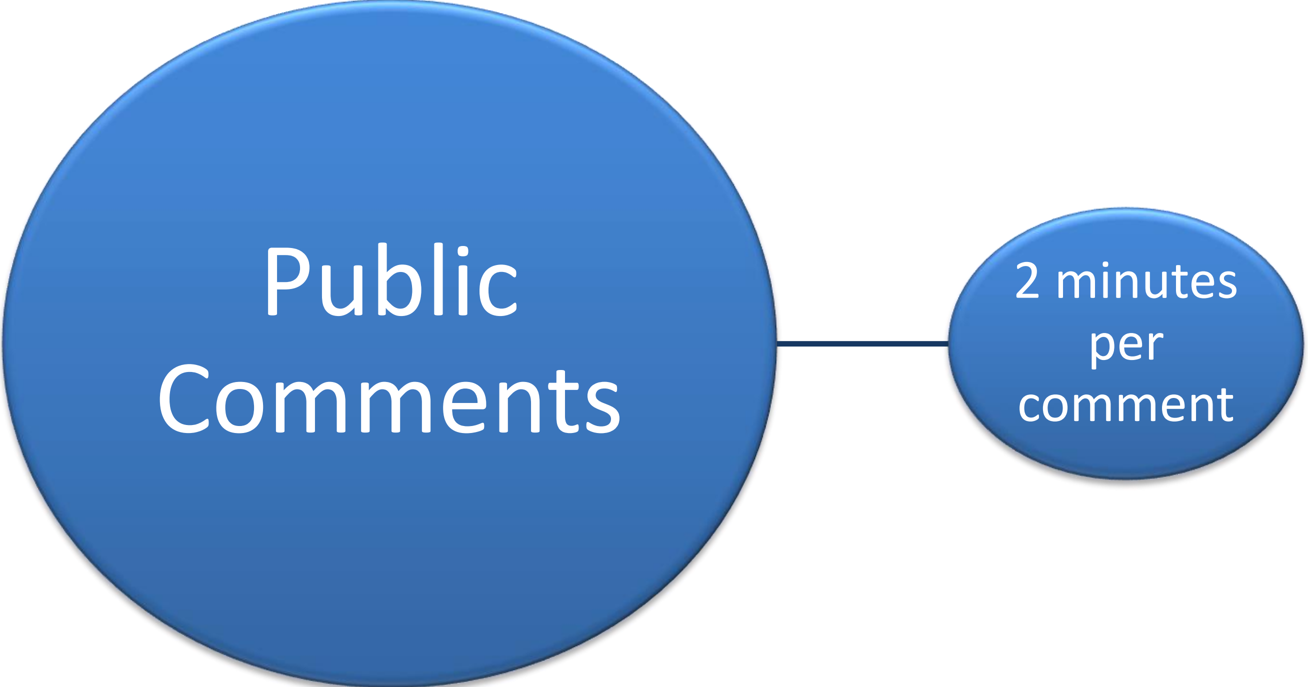
Practice Transformation Task Force

January 10, 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. Purpose of Today's Meeting	5 min
5. Update on PCMH+, AMH, and CCIP	20 min
6. CCIP- The Path to Transformation	30 min
7. Primary Care Payment Reform	40 min
8. Next Steps and Adjourn	5 min


Public Comments
2 minutes per comment

Approval of the Minutes

Purpose of Today's Meeting

PCPM program example: CPC+ Initiative

Discuss…

What are your reactions to and recommendations for the SIM payment reform and practice transformation initiatives and strategies?

How can the PTTF support and provide guidance on these initiatives over the next year?

Update on PCMH+, AMH, and CCIP

Update on PCMH+

Kate McEvoy, Medicaid Director

CT SIM: Primary Drivers to achieve Our Aims

Population Health

Payment Reform

Transform Care Delivery

Empower Consumers

Health Information Technology

Evaluation

CT SIM: Primary Drivers to achieve Our Aims

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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

Patient Centered Medical Home Plus

Quality Measure Alignment

Empower Consumers

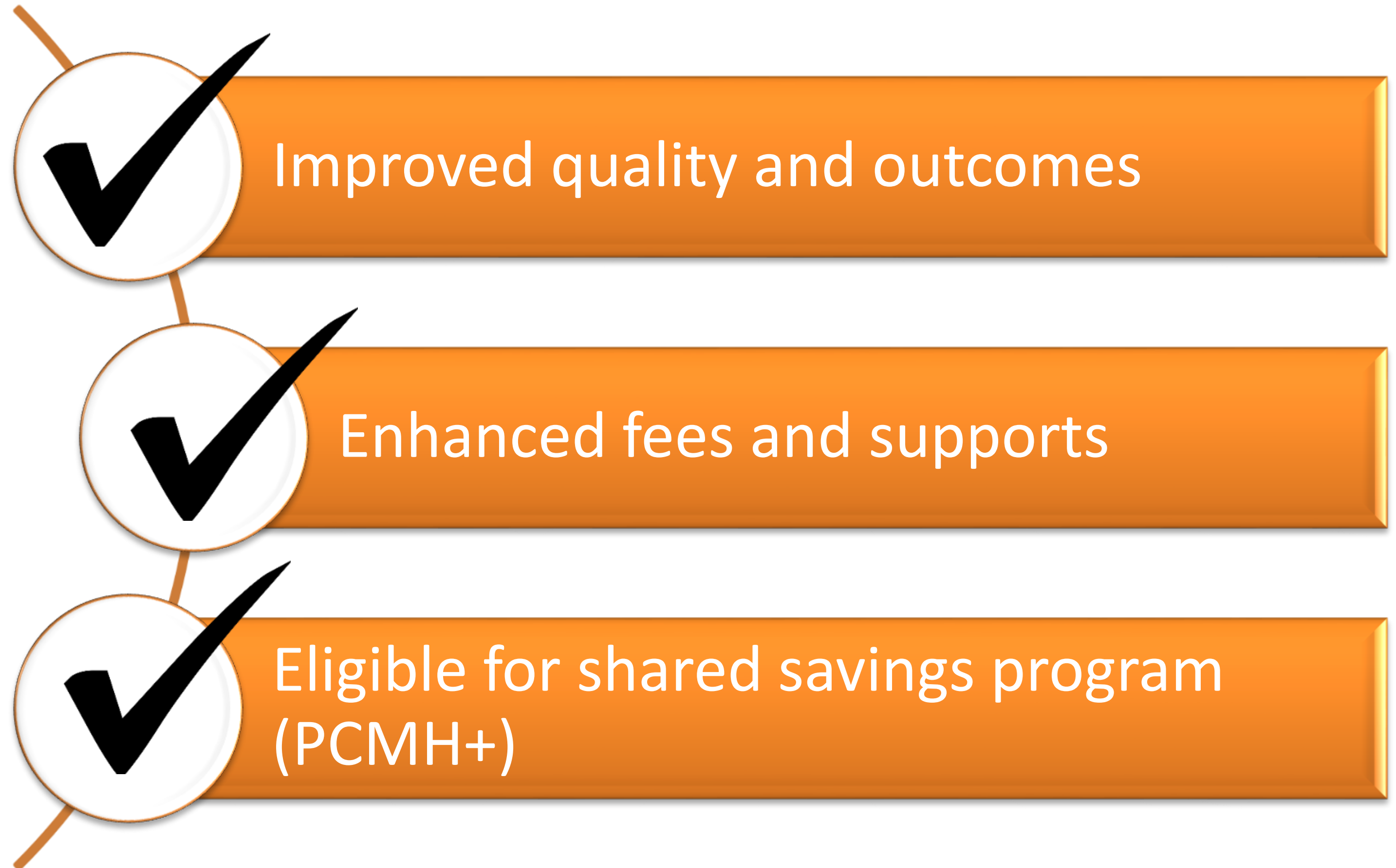
Value Based Insurance Design

Public Quality Scorecard

Consumer Outreach

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

RFP released June, 2016

Contract Negotiation with 9 selected entities began October, 2016

PCMH+ Launched January 1, 2017

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

Advanced Medical Home (AMH) Program Update

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

Update on
Community & Clinical Integration Program
(CCIP)

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
- Patient Centered Medical Home Plus
- Quality Measure Alignment

Empower Consumers

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

What is CCIP?

CCIP provides:

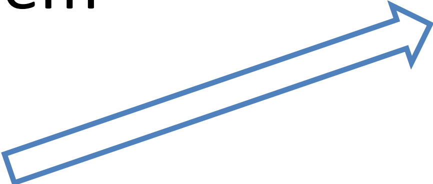
•**Technical Assistance & Peer Learning**

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

Behavioral Health Integration

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

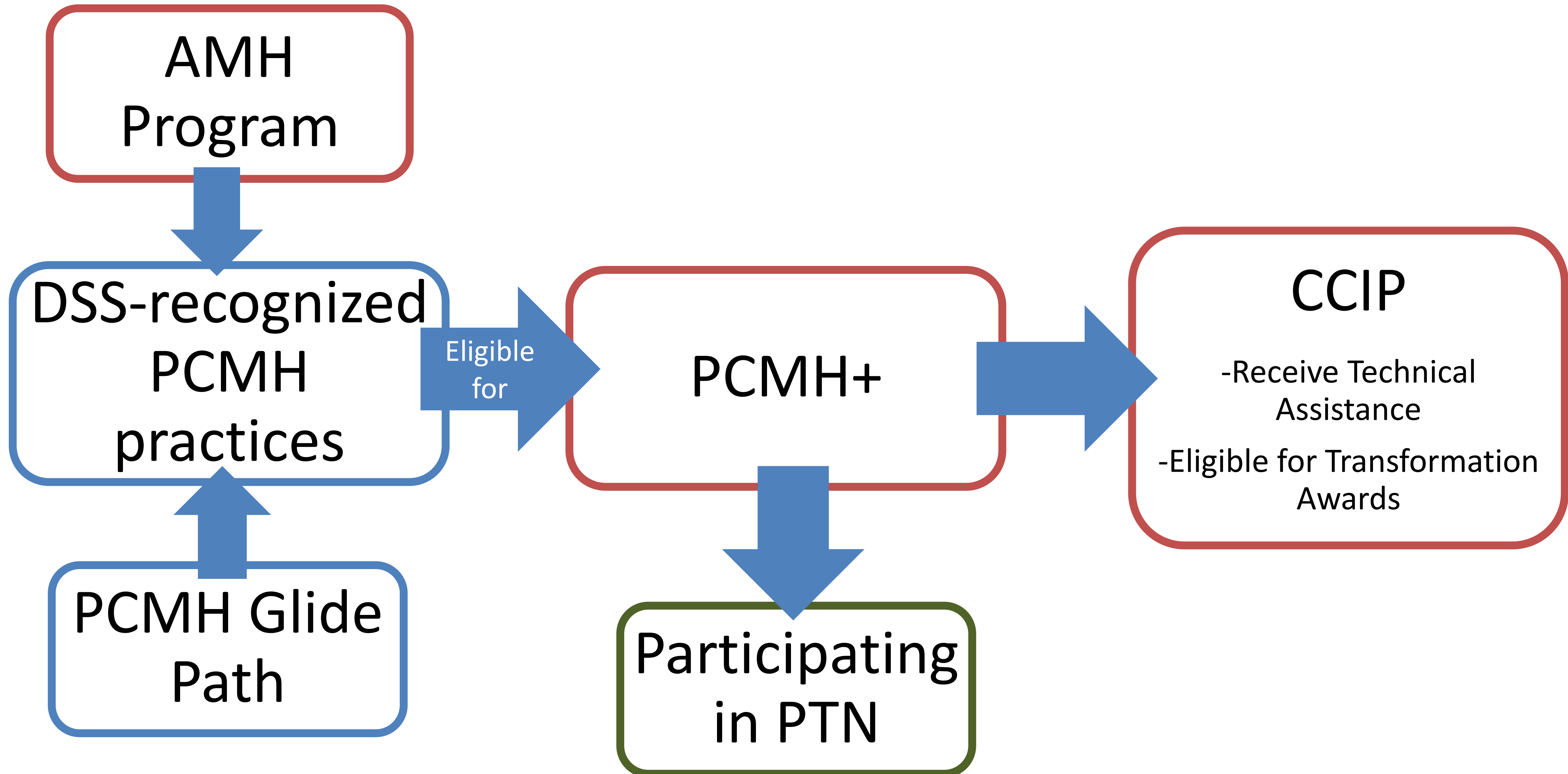
Community Health Collaboratives

Oral health Integration

E-Consult

Comprehensive Medication Management

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



CCIP Participating Entities

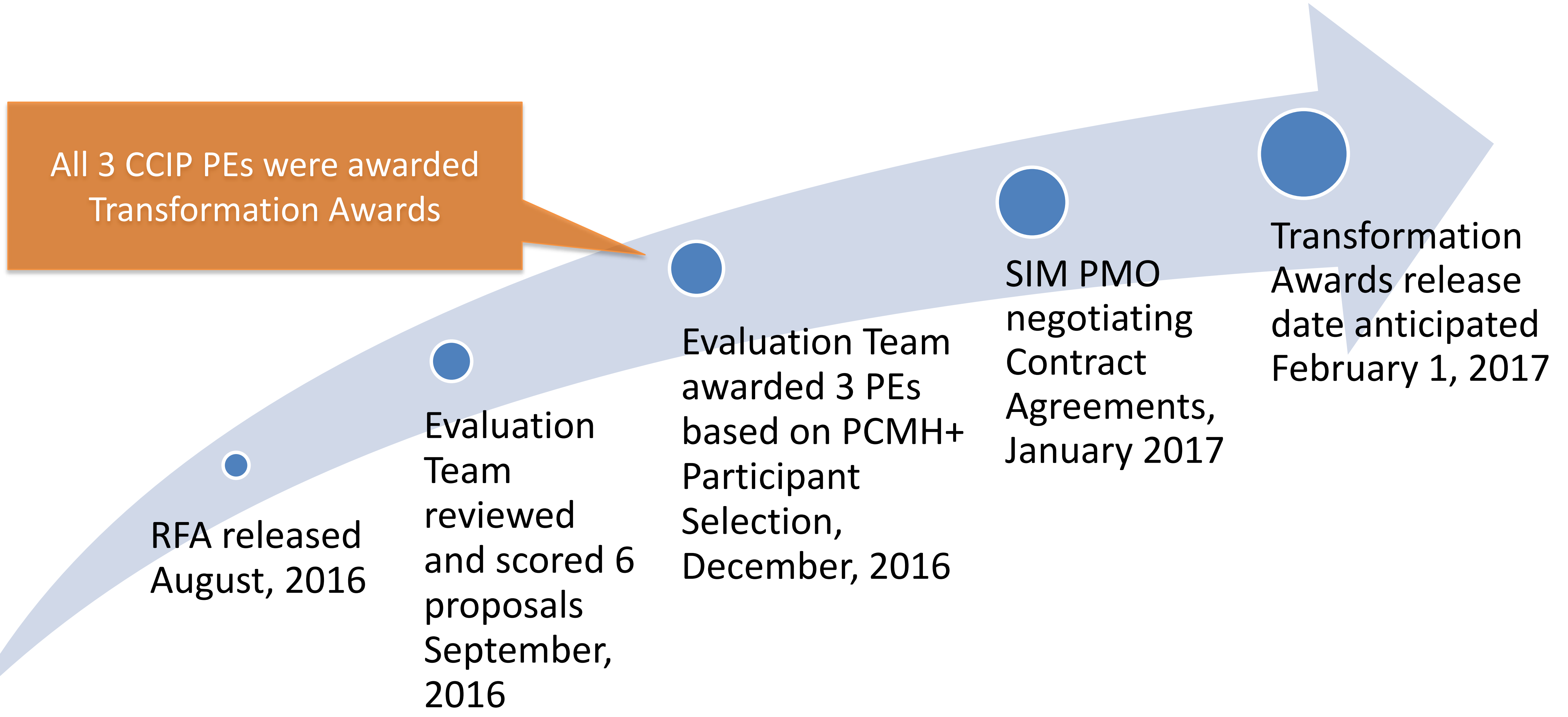
Advanced Networks

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

Federally Qualified Health Centers

- Community Health Center, Inc.

Transformation Awards: Selection Process



How will the Transformation Awards be used?

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

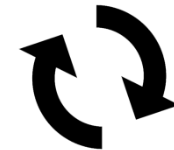
The awards will be used for:

Community Health Workers

Behavioral Health specialists

Data analytics and IT support

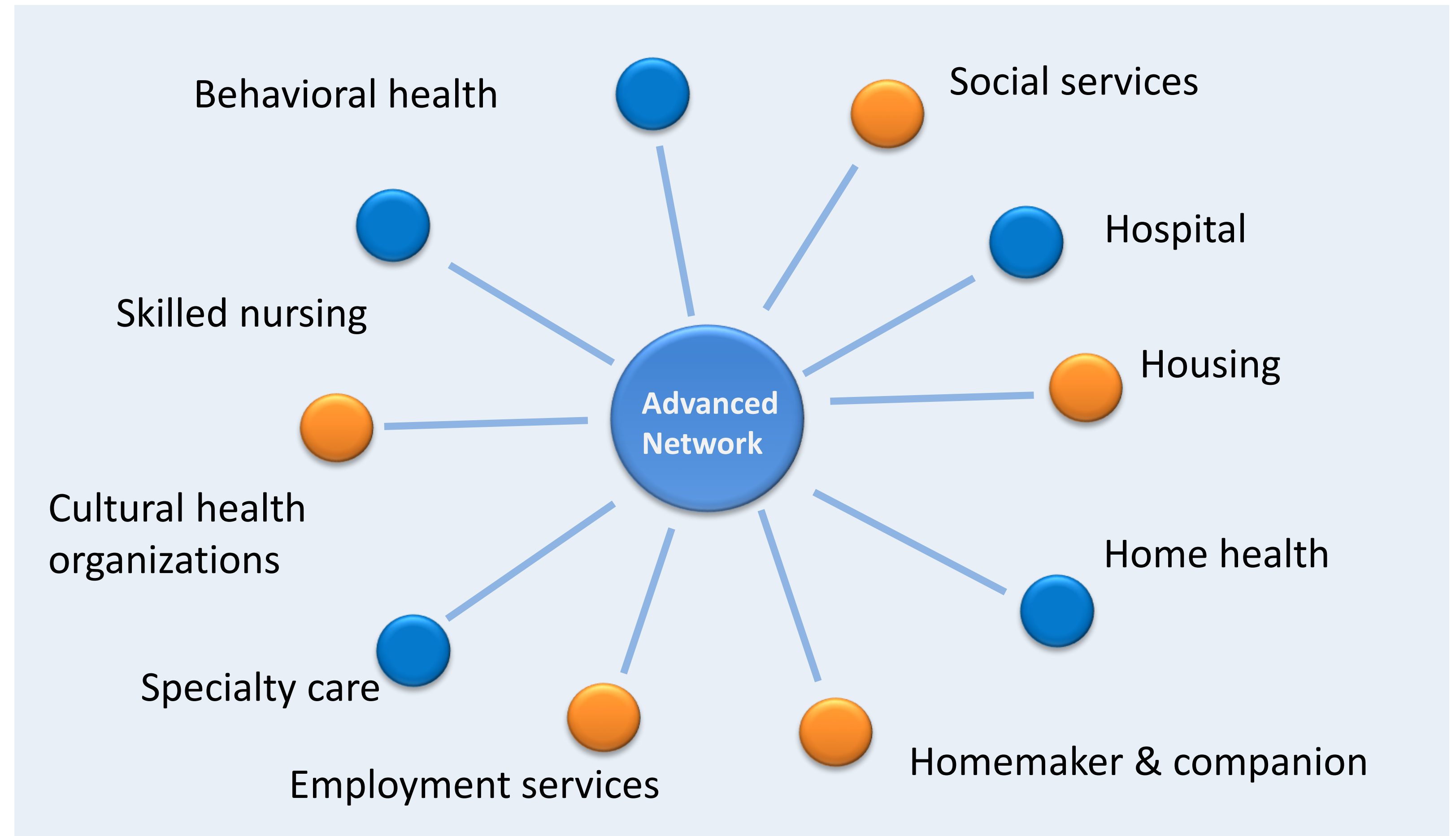
Program Coordinators and Administrative support staff



Staff time/consulting dedicated to process/system redesign

Community Health Collaboratives

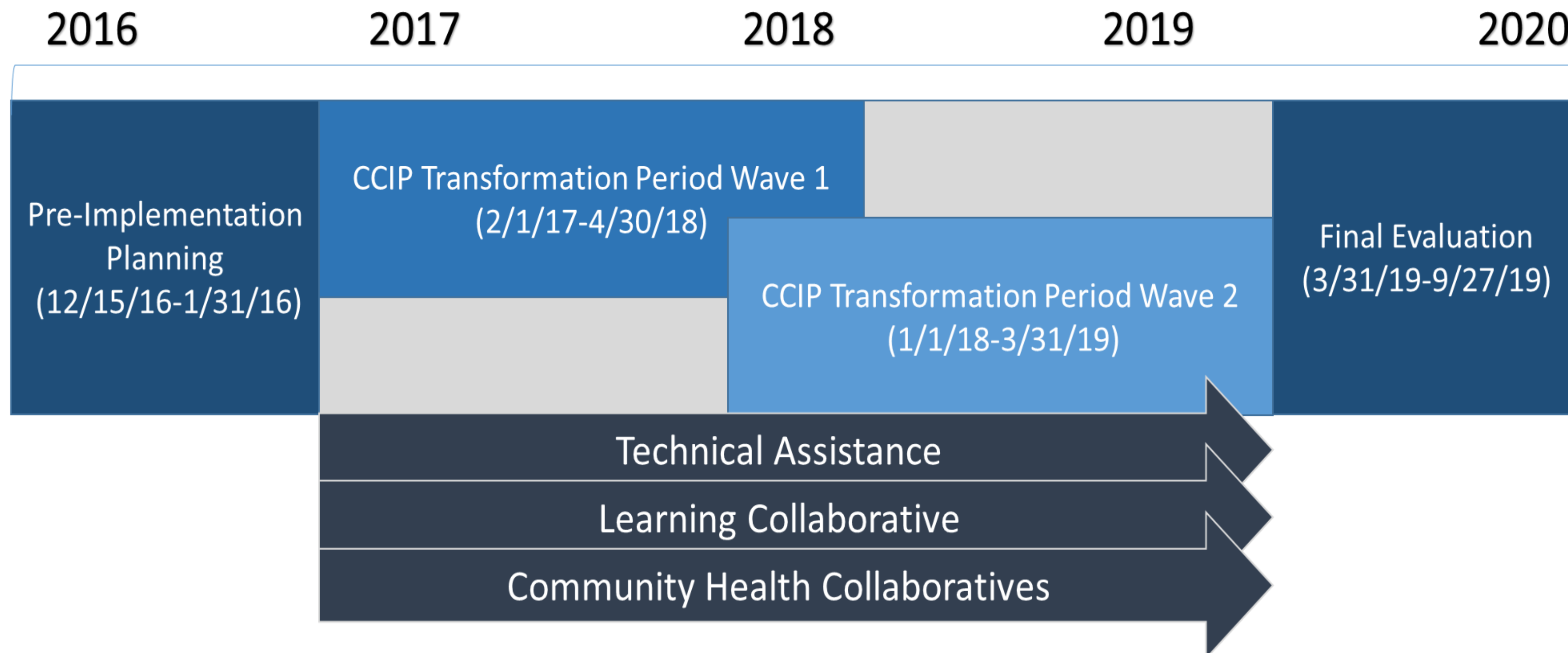
- CCIP PEs are required to participate in a **Community Health Collaborative** to promote coordination between clinical and community organizations
- The PMO will work with DSS and DPH to weigh criteria for selecting the regions for Collaboratives. Criteria may include:



- 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

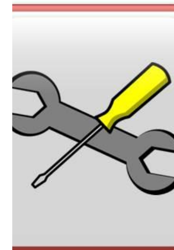
- Technical Assistance and Peer Learning opportunities through a Learning Collaborative will be provided by the Technical Assistance vendor, Qualidigm
- Qualidigm was selected through a competitive procurement process and includes a fully Connecticut-based team



CCIP- The Path to Transformation

Our Team

Connecticut-based



Advanced Medical Home Vendor and TCPI contract

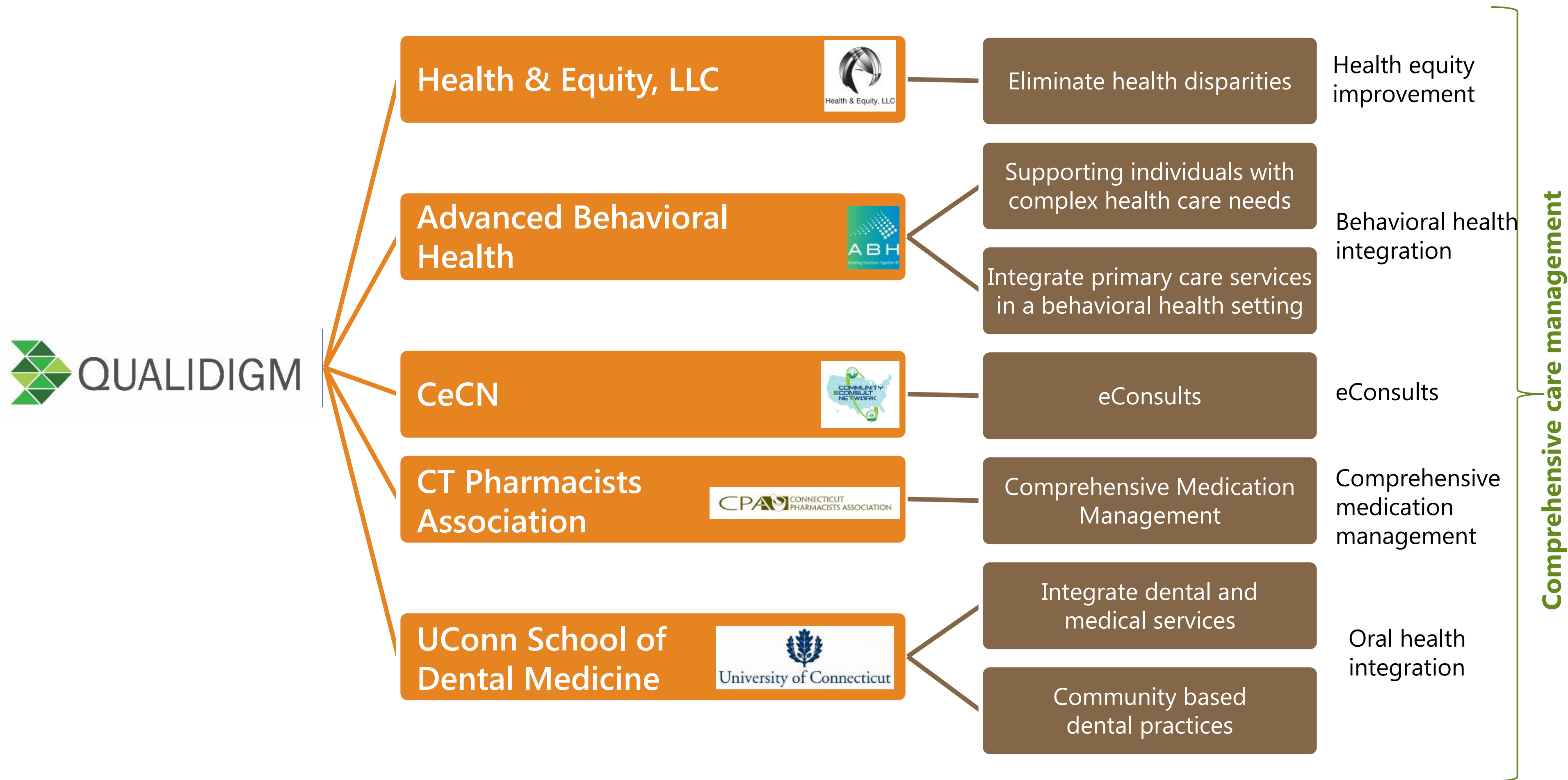
Substantial relationships within the provider community

Deep understanding and successful experience with over 250 offices in primary care transformation

Expertise in health information technology, behavioral health integration, health equity program design, care management, predictive analytics, population health management, risk stratification, oral health integration, and electronic consultative approaches to healthcare management.

QIN QIO contract allows us to train new staff in quality improvement, and leverage their experience on other projects

Proposed Strategy

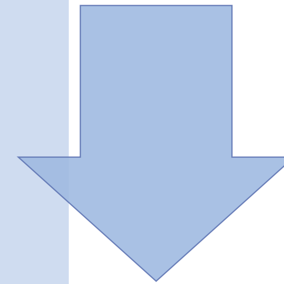


Adult Learning & Change Management Theories

Our purpose is to engage clinicians and their offices using an integrated strategy that incorporates adult learning theory and change management to achieve transformational change as defined jointly by the OHA and the participating entities.

Our position is supported by the theory that adults must endure an indelible experience, whether positive or negative, in order to reflect and make changes in their lives.

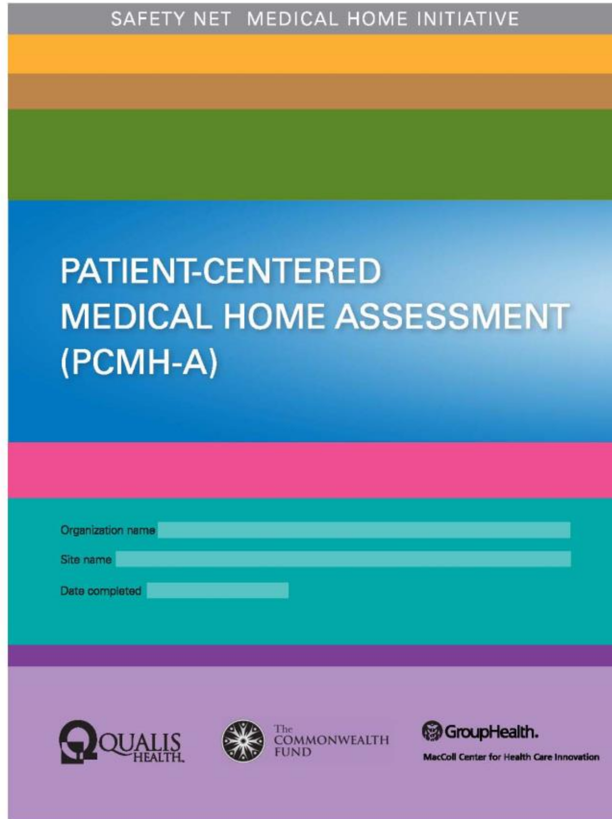
- Adults have unique motivations for learning, and theory demonstrates that no two adults learn the same.
- Continuous adaptation of methods and strategies to motivate adult learners towards transformational change

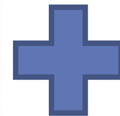


- Leveraging multidimensional approach that includes a learning management system to incorporate:
  - Short Videos
  - Certifications
  - Podcasts
  - Assessments/ Tests
  - Live Peer-To-Peer Interactions
  - Social Learning
  - Competitive Gamification
  - Just-in-time learning

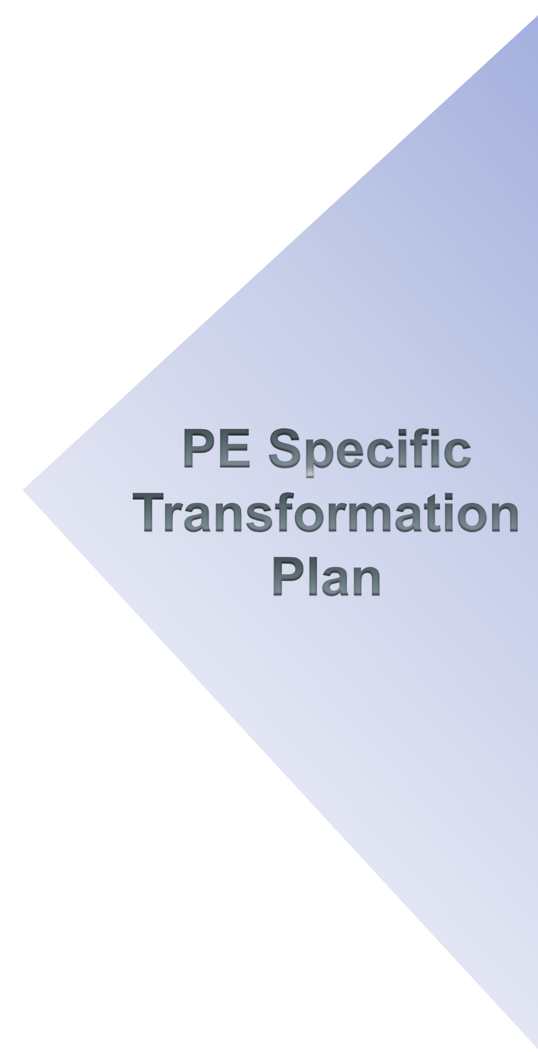
QUALIDIGM

Assessments

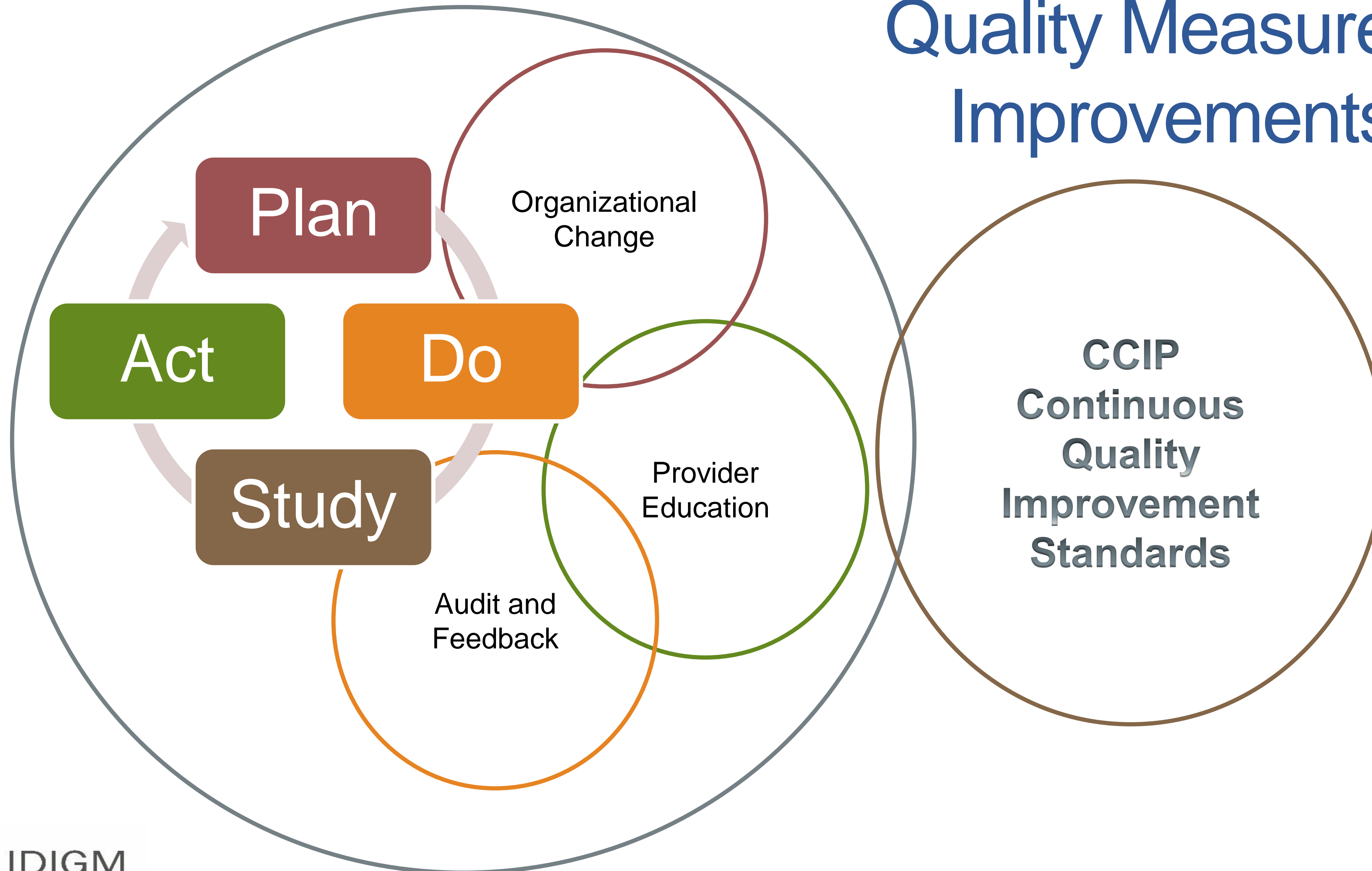




Elements from established assessments to address core and elective standards

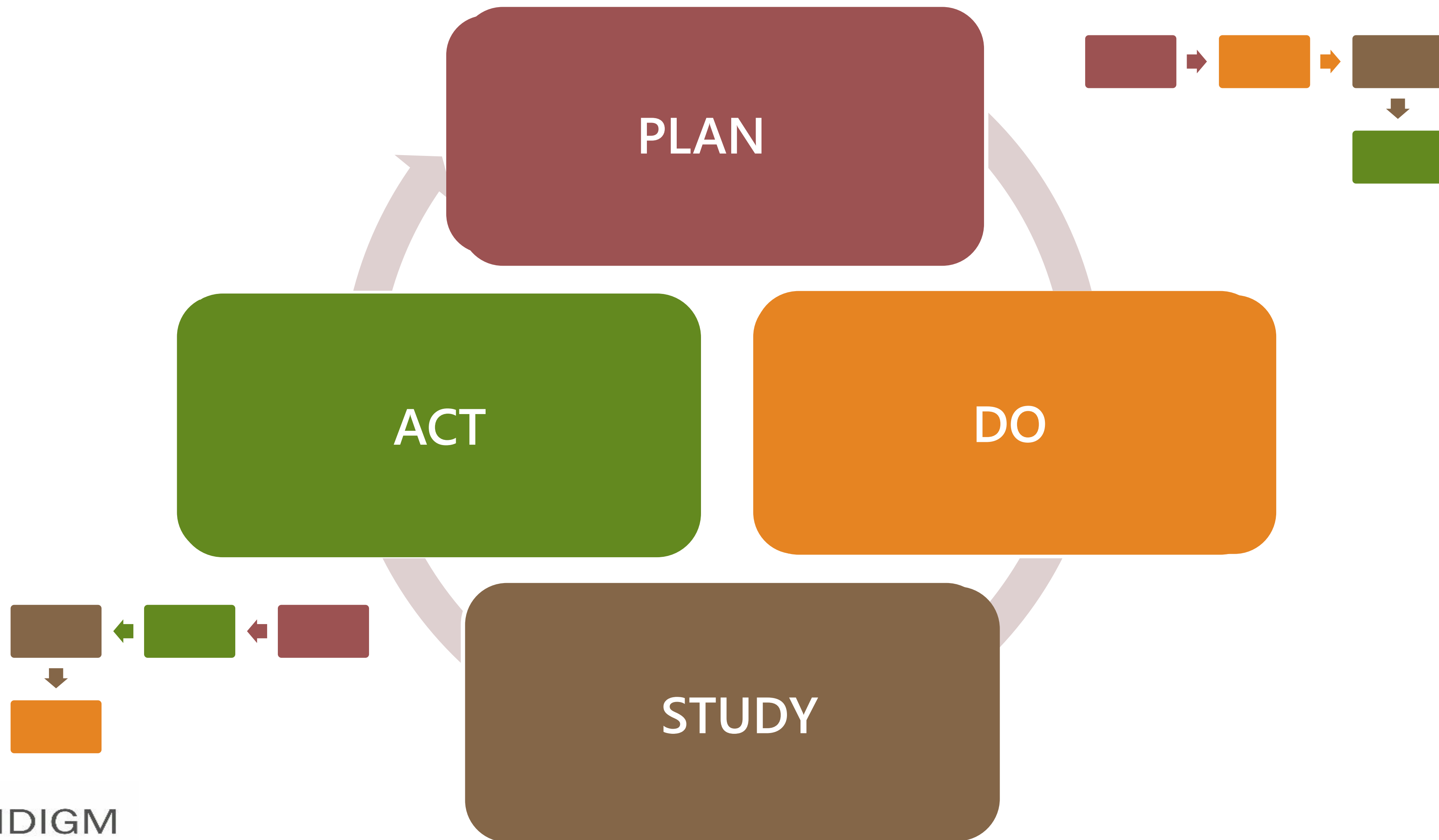


Linking Transformation Interventions to Quality Measure Improvements



QUALIDIGM

An Example: PDSA and HbA1c



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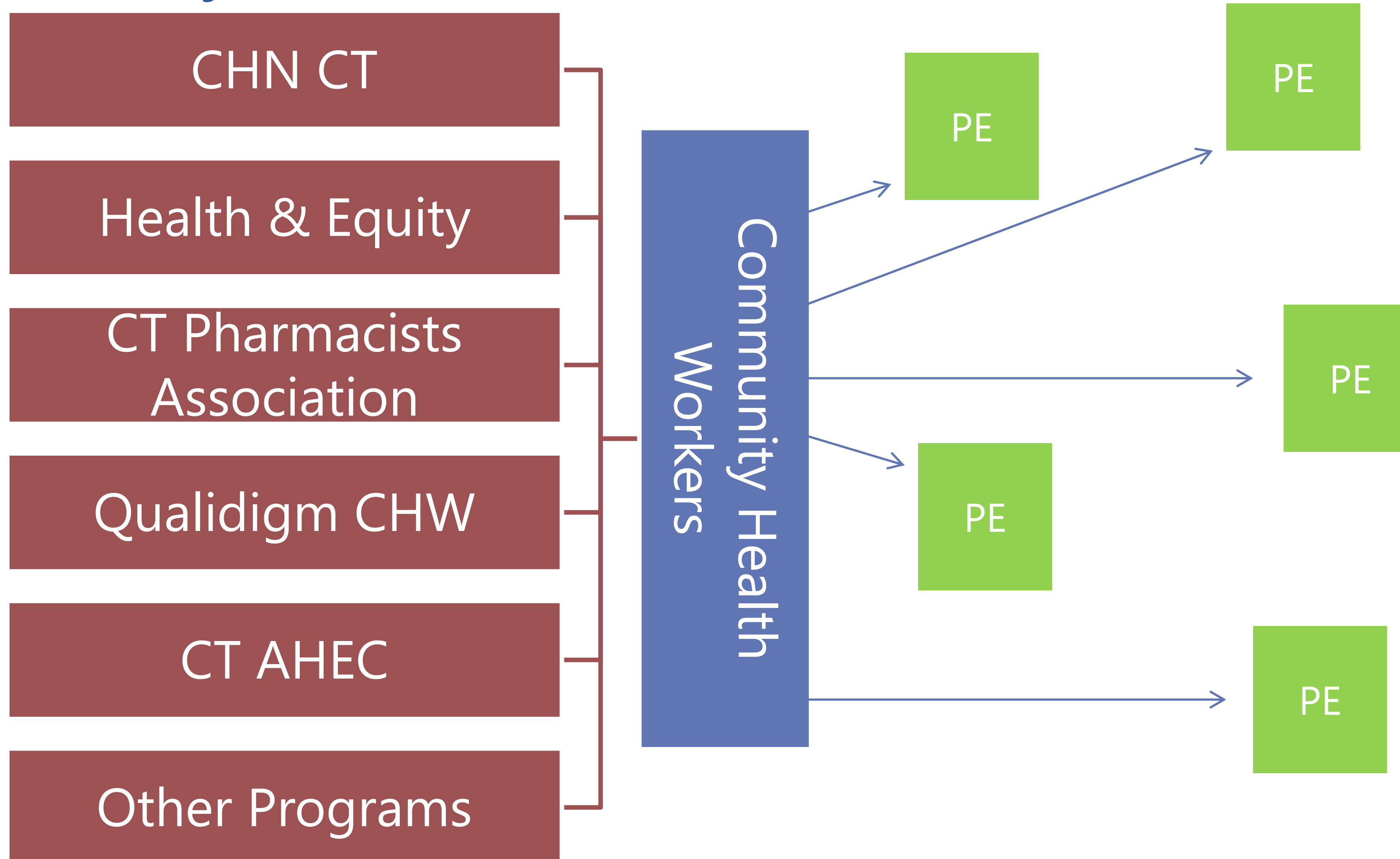
Community Health Workers



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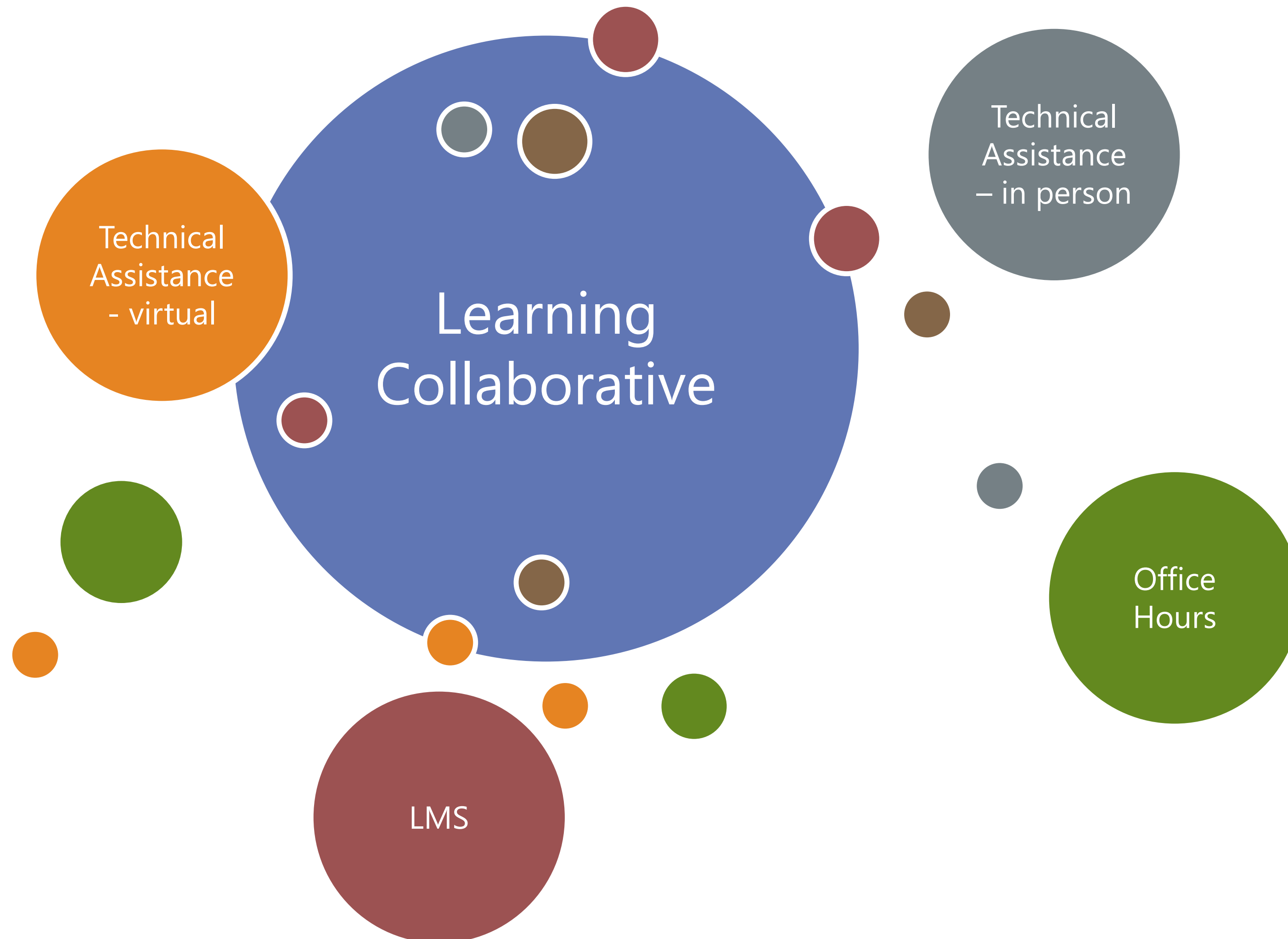
Learning Collaborative



QUALIDIGM

Engaging Community Partners

Benefits

More affordable, whole person-centered, higher quality, equitable healthcare

Integration of non-clinical community services with primary care

Improve overall efficiency and effectiveness for all patients

Complements existing initiatives

Patient and provider satisfaction

Prepare for new payment models

Challenges

- Identification of target populations
- Sustainability
- Lack of funding
- Data collection/ reporting issues
- Define metrics for performance
- Clinical care team and community member collaboration
- Inadequate clinician participation
- Standardization of CCIP implementation across networks

Transformation Approach

"We are flexible"

QUALIDIGM

Primary Care Payment Reform

Shared Savings: Opportunities and Limitations

Opportunities

- Return on Investment for improved healthcare outcomes based on quality measures
- Provides a first step toward value-based care

Limitations

- Savings are difficult to predict so ROI is uncertain
- Lack of capital for up-front investments needed to improve care
- Only supports practice changes that yield substantial ROI in 1-3 years

My doctor only saw me for 15 minutes- how can she understand what's causing all of my health problems?

I have ten more patients waiting to see me, and a ton of data entry.

Story 1 – Iora Health

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

Story 2 – Esse Health Physician Practice

St. Louis based Practice since 1996

PCMH Approach to Care Management

ACO Shared Savings

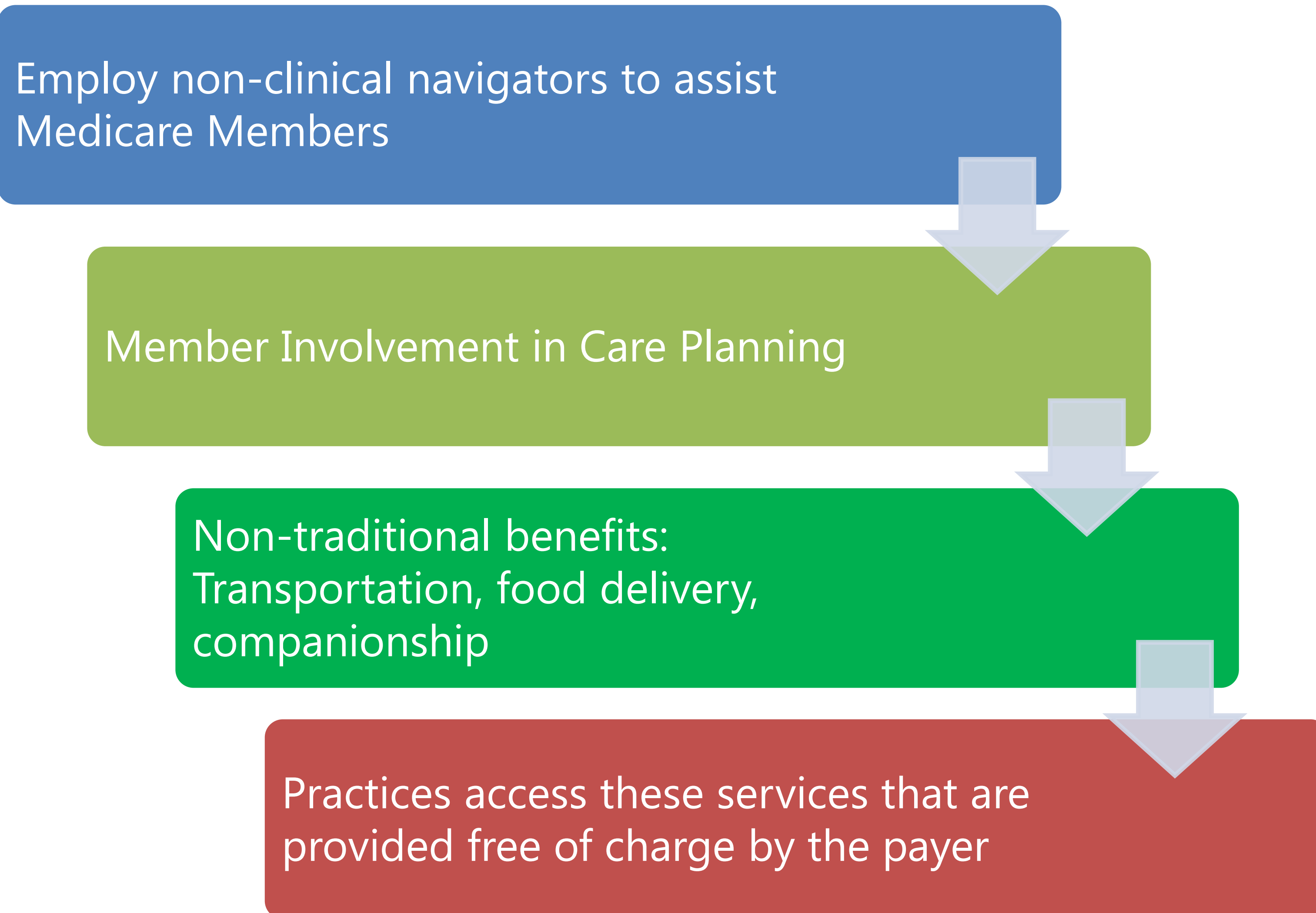
Started Essence Healthcare in 2003 to better manage patients

Medicare Advantage Payment Model

Essence Healthcare Medicare Advantage HMO
(http://www.essencehealthcare.com/)

Esse Health Physician Practice
(http://www.essehealth.com/)

Story 3 – Fallon Health



Financial Model of a Solo Practice

Physician Compensation Overview w/Options for Advanced Payment $

Revenue Estimate	
Panel Size	2,500
Advanced Payment	$0.00
$ / Visit	$95.00
Visits/Day	25
Visits/Patient/Yr	2.16
Days/Week	4.5
Weeks/Yr	48
Total Revenue	$513,000

Expense Estimate	
Staff (RN, Admin, Billing, Med Assist, Benefits)	$200,000
Other Overhead (Rent, Insurances, Fees, etc)	$100,000
Additional Staff, Services, Coordination, Technology	$0
Physician Take Home Compensation	$213,000

This example demonstrates basic compensation for a solo practitioner

Financial Model of a Solo Practice

Physician Compensation Overview w/Options for Advanced Payment $

Revenue Estimate	
Panel Size	2,500
Advanced Payment	$0.00
$ / Visit	$95.00
Visits/Day	20
Visits/Patient/Yr	1.73
Days/Week	4.5
Weeks/Yr	48
Total Revenue	$410,400

Expense Estimate	
Staff (RN, Admin, Billing, Med Assist, Benefits)	$200,000
Other Overhead (Rent, Insurances, Fees, etc)	$100,000
Additional Staff, Services, Coordination, Technology	$0
Physician Take Home Compensation	$110,400

This example demonstrates the impact of reduced visits per day to increase care coordination

Financial Model of a Solo Practice

Physician Compensation Overview w/Options for Advanced Payment $

Revenue Estimate	
Panel Size	2,500
Advanced Payment	$5.00
$ / Visit	$95.00
Visits/Day	25
Visits/Patient/Yr	2.16
Days/Week	4.5
Weeks/Yr	48
Total Revenue	$663,000

Expense Estimate	
Staff (RN, Admin, Billing, Med Assist, Benefits)	$200,000
Other Overhead (Rent, Insurances, Fees, etc)	$100,000
Additional Staff, Services, Coordination, Technology	$150,000
Physician Take Home Compensation	$213,000

This example demonstrates the impact of providing an Advanced Payment for delivery of alternative services

Financial Model of a Solo Practice

Physician Compensation Overview w/Options for Advanced Payment $

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Panel Size	2,500
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Variables in a primary care bundle scenario

Key Informant Interview/Case Study – CPC+

Comprehensive Primary Care Plus

America's Largest-Ever Multi-Payer Initiative to Improve Primary Care

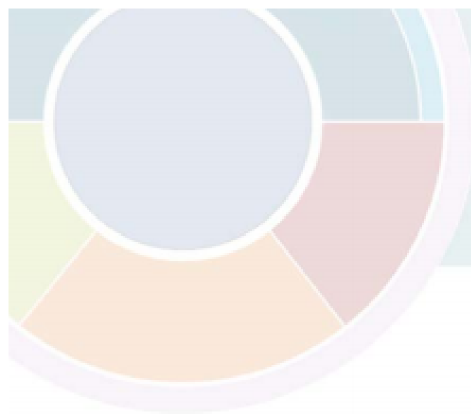
CPC+: Getting off the Fee-for-Service Treadmill

Key Informant Interview/Case Study – CPC+

Three Payment Innovations Support CPC+ Practice Transformation

	Care Management Fee (PBPM)	**Performance-Based Incentive Payment** (PBPM)	**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)

Key Informant Interview/Case Study – CPC+

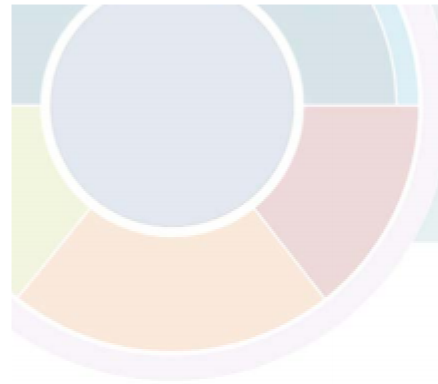


CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

	Requirements for Track 1	Requirements for Track 2
Access and Continuity	Empanelment 24/7 patient access Assigned care teams	Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
Care Management	Risk stratified patient population Short-term and targeted, proactive, relationship-based care management ED visit and hospital follow-up	Two-step risk stratification process for all empanelled patients Care plans for high-risk chronic disease patients

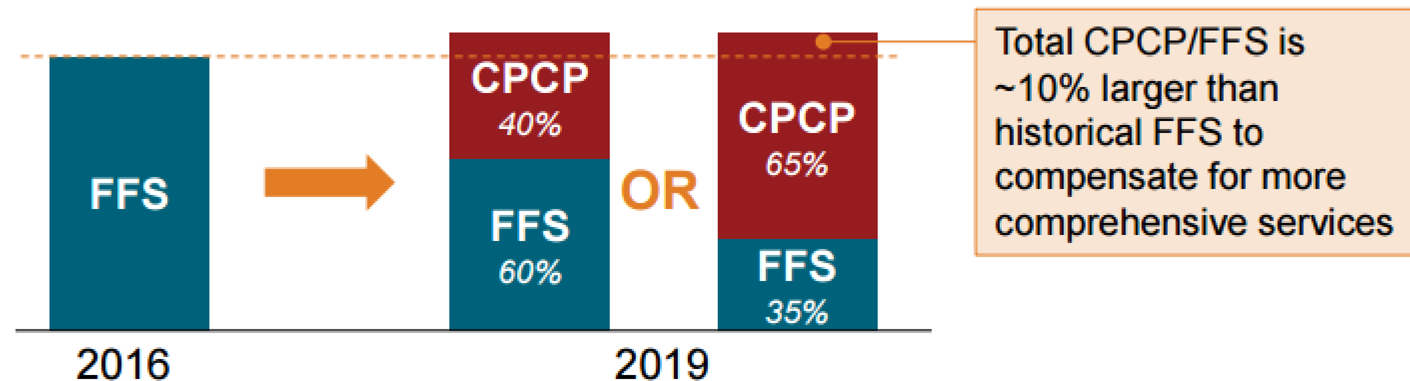
Key Informant Interview/Case Study – CPC+



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



- 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

PCPM – Next Steps

- Literature Review including summary and analysis of primary care payment models that have been implemented in other states/regions
- Stakeholder interviews and/or focus groups 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

Adjourn