OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization and Health Enhancement Communities: Pathways to Better Care and Better Health

Presentation to the Behavioral Health Partnership Oversight Council

October 10, 2018

How We Will Spend Our Time Together

- Discuss CT healthcare reform history and current landscape
- Discuss two design initiatives to promote better care and better health: *Primary Care Modernization* and *Health Enhancement Communities*
- Share information on a Medicare Multi-payer Demonstration as the vehicle for advancing these reform initiatives
- Consider relationship to the work of the BHPOC

We are seeking *your advice and expertise* as we move forward with this important work

Healthcare Reform in Connecticut

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- SIM achievements
  - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
  - 1,000,000+ beneficiaries (all payer) attributed under shared savings arrangements
  - Commercial payers 60% aligned on Core Quality Measure Set
  - 125 practices achieved PCMH recognition through SIM
  - 5 provider organizations representing 735 PCPs and 414,174 attributed lives receiving Community and Clinical Integration Program support
  - 14 provider organizations and CBOs negotiating service agreements under Prevention Service Initiative
  - Implementation of information exchange and data analytic solutions underway

Healthcare Reform in Connecticut

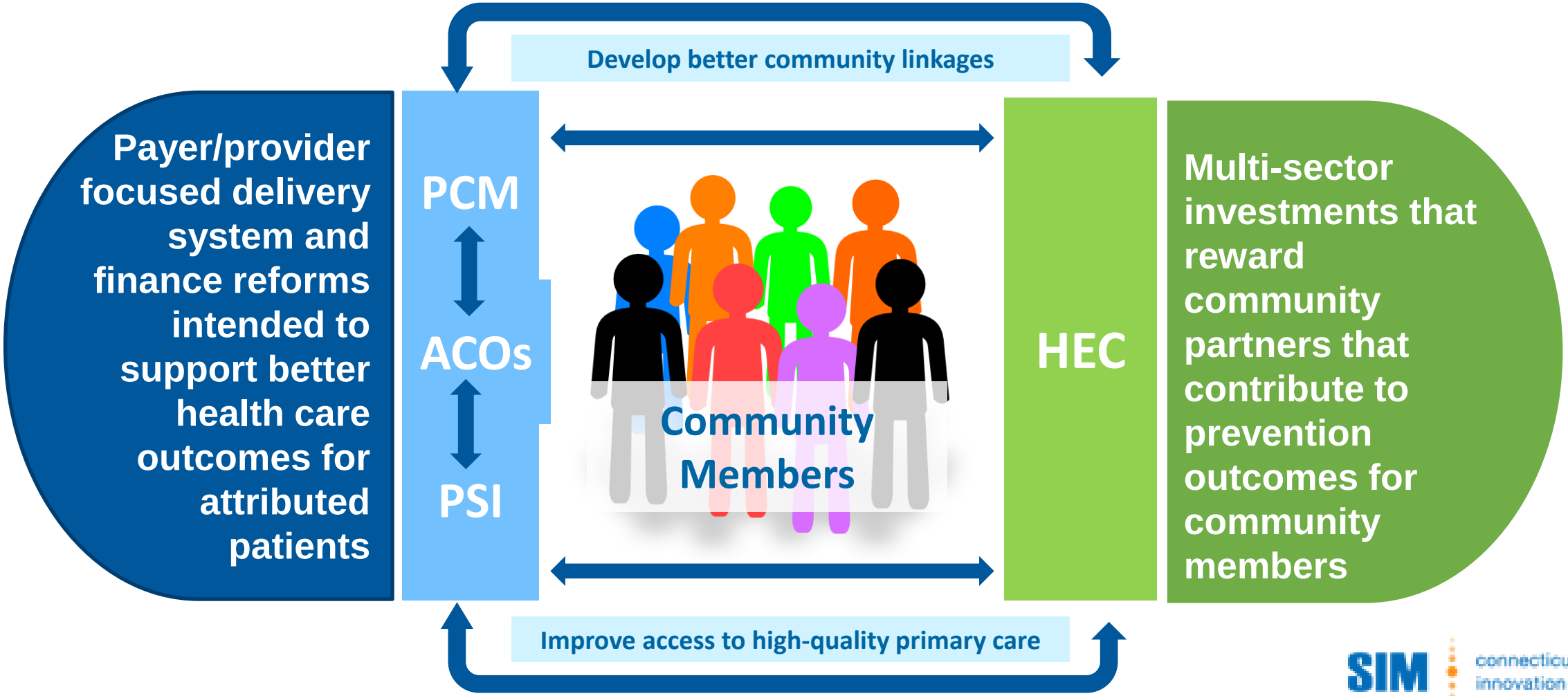
- Limitations…
  - Primary care remains largely untransformed
  - Limited investments in preventing avoidable illness and injury

The Opportunity

- A multi-payer demonstration project to improve health, drive efficiency and reduce total cost of care (with Medicare participating, but not a “state-run” Medicare program)
- Pay for primary care differently by leveraging payment ‘bundles’ to support advanced care delivery
- Focus on payment features that facilitate using some resources at the system level and the practice level
- Create an innovative community-driven model that can encourage investments in community health by monetizing prevention efforts

Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention

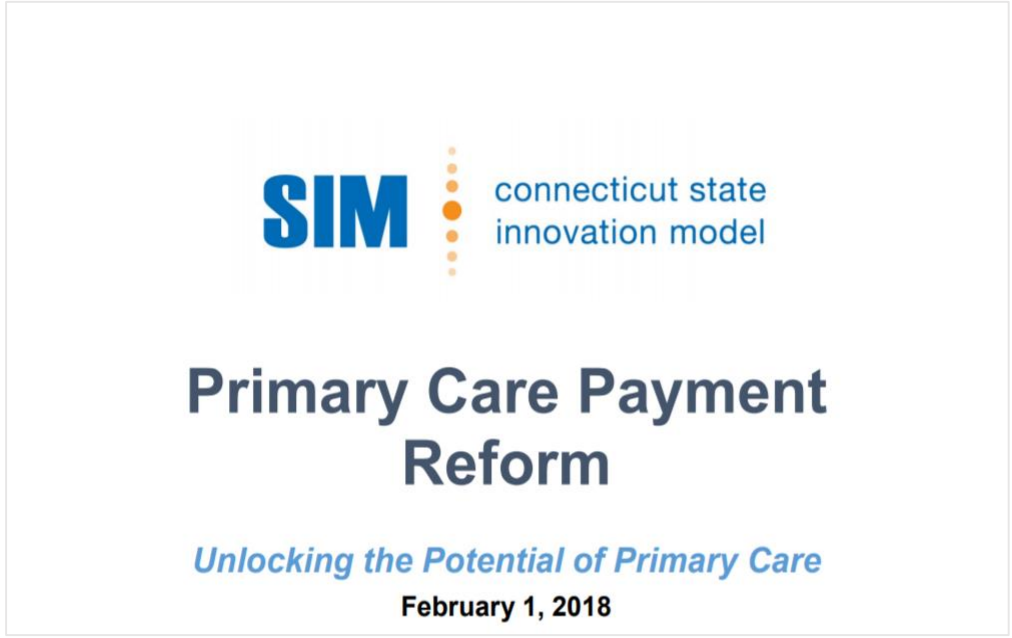


SIM connecticut state innovation model

Primary Care Modernization

Design a new model for primary care to:

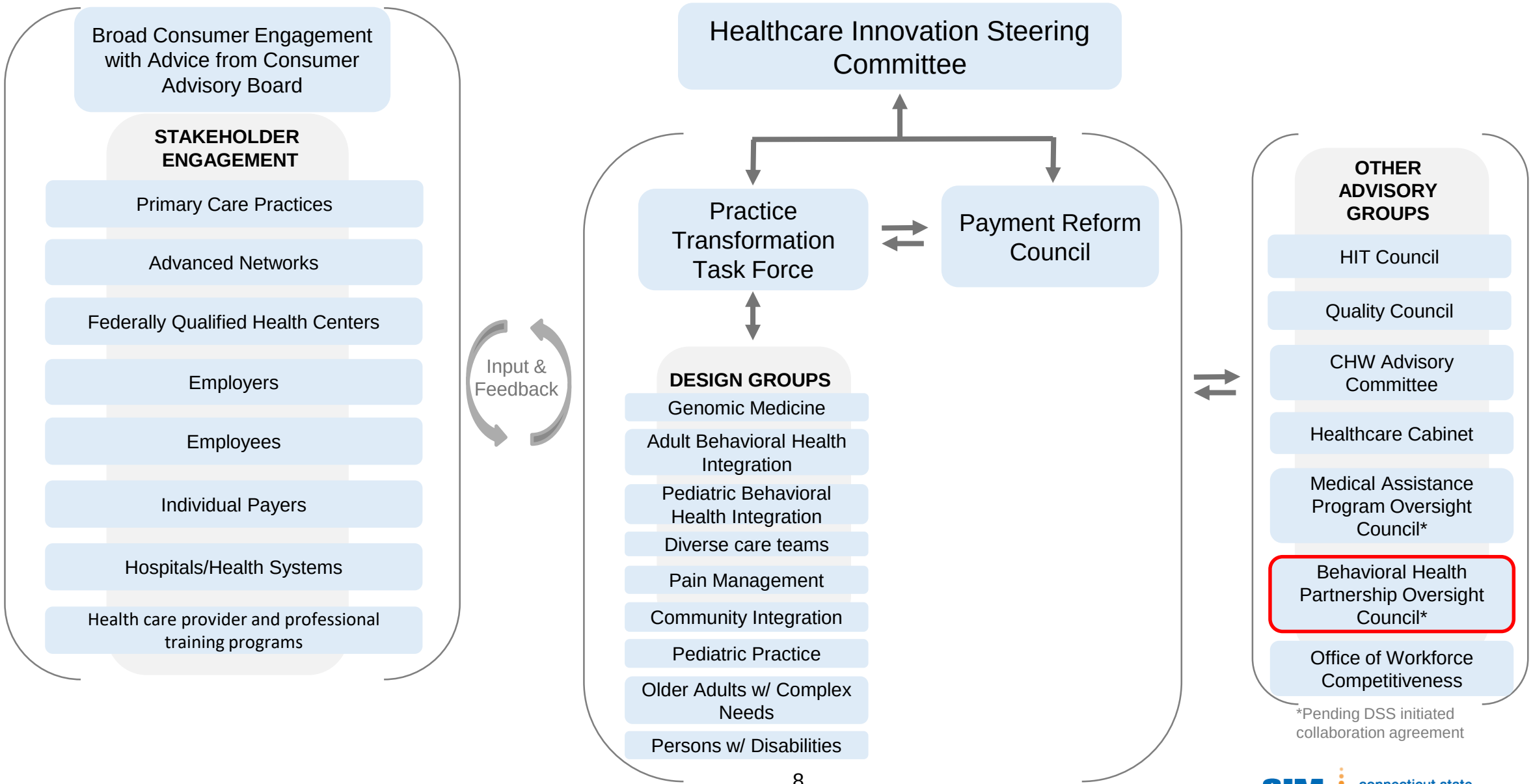
- Expand and diversify care teams
- Expand patient care and support outside of the traditional office visit
- Double investment in primary care over five years through more flexible payments
- Reduce trend in total cost of care



Foundational Assumptions for designing model:

- Eligibility limited to practices in Advanced Networks/ACOs/FQHCs
- Multi-payer
- Existing MSSP or other shared savings arrangements remain in place, but model introduces downside risk *(may propose program adjustments)*
- Hybrid, partial or full bundles for primary care services

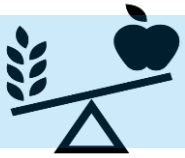
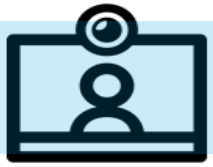
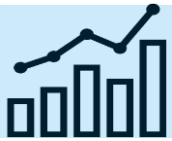
Stakeholder Engagement Progress



*Pending DSS initiated collaboration agreement

SIM connecticut state innovation model

Capabilities Under Consideration

Diverse Care Teams	 Pharmacists, Nurses	 Care Coordinators, Community Health Workers, Navigators	 Health Coaches, Nutritionists
Alternative Modes of Support & Engagement	 Phone/Text/e-mail	 Home Visits	 Telemedicine
Technology	 Patient generated data & Remote patient monitoring	 Precision & Genomic Medicine	 E-Consults
Integration and Specialization	 Behavioral Health Integration	 Practice Specialization (e.g., geriatrics, chronic pain)	 Community Integration

Payment Reform Model Options Under Consideration

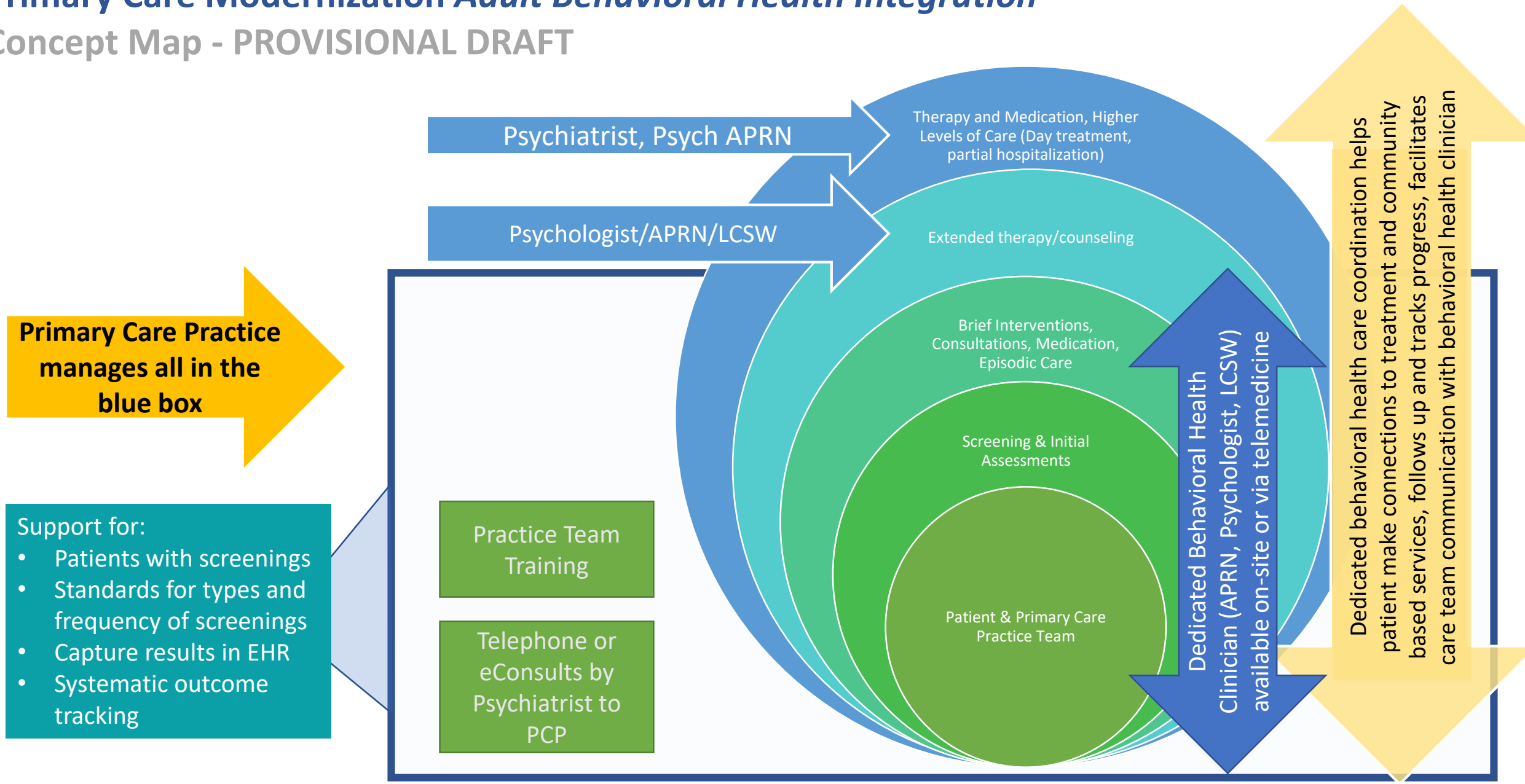
Basic Bundle + **Supplemental Bundle** + **Fee for Service Payments**

MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

Options:
Hybrid basic bundle (partial bundle with reduced fees for office visits)
Combined bundle (single upfront payment that combines basic and supplemental bundles)

Primary Care Modernization *Adult Behavioral Health Integration*

Concept Map - PROVISIONAL DRAFT



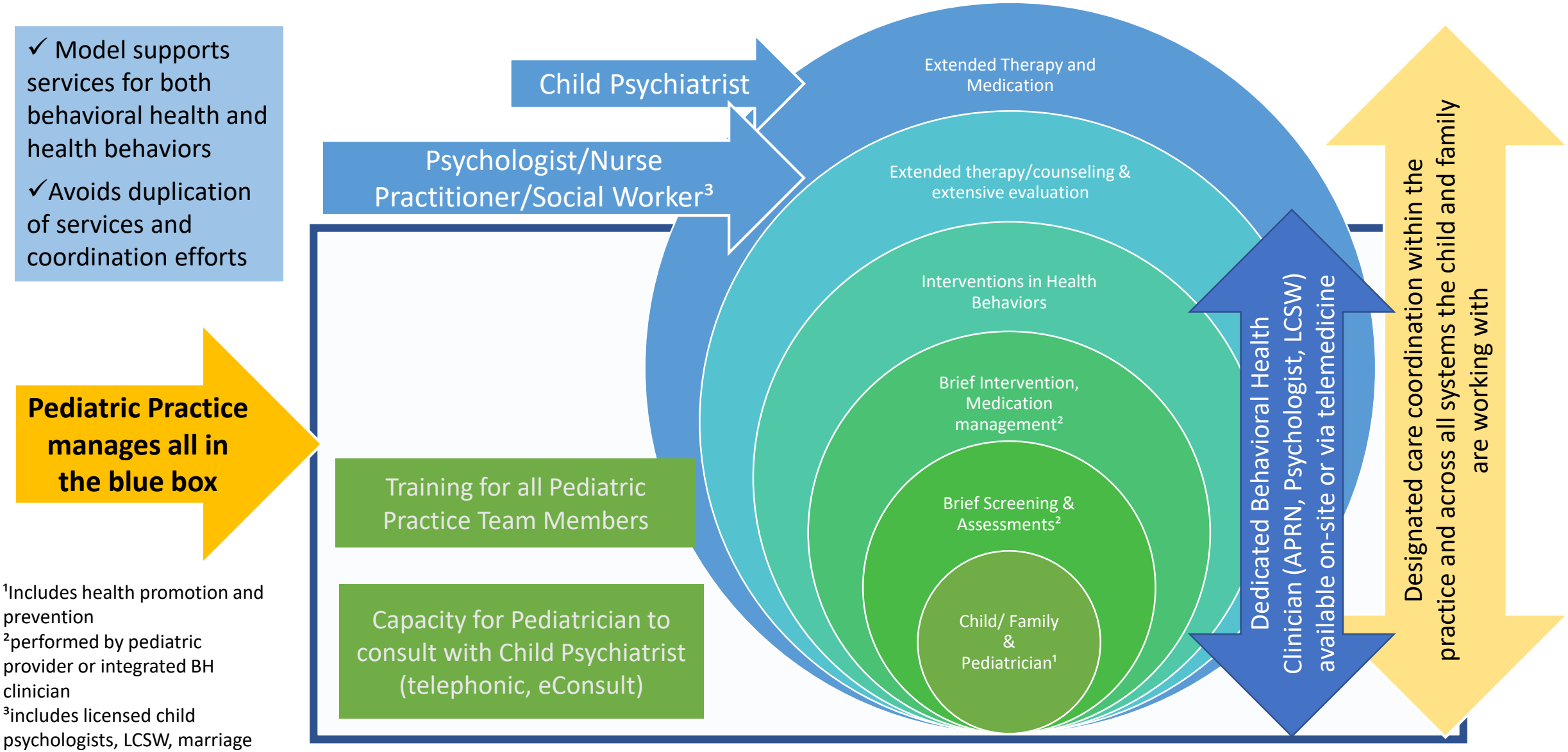
Based on feedback prior to September 25, 2018

Primary Care Modernization *Pediatric Behavioral Health Integration*

Concept Map - PROVISIONAL DRAFT

✓ Model supports services for both behavioral health and health behaviors

✓Avoids duplication of services and coordination efforts



[1]Includes health promotion and prevention

[2]performed by pediatric provider or integrated BH clinician

[3]includes licensed child psychologists, LCSW, marriage and family therapists

Based on feedback prior to September 25, 2018

Health Enhancement Community Initiative

Proposed Features

- HECs will be new, multi-sector collaboratives operating in defined geographic areas that will be accountable for:
  - Improving child well-being for Connecticut children aged 0-5 years
  - Improving healthy weight and physical fitness for all Connecticut residents
  - Increasing health equity
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable and rewards communities for prevention, health improvement, and the economic value they produce.

Primary Prevention Priorities Across HECs

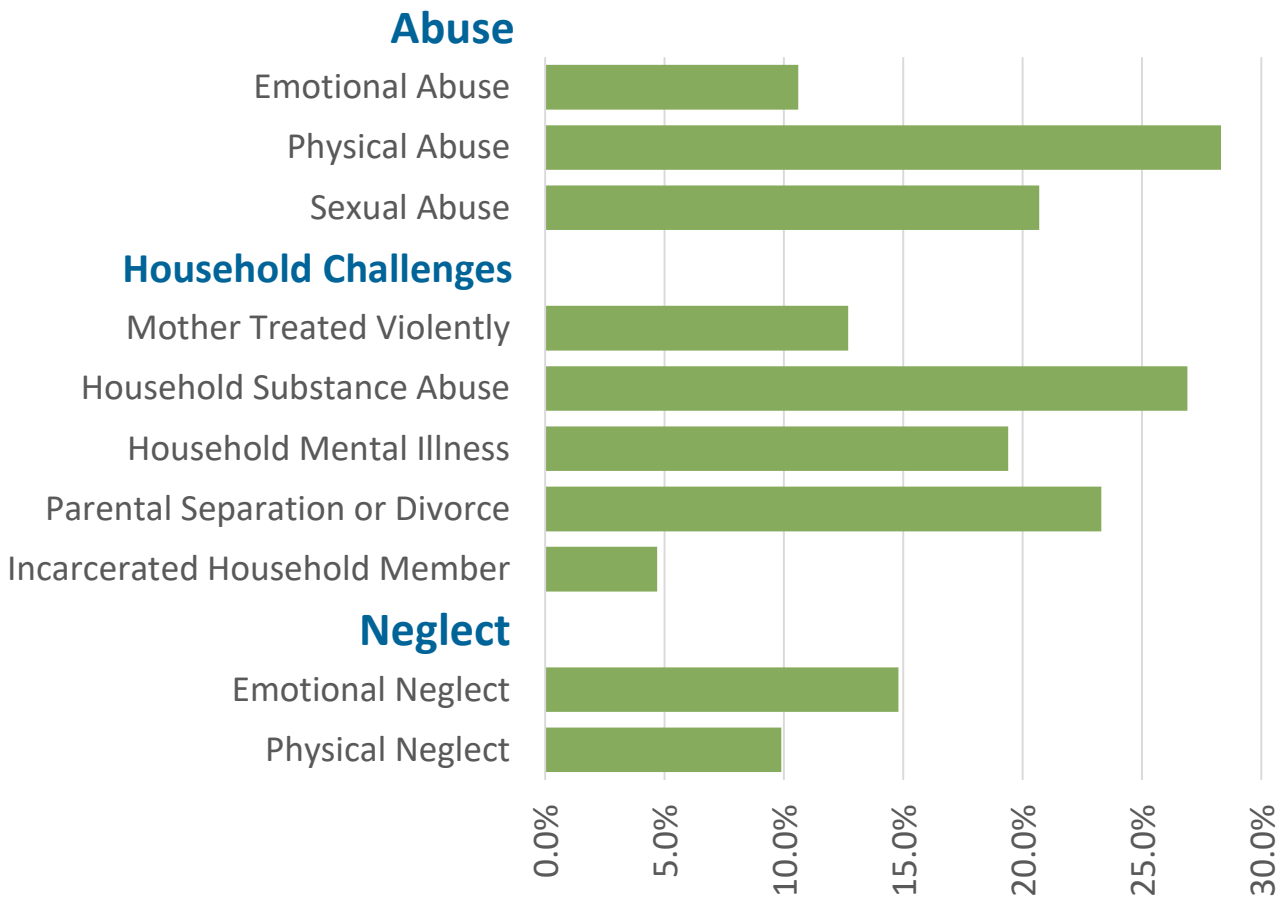
Improve Child Well-Being

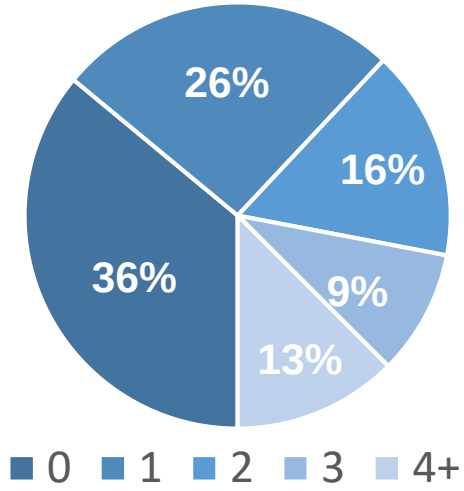
HECs will implement interventions to prevent Adverse Childhood Experiences (ACEs) and increase protective factors that build resilience among children aged 0-5 years.

Increase Healthy Weight and Physical Fitness

HECs will implement interventions to prevent overweight and obesity across the lifespan and the associated risks of developing serious health conditions.

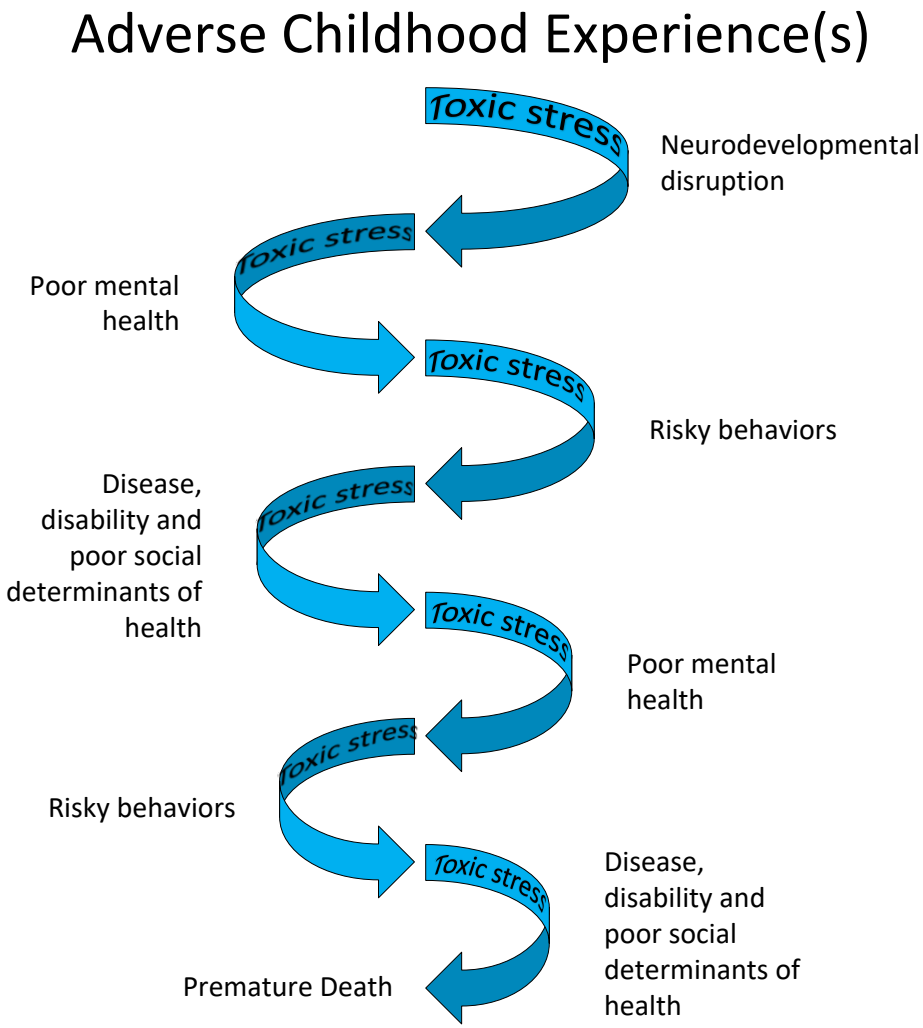
Adverse Childhood Experiences Are Prevalent





Note: Data shown above are from the original ACE study.

ACEs lead to a downward health spiral

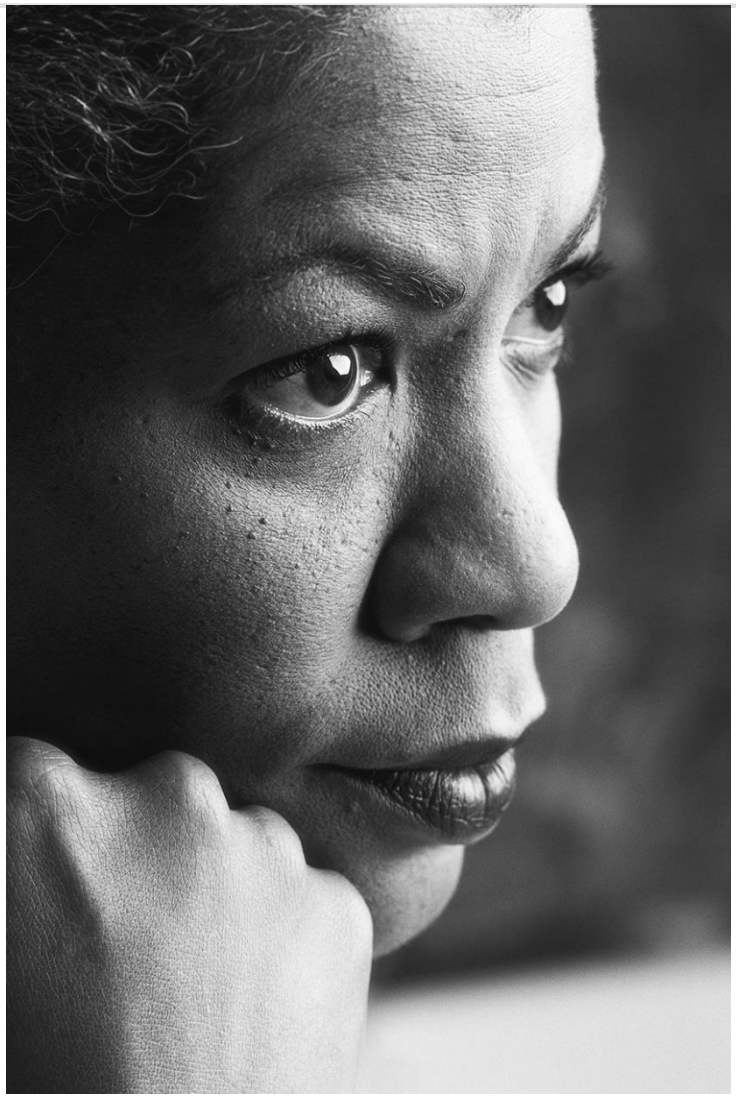


ACEs Correlate with Poor Medical Outcomes

As the number of ACEs increases, so does the risk of numerous poor medical outcomes, including:

- ☑ Chronic obstructive pulmonary disease
- ☑ Ischemic heart disease
- ☑ Liver disease
- ☑ Myocardial infarction
- ☑ Fetal death
- ☑ Disability
- ☑ Coronary heart disease
- ☑ Stroke
- ☑ Diabetes
- ☑ Asthma
- ☑ Obesity

ACEs Correlate with Poor Behavioral Health Outcomes



Adverse Childhood Experiences (ACE) have been found to correlate with an increased risk of numerous poor behavioral health outcomes, including:

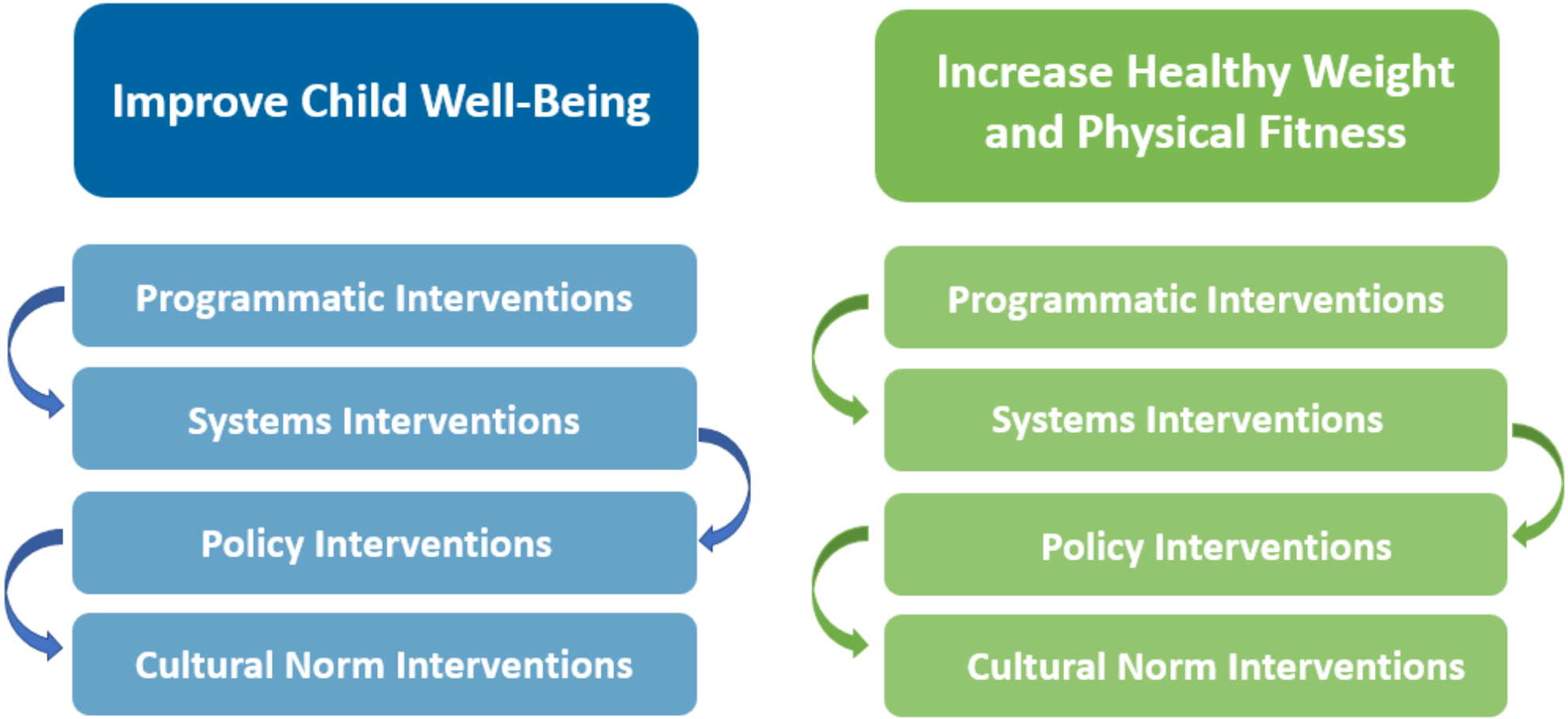
- Alcoholism and alcohol abuse
- Depression and depressive disorders
- Mental distress
- Anxiety
- Illicit drug use
- Suicide attempts
- Hallucinations
- Childhood autobiographical memory disorder

ACEs Correlate with Risky Behaviors

Adverse Childhood Experiences (ACE) have been found to correlate with an increased risk of numerous risky behaviors and problematic social determinants, including:

- ☑ Poor work performance
- ☑ Financial stress
- ☑ Risk for intimate partner violence
- ☑ Low reported income
- ☑ Unemployment
- ☑ Lowered educational attainment
- ☑ Multiple sexual partners
- ☑ Sexually transmitted diseases
- ☑ Smoking/Early initiation of smoking
- ☑ Unintended pregnancies
- ☑ Early initiation of sexual activity
- ☑ Adolescent pregnancy
- ☑ Risk for sexual violence
- ☑ Poor academic achievement

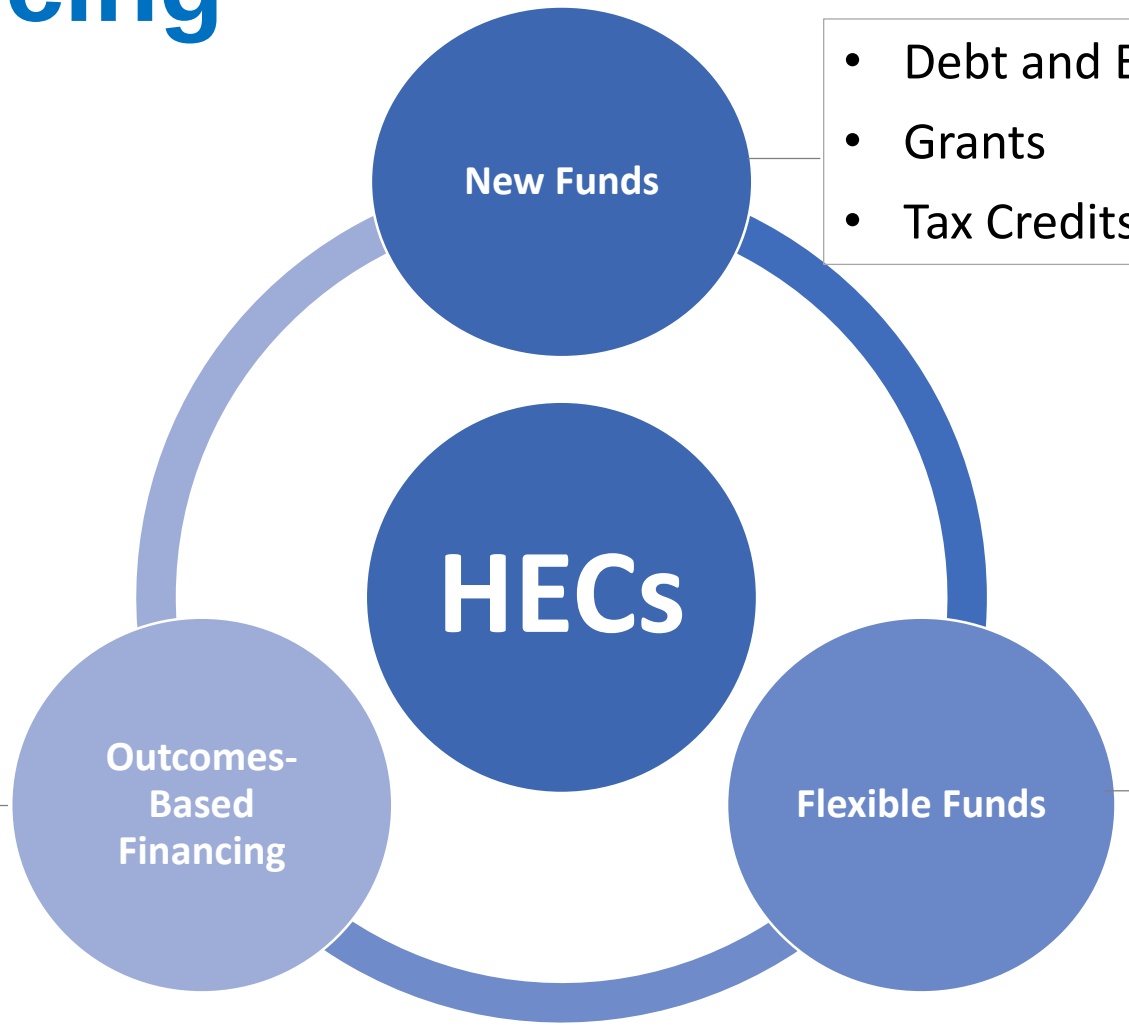
HEC Intervention Framework



HECs Proposed Financing Approach

- Monetizing prevention is at the core of the HEC Model
- Will require a mix of:
  - **Near-term**, upfront funding in the first five years of implementation
  - Sustainable **long-term** sources of funds beyond five years
  - Assumption that near-term financing options will serve as a bridge to longer-term financing
  - Long-term financing will rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and potentially other payers.
- Pursuing multiple strategies
  - Multi-payer demonstration
  - Social finance options

HECs Financing Options



- Debt and Equity
- Grants
- Tax Credits

- Capture and Reinvest (e.g., shared savings arrangements)
- Pay for Success/ Social Impact Bonds
- Outcomes Rate Cards

- Braided Funds
- Blended Funds
- Wellness Trust

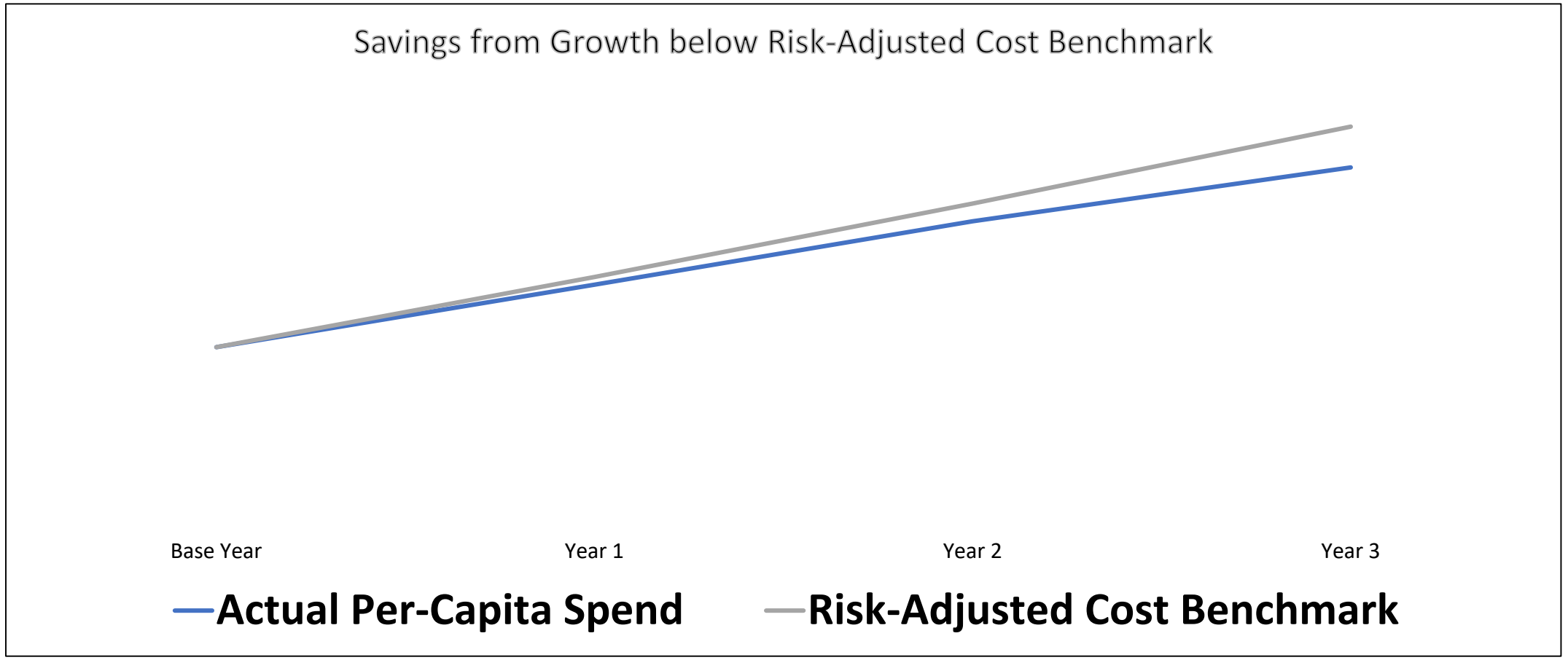
Longer-Term Financing

Outcomes Based-Financing: Capture and Reinvest Shared Savings

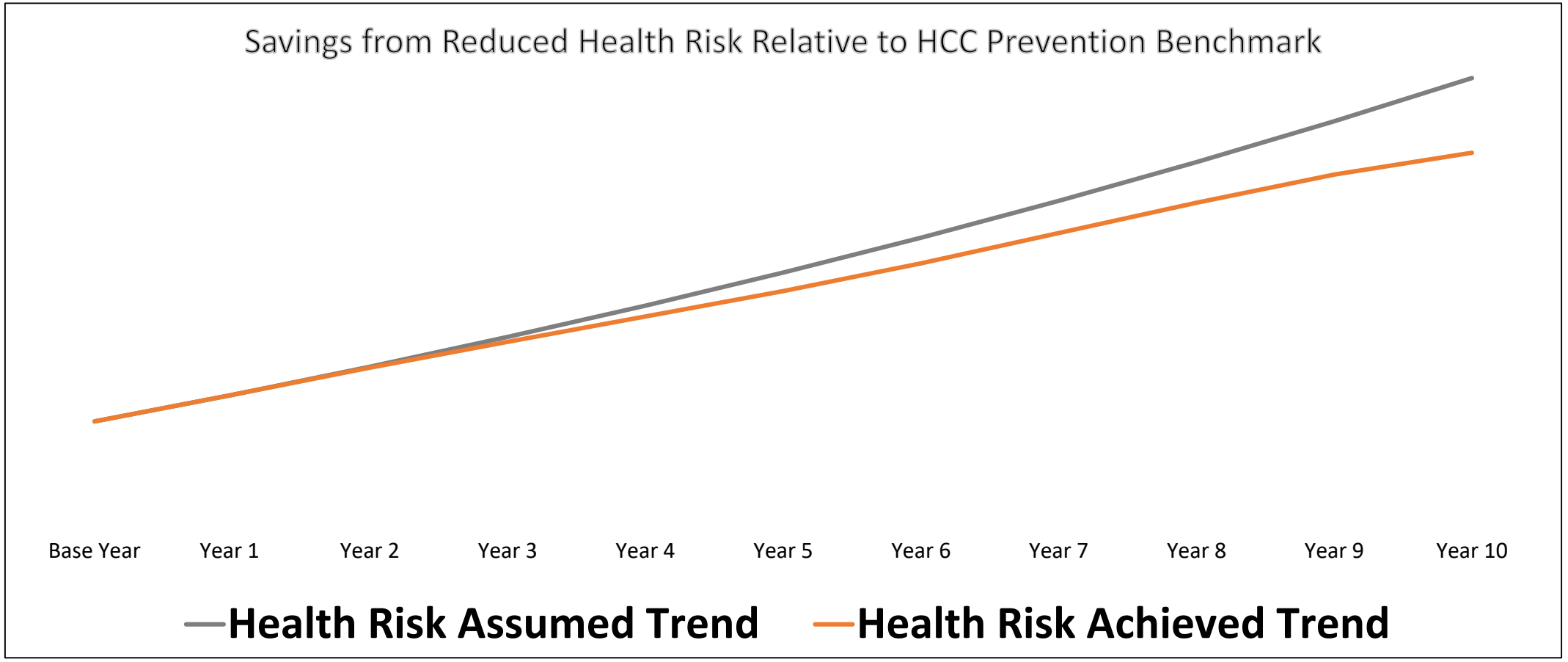
A critical component of securing long-term financing for HECs is developing **prevention-oriented shared savings arrangements with Medicare, Medicaid and potentially other payers**

- Prevention-oriented shared savings arrangement would complement the existing Medicare Shared Savings Program (MSSP) with Accountable Care Organizations (ACOs)
- HECs will be measured on success with upstream prevention efforts through reduction in condition-specific prevalence trends
- Longer time horizon to demonstrate impact (5 to 10 years)

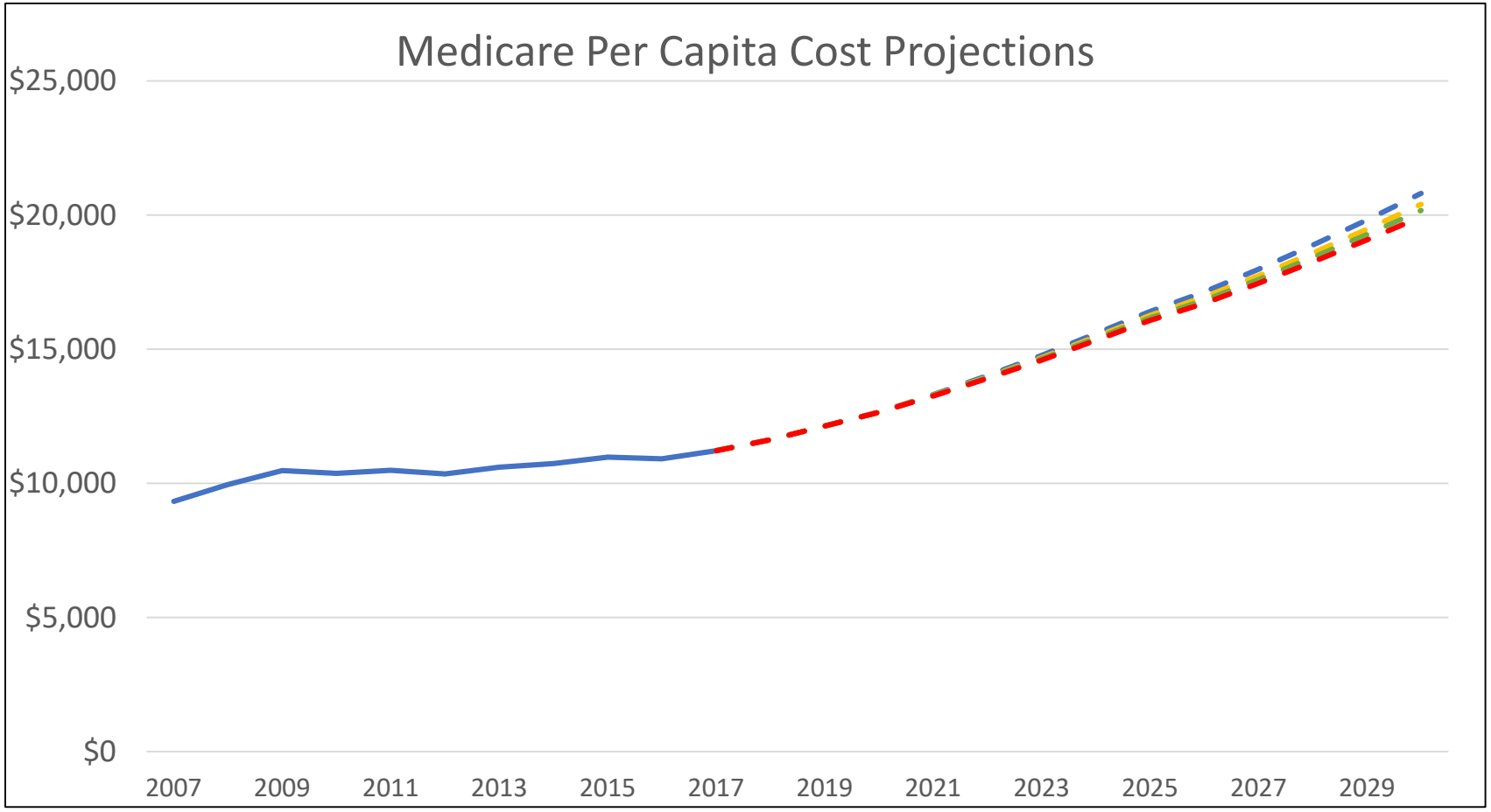
Traditional Shared Savings Arrangement



Savings from Community Health Improvements



Medicare Expenditure Savings



Preliminary analysis suggests that reducing the trend in obesity prevalence among the Medicare population (age 65+) over a 10-year period (2021 – 2030) could yield cumulative health care cost savings of **$1 to $3 billion**.

Reform Goals Require Engagement Across Payers and Providers

Medicare Multi-Payer Demonstration

- SIM was designed to transform health care delivery across government and commercial payers

- In Maryland, Vermont, and Pennsylvania, negotiated agreements with CMS have enabled Medicare investment and participation in model reforms.

- These demonstrations typically:
  - Define how Medicare will invest in the model
  - Constrain Medicare growth compared to a defined baseline
  - Achieve statewide cost growth reductions compared to a defined baseline

- OHS has begun preliminary discussions with CMS about engaging Medicare in our reform efforts
  - CMS has been receptive to the concept of finding unique ways to reward prevention

End