# Population Health Council Meeting

## Health Enhancement Community

March 12, 2020

# Agenda

| Item | Lead | Time | Mins |
|---|---|---|---|
| Welcome, Introductions, and Meeting Purpose | OHS<br>HMA | 10:00 – 10:10 | 10 |
| HEC: Progress Since the Release of the HEC Framework | HMA | 10:10 – 11:35 | 85 |
| HEC Status Overview | HMA | 10:10 – 10:20 | 10 |
| HEC Pre-Planning Communities | HMA | 10:20 – 10:35 | 15 |
| HEC Funding Strategies | HMA | 10:35 – 10:55 | 20 |
| HEC Financial Model | HMA | 10:55 – 11:10 | 15 |
| HEC Measurement Development | HMA | 11:10 – 11:20 | 10 |
| Feedback and Discussion | OHS<br>HMA | 11:20 – 11:50 | 30 |
| Next Steps and Adjourn | All | 11:50 – 12:00 | 10 |

# Health Enhancement Communities Update

# Post-HEC Framework Approval (May 2019 - March 2020)

- HEC status overview
- HEC pre-planning communities
- HEC funding strategies
- Financial modeling
- HEC measurement development

# HEC Status Overview

- 9 communities doing initial planning
  - Office of Health Strategy has provided funds to support initial community-level planning and Technical Assistance
- Fundraising strategy with support from the Office of Health Strategy
- Two new financial impact models that complement the Medicare Impact Model to tell us if the HEC Initiative makes economic sense for Connecticut and potentially inform considerations around reinvestment opportunities.
  - A Medicaid Impact Model
  - A Commercial Impact Model, which includes the State employees

# HEC Status Overview

- Further work on potential HEC measurement
- Examination of alignment opportunities with other initiatives, including the Hospital Anchor Institution strategy that is now starting
  - OHS is currently leading in collaboration with the Office of the Governor and various stakeholders including the Connecticut Hospital Association.

# HEC Pre-Planning Communities

# HEC Pre-Planning Communities

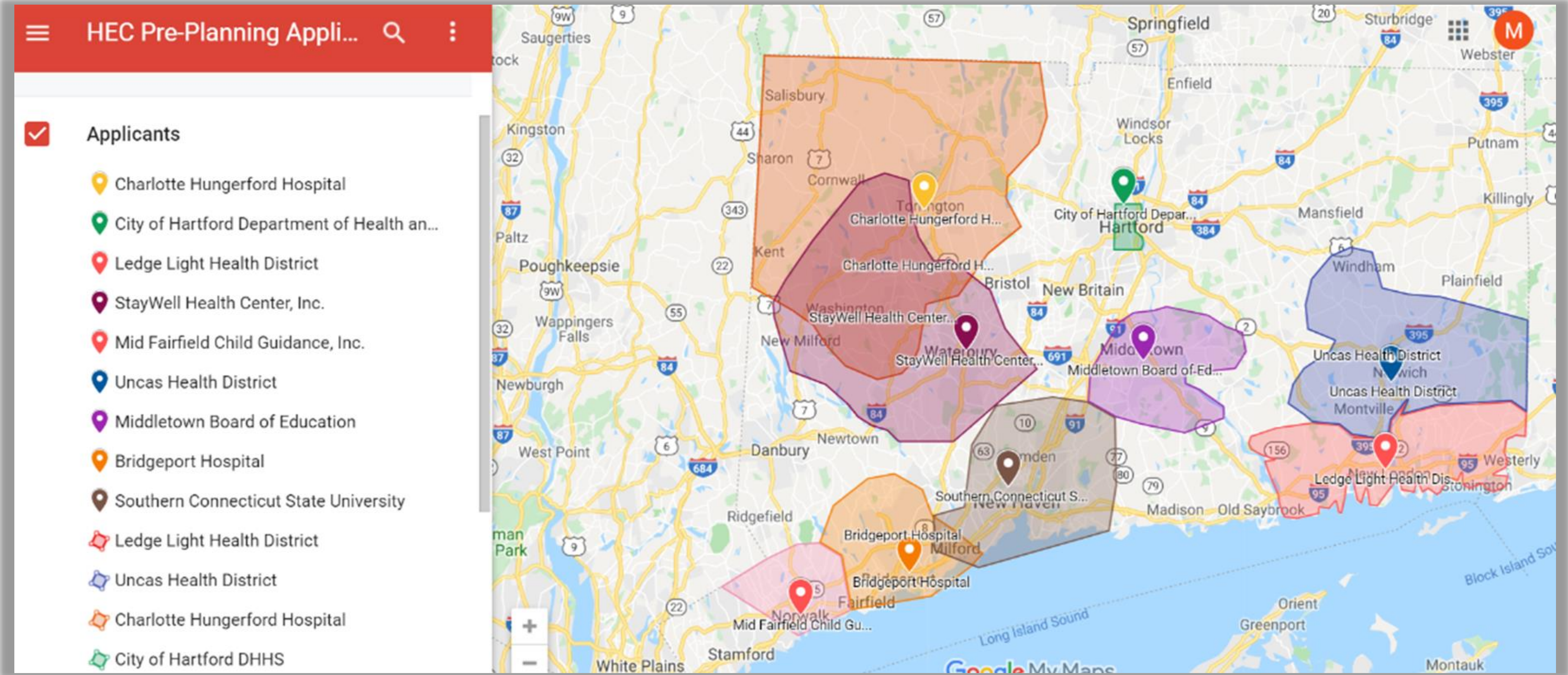
- HEC Pre-Planning RFP issued August 15, 2019; responses were due October 1, 2019
  - Up to $25,000 to participate in a 90-day HEC pre-planning process to develop key elements of an HEC for their community (Scope 1)
  - Up to an additional $10,000 for rapid-cycle measurement (Scope 2)
- 9 awardees (participant communities) were selected
- The RFP included an option for second planning period dependent upon funding.
  - OHS has provided funding for that second planning period.
- Work to be done by Participant Communities in this RFP are intended to inform a future process to establish and designate HEC.

# Awardees

| Awardees | Phase 1 Scope*<br>Nov 1 – Jan 31 |
|---|---|
| Bridgeport Hospital/YNHHS | Scope 1 & 2 |
| Charlotte Hungerford Hospital | Scope 1 |
| City of Hartford, DHHS | Scope 1 & 2 |
| Ledge Light Health District | Scope 1 |
| Middletown Board of Education | Scope 1 |
| Mid Fairfield Child Guidance, Inc. | Scope 1 |
| Southern Connecticut State University | Scope 1 & 2 |
| StayWell Health Center, Inc. | Scope 1 |
| Uncas Health District | Scope 1 |

* Scope 1 – Main grant; Scope 2 – Rapid Cycle Measures

# Awardee Map



# HEC Pre-Planning Phase 1: Activities

- Awardees:
  - Engaged community residents in the planning process
  - Convened participant organization members
  - Identified primary and secondary drivers impacting need related to the HEC health priority aims
  - Identified partners within their geography
  - Identified potential cities or towns outside of their initial geographic boundary with which it would be beneficial to align
- Each awardee was assigned a coach from Health Management Associates to work with them throughout the pre-planning process and provide technical assistance.

# HEC Pre-Planning Phase 1: Rapid Cycle Measures

- Goal: develop an approach in communities to collect measurement information to provide rapid-cycle feedback on the effectiveness of HEC interventions.
- 3 awardees received additional $10,000 to participate.
- Awardees:
  - Defined a set of measures that include information **generated directly by community members.**
  - Created a plan for implementing data collection to measure population outcomes at the local community level.

# HEC Pre-Planning Phase 2

- All 9 communities continued onto Phase 2 planning
- Performance Period: February 1, 2020 – June 30, 2020 (5 months)
  - Seamless continuation of work
- Funding supported by OHS
- Phase 2 objectives include:
  - Creation of MOA among partners outlining governance structure
  - Develop a preliminary or core set of interventions to pursue as an HEC
  - Initiate discussion related to the measurement and analysis of collected data aligned with HEC measurement guidance
  - Continue to meaningfully engage community residents in process
- Tools developed and provided to support work

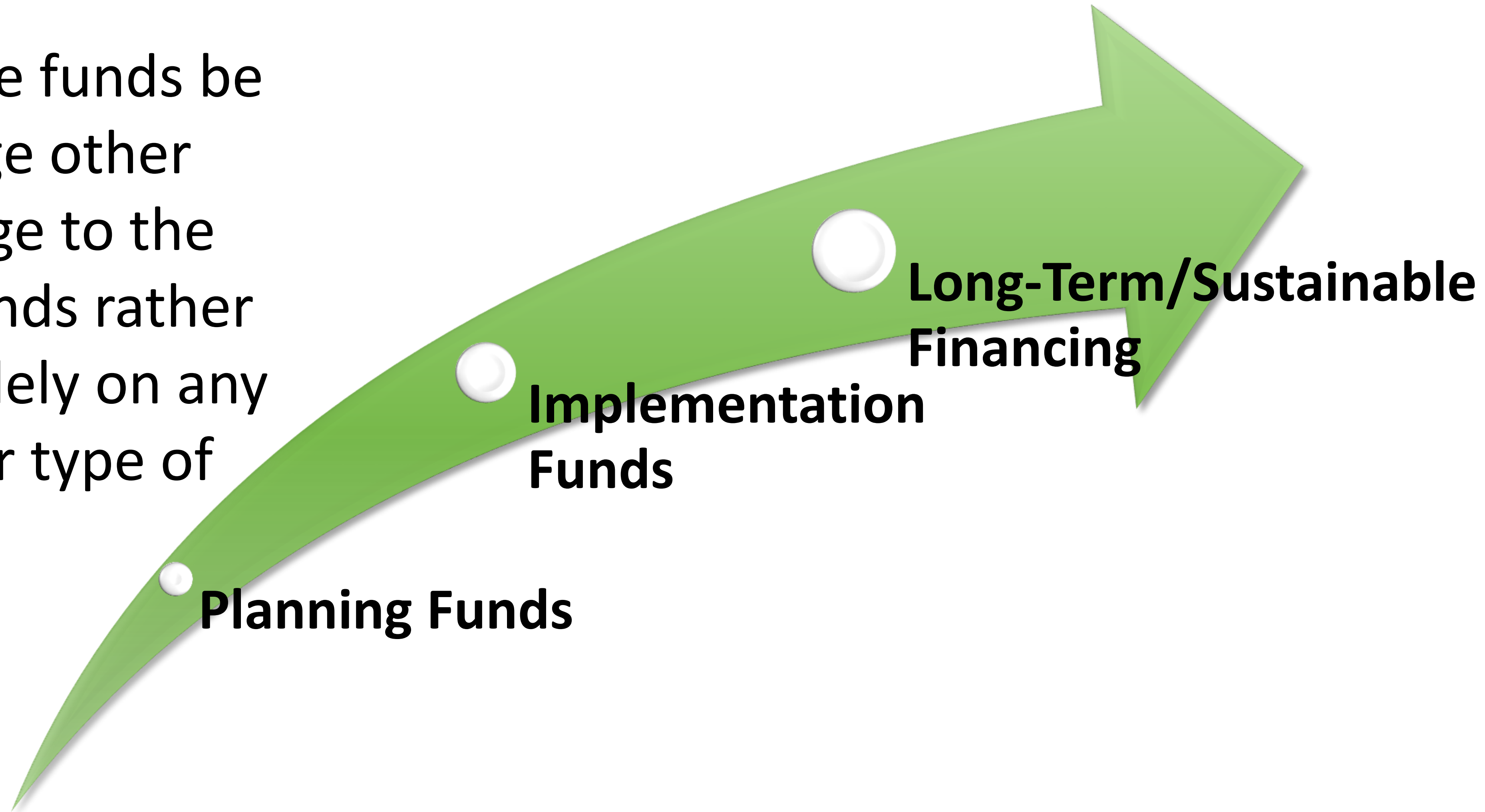
# Funding Strategies

# HEC Funding

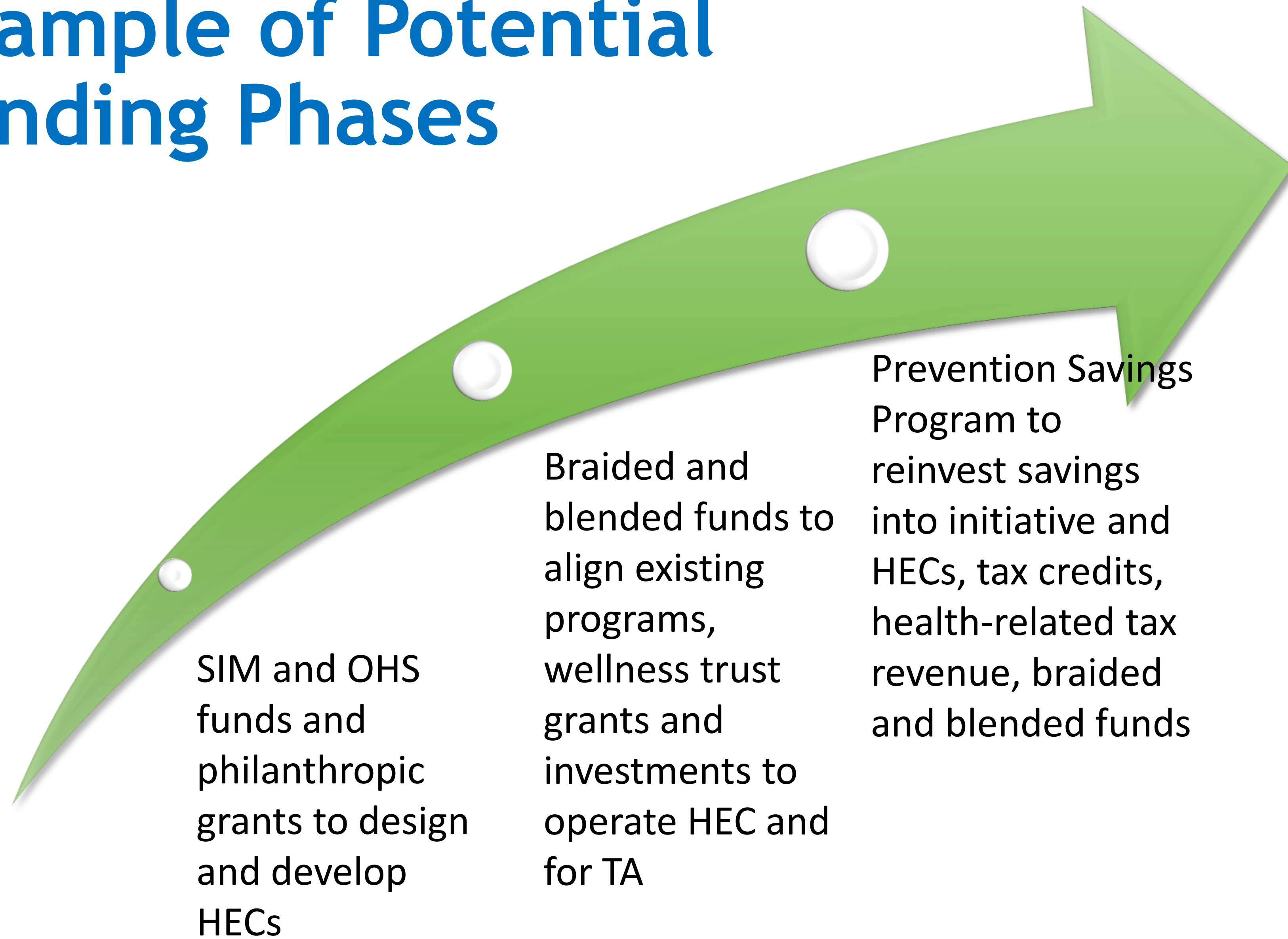
- Although SIM funding ends January 31, 2020, the work will continue to advance with funding from OHS.
- Strategies to move forward:
  - Securing a mix of near-term/upfront funding for implementation and administration
  - Pursuing braided and blended funding opportunities
  - Pursuing federal opportunities when available
  - Scaling and/or timing HEC initiative roll out based on availability of near-term and long-term resources
    - Because this is a “home-grown” initiative, have flexibility to make decisions about the scale and timing

# Funding Phases

Intent is to have funds be used to leverage other funds and bridge to the next type of funds rather than relying solely on any single source or type of resource.



# Example of Potential Funding Phases

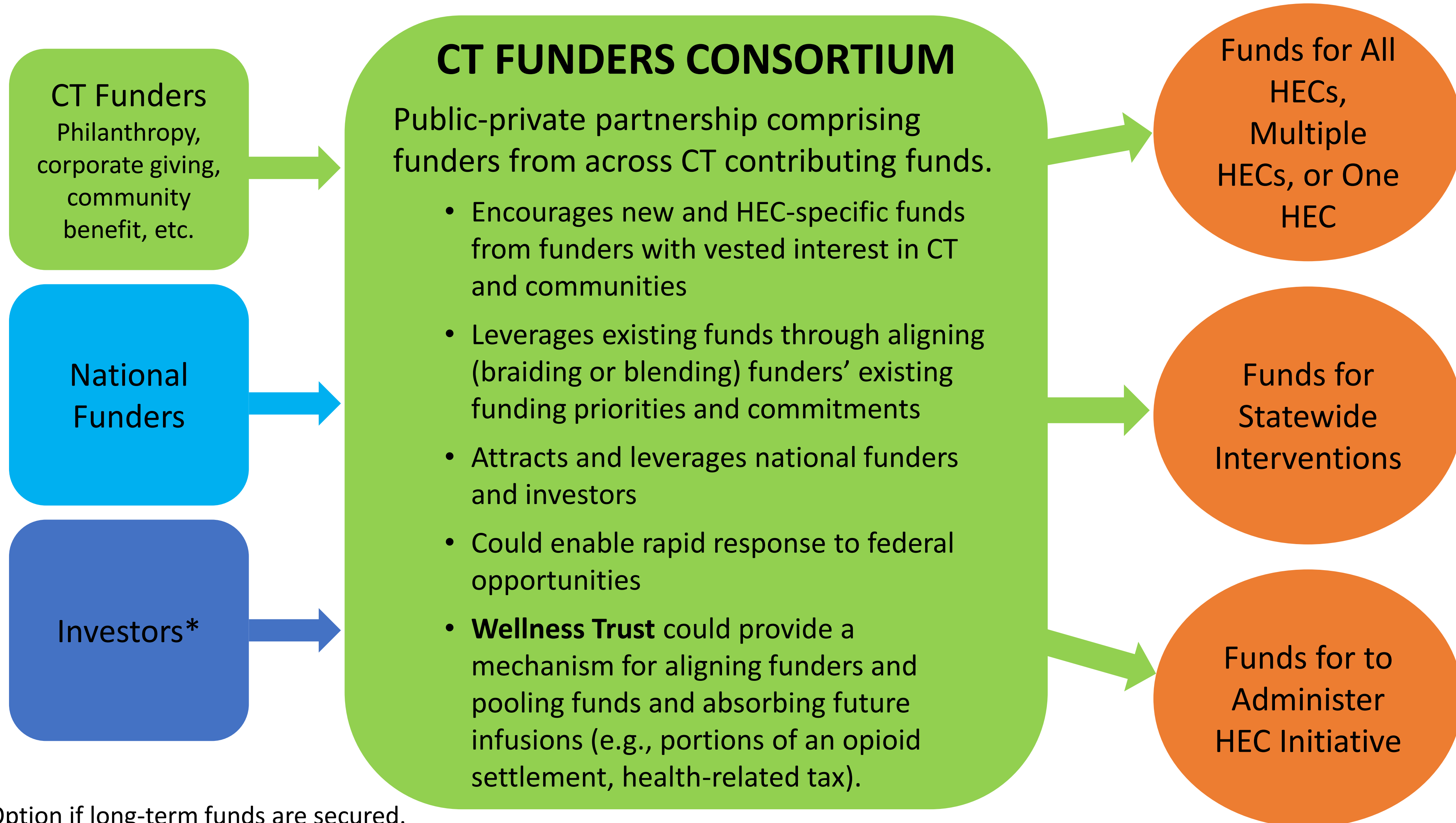


SIM and OHS funds and philanthropic grants to design and develop HECs

Braided and blended funds to align existing programs, wellness trust grants and investments to operate HEC and for TA

Prevention Savings Program to reinvest savings into initiative and HECs, tax credits, health-related tax revenue, braided and blended funds

# CT Funders Consortium and Wellness Trust Potential Approach




* Option if long-term funds are secured.

# Wellness Trust 101 Podcast

- https://nff.org/commentary/wellness-trusts-101

# New Developments: Medicare Demonstration

- The HEC Initiative framework envisioned negotiating a multi-payer demonstration with the federal government. This strategy is no longer being pursued.
- However, there may be opportunities to pursue other reinvestment strategies in the future.
  - The Medicare, Medicaid, and Commercial financial modeling could inform such strategies.
  - The federal government may also issue their own opportunities.

# Financial Modeling

# Medicaid Impact Model

- **Objective:** The HEC **Medicaid Impact Model** quantifies the potential short-term and long-term savings impact of the HECs on Medicaid spending, both per capita and total
- Using **Medicaid claims and eligibility data from the Connecticut Department of Social Services (2012-2018)**, the model projects per capita costs and risk scores for the Medicaid population without HEC interventions
- **Estimated potential savings through 2030** with HEC interventions are based on evidence-based population health interventions associated with reducing obesity and adverse childhood experiences (ACEs)
- Note: similar analysis was conducted for commercial health insurance, including state employees and dependents

# Data Strengths and Limitations

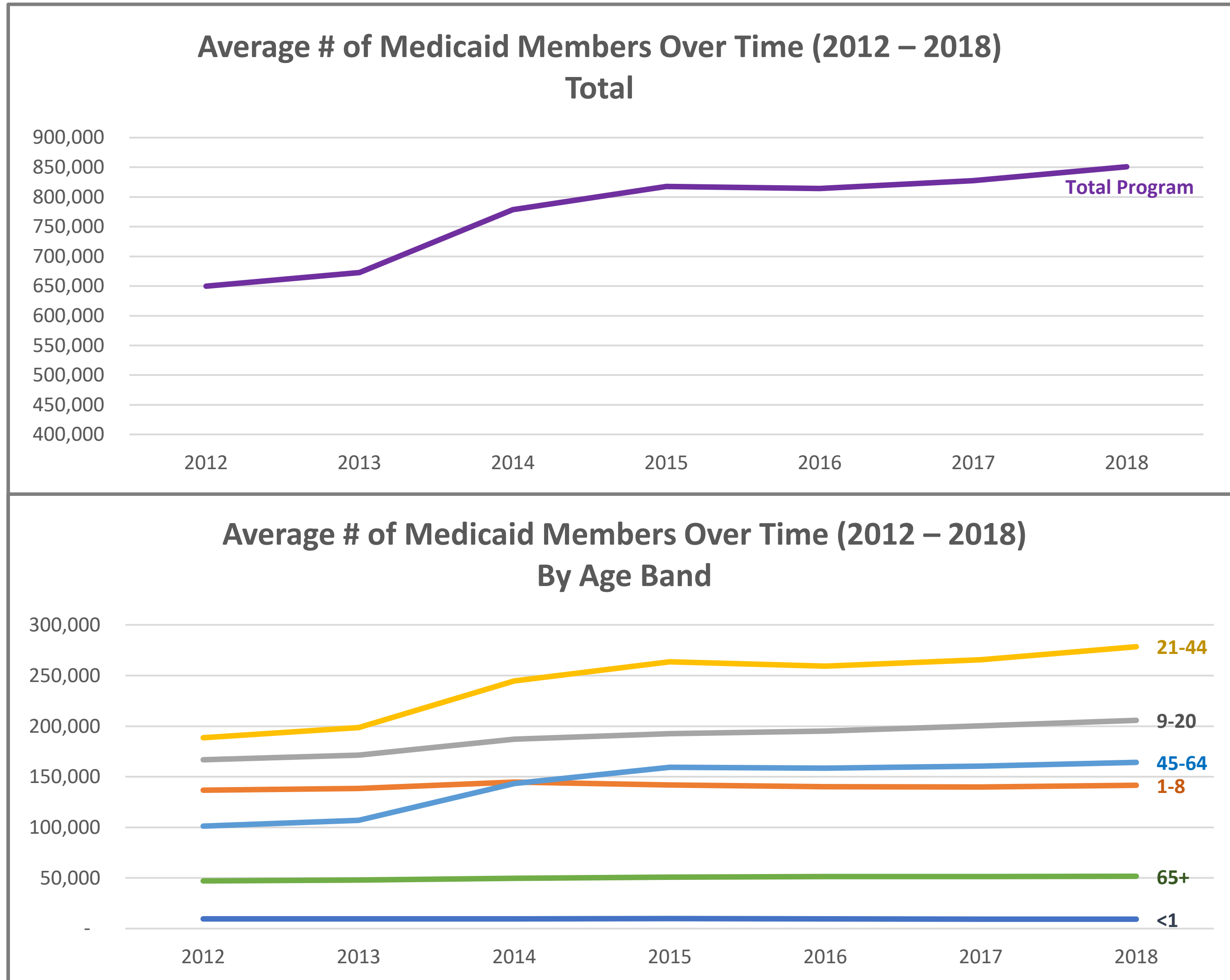
**Strengths**

- The Medicaid Impact Model is based on **detailed longitudinal claims and eligibility data that is then summarized** into major groupings for analysis
- File **includes most Medicaid Fee for Service (FFS) claims data,** except for certain individuals who are dually eligible for Medicare and Medicaid and some state only expenses (not federally matched)

**Limitations**

- Diagnosis codes, used to identify people who are obese or potentially have an ACE, are likely **underreported**
- Unable to perform national and state comparisons and **benchmarking**
- File does not include non-health sector spending

# Historical Enrollment Trends by Age Group

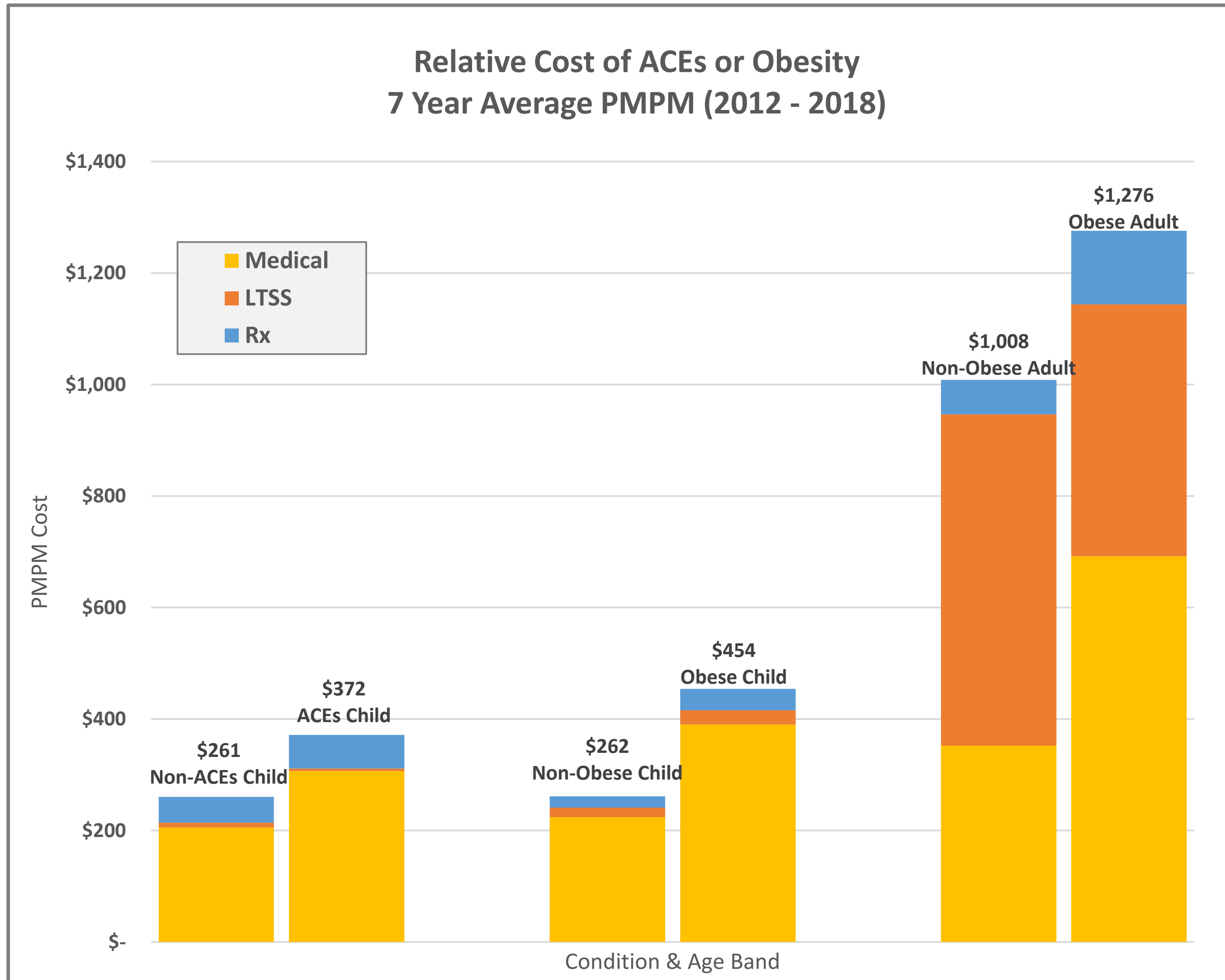



*Source: CHN Developed Dataset for CT Medicaid Population*

## Key Takeaways

- The average annual growth rate of 4.6% for all age groups from 2012 – 2018 is driven by adults age 21 to 64
- Age 21 to 61 average annual growth rate of 7.3% driven primarily by HUSKY D (Adult ACA Expansion Group)
- The <1 age band had a slight decrease (-0.5% average annual growth)

# Relative Cost of ACEs or Obesity



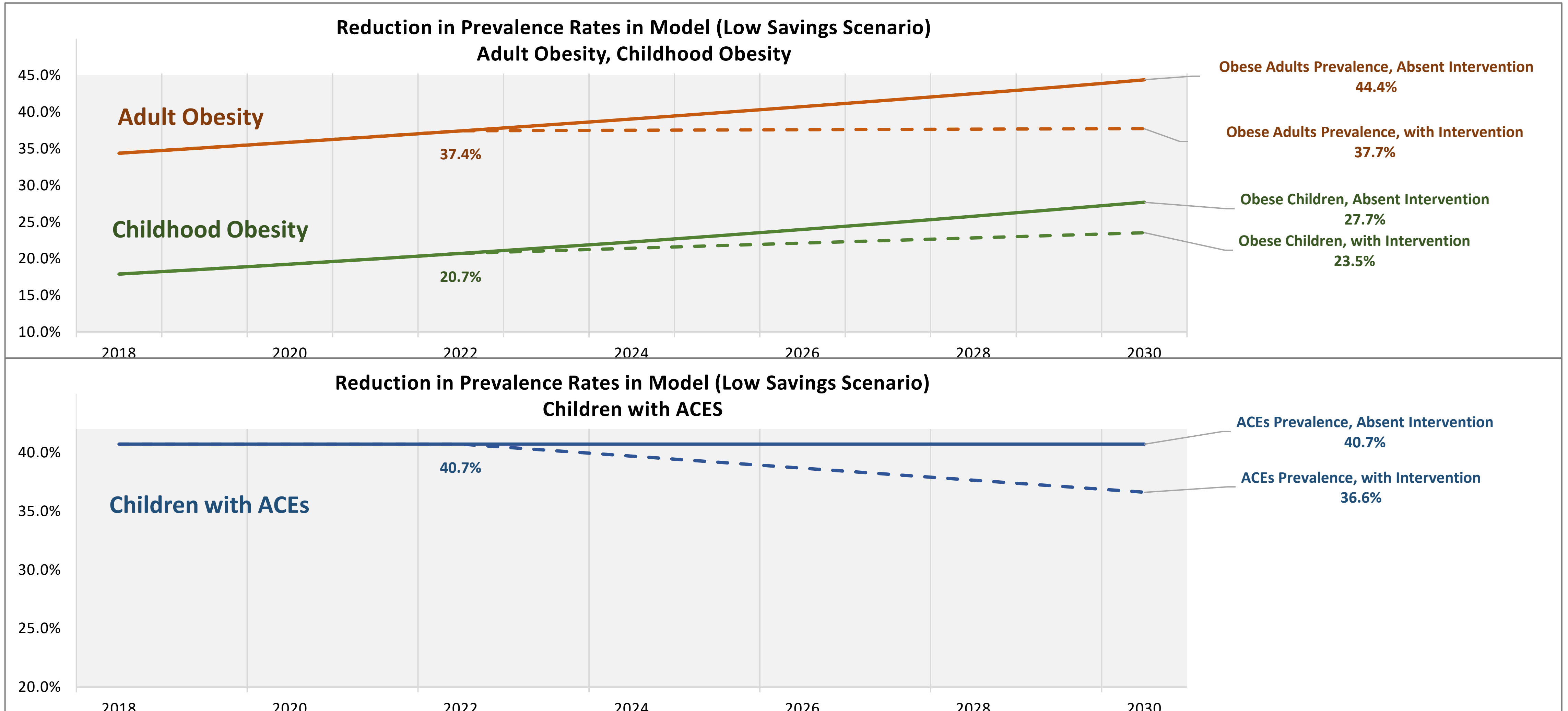

*Source: CHN Developed Dataset for CT Medicaid Population*
*Dollar amounts adjusted for non-system claims including: Rx Rebates, GME, TPL*

## Key Takeaways

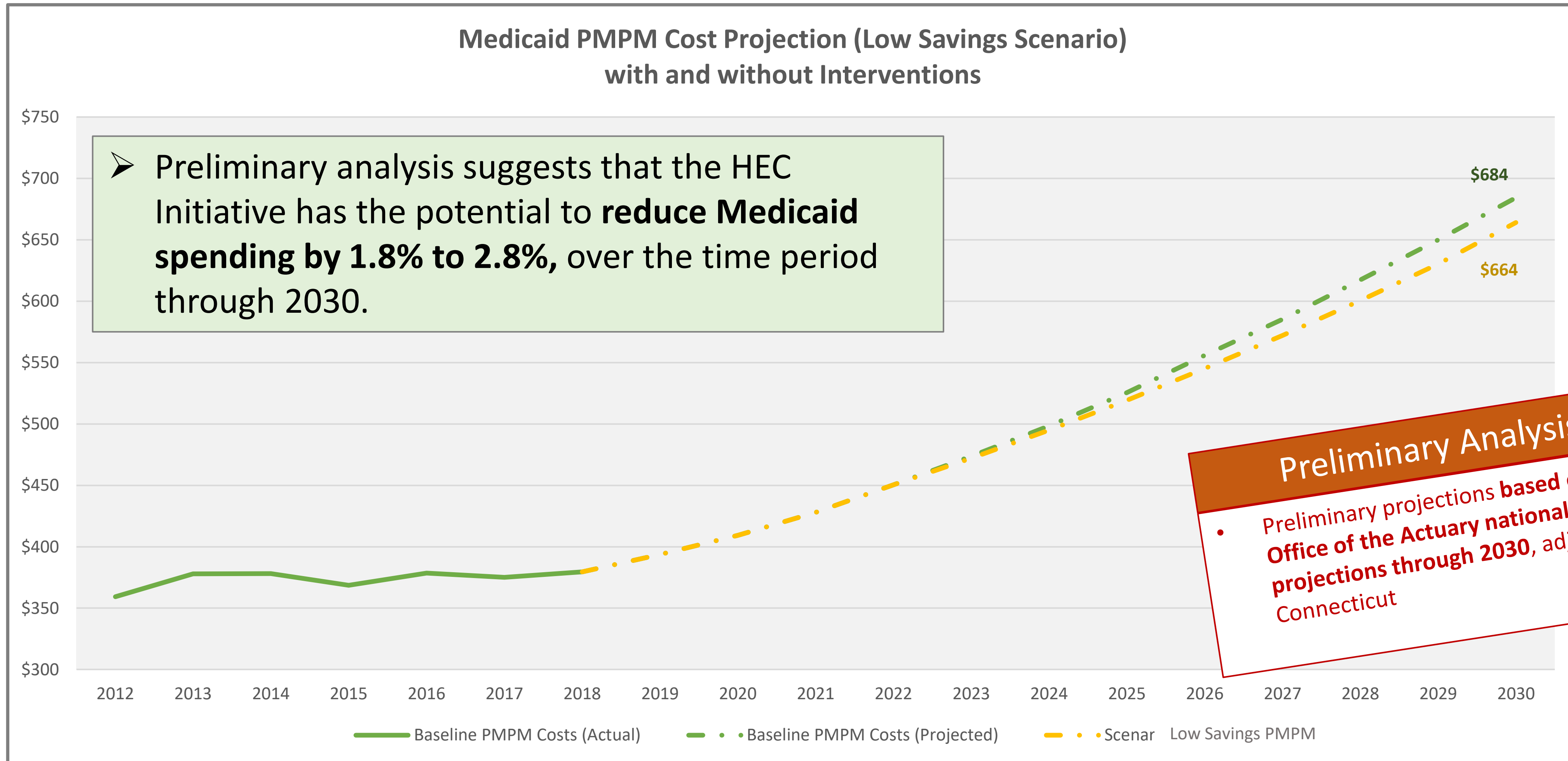
- The relative cost of care for a Medicaid member with an ACE or Obesity is pronounced when compared to members without these conditions
- A child with an ACE is 1.4 times more expensive than a child without an ACE
- An obese child is 1.7 times more expensive than a child without obesity
- An obese adult is 1.3 times more expensive than an adult without obesity
  - ➢ When excluding LTSS—services that are predominantly utilized by Medicaid members 65+—**the cost of an obese adult is nearly double the cost of an adult without obesity**

# Opportunity to Bend the Cost Curve by Reducing Future Prevalence Rates

## Savings are dependent on statewide prevention strategies and success of HECs interventions



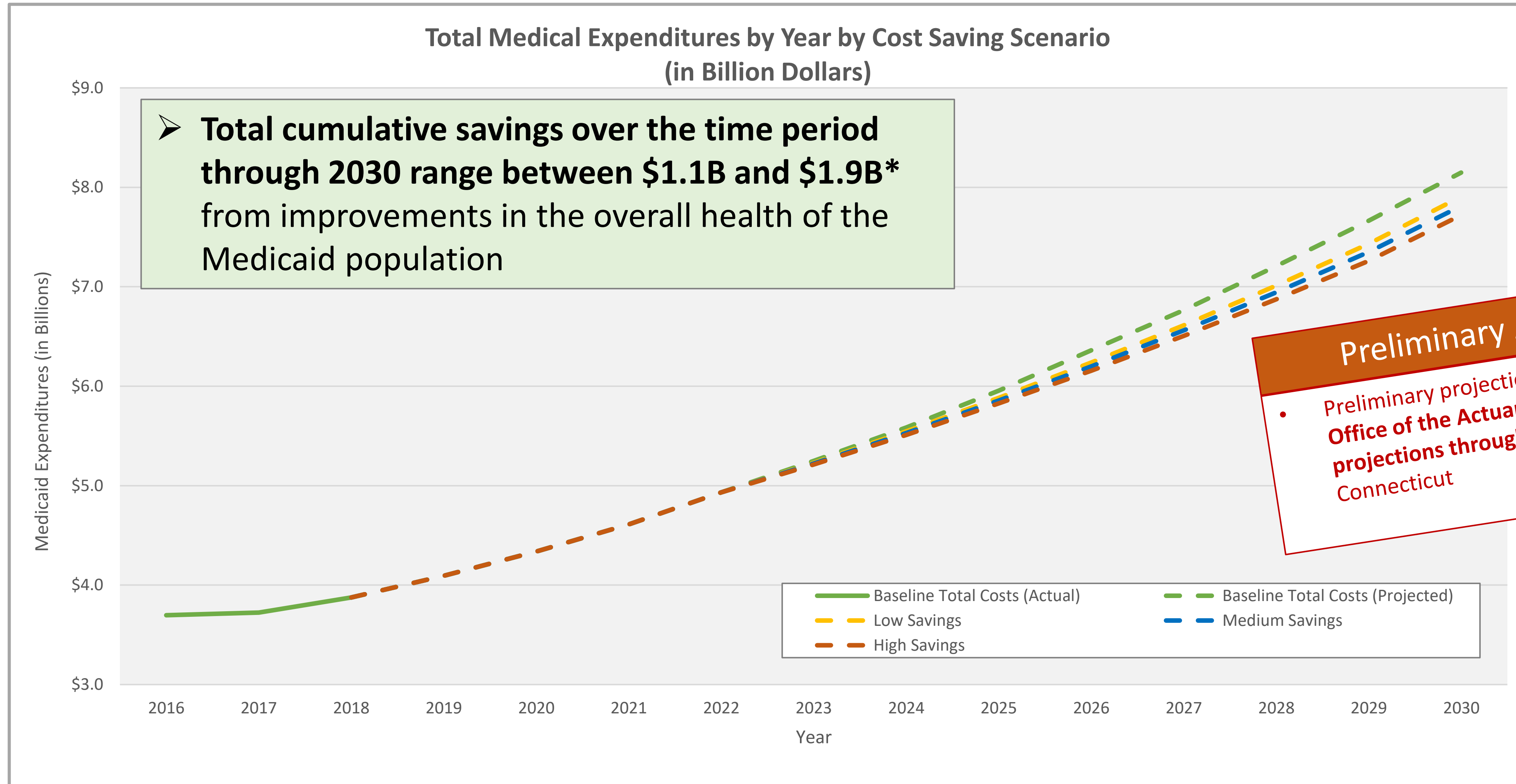
# HEC Impact Model Projections Summary: Medicaid PMPM Savings




*Years 2012 – 2018 Source: CHN Developed Dataset for CT Medicaid Population*

*Medicaid Per Capita Cost projections are estimated using trends from the CMS Office of the Actuary and exclude LTSS*
*Dollar amounts are adjusted for Rx Rebates, GME and TPL in the model; assumes HEC interventions fully implemented by January 2023*

# HEC Impact Model Projections: Medicaid Expenditures Savings Scenarios




*Years 2016 – 2018 Source: CHN Developed Dataset for CT Medicaid Population*
*Expenditures exclude LTSS*
*Dollar amounts are adjusted for Rx Rebates, GME and TPL in the model; assumes HEC interventions fully implemented by January 2023*

# HEC Measurement Development

# HEC Measurement Development

- Reviewed the full compendium of measures and identified alignment with SHIP and other state/national initiatives and data sources
- Developed a preliminary list of Stage 1, Stage 2, and Stage 3 measures and recommended a process to revise measures over time based on factors such as experience and funder input
  - Aligned these stages with level of administrative burden based on whether additional data sharing agreements and collaboration are required to collect and analyze measures
  - Determined that it was premature to start process of developing data sharing agreements for later stages
- Presented recommended Stage 1 measures for long-term outcomes in conjunction with rapid cycle measures for short to intermediate term outcomes

# Questions & Discussion