Connecticut SIM
VBID Consortium Meeting: February 2, 2016

Connecticut SIM: Program Overview

December 7, 2015

Agenda

1. What is the State Innovation Model Initiative?
2. What are the components of CT's SIM?
3. What problems are we trying to address?
4. What care delivery reforms are we promoting?
5. Value-based Payment Reform
6. Quality Measure Alignment
7. Value-based Insurance Design

What is a State Innovation Model Grant?

SIM grants are awarded by the federal government through the ***Center for Medicaid and Medicare Services (CMS) Innovation center***. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

1. Improve health system performance
2. Increase quality of care
3. Decrease Costs

Connecticut awarded a $45 million test grant in December 2014 which will be implemented over the next five years.

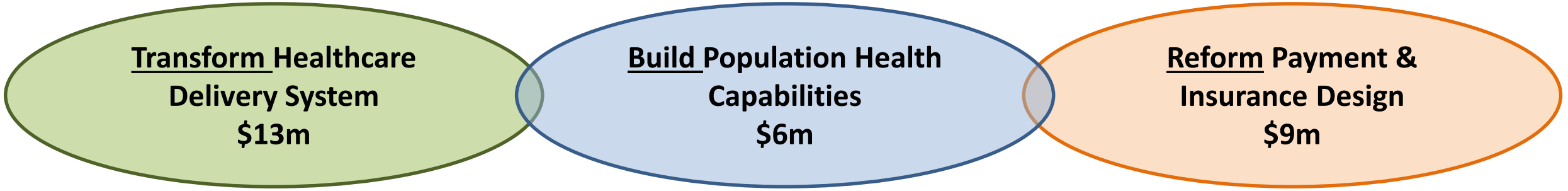
Vision

Establish a whole-person-centered healthcare system that:

- improves population health
- eliminates health inequities
- ensures superior access, quality, and care experience
- empowers individuals to actively participate in their healthcare
- improves affordability by reducing healthcare costs

Our Journey from Current to Future: Components

CT SIM Component Areas of Activity



Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

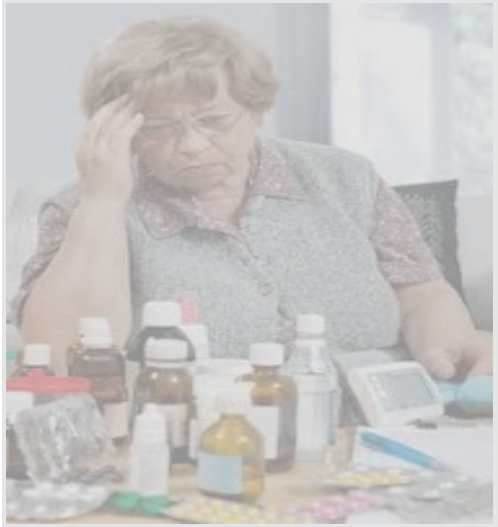
Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout	**$376k**
Invest in enabling health IT infrastructure	**$10.7m**
Evaluate the results, learn, and adjust	**$2.7m**

Healthcare today – 1.0

Connecticut's Current Health System: "As Is"

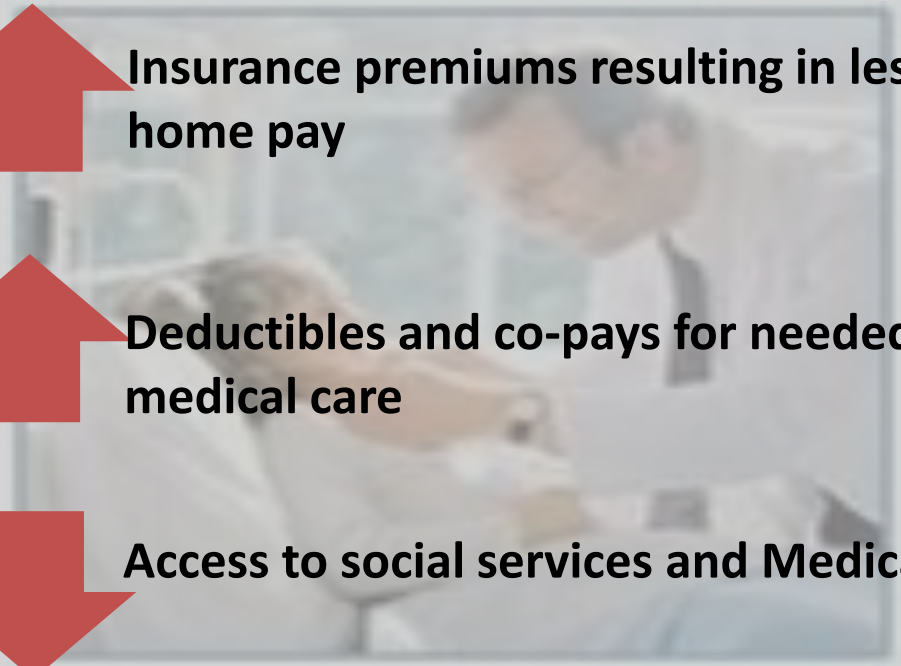


Fee For Service Healthcare ***1.0***

- Limited accountability
- Poorly coordinated
- Pays for quantity without regard to quality
- Uneven quality and health inequities
- Limited data infrastructure
- Unsustainable growth in costs

Escalating costs mean…

….patients will experience



- Insurance premiums resulting in less take-home pay
- Deductibles and co-pays for needed medical care
- Access to social services and Medicaid

….communities will experience

- Money for programs that support housing, education, the environment, and community development

Escalating costs mean…

….the business community will experience

How about Connecticut?

Connecticut Healthcare Costs

Connecticut *- healthcare spending = More than $30 billion,* ***fourth highest of all states*** *for healthcare spending per capita*

CMS (2011) Health Spending by State of Residence, 1991-2009.
http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Connecticut: Uneven Quality of Care

Rising rate of Emergency Department utilization

Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40

CT ranking out of 50 states

High Hospital Readmissions

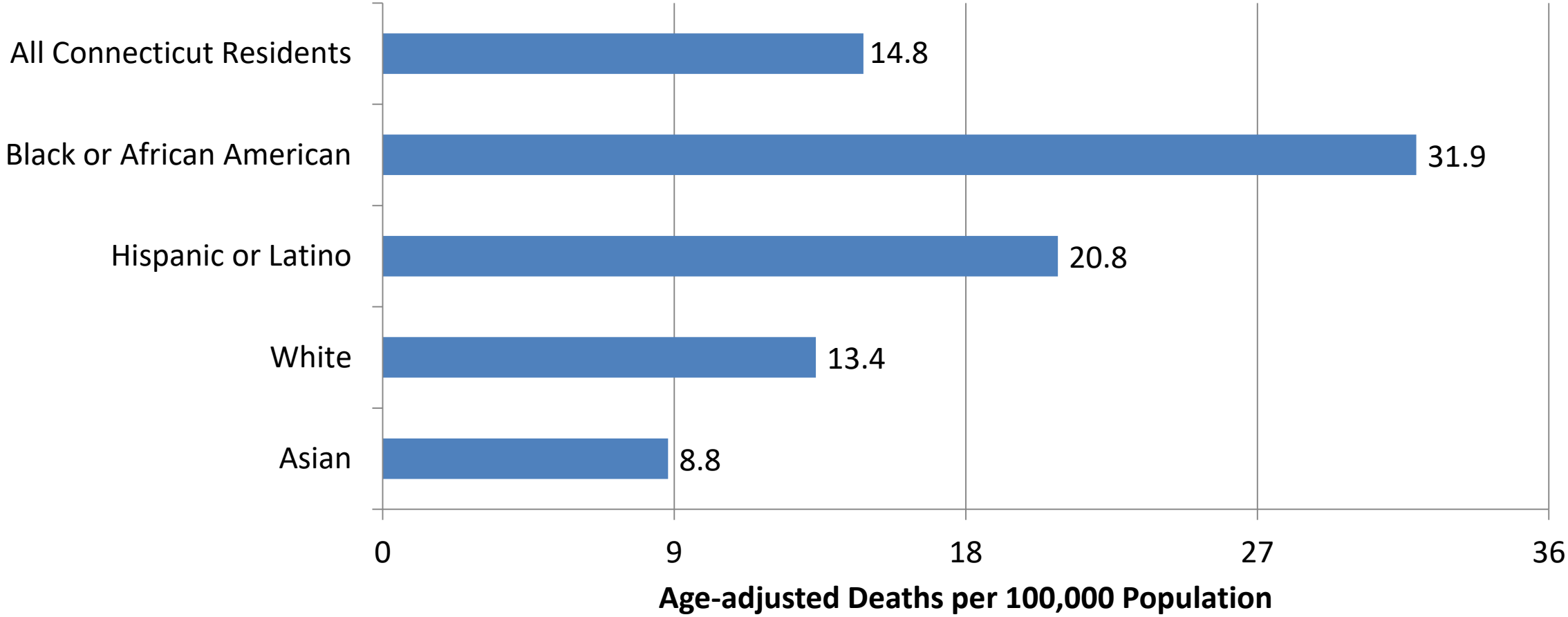
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36

CT ranks 36th out of 50 states

D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fund, April 2014.

Health disparities persist in Connecticut

Age-adjusted Death Rate for Diabetes, Connecticut Residents, by Race and Ethnicity, 2008-2012



Data Source: CT DPH, Vital Records Mortality Files, 2008-2012 data.

Health disparities persist in Connecticut

Health disparities devastate individuals, families and communities, and are *costly*:

- **The cost of the disparity for the Black population in Connecticut is between $550 million - $650 million a year**

Source: LaVeist, Gaskin & Richard (2009). The Economic Burden of Health Inequalities in the US. The Joint Center for Political & Economic Studies. As reported by DPH

Stages of Transformation

Stages of Transformation

Connecticut's Current Health System: "As Is"

Fee for Service 1.0

Limited accountability

Pays for quantity without regard to quality

Lack of transparency

Unnecessary or avoidable care

Limited data infrastructure

Health inequities

Unsustainable growth in costs

Our Vision for the Future: "To Be"

Accountable Care 2.0

Accountable for patient population

Rewards
- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost

Coordination of care across the medical neighborhood

Community integration to address social & environmental factors that affect outcomes

Health Enhancement Communities 3.0

Accountable for all community members

Rewards
- prevention outcomes
- lower cost of healthcare & the cost of poor health

Cooperation to reduce risk and improve health

Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities

Community initiatives to address social-demographic factors that affect health

Targeted Initiatives

Statewide Initiatives

Model Test Hypothesis for SIM Targeted Initiatives

High percentage of patients in value-based payment arrangements

+

Resources to develop advanced primary care and organization-wide capabilities

=

Accelerate improvement on population health goals of better quality and affordability

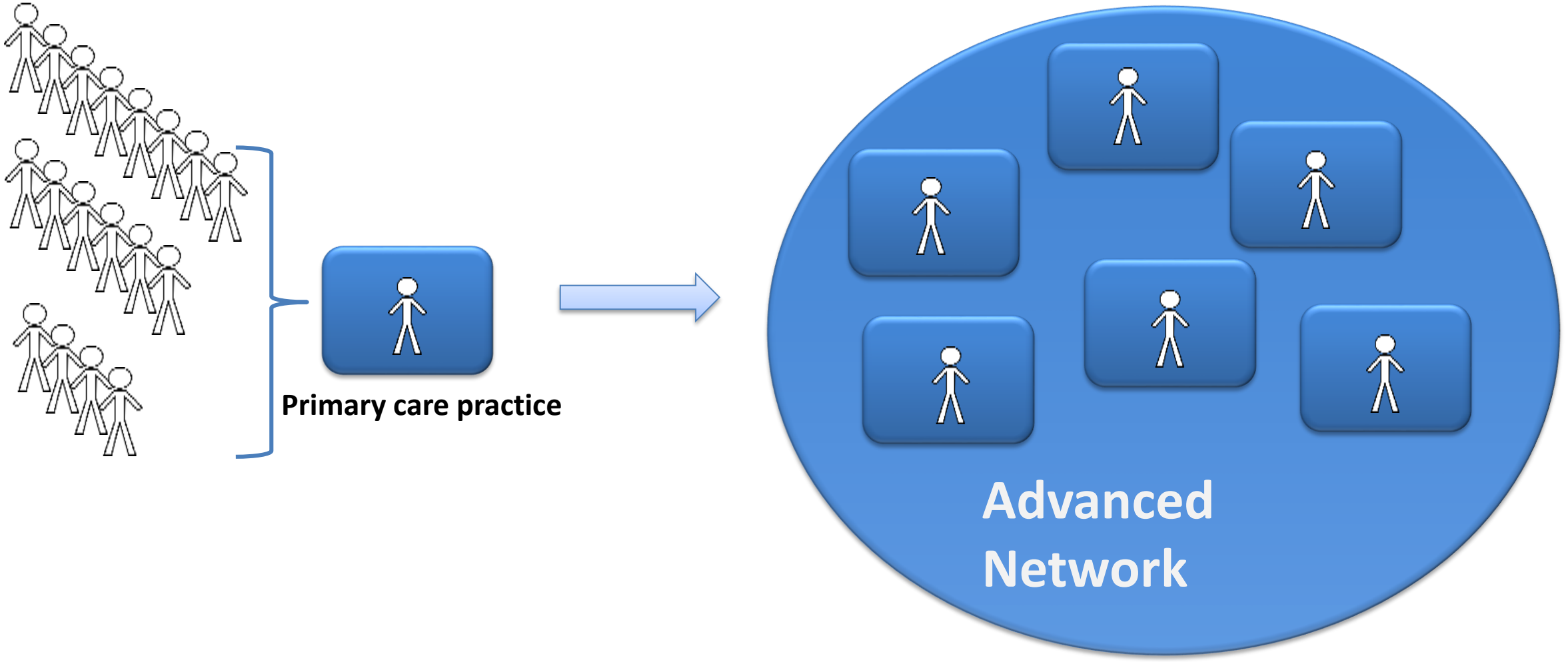
MQISSP
Medicare SSP
Commercial SSP

+

- Advanced Medical Home Program
&
- Community & Clinical Integration Program (CCIP)

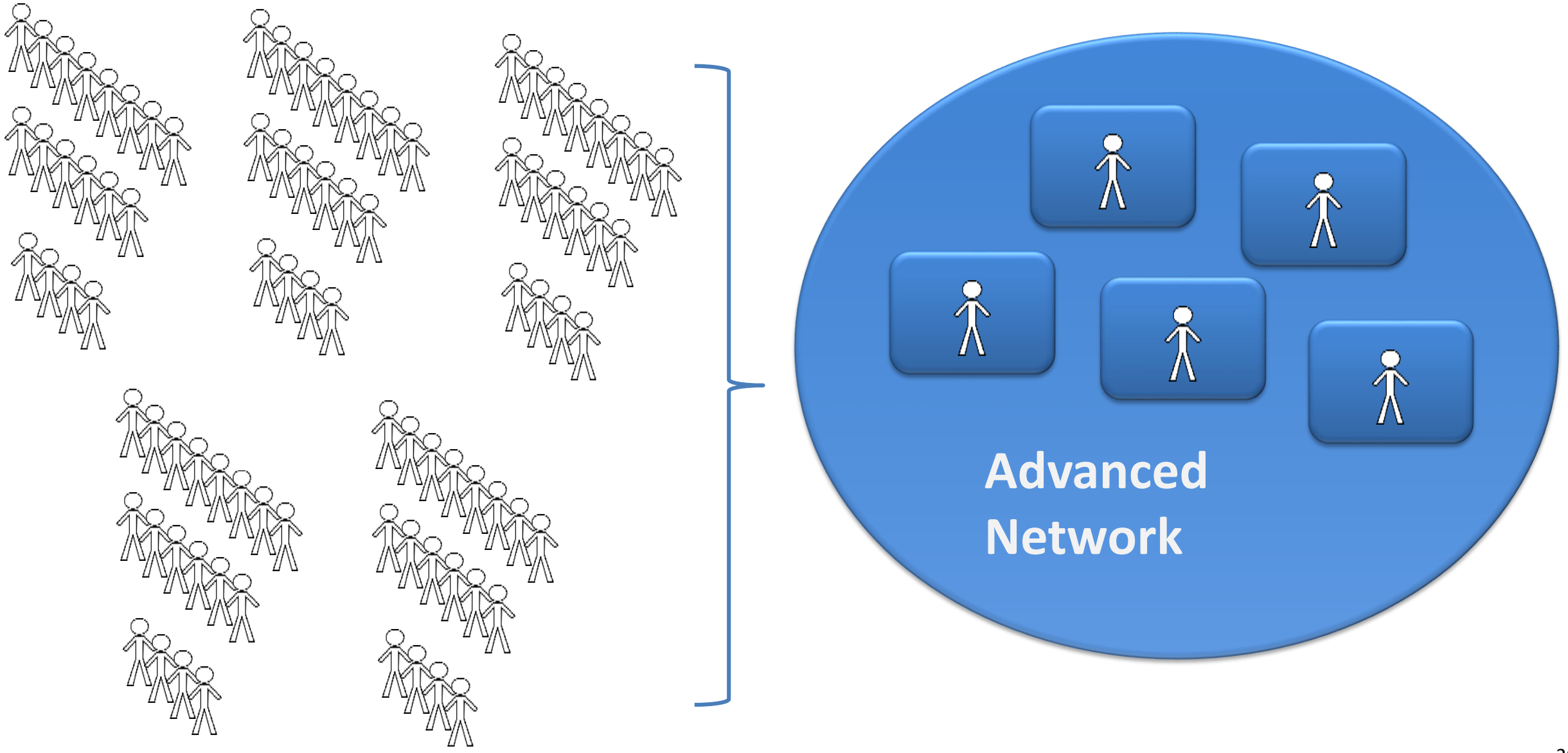
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability

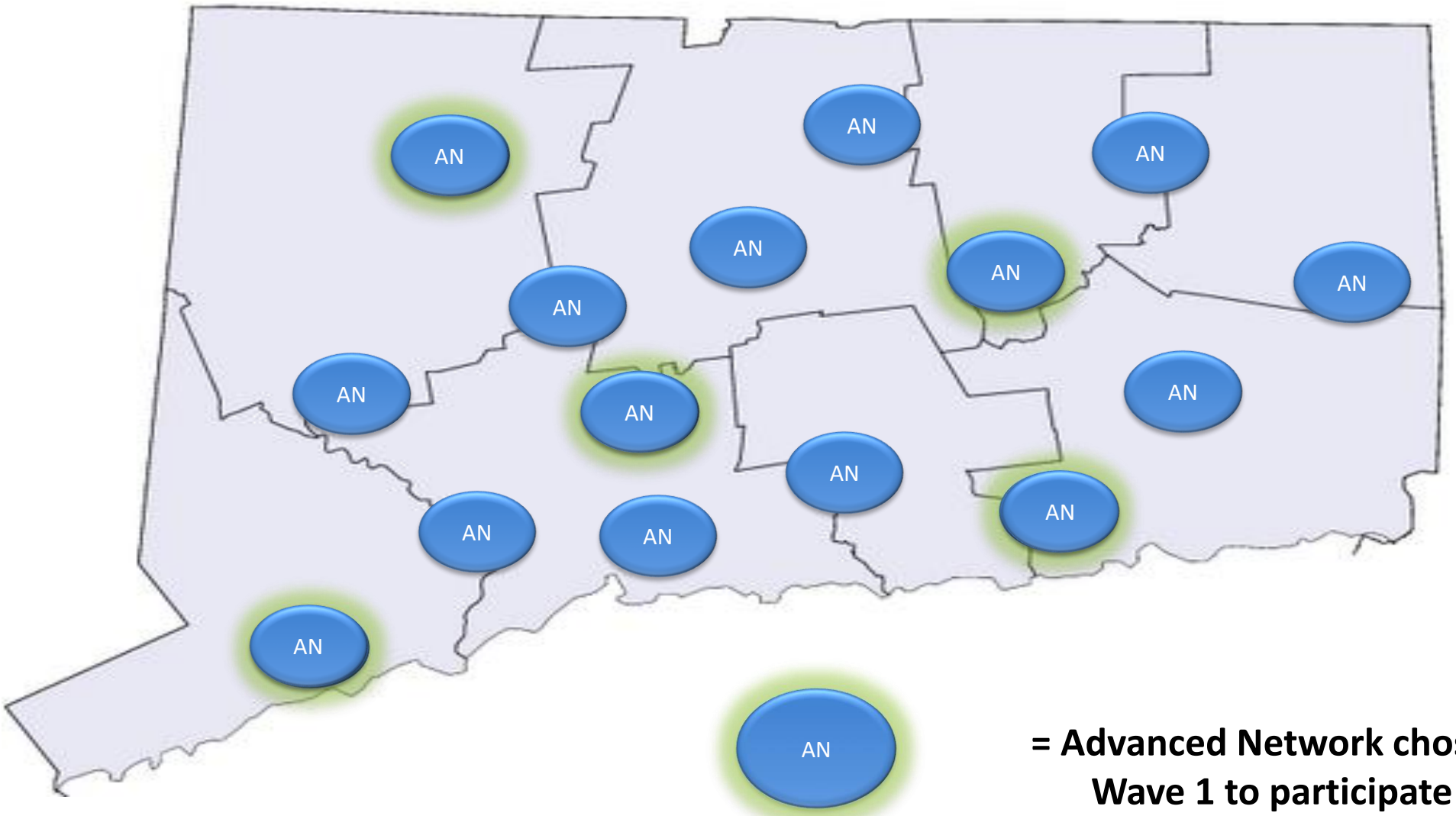


Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

Accountability for quality and total cost

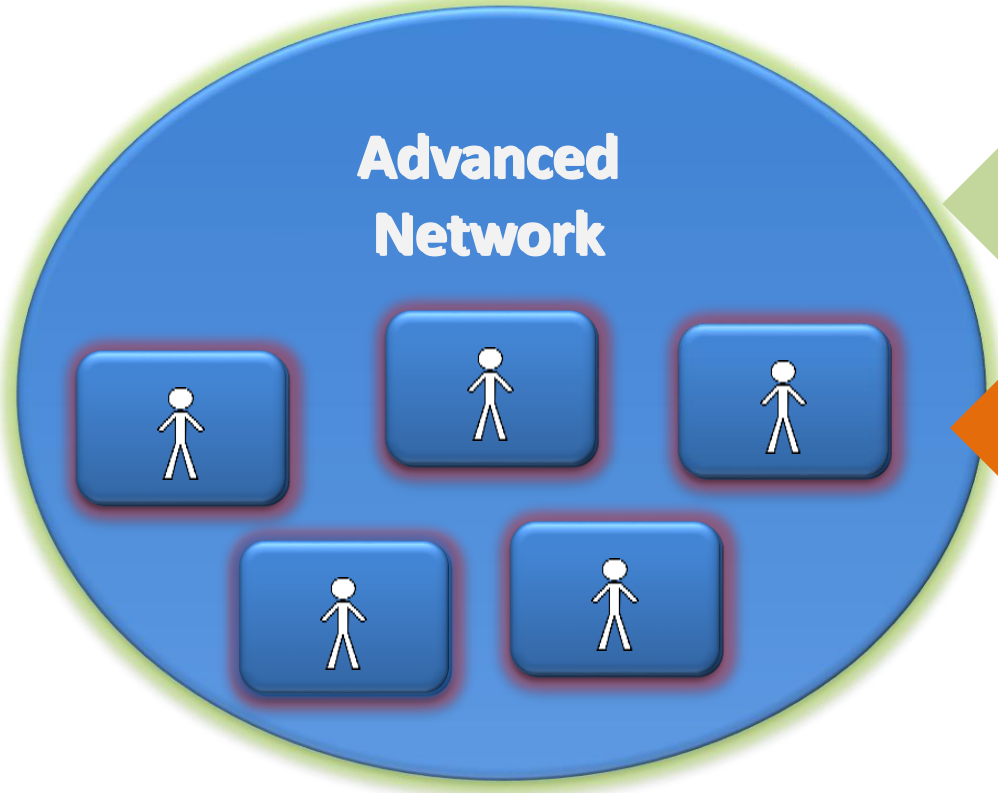


Connecticut has many Advanced Networks



= Advanced Network chosen in Wave 1 to participate in Medicaid Quality Improvement & Shared Savings Program (MQISSP)

Resources aligned to support transformation



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

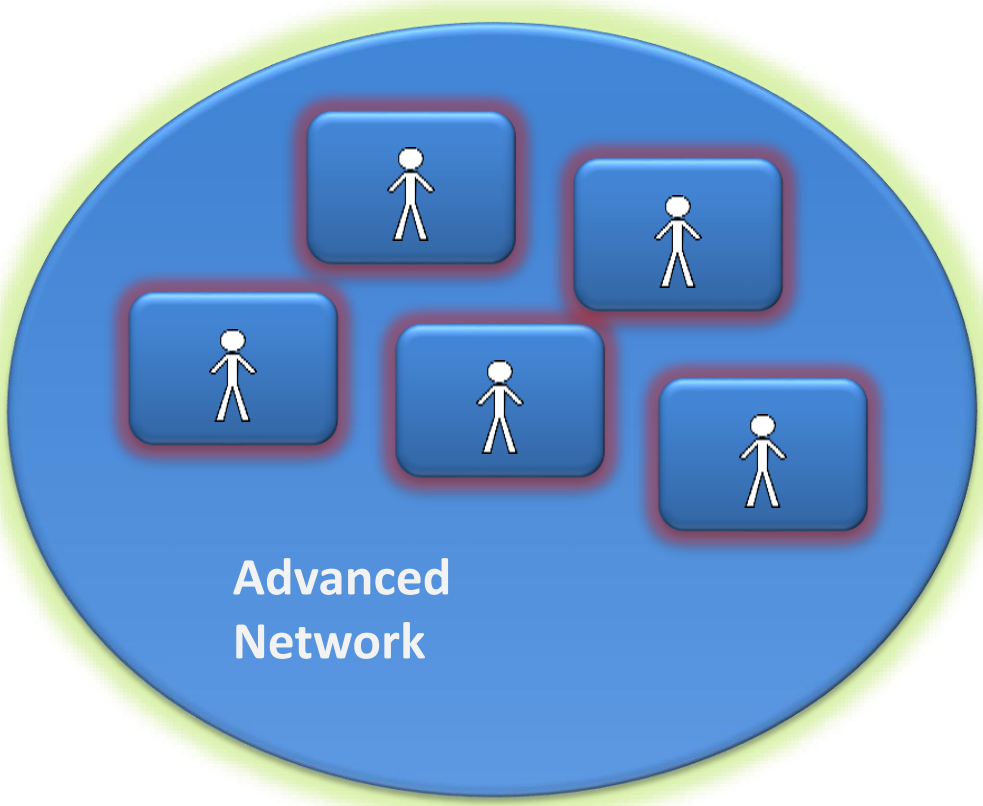
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations
Using population health strategies

Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ **CHW & culturally tuned materials**

Integrating Behavioral Health

Network wide screening, assessment, treatment/referral, coordination, & follow-up

Community Health Collaboratives

Comprehensive Medication Management

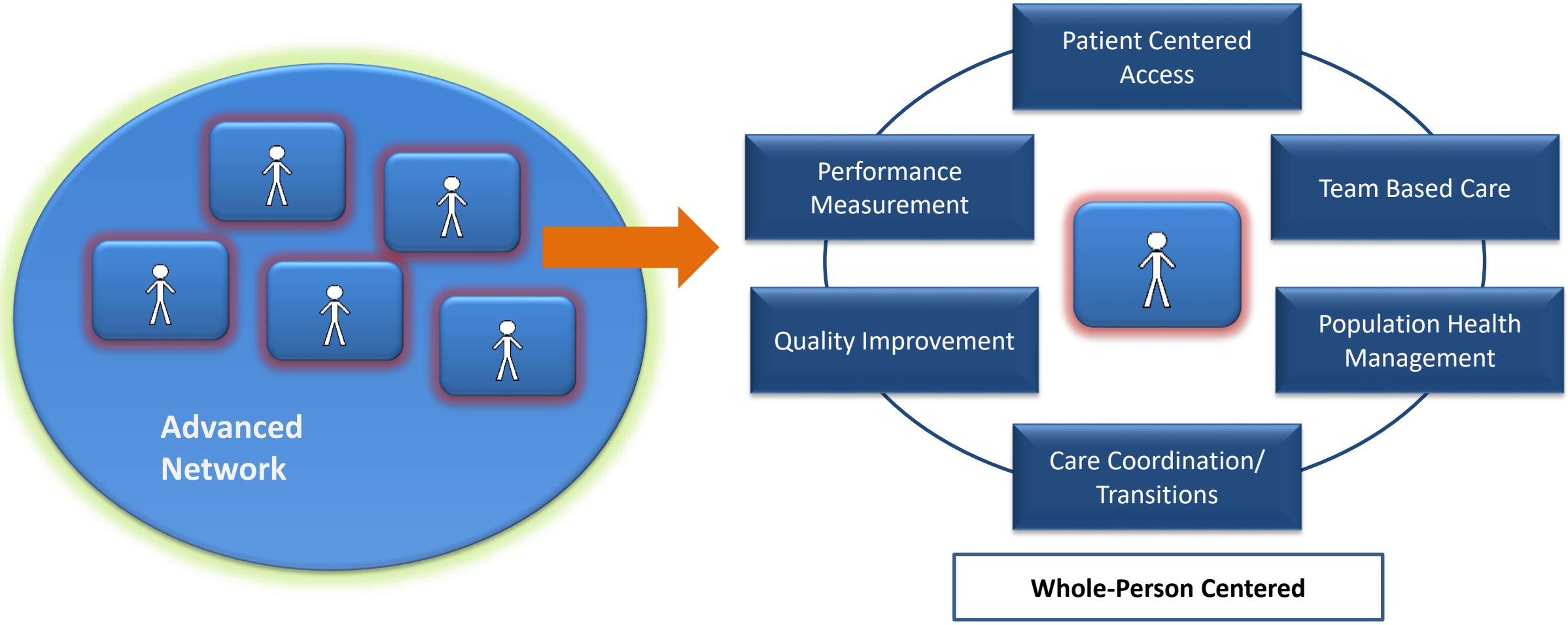
E-Consults

Oral health

Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

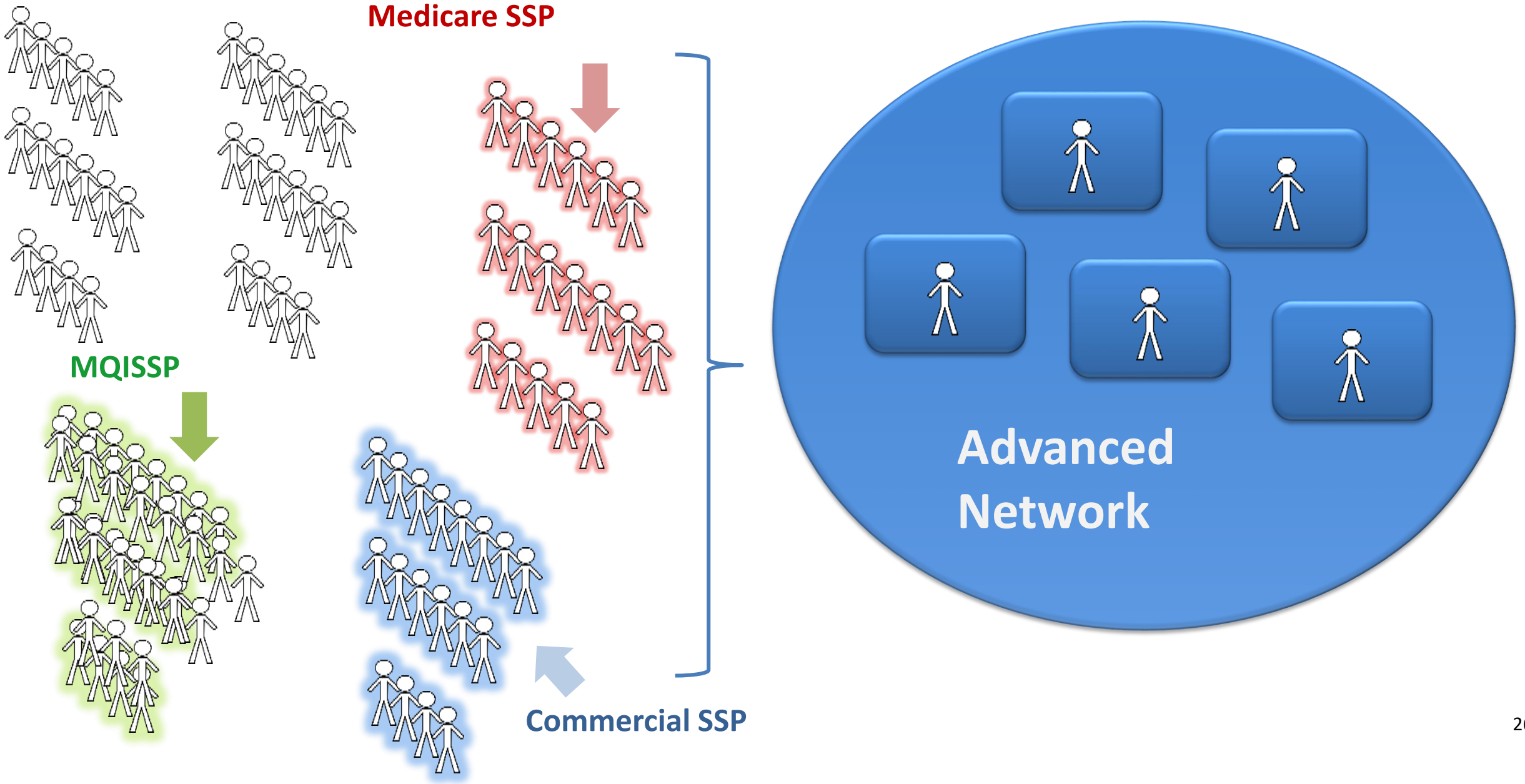
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



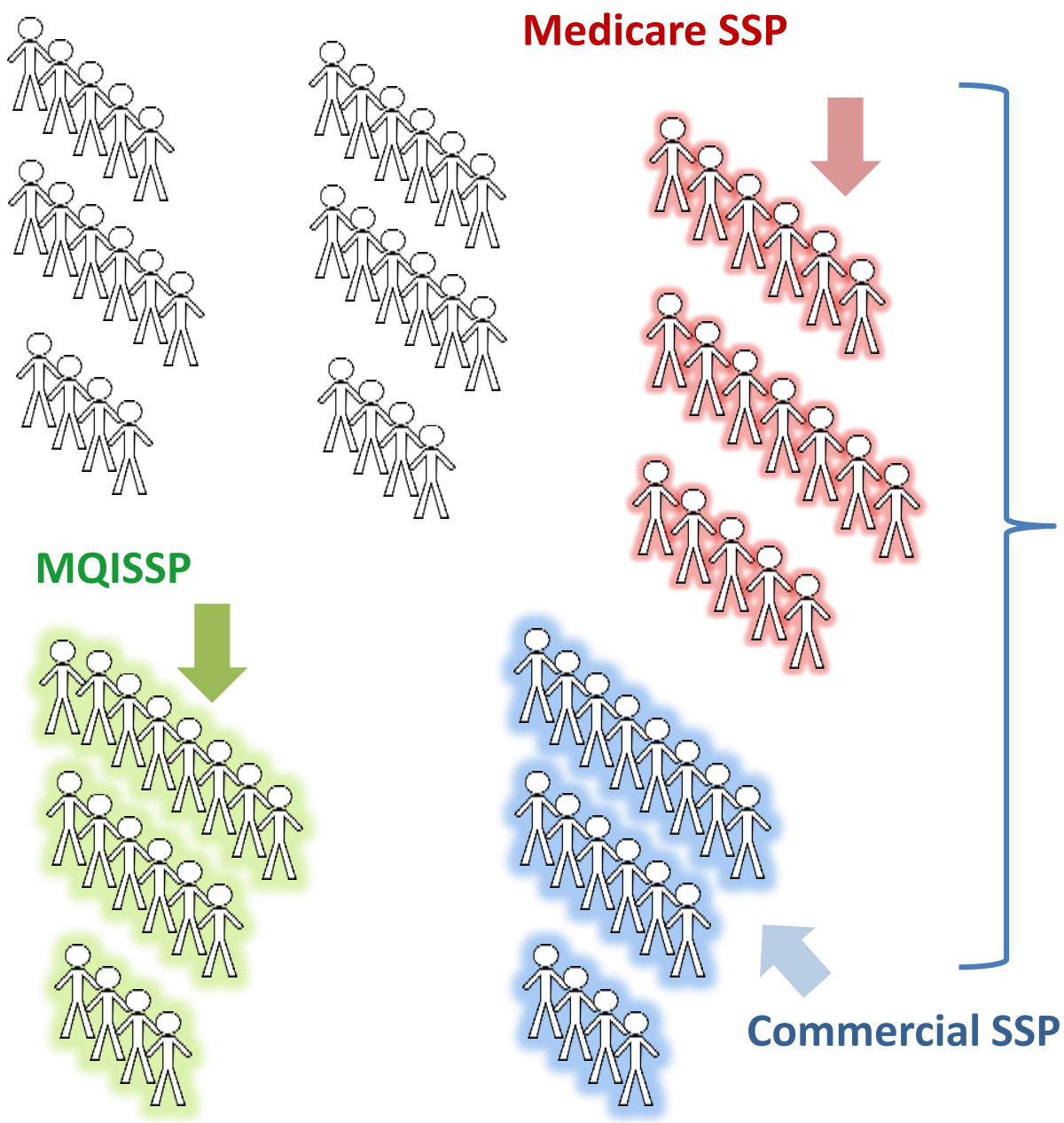
Value Based Payment

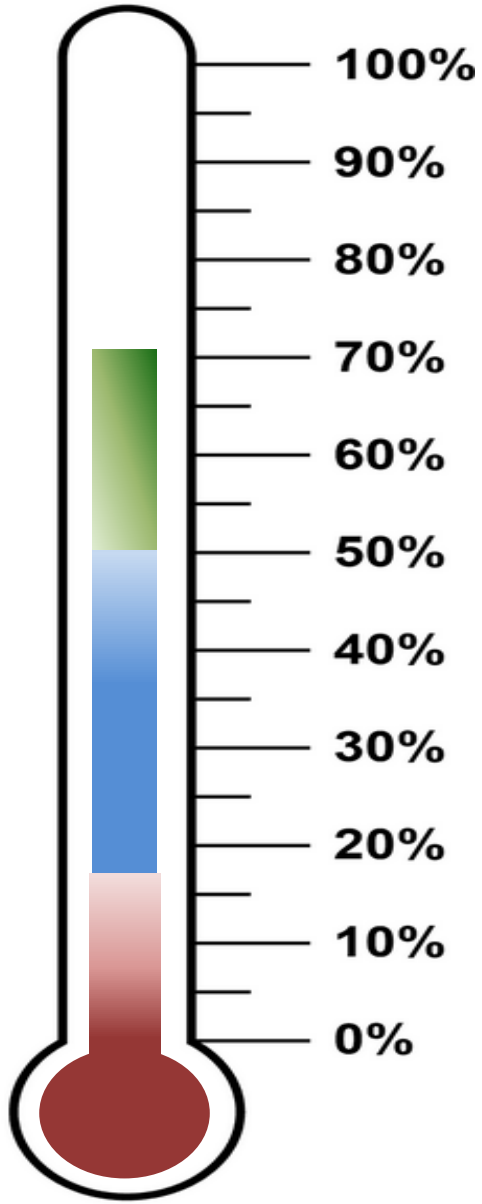
$$\text{Value} = \frac{\text{Quality \& Care Experience}}{\text{Total Cost of Care}}$$

Expanding the reach of Value-Based Payment



Reaching the tipping point





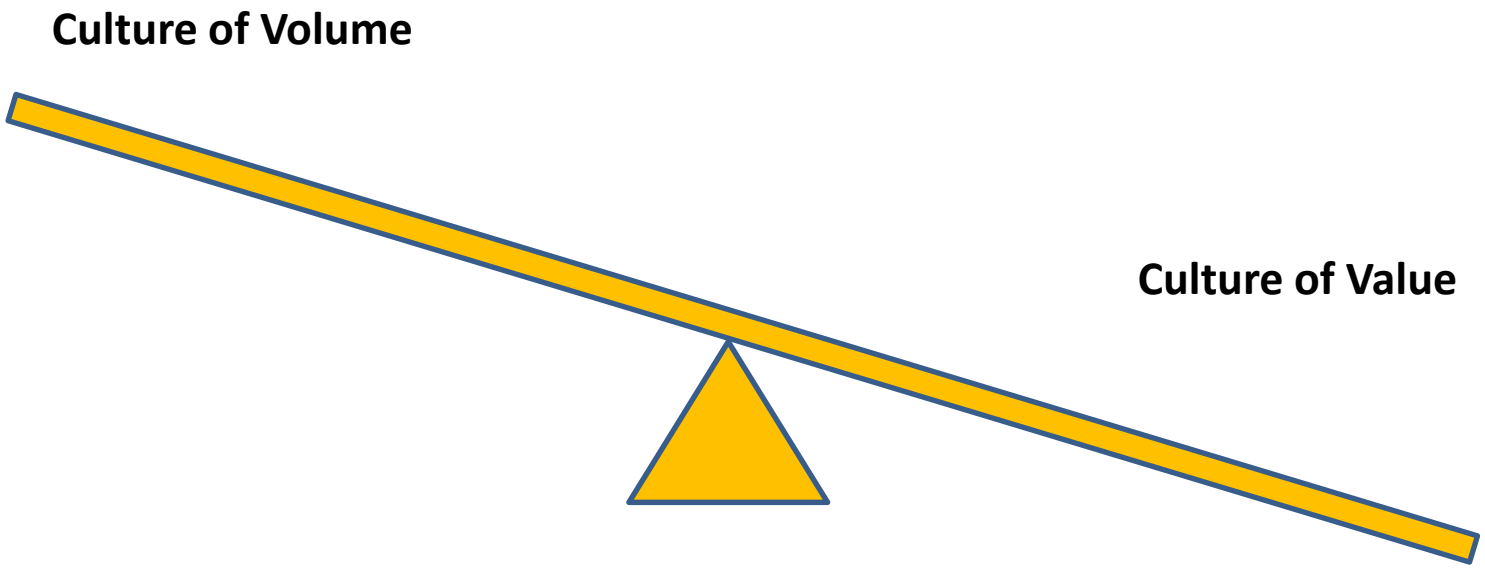
MQISSP

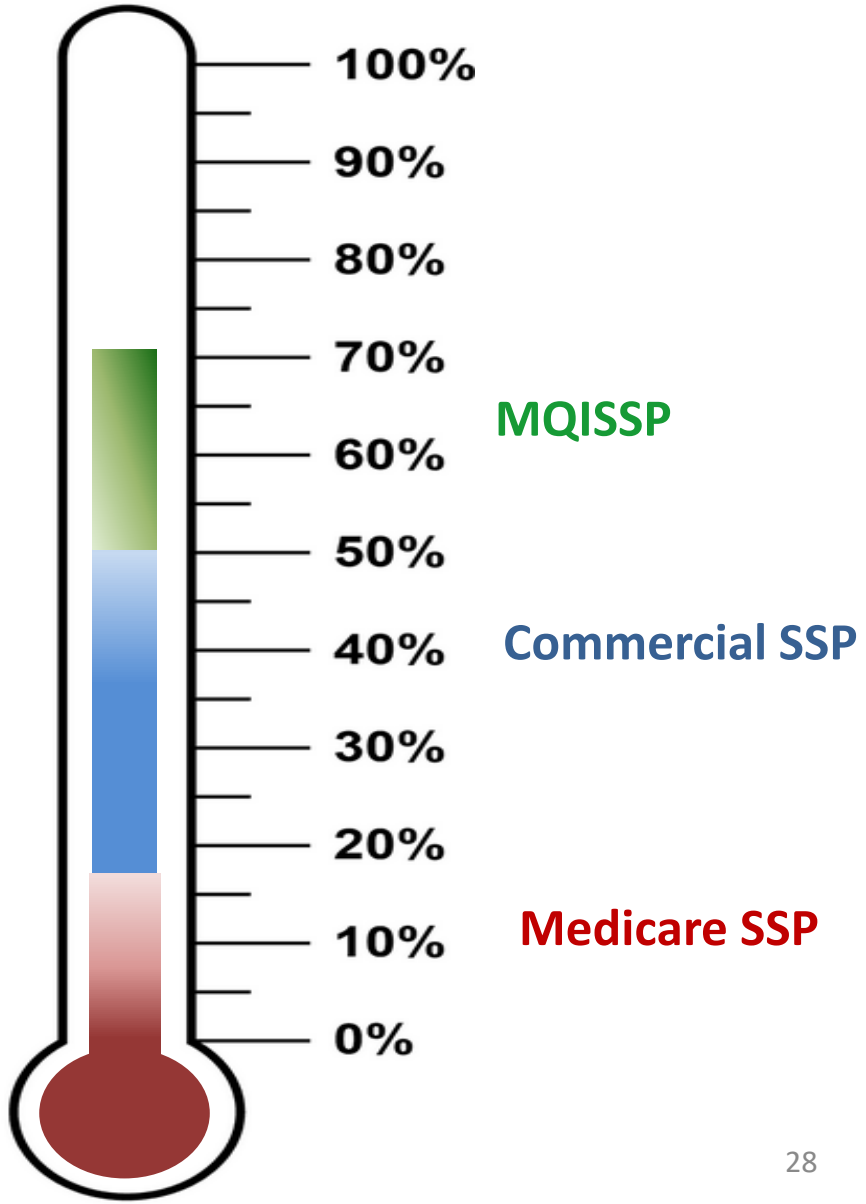
Commercial SSP

Medicare SSP

% of consumers in an Advanced Network in value-based payment arrangement

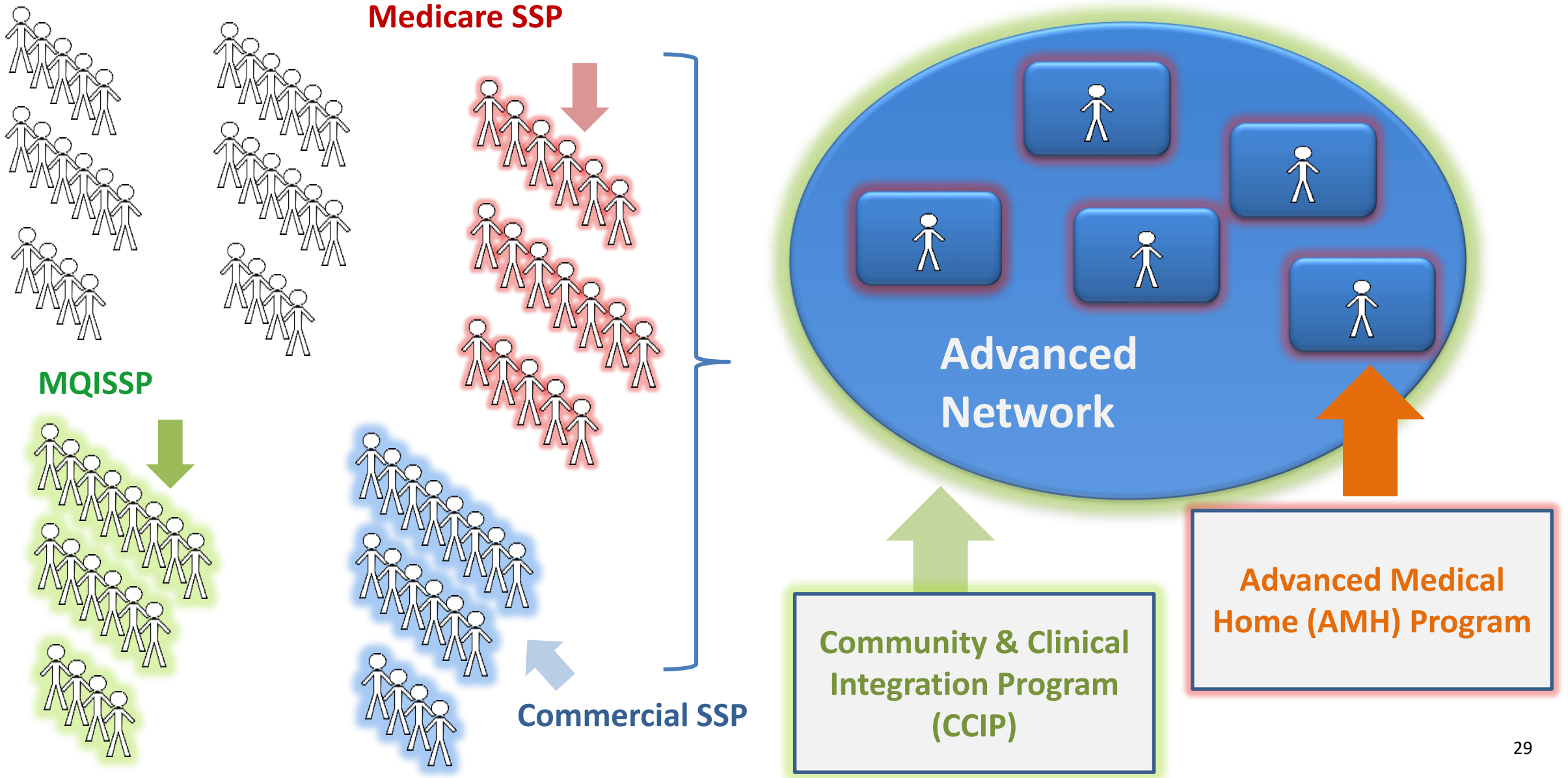
Reaching the tipping point





% of consumers in an Advanced Network in value-based payment arrangement

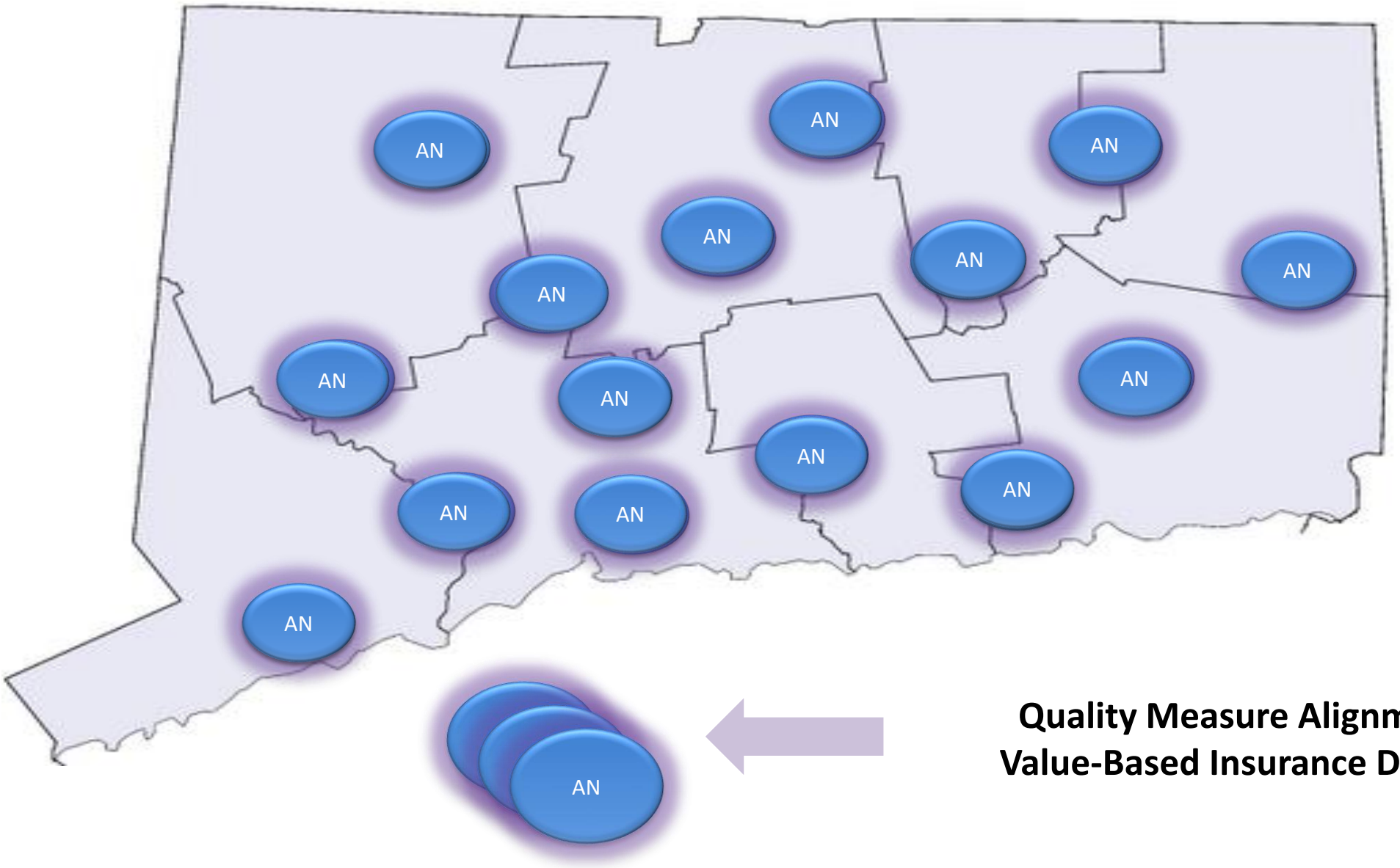
Putting it all together



Targeted Initiatives

Statewide Initiatives

Statewide Initiatives



Quality Measure Alignment
Value-Based Insurance Design

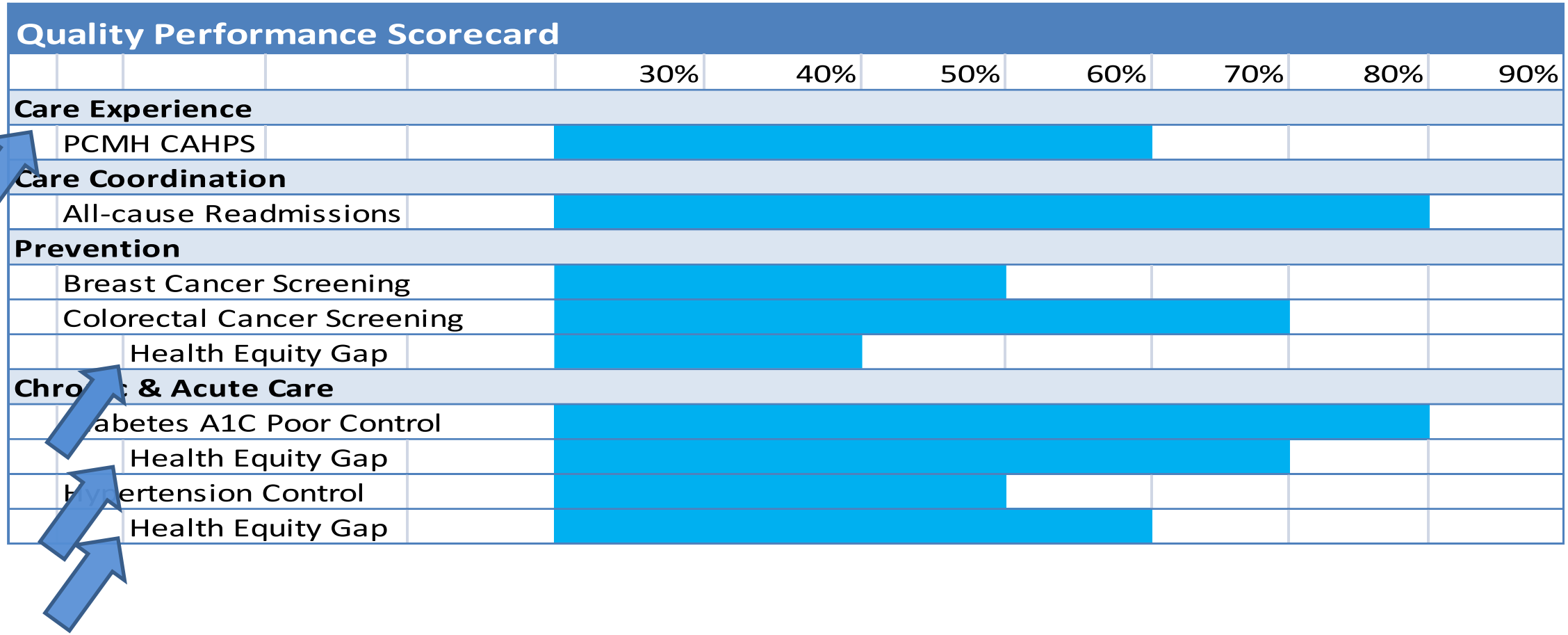
Quality Measure Alignment

Quality Measure Alignment

Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard

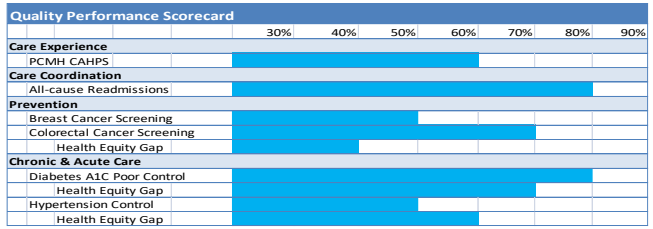
Common Quality Measure Set and Scorecard



Outcomes Measures

Today:

Health Plan → *Claims Data*



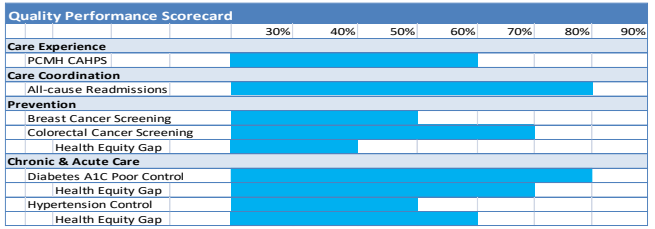
Process Measures

(E.g., Diabetes foot exam, well-care visits, medication adherence)

National consensus to move towards outcomes:

Health Plan → *Claims Data*

Health Plan → ***EHR Data***



Process & Outcome Measures

(E.g., diabetes A1C control, blood pressure control, depression remission)

Value-based Insurance Design

Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

Use high value services
(e.g., preventative services, certain prescription drugs)

Use high performance providers
Who adhere to evidence-based treatment

Health promotion & disease management

Health coaching & treatment support

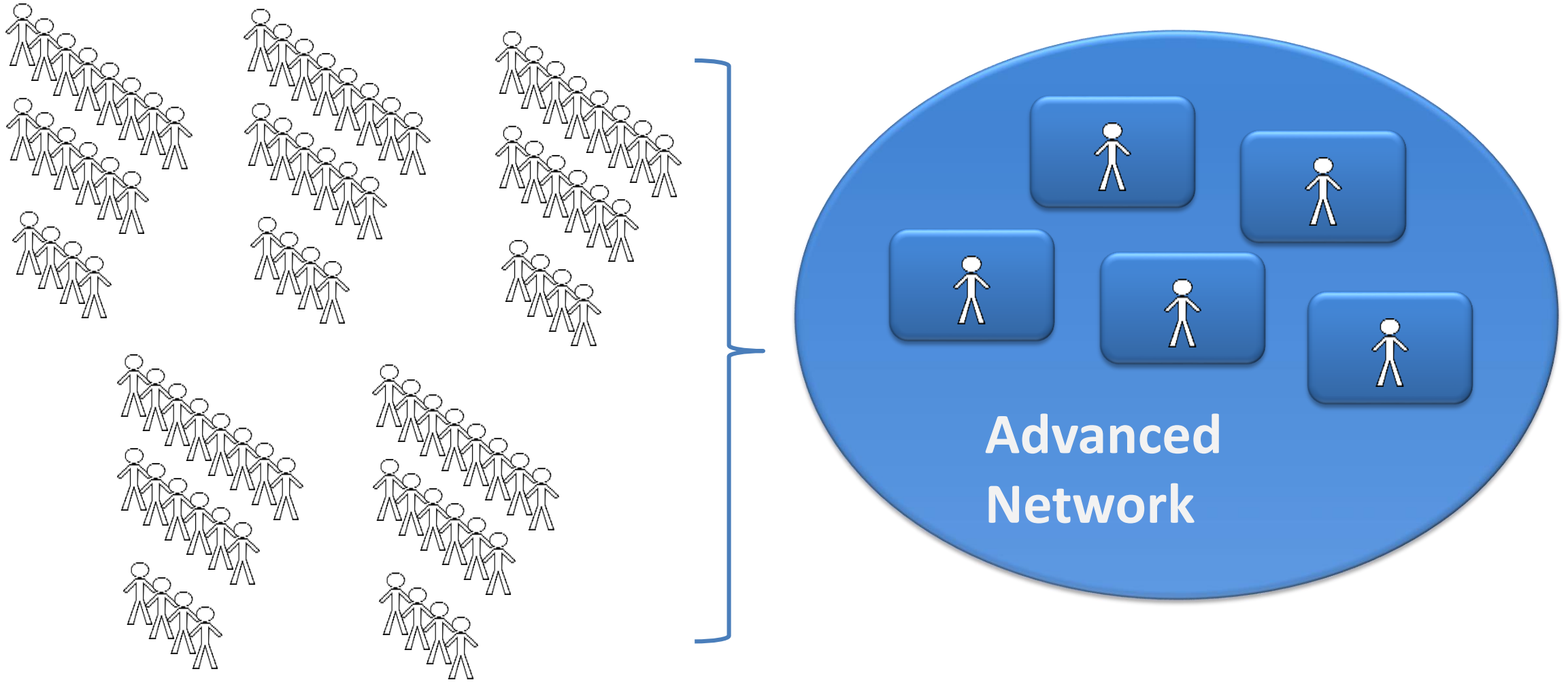
SIM VBID Components

- **Employer-led Consortium**: peer-to-peer sharing of best practices
- **Prototype VBID Designs**: using latest evidence, to make it easy for employers to implement
- **Annual Learning Collaborative**: including panel discussions with nationally recognized experts and technical assistance

access health CT
Connecticut's Health Insurance Marketplace

CT's Health Insurance Market Exchange) will implement VBID in Year 2 of the Model Test (subject to Board approval)

Aligning strategies to engage consumers and providers



Value-based Insurance Design

Value-based Payment

Value-Based Insurance Design - Accountability Metrics

Year	Percent adoption
2016	44%*
2017	53%
2018	65%
2019	74%
2020	87%

*Estimate – will establish empirical baseline 2015

Questions

VBID Landscape in Connecticut

THOMAS WOODRUFF, PHD, OFFICE OF THE STATE COMPTROLLER

V-BID Principles

Clinical Nuance:

1) Medical services differ in the amount of health produced
2) Clinical benefit derived from specific service depends on the consumer using it

With a Value-Based Insurance Design, consumer cost-sharing level is based on clinical benefit – not acquisition price – of the service

- Reduces or eliminates financial barriers to high-value clinical services and providers

V-BID Principles

An effective V-BID plan uses carrots and sticks

- Reduce barriers to high value services
    - Preventive care screenings
    - Chronic condition treatment
    - Reduce prescription drug co-pays

- Members maintain medical choice
    - Personal autonomy key union value

Connecticut's Health Enhancement Program (HEP)

- Joint Labor/Management Healthcare Cost Containment Committee
- Between 2007-2011 HCCCC discussed Value Based Purchasing and Value Based Insurance Design
- In 2010 the state required ASOs to enter Patient Centered Medical Home arrangements to improve healthcare delivery and lower costs
- Labor members of HCCCC explored VBID to increase member engagement and lower costs
- In 2011, Malloy administration took office with a $3.8B deficit
  - Administration proposed savings through traditional cost shifting
  - Labor coalition countered with VBID proposal to make employees healthier
  - Labor proposal turned win/loss fight to win/win

HEP

Targets preventive care and chronic disease through:

- Voluntary enrollment for employees
- Required age appropriate preventive screenings and care
- Lower co-pays for medications/care associated with five chronic diseases and conditions
- Chronic disease management education program

Lowers costs for participating/compliant employees by:

- Waiving co-pays for preventive care and chronic disease management
- Reducing monthly premium share ($100 per month)

About the Project

JOHN FREEDMAN, MD, FREEDMAN HEALTHCARE

ALYSSA URSILLO, MPH, FREEDMAN HEALTHCARE

Goal

This initiative aims to increase uptake of V-BID in Connecticut
by developing a V-BID prototype of recommended practices and plans,
with strategies and tools to select and promote V-BID plans

Deliverables

1. **Assess and index V-BID models** both in Connecticut and nationally
2. Make **recommendations** for the best models for Connecticut markets
3. Develop **templates and employer guidance** for recommended content of a V-BID benefit plan that is applicable to self and fully-insured employers, and public and private exchanges
4. A web-based **V-BID Toolkit** for employers
5. Targeted **communications materials** for employers and consumers
6. Disseminate best practices through **V-BID Learning Collaborative**

Role of Consortium

The Consortium will serve as an advisory body for the V-BID Initiative:

- ✧Advise on strategies for health plan/employer engagement
- ✧Make recommendations for employer adoption of V-BID
- ✧Advise on structure and goals of Learning Collaborative
- ✧Recommend members/networks for Learning Collaborative
- ✧Inform development of
  - V-BID plan template(s)
  - V-BID Toolkit
  - Communications materials
  - Employer guidance for V-BID adoption

Timeline

Meetings and Deliverables	Date
First Consortium Meeting	February 2, 2016
• Introduce VBID framework and HEP, feedback on VBID concepts as part of plans	
Second Consortium Meeting	March 22, 2016
• Recommendations and feedback on assessments of VBID plans for CT markets, employer barriers to uptake	
Third Consortium Meeting	April 27, 2016
• Recommendations and feedback on VBID templates, Toolkit, communications materials	
Finalize VBID templates, employer guidance and Toolkit	May 23, 2016
First Learning Collaborative Meeting	Mid June

What Does a Model V-BID Plan Look Like?

JOHN FREEDMAN, MD, FREEDMAN HEALTHCARE
MARK FENDRICK, MD, VBID HEALTH
THOMAS WOODRUFF, PHD, OFFICE OF THE STATE COMPTROLLER

Building a Framework for V-BID Assessment

Purpose of assessment framework:

- To guide recommendations of value based insurance design concepts to be adopted by employers, health plans and exchanges as part of VBID plan templates for various Connecticut market segments

Concepts Adapted from CMS Medicare Advantage Model

- 5 year demonstration program for state grantees
- Testing utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high value services and providers

V-BID Concepts

V-BID Concept	Reduced cost sharing for high value services and drugs
Purpose	Encourage healthy patient choices; Encourage use of high value, evidence-based services and treatments
Leverage point	Patient-based: clinically nuanced
Examples	Waive copay for biennial colonoscopy in ulcerative colitis (nuanced)
V-BID Concept	**Increased cost sharing for low value services and drugs**
Purpose	Discourage unhealthy patient choices; Discourage use of low value services and treatments
Leverage point	Patient-based: clinically nuanced
Examples	Increase co-pay on inappropriate imaging for acute low back pain

V-BID Concepts

VBID Concept	Reduced cost sharing for high value providers
Purpose	Encourage healthy patient choices. Encourage prudent provider practice.
Leverage point	Patient-based: clinically nuanced Provider-based: specialty, affiliation, or past behavior
Examples	Lower copay if MD affiliated with high-performing ACO (tiering).

V-BID Concepts

VBID Concept	Reduced cost sharing for disease management programs
Purpose	Encourage healthy patient choices for targeted groups
Leverage point	Patient-based: clinically nuanced. Based on participation
Examples	Waive co-pay for recommended medications for patients with asthma who participate in medication adherence program

V-BID Concepts

VBID Concept	Coverage of supplemental, high value benefits
Purpose	Encourage healthy patient choices for targeted groups
Leverage point	Patient-based: clinically nuanced
Examples	Coverage of transportation to primary care appointments for patients with multiple chronic diseases.

Building a Framework for V-BID Assessment

How are VBID concepts implemented in health plan design?

Consider:

1. Are VBID concepts present?
2. What percent of members do they apply to?
3. What percent of spending do they apply to?
4. What percent of conditions do they apply to?
5. How strong are the incentives (e.g., how big is cost differential)?
6. How closely targeted (how close to Evidence Based Medicine)?
7. How easy is it to implement?
8. Are the outcomes/impact measurable?
9. Are the outcomes/impact significant?

Discussion:
Challenges and opportunities of adopting V-BID in Connecticut

Next Steps:

- V-BID plans in Connecticut survey and assessment
- SWOT analysis of employer uptake of V-BID
- Executive Team Meeting: TBD
- **Second Consortium Meeting: March 22, 2016**