OHS CONNECTICUT Office of Health Strategy

Payment Reform Council

February 21st 2019

Meeting Agenda

1. Introductions/Call to Order	5 min
2. Public Comment	10 min
3. Approval of Minutes	5 min
4. Review Purpose of Today's Meeting	5 min
5. Review PCM Primary Care Capabilities	30 min
6. Medicare Cost and Savings Estimates	30 min
7. Accountability and Performance Measurement	30 min
8. Next Steps and Adjourn	5 min

Introductions/ Call to Order

Public Comment

Approval of the Minutes

Primary Care Modernization Model Design: Advisory Process

Goal - Develop a primary care modernization program model that details:

1) ***new care delivery capabilities for Connecticut's primary care practices*** (PTTF charge)
2) ***payment model options that support those capabilities*** (PRC Charge)

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 Outcomes

Patient Experience	Quality
• Improved communication, convenience, care coordination and self-management. • Increased access to primary and specialty care including behavioral health and dental care. • Increased overall satisfaction with providers, feeling of providers' care and concern. • Shorter wait times • Less time off from work, improved functioning at work	• Earlier identification and treatment of some medical and behavioral health conditions; improved outcomes (e.g., depression remission rates) • Improved chronic illness outcomes (e.g., A1C control) • Reduced preventable admissions for ambulatory care sensitive conditions and all-cause unplanned hospital readmissions • Improved preventive care (e.g., cancer screening, immunizations, oral health) • Improved care plan adherence • Reduced use of opioid painkillers and less opioid addiction; earlier recognition of risk for opioid addiction; improved opioid use disorder treatment outcomes
Access	**Cost**
• Increased access to primary and specialty care including behavioral health and dental care and reduced barriers to access (e.g., transportation, childcare, time off work) • Reduced wait times to address new diagnoses, changes in condition and response to treatment • Improved access to local, culturally-competent community resources to address social determinant barriers • Easier access to services in the practice, home, and community • Easier access to high quality pain management support from primary care team and medication assisted treatment for substance use disorders	• Lower out of pocket costs for patients when treated in primary care • Reduced avoidable specialty care, urgent care, tests, treatments, procedures • Reduced avoidable emergency department visits and hospital stays • Reduced avoidable physical health utilization related to unmet BH needs • Averted or reduced length of stay in skilled nursing facilities with coordination of home-based supports • Reduced cost associated with time off work

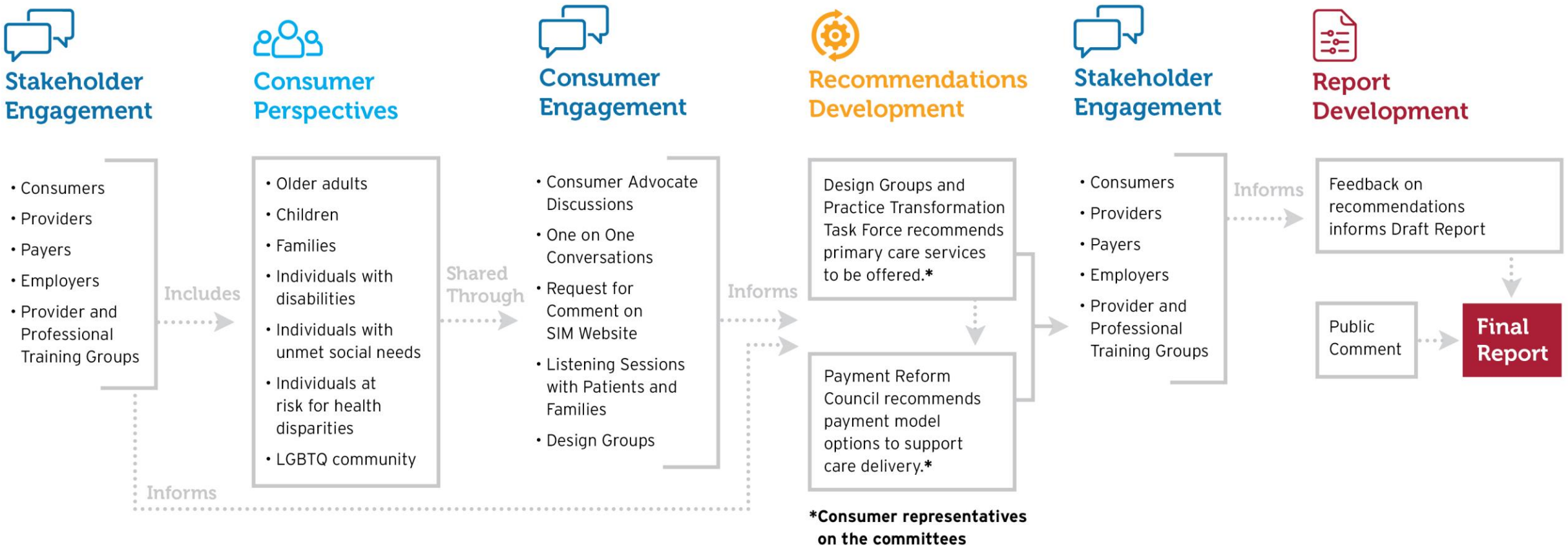
Primary Care Modernization Health Equity Impact

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. These disparities are largely driven by systemic barriers.

By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to address the following barriers:

- Language Differences
- Culture
- Lack of Transportation
- Lack of Childcare
- Difficulty Taking Time Off Work
- Literacy

Primary Care Modernization Process



PCM Primary Care Capabilities

Adult Primary Care Capabilities

		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Home Visits • Remote Patient Monitoring • Integrative/functional medicine	• Older Adults w/Complex Needs • Pain Management and Medication Assisted Treatment • Individuals with disabilities
	Elective	• Community Purchasing Partnerships • Oral Health Integration	• Shared Medical Appointments	

ADULT DIVERSE CARE TEAMS

CORE

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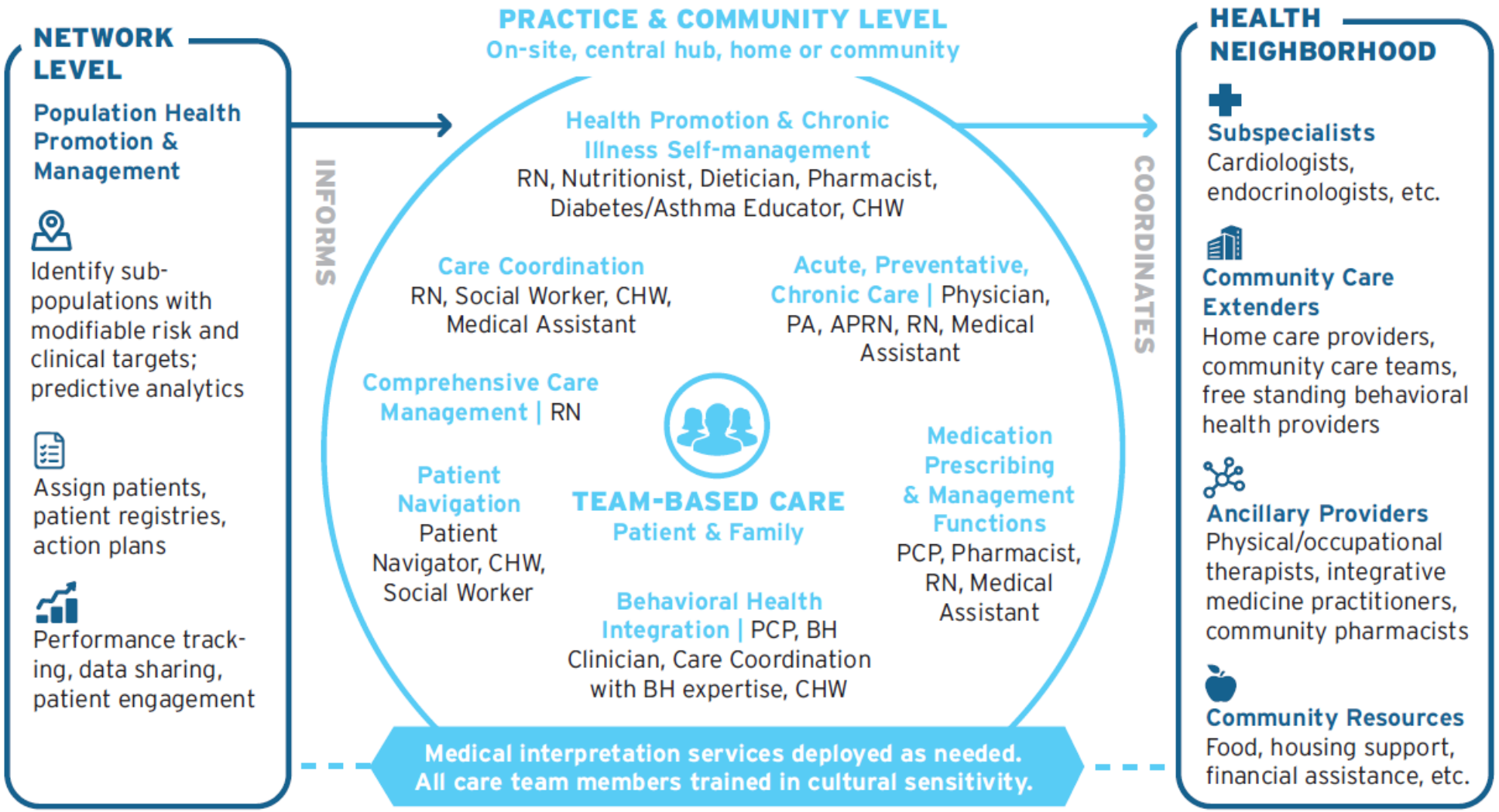

ADULT BEHAVIORAL HEALTH INTEGRATION

CORE

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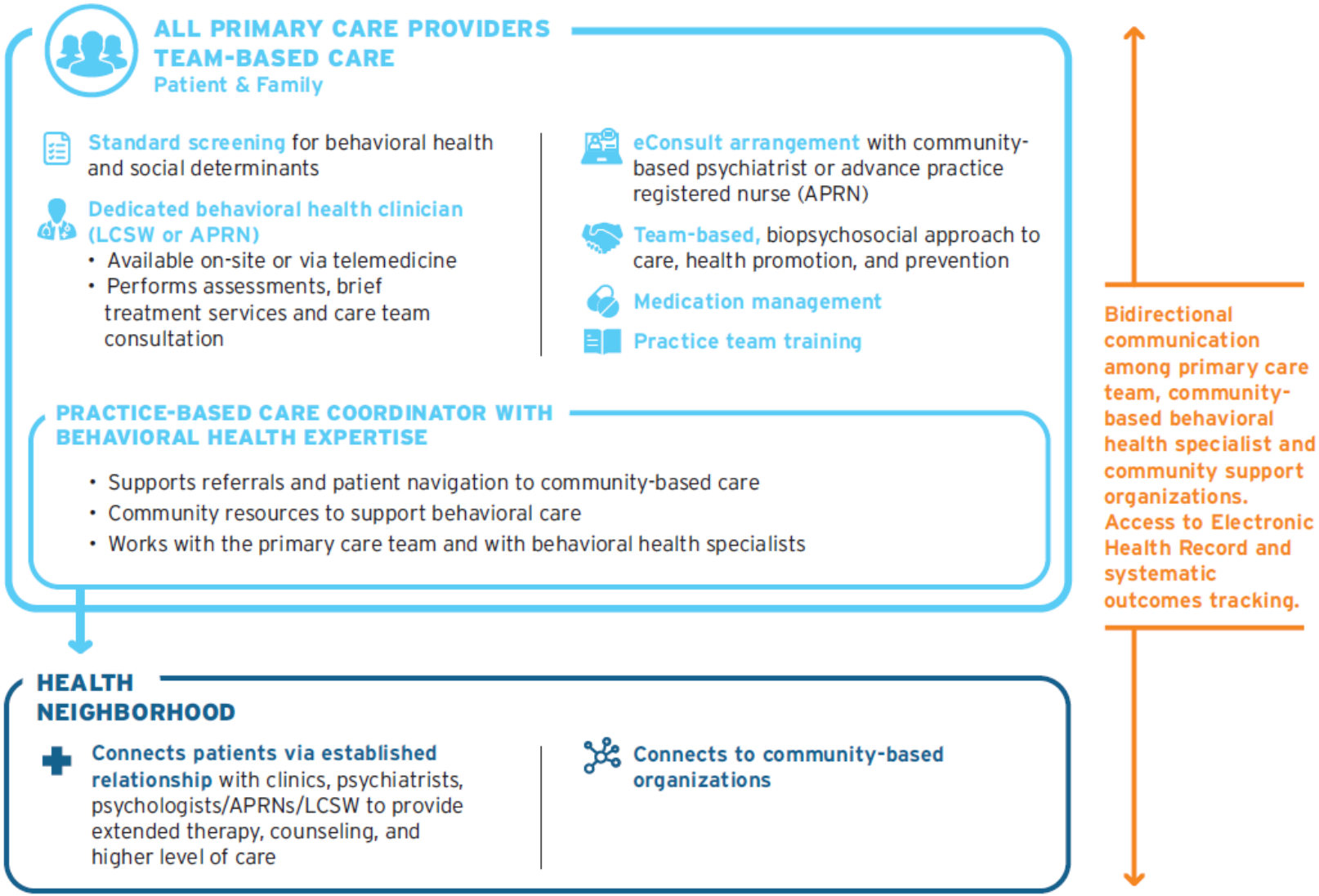

ELECTIVE

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ADULT COMMUNITY PURCHASING PARTNERSHIPS

CARE TEAM AND NETWORK

Networks use person-centered assessments (including SDOH screening) and/or analytics to identify patients whose needs are best met through community placed services
[See also: Community Integration to Address Social Determinants]

ONGOING COMMUNICATION ABOUT PATIENTS

HEALTH NEIGHBORHOOD
Arrangements With Community Placed Services

TYPE OF SERVICE	Community Placed Navigation or Linkage Services	Early Intervention and Secondary Prevention Services	Chronic Illness Self-management Services	Complex Care Coordination for High Risk Patients, Often with SDOH Needs	Support for Patients with Acute or Chronic Medical Risk at Home
EXAMPLES OF MODELS	Health Leads or Project Access	Community Meeting Place Approach	Prevention Services Initiative	Community Care Teams, Leeway Community Living	Mobile Integrated Health/Community Paramedicine

INCREASE EXPERTISE IN PAIN MANAGEMENT

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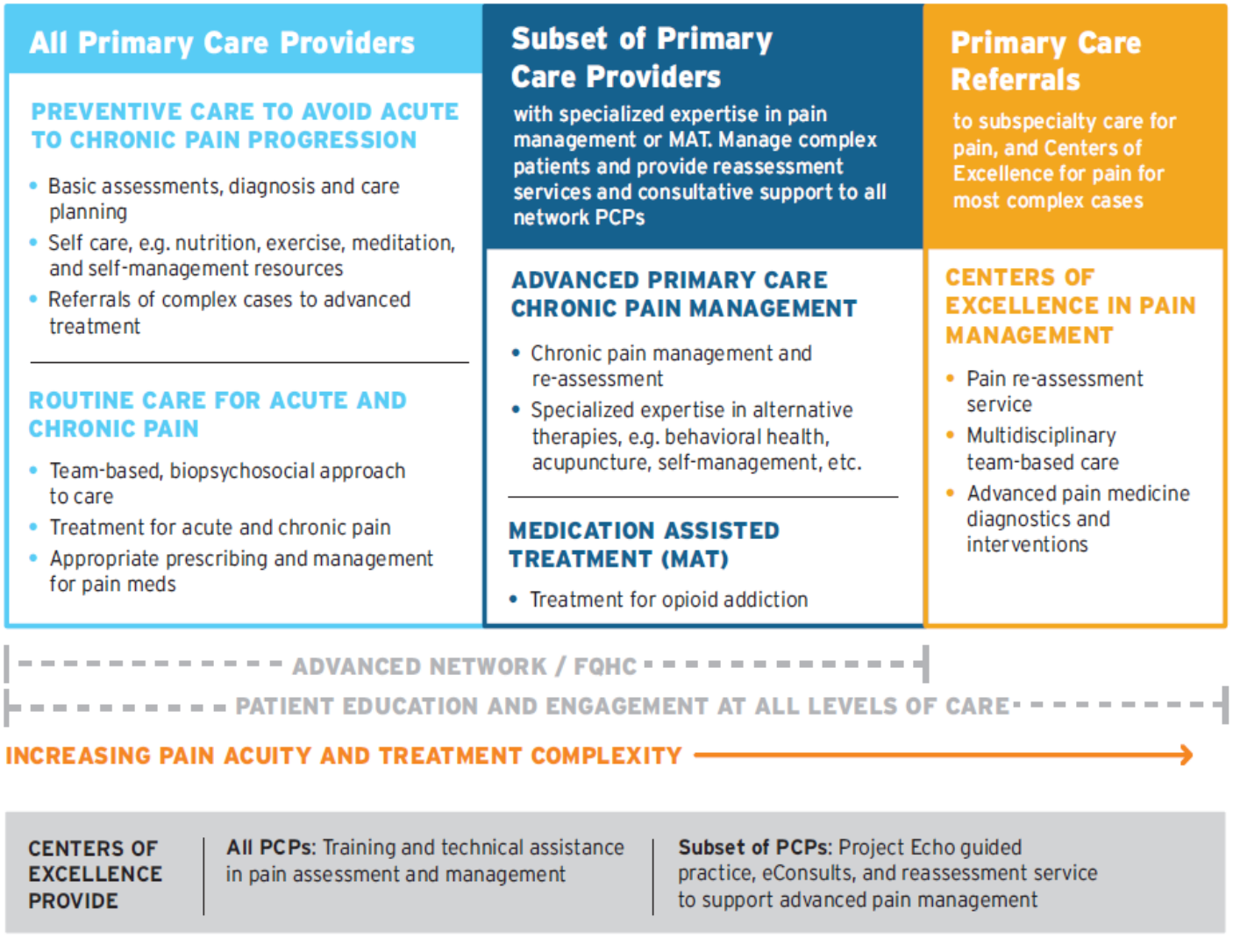

CENTERS OF EXCELLENCE PROVIDE	**All PCPs**: Training and technical assistance in pain assessment and management	**Subset of PCPs**: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management

SPECIALIZED CARE FOR OLDER ADULTS WITH COMPLEX NEEDS

Patients and families choose primary care team based on needs, provider expertise and practice capabilities

CORE

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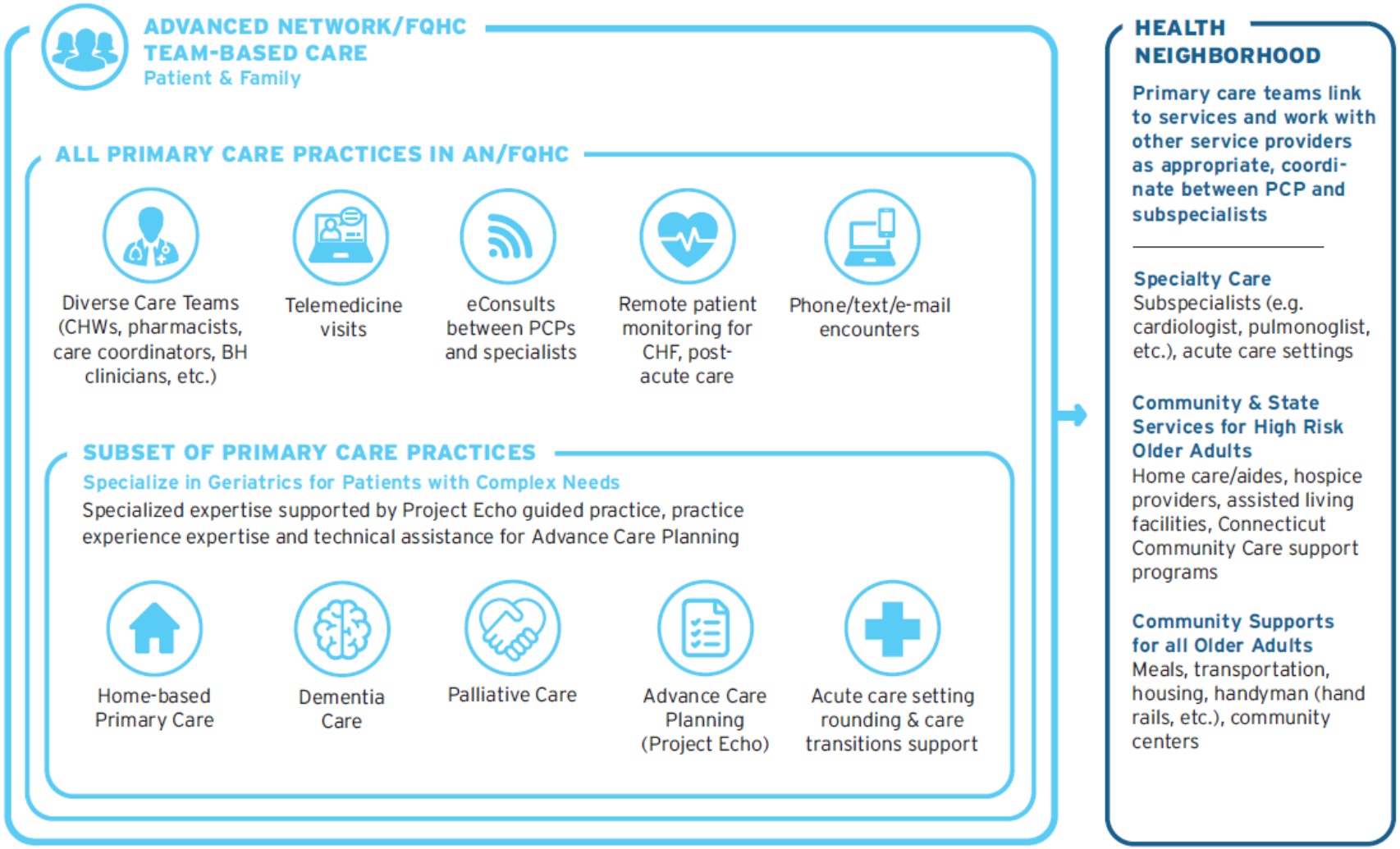


HEALTH NEIGHBORHOOD

Primary care teams link to services and work with other service providers as appropriate, coordinate between PCP and subspecialists

Specialty Care
Subspecialists (e.g. cardiologist, pulmonoglist, etc.), acute care settings

Community & State Services for High Risk Older Adults
Home care/aides, hospice providers, assisted living facilities, Connecticut Community Care support programs

Community Supports for all Older Adults
Meals, transportation, housing, handyman (hand rails, etc.), community centers

Other Adult Capabilities

- Telemedicine, Phone, Text & Email **(CORE)**
- eConsults and Co-management **(CORE)**
- Remote Patient Monitoring **(CORE)**
- Shared Medical Appointments (ELECTIVE)
- Oral Health Integration (ELECTIVE)
- Under Consideration
  - Individuals with Disabilities
  - Integrative/Functional Medicine

Dr. Neil

Dr. Neil's Adult Patients

Chris's Story

Chris's Needs

- Help managing his Crohn's flare-ups
- Support for his depression
- More coordinated care to reduce the number of specialists he is seeing
- Fewer days of missed work and fewer trips to the emergency room

Dr. Neil's Practice Solutions

- Part-time LCSW to identify behavioral health needs, make referrals, and provide monthly support
- Coordinated care between the his gastroenterologist, PCP, and LCSW
- eConsult to address emerging skin problems

Mr. Jones's Story

Mr. Jones's Needs

- Help managing prescriptions for diabetes, congestive heart failure, kidney disease
- More frequent and closer monitoring of changes in condition
- Fewer avoidable trips to the doctor due to stroke related mobility challenges

Dr. Neil's Practice Solutions

- Home-visit by part-time pharmacist
- eConsult option with cardiologist
- Video check-in visits with PCP and/or RN care manager
- Remote patient monitoring for congestive heart failure
- Communication with care team through phone and email

Mr. Jones

Christina Polomoff,
PharmD, BCACP, BCGP

Assistant Clinical Professor

University of Connecticut School of Pharmacy

Population Health Clinical Pharmacist

Hartford Healthcare Integrated Care Partners

Pediatric Primary Care Capabilities

		Team-Based Care	Alternative Ways to Engage Patients and Their Families	Specialized Practices
Health Equity Improvement	Core	• Diverse Care Teams • Behavioral Health Integration • Oral Health Integration • Community Integration to Address Social Determinants • eConsults and Co-management	• Telemedicine, Phone, Text & Email • Universal Home Visits (for newborns)	• Individuals with disabilities
	Elective	• Community Purchasing Partnerships	• Shared Medical Appointments	

Universal Capabilities for Adult and Pediatric Primary Care Practices

CORE

Health Equity Improvement

This capability identifies key components of an effective Health Equity Improvement strategy. In order to achieve the capability, your network must achieve the goals and demonstrate improvement on the process measures. Your network has a clear, documented policy and procedure to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

Community Integration to Address Social Determinants

Every practice and network will identify social determinants of health and other barriers that may affect patents' healthcare outcomes and address those barriers by connecting patients to community resources.

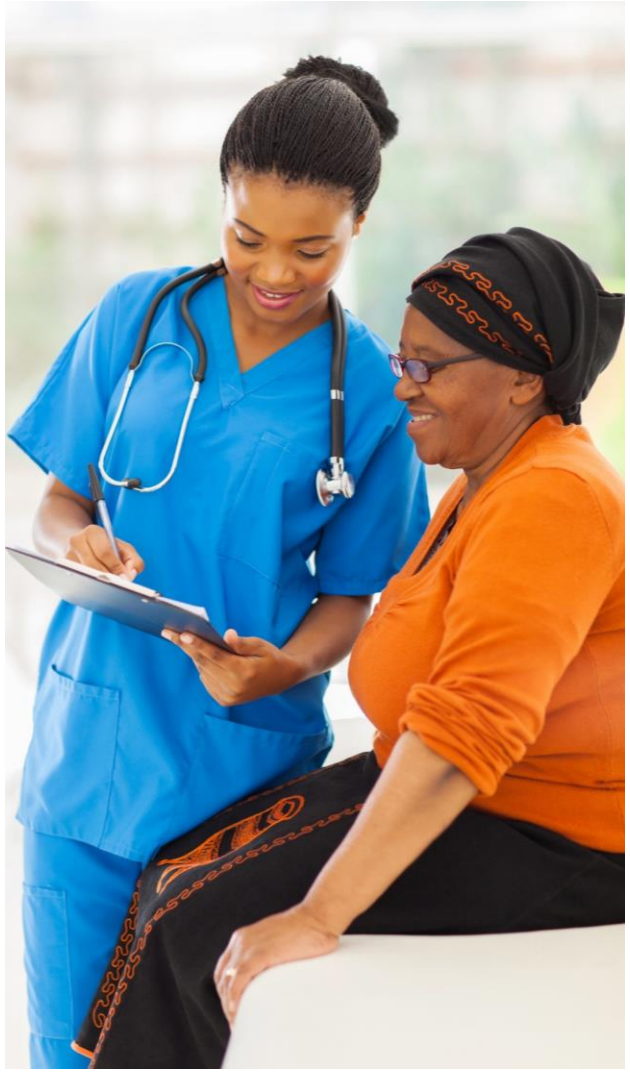
Hypothetical Approach to Phase-In of Adult Capabilities

We anticipate capabilities will be phased-in over the five years. ANs/FQHCs may pilot strategies, refine and expand.

	Year 1	Year 2	Year 3	Year 4	Year 5
Required Core*	• Diverse Care Teams (***may want to prioritize RN care manager, CHW***) • Phone, Text, Email, Telemedicine • Training and technical assistance	• Enhanced Year 1 Capabilities • Integrated Behavioral Health • eConsult and Co-management • Health Equity Improvement • Community Integration to Address SDOH	• Enhanced Year 2 Capabilities	• Enhanced Year 3 Capabilities • One Additional Core Option	• Enhanced Year 4 Capabilities • Any Remaining Additional Core Options
Menu of Additional Core Options	• Integrated Behavioral Health • eConsult and Co-management • Community Integration to Address SDOH • Health Equity Improvement	• Specialized practices • Remote patient monitoring	• Specialized practices • Remote patient monitoring	• Specialized practices • Remote patient monitoring	
Elective	**Elective Capabilities Permissible Within Available Resources**				

Fictional Case Study: ABC HealthCare

ABC HealthCare, is a fictional advanced network in Stars Hollow, Connecticut. Its adult internal medicine physicians and nurse practitioners serve about 50,000 patients a year. They have decided to pursue Primary Care Modernization.



ABC HealthCare's Implementation Approach:

Year One: Begin to build out its care team with additional registered nurse care managers and community health workers. Provide physicians with training and technical assistance in care team leadership. Make HIT upgrades to support a better phone, text, email patient experience.

Year Two: Continue care team expansion, technical assistance and training. Launch a pilot to integrate behavioral health at three of its seven primary care sites. Begin analysis of social determinants of health data and utilize it to better connect patients to community-placed resources. Begin offering eConsult.

Year Three: Begin deploying pharmacists to the homes of patients at high risk of readmission. Refine and expand integrated behavioral health pilot to additional practice sites. Launch formal partnership with local housing referral service.

Year Four: Continue refining and expanding existing capabilities. Develop two specialized practices, one for older adults with complex medical needs and one focused on chronic pain management. Pilot remote patient monitoring at the specialized practice for older adults.

Year Five: All practices achieve all core capabilities. Training and technical assistance continues to support evolution. Two additional partnerships with community-placed resources launch.

Phase-In Approach Addresses Common Barriers to Success:

- Advancements in primary care, such as the introduction of new methods of patient support (e.g., telemedicine) or the integration of new care team members (e.g., community health workers) takes time.

- Managing change is a complex endeavor that requires investments in clinical workflow re-engineering and training as well as connections to technical assistance and peer learning opportunities. It also requires a cultural shift unlikely to occur immediately.

- An available workforce will not be fully available on day one and it will take time for the market to adjust.

Medicare Cost and Savings Estimates

Our Process for Estimating Cost and Savings

PTTF Core Capabilities Defined:

- Capabilities to be included in PCM
- Whether each capability would be core or elective
- Whether each capability would be deployed by care teams or the network

Provisional Payment Mechanism Assigned:

New or Existing Resources

Cost and Savings Estimates Developed:

Peer-reviewed research, experiences in clinical and operational leadership, and CT-specific data inform estimates of expenses and potential reductions in facility-based utilization.

Costs and Savings Estimates Analyzed:

- Avoid duplication of cost or savings
- Account for variation in cost and savings

Key Affordability Questions Considered:

- Does each capability offer an ROI or meaningfully contribute to the ROI of another capability?
- Is the package of capabilities likely to lower total cost of care over time?
- Would the hypothetical supplemental bundle generate sufficient return on investment and cover the cost of the program?
- Can the hypothetical supplemental bundle cover the cost of achieving the capabilities?

Please note…

- The data shared today are educated estimates meant to inform our conversations. Estimates could be very different depending on a provider's approach to achieving the capability and its existing infrastructure.
- Through the work of the design groups and PTTF, we have a better sense of the core and elective capabilities and the specific requirements to achieve them. However, additional changes may occur as stakeholders continue to weigh in.
- In addition to achieving core and elective capabilities, the PRC has provisionally recommended other approved uses of supplemental revenue which may include:
  - Patient-specific expenses to address social determinant of health needs such as food security/food as medicine, housing instability and transportation;
  - New investments in technology and infrastructure to support achieving the capabilities;
  - Beneficiary incentives

Hypothetical Medicare Cost Estimates for Adult Core Capabilities

Core Capabilities	Estimated PMPM Cost to the Supplemental Bundle Over Five Years	Assumptions (*all cost estimates based on "average" Medicare beneficiaries' contribution to "average" multi-payer, 1500/per FTE MD panel*)
Phone, Text, Email, Telemedicine	$0	Assumes AN/FQHC has necessary technology. Assumes PCP time paid via existing resources. Other care team members included in diverse care teams estimates.
Diverse Care Teams	$14.00-$15.75	Assumes access to RN Care Manager, Health Coach, Pharmacist, Nutritionist, Community Health Worker (CHW), Medical Interpreter/Medical Interpretation Services
BH Integration	$3.50-$4.00	Assumes AN/FQHC has necessary technology. PCP time paid via existing resources. Care coordination included in diverse care teams. Adds BH clinicians. (LCSW).
Community Integration to Address Social Determinants	$0.75	Assumes AN/FQHC has necessary technology. Adds additional CHW time.
Health Equity Improvement	$0.50	Adds clinical data analyst and additional time for CHW.
eConsult	$0	Assumes PCP time paid via existing resources. Assumes specialist time is paid FFS, via recent changes to FFS codes.
Remote Monitoring ***(For patients with congestive heart failure)***	$0	Recent changes to FFS codes would cover provider time setting up the technology and explaining it to patients, the device(s) supply with daily recording(s) or programmed alert(s) transmission, and clinical staff time to manage treatment based on the data. Diverse care teams could support additional time to connect patients to needed support
Specialized Practices	$5-$10	Most of the cost dedicated to home visits for older adults with complex needs. Range depends on percent of patients receiving home visits. Technical assistance & access to learning network like Project Echo also included.
Training and Technical Assistance	$1.50	Training in collaboration and leadership for expanded care teams.
Total	$27.00-$34.00	

Note: Remaining supplemental bundle dollars could be spent to pursue elective capabilities and/or on other approved expenses including patient-specific expenses to address social determinant of health needs such as food security/food as medicine, housing instability and transportation; new investments in technology and infrastructure to support achieving the capabilities; and beneficiary incentives.

Medicare Savings Model Estimates for Adult Core Capabilities

Capability	What the Research Says	Estimated PBPM* Savings
Phone, Text, Email and Telemedicine	Avoidable specialist costs reduced by 6% which equals a $2.70 PBPM decrease in total medical expense.	$2.70
Diverse Care Teams	Emergency department costs decrease by 20%, inpatient costs decrease by 10%. This results in a $36 PBPM savings estimate. Savings were decreased to $32 PBPM to account for overlapping benefit with other capabilities.	$32.00
Behavioral Health Integration	Total medical expenses decrease 10% for adults with included in the intervention. This translates to a $4.03 PBPM savings. Patients participating in the intervention had lower outpatient and inpatient mental health specialty costs, outpatient and inpatient medical and surgical costs, pharmacy costs, and other outpatient costs	$4.03
Community Integration to Address SDOH	Total medical expenses decrease $180 PBPM with intense food support program and $900 PBPM with housing support. Less than 1 percent of the total population is impacted so estimated PBPM savings equals $1.61.	$1.61
Specialized Practices - Pain Management/MAT	Total medical expenses decrease 45% for patients enrolled in the program. If all high-utilizing adults with chronic pain participated in program savings estimate is $6.35 PBPM. Model assumes 33% program participation and a estimated PBPM savings of $2.10.	$2.10

* PBPM savings reflects the expected per beneficiary, per month savings across the payer's entire population. Since many capabilities will not be applicable to all patients, this figure is typically smaller than the savings estimates for each beneficiary benefiting from the capability.

Medicare Savings Model Estimates for Adult Core Capabilities

Capability	What the Research Says	Estimated PBPM* Savings
Specialized Practices - Older Adults with Complex Medical Needs	Skilled nursing facility costs decrease 16%, which leads to a $15.03 PBPM reduction in total cost.	$15.03
Health Equity Improvement	This capability promotes greater equity in the deployment of other capabilities. As such, its cost savings are included in those capability estimates.	$0.00
eConsult and Co-management	Approximately 69% of eConsults will replace the need for a face to face encounter. Savings of $2.34 PBPM reflects the cost of the avoided encounter offset by specialist consult fees. Convenience may drive an increase in visits. However, some avoided visits may have been hospital based or generated unnecessary testing and be more costly than estimated.	$2.34
Remote Patient Monitoring	Avoidable readmission costs will be reduced by 50% over three years for patients with congestive heart failure which equals savings of $.33 PBPM.	$0.33

* PBPM savings reflects the expected per beneficiary, per month savings across the payer's entire population. Since many capabilities will not be applicable to all patients, this figure is typically smaller than the savings estimates for each beneficiary benefiting from the capability.

Focus: Diverse Care Teams Cost and Savings Estimates

Why Focus on Diverse Care Teams….

1. Its where **most** of the cost and savings sit.

2. It intersects with every other capability.
   - Diverse care teams support the success of other capabilities (e.g. phone, text, email; remote patient monitoring; community integration to address social determinants)
   - Diverse care teams are more effective because of other capabilities (e.g. health equity improvement; remote patient monitoring)

3. It highlights the somewhat artificial dividing lines drawn to more clearly differentiate capabilities and their requirements (behavioral health integration).

Note: All of these factors can make it more challenging to determine the best allocations of cost and savings.

Focus: Diverse Care Teams Cost and Savings Estimates

Context for Diverse Care Team Estimates

Design Group and PTTF Discussions:

- Strong emphasis on the effectiveness and versatility of community health workers.
- Sufficient numbers of RNs needed to oversee complex care management.
- Pharmacists have an important role to play, including visiting patients at home and in the community.
- Integrating Behavioral Health is a separate, aligned capability.

Peer Reviewed Research:

- Research offers a savings range of 1.3% to 4.3% of total medical expense.
- Lower end savings were typically attributed to less robust programs, such as primary care medical homes.
- The study most similar to PCM is one proposed by PWC Research Institute, which targeted 20% reduction in emergency department utilization and a 10% reduction in inpatient utilization.
- Salary estimates on high end of those cited in the research.

Focus: Diverse Care Teams Cost and Savings Estimates

Our Approach: Developing Cost Estimates for the Medicare Population

1. Build out a hypothetical care team based on the PWC model but augmented with additional staff to align with the vision of the design group and PTTF.
2. Determine what professions and how many care team members should be added per 10,000 Medicare patients.
3. Use the high end estimates of published salary information and add 30% for benefits to estimate workforce costs.
4. Use data on chronic condition prevalence to allocate a higher percentage of the workforce to Medicare.

Cost Estimates Based on the Following Care Team Composition per 10,000 Medicare Patients

RN Care Manager	6-7
Health Coach/Educator	2-3
Pharmacist	2
Nutritionist	1.5
Community Health Worker	6-7
Medical Interpretation Services	0.5

Focus: Diverse Care Teams Cost and Savings Estimates

Our Approach: Developing Savings Estimates for the Medicare Population

1. Apply the reductions in ED and inpatient use found in PWC research to Medicare utilization data in the public use file.
2. Attribute no incremental benefit to the care team members added to align with the design group and PTTF input.
3. Based on the calculations in Step 1, attribute $32 PMPM savings to diverse care teams, which is below the potential of ~ $38 PMPM.

Why attribute less than full expected savings? Some savings are attributed to other programs. If more than one capability work together to prevent a hospital stay or ED visit, the cost savings only occurred once.

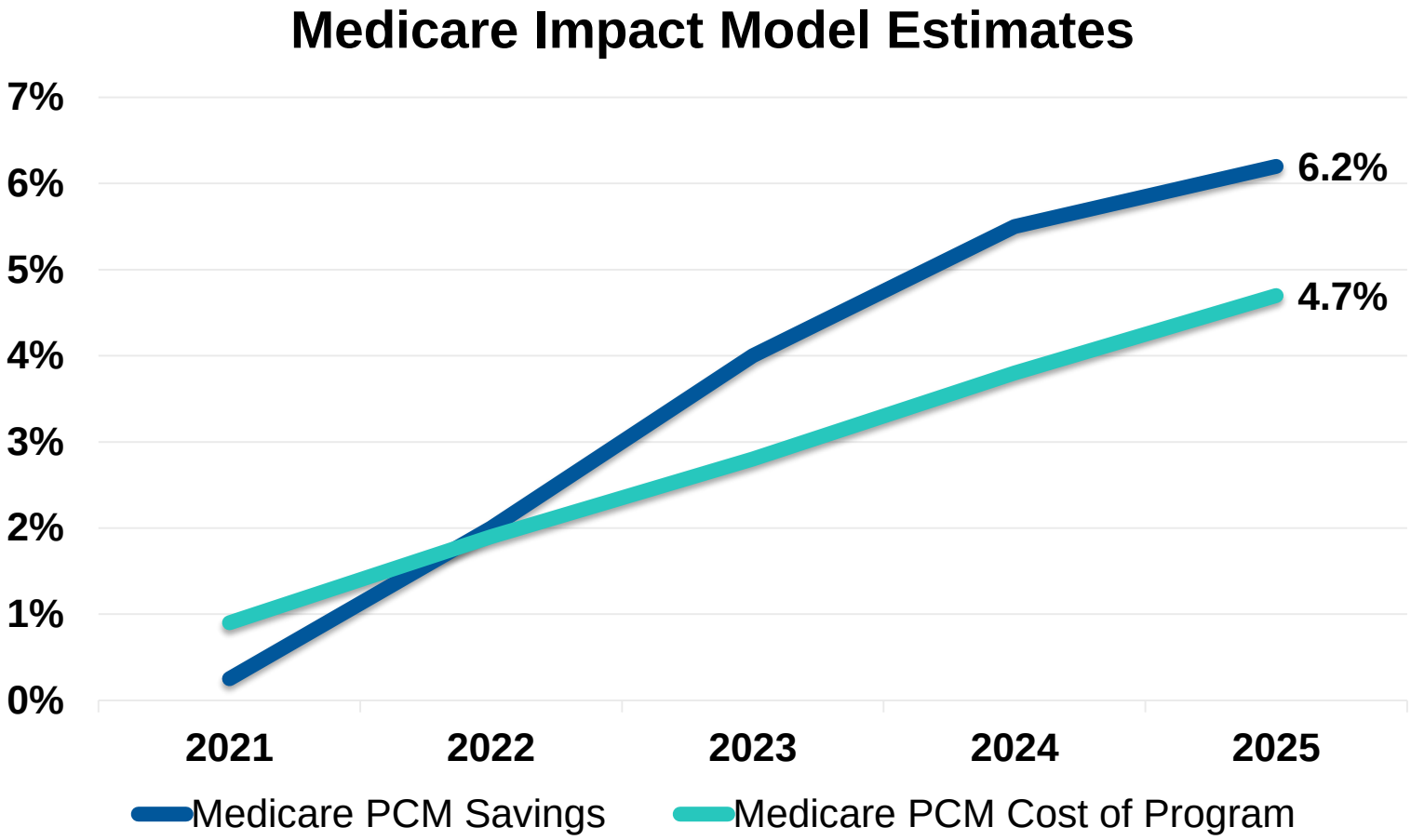
Medicare Impact Model Estimates

	Capabilities Savings Glidepath	Cost of Supplemental Bundle (% of Medical Spend)	Target Medicare Supplemental Bundle PMPM	PCM Trend Impact
Year 1	0.25%	0.9%	$9	0.6%
Year 2	2.00%	1.9%	$18	-0.1%
Year 3	4.00%	2.8%	$27	-1.3%
Year 4	5.50%	3.8%	$36	-1.9%
Year 5	6.20%	4.7%	$45	-1.8%
Cumulative Impact	-16.8%	14.9%		-4.4%

Check In on Key Goals:

- ✓Sufficient investment in care delivery transformation to meet the capability requirements and improve access, health outcomes, equity, patient experience and provider satisfaction.
- ✓Doubled investment in primary care spend over five years.
- ✓Reduced total cost of care over five years.
- ✓Gradual increase in investment that offers:
  - ✓ANs/FQHCs time to ramp up capabilities and test implementation strategies.
  - ✓Payers the opportunity to see incremental success before committing to the highest levels of investment.

Savings Increase as Capabilities are Implemented, Improve Outcomes

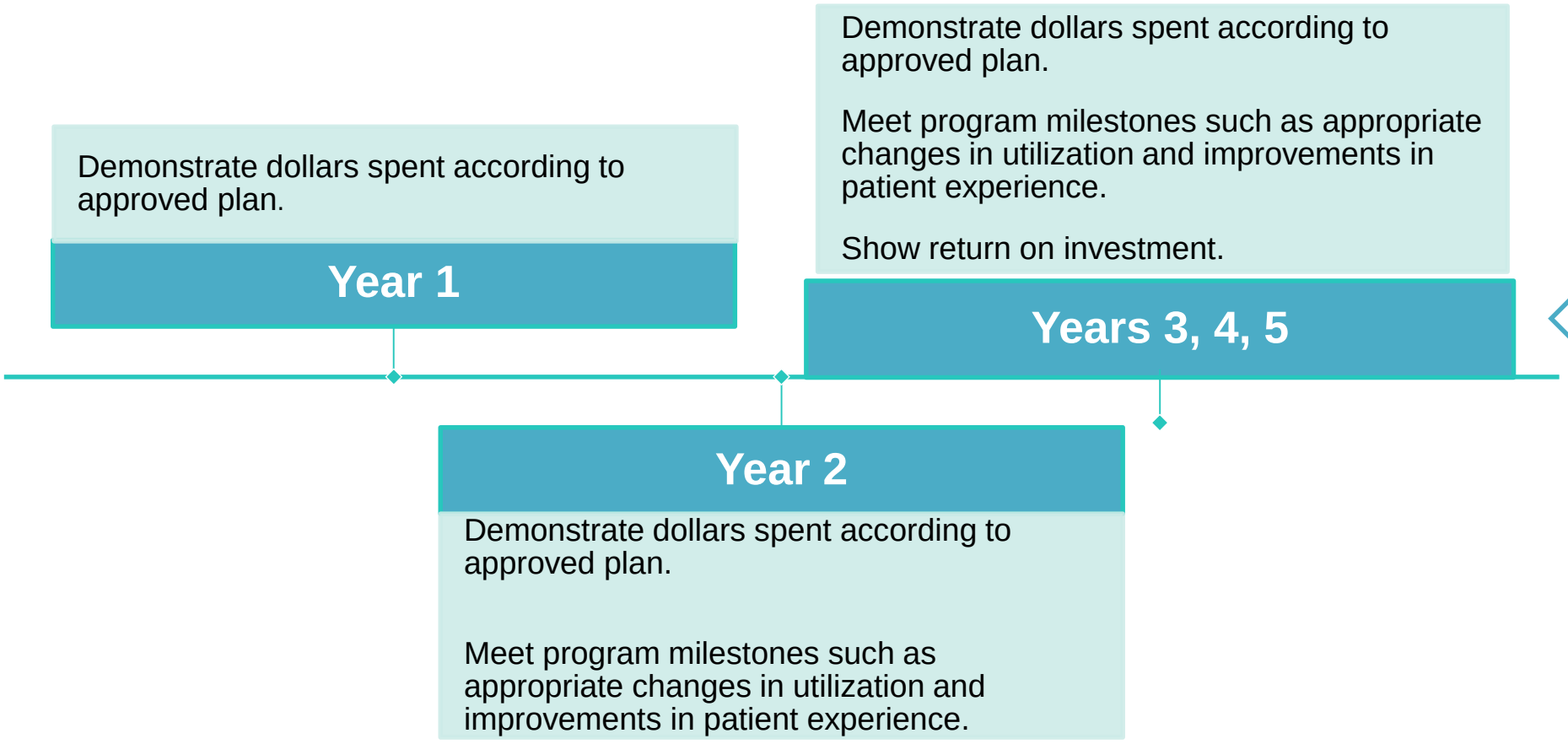


Accountability and Performance Measurement

PCM Accountability Principles

- Individual payer shared savings arrangements and corresponding scorecards and other reporting requirements will remain in place, be applied to PCM and be the foundation for performance measurement in PCM.
- Within the commercial space, state would request that payers harmonize on the quality measures used for shared savings programs in Connecticut for PCM participating entities
- PCM must include additional methods of accountability that demonstrate achievement of PCM transformation process, quality, care experience and savings goals and appropriate utilization.
- The state should enable public performance reporting, which will include reporting by race, ethnic language and disability status.
- Publicly reported data should be presented in a way that is easily understood by consumers.

PCM Accountability Timeline



Proof of Performance

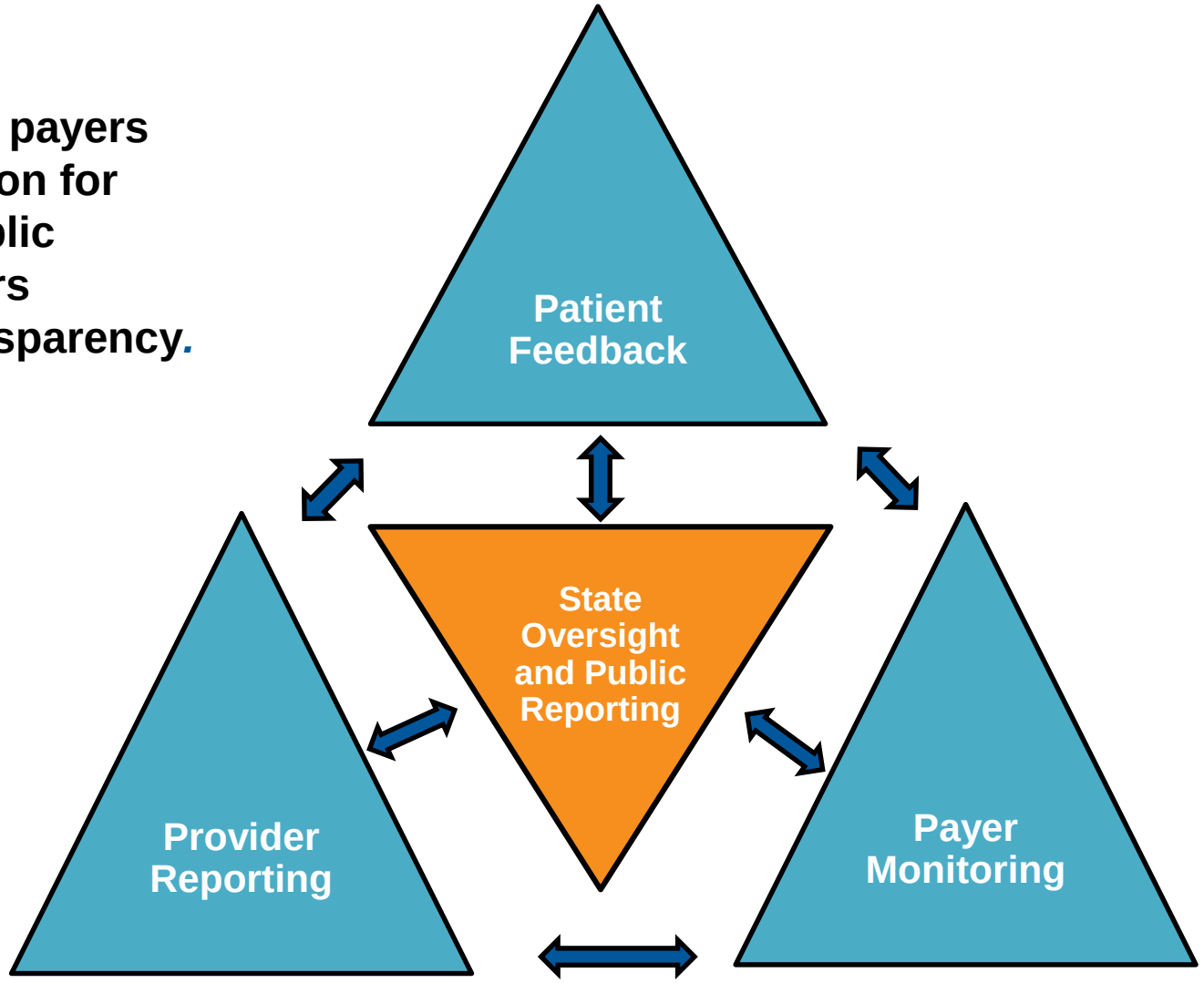
Year 3: Must show savings in excess of Year 2 supplemental payment or not advance to Year 3 and may be subject to a corrective action plan.

Year 4: Must show savings in excess of Year 2 supplemental payment or may face termination. If savings are not in excess of Year 3 supplemental payment, AN/FQHC will not advance to Year 4, and may be subject to a corrective action plan.

Year 5: Must show savings in excess of Year 3 supplemental payment or may face termination. If savings are not in excess of Year 4 supplemental payment, AN/FQHC will not advance to Year 5 and may be subject to a corrective action plan.

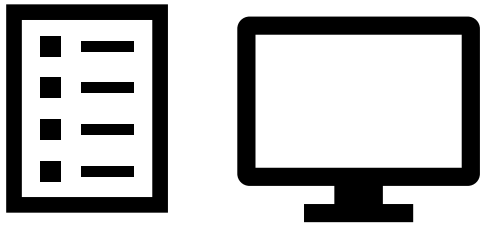
PCM Accountability Matrix

Patients, providers and payers would submit information for state oversight and public reporting, offering layers accountability and transparency.



Capturing Data on Primary Care Engagement, Experience and Access

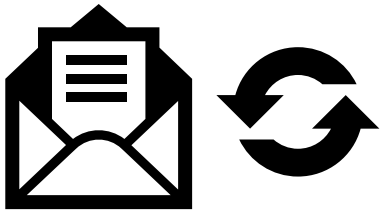
Measuring and Reporting on Utilization :



Claims data and electronic health records capture office and telemedicine visits, and other contacts with care team members

Data is shared publicly through routine provider reports and other sources

Protecting Against Patient Selection:



Patient experience surveys and consumer feedback loop relay patient perspective

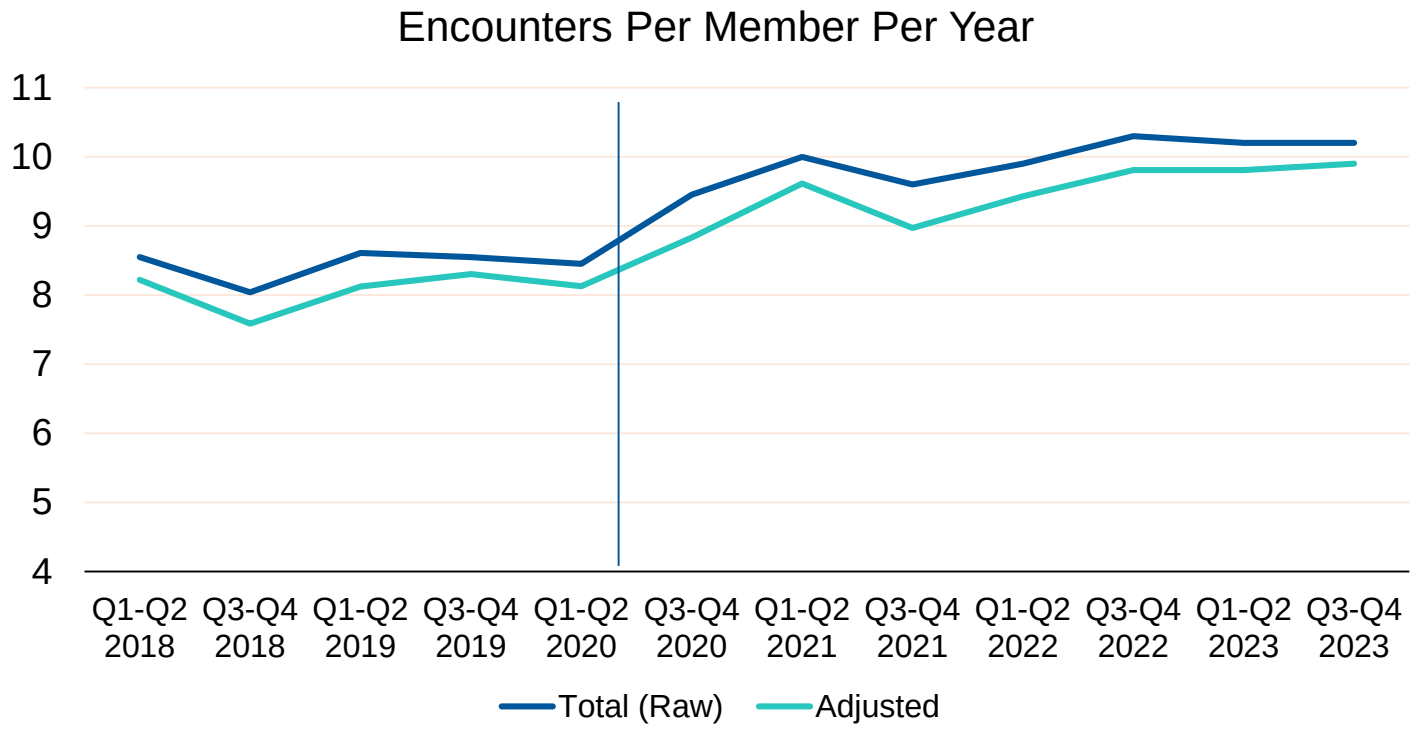
Mystery shopper to monitor access

How Would Networks Generate the Report?

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in the *normal course of business* similar to other visit types
- AN/FQHC runs a quarterly contact summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers
- Summary report includes contacts/patient by category of coverage (Medicare, Medicaid and commercial)

Note: It is anticipated that this requirement will require no on-going administrative effort on the part of the AN/FQHC as the provider will already have a need to capture this information for the purpose of managing care team activity

Publicly Shared Data

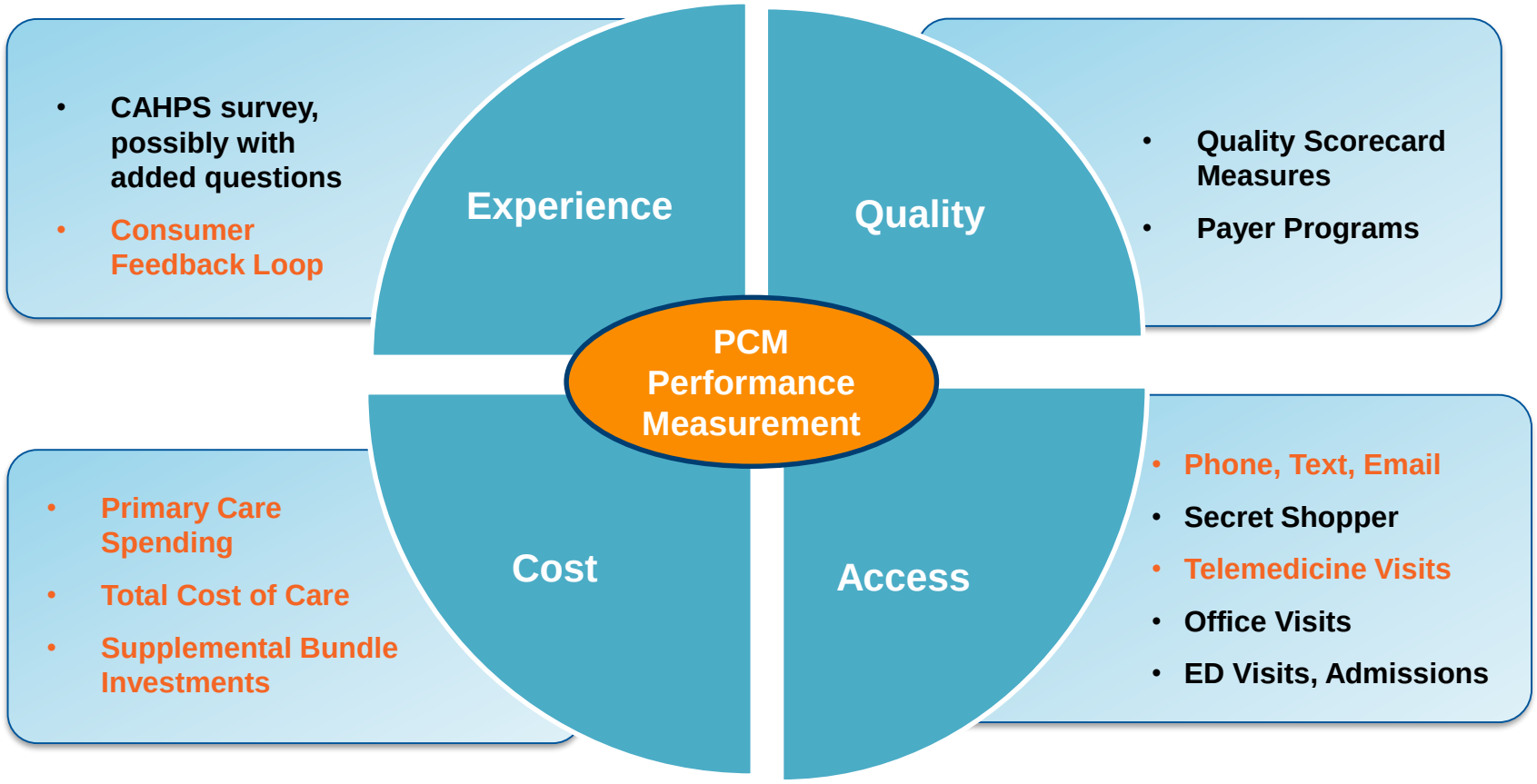


The state could monitor both practice and system performance from the data over time.

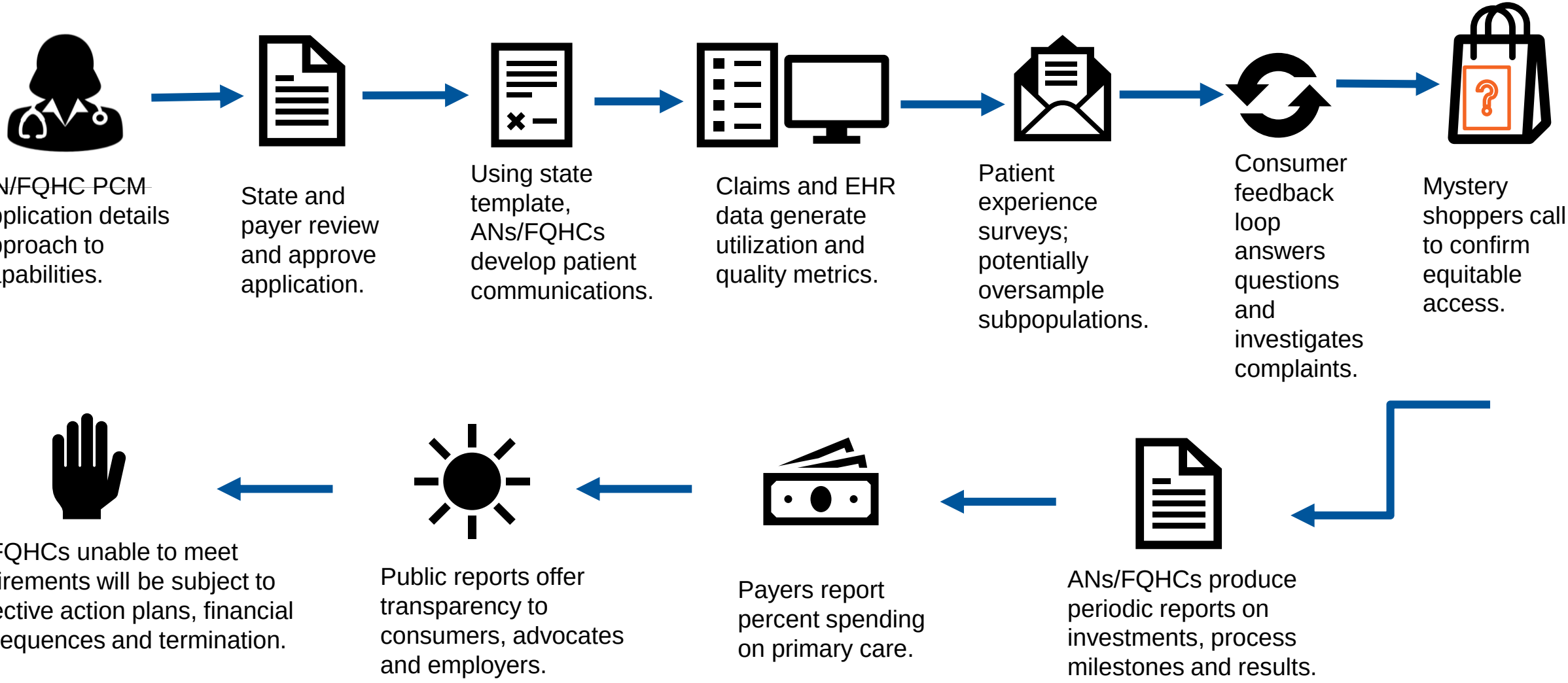
As an example, the total encounters for one group might appear as follow, with the vertical line representing the start of bundled payments.

Other Data to Measure Progress on PCM Goals

Measures and programs in orange would need to be developed.



Strawman PCM Accountability Process



What's Next

March:

Solicit feedback from stakeholders, review feedback with PTTF & PRC

April 2019 and Beyond:

- Produce draft PCM report
- Release for public comment
- Review feedback with PTTF & PRC
- Release final report

QUESTIONS?

Contact: Vinayak Sinha

Vinayak Sinha, vsinha@freedmanhealthcare.com